

ONTARIO WORKS IN PEEL



SCHEDULE OF EMERGENCY DENTAL/DENTURE SERVICES and FEES

Mandatory Dental Plan for Dependent Children under 18
Adult Emergency Discretionary Dental/Denture Plan

Revised June 2009

TABLE OF CONTENTS

ADULT EMERGENCY DISCRETIONARY DENTAL AND DENTURE PLAN.....3

 Who administers the plan on behalf of Ontario Works?3

 The Adult Emergency Discretionary Dental Plan.....3

 Who is covered for adult emergency discretionary dental services?3

 Who is covered for denture services?3

MANDATORY DENTAL PLAN (CHILDREN UNDER 18)4

 Who is covered for mandatory dental services?.....4

INFORMATION REQUIRED BY A DENTAL/DENTURE PROVIDER5

 What should the dental provider do5

CLAIMS FOR DENTURES.....6

 Submitting a Claim:6

PLAN DESCRIPTIONS7

MANDATORY DENTAL PLAN - POLICY #51607.....7

ADULT EMERGENCY DISCRETIONARY DENTAL PLAN - POLICY #51616.....7

 Coverage Verification7

 Fee Schedule8

 Reimbursement Level8

EXTENUATING CIRCUMSTANCES.....9

 Princess Margaret Hospital9

CLAIMS SUBMISSIONS.....10

RECONSIDERATION FOR CLAIMS DENIED BY GREAT WEST LIFE.....10

Inquiries11

ADULT EMERGENCY DISCRETIONARY DENTURE PLAN - POLICY #5161613

 Benefit Provision13

 Coverage Verification13

 Pre-treatment Plan13

 Fee Schedule13

 Coverage Provision13

 Reimbursement Level14

CLAIMS SUBMISSIONS.....14

RECONSIDERATION FOR CLAIMS DENIED BY GREAT WEST LIFE.....15

Inquiries16

APPENDIX I - Schedule of Covered Adult Emergency Dental Procedures.....18

APPENDIX II - Schedule of Covered Denture Procedures23

ADULT EMERGENCY DISCRETIONARY DENTAL AND DENTURE PLAN

Who administers the plan on behalf of Ontario Works?

Great West Life Assurance Company (GWL) administers the mandatory and adult emergency discretionary dental/denture plan on behalf of Ontario Works. Dental providers requesting information regarding client eligibility or coverage should contact Great West Life directly at (416) 440-1348.

The Adult Emergency Discretionary Dental Plan

Coverage under this plan is for Emergency Services only. Emergency services are defined as immediate circumstances where the client appears in immediate suffering, requiring care and immediate appropriate treatment to correct the problem.

What services are covered under the discretionary dental/denture services?

Services and fees are listed in the Ontario Works schedule of dental services and fee guide (Appendix I) and denture services and fees are listed in (Appendix II). Refer to the schedule of services and fee guide to determine which dental/denture procedures are covered and the amounts that will be paid for the procedure.

Who is covered for adult emergency discretionary dental services?

The following Ontario Works clients are covered for adult emergency dental services:

- An applicant/head of household who is receiving Ontario Works assistance; and
- Their spouse; and/or
- Their dependent children who are 18 years of age and older; or
- An 18 year old youth receiving assistance in their own right; or
- Dependent adults 18 years of age or older receiving Ontario Works assistance and whose parents are receiving assistance from the Ontario Disability Support Program (ODSP).

Who is covered for denture services?

The following Ontario Works clients are covered for denture services:

- An applicant/head of household who is receiving Ontario Works assistance; and
- Their spouse; and/or
- Their dependent children who are 18 years of age and older; or
- An 18 year old youth receiving assistance in their own right; or
- Dependent adults 18 years of age or older who are receiving Ontario Works assistance and whose parents are receiving assistance from ODSP; and
- ODSP recipients; and their spouse.

What policy plan # do I use?

Ontario Works policy plan number for adult emergency dental/denture services and denture services for ODSP recipients is **#51616**. This policy plan number is used when:

- The client resides in Peel; and
- Is receiving Ontario Works or ODSP assistance in the Region of Peel.

MANDATORY DENTAL PLAN (CHILDREN UNDER 18)

The Mandatory Dental Care Plan

Coverage for services is listed in the Ministry of Community and Social Services (MCSS) Schedule of Dental Services and Fees. This guide is distributed to dentists across Ontario.

Who is covered for mandatory dental services?

The following Ontario Works clients are covered for mandatory dental services:

- Dependent children (under the age of 18) of eligible Ontario Works clients; or
- Children in Temporary care; or
- A youth 16 or 17 years of age eligible for Ontario Works in their own right; or
- An 18 year old in the month of their 18th birthday.

The 1st month following a youth's 18th birthday they are eligible for dental services under the Ontario Works adult emergency discretionary dental plan.

What services are covered under the Mandatory Dental Care Plan?

Services and fees are listed in the MCSS Schedule of dental services and fees guide. Refer to the MCSS schedule of services and fee guide to determine which procedures are covered and the amounts that will be paid for the procedure. Service providers who require a copy of the guide should contact MCSS's plan administrator, Accerta at 1-800-505-7430 or (416) 922-6565.

What policy plan # do I use?

Ontario Works in the Region of Peel policy plan number for the mandatory dental services program is **#51607**. This policy plan number is used when:

- The client resides in Peel; and
- Is receiving Ontario Works assistance in Peel.

INFORMATION REQUIRED BY A DENTAL/DENTURE PROVIDER

What should the dental provider do when an Ontario Works client and/or their dependent is seeking dental care?

For adult Ontario Works and eligible ODSP clients service providers should:

- Refer to the Ontario Works Schedule of dental/denture services and fee guide (Appendix I) and (Appendix II) to determine what procedures are covered and the amounts covered for the procedure.

For children under the age of 18 service providers should:

- Refer to the MCSS Schedule of dental services and fee guide to determine what procedures are covered and the amounts covered for the procedure.

The dental provider must have the following information:

- A copy of the client's **Statement of Assistance** for the current month;
- The applicant/head of household's **9 digit Member ID#** which is indicated on the Statement of Assistance;
- The Statement of Assistance in the period covered box must reflect the dates of the current month e.g. 010706 to 310706;
- The applicant/head of household's first and last name and their date of birth;
- The name and date of birth of the family member/patient who received treatment;
- The patient's relationship to the applicant/head of household; and
- A completed Great West Life dental claim form signed by the client which must be received by Great West Life within 90 days of services being rendered.

What to do if the client does not have their Statement of Assistance:

The dental provider must ensure they have the following information:

- The applicant/head of household's **9 digit Member ID #**;
- The applicant/head of household's first and last name;
- Their date of birth;
- The first/last name and date of birth of the family member who received treatment;
- Their relationship to the applicant/head of household; and
- Contact and verify with Great West Life that the client is currently eligible for assistance.

What should the dental provider do if the client only has their Drug Benefit Eligibility Card.

The dental provider must ensure they have the following information:

- The applicant/head of household's **9 digit Member ID #**;
- The client's first and last name;
- Their date of birth;
- The name and date of birth of the family member who received treatment;
- Their relationship to the applicant/head of household; and
- A copy of the client's Drug Benefit Eligibility Card for the current month.

CLAIMS FOR DENTURES

The dentist/denturist must complete the following:

- Contact Great West Life for a Verification # prior to submitting an estimate for denture services;
- Great West Life will verify if they have a current file set up for the patient (a verification # is not an approval for the services required);
- A pre-determination and authorization of treatment is required for any denture services; and
- The provider must wait for written approval prior to commencing any treatment.

Submitting a Claim:

Service providers must:

- Submit their claim by mail using the Regional Municipality of Peel Mandatory and Discretionary dental/denture benefits claim form; and
- Ensure their claims are received by Great West Life within 90 days of services being rendered.

Requests for appeal of a claim declined beyond the 90-day submission period must be submitted to Great West Life in writing providing the reasons for the extension.

Providers should not be requesting the client pay upfront as Great West Life will not reimburse a client directly.

Claims must be mailed to: The Great West Life Assurance Company
P.O. Box 4076, Station A
Toronto, Ontario
M5W 3A3

PLAN DESCRIPTIONS

MANDATORY DENTAL PLAN - POLICY #51607

Ontario Works mandatory dental care procedures, restrictions and fees are outlined in the MCSS's Schedule of Dental Services and Fees. The Plan Administrator (Great West Life Assurance Company) will only reimburse dental providers based on the MCSS Schedule of Services and Fees and are restricted to the services and fees listed in the MCSS's Schedule of Dental Services and Fees.

Benefit Provision

If the client requires dental services, which are **not** authorized by the MCSS Schedule of Services and Fees, or fees exceed the maximums as outlined in the schedule the dentist may proceed with work only if the client agrees to pay directly for services not covered or the difference in cost for services covered.

Co-ordination of Benefits: For Ontario Works mandatory dental care co-ordination of benefits procedures, all dental office providers are to follow the MCSS's restrictions and fees as outlined in the MCSS's Schedule of Dental Services and Fees.

ADULT EMERGENCY DISCRETIONARY DENTAL PLAN - POLICY #51616

Coverage is for Emergency Services only as described on page 3.

Benefit Provision

Coverage is provided for the services listed in the Ontario Works in Peel Schedule of Emergency Dental/Denture Services and Fees (Appendix I) when they are required as a result of a dental emergency.

If the client requires dental services, which are **not** authorized by the Ontario Works in Peel's Schedule of Services and Fees, or fees exceed the maximums as outlined in the Fee Schedule the dentist may proceed with work only if the client agrees to pay directly for services not covered or the difference in cost for services covered.

Coverage Verification

Coverage is provided for emergency services only and is strictly limited to the services described in the section entitled "Schedule of Covered Adult Emergency Dental Procedures" (Appendix I). By referring to this section, it can be determined whether or not the services will be covered. If the procedure code is not listed, then the code is not a covered service and no benefits will be paid.

If the client requires dental services, which are **not** authorized by this program, the dentist may proceed with work only if the client agrees to pay directly for these services. **Ongoing treatment and/or maintenance treatment are not considered emergency services.**

Providers should not be requesting the client pay upfront as Great West Life will not reimburse a client directly.

Should treatment continue over a period of more than one month, verification of eligibility from GWL must be obtained for each subsequent month.

Fee Schedule

Coverage Provision: Ontario Works Fee Schedule as outlined in the Schedule of Covered Adult Emergency Dental Procedures (Appendix I), is limited to the listed fees. Any other procedures required that are not considered emergency services will be at the cost to the client.

Great West Life Assurance Company does NOT approve or verify payment by phone, as the fee schedule is procedure specific.

Reimbursement Level

Coverage Provision: 100% as per the Ontario Works in Peel's Fee Schedule. Any other procedures required that are not considered emergency services will be at the cost to the client.

Co-ordination of Benefits: Claims for services performed for patients who have dental benefits under a private dental plan, contract or insurance policy, must be submitted through the private plan first. All dental offices must first request payment through the private plan. Ontario Works coverage is the second payor if the amount paid by the first payor is less than this schedule, or if the first payor declines payment, benefits may be co-ordinated through this plan.

EXTENUATING CIRCUMSTANCES

The following applies to those eligible under the Mandatory Dental and Adult Emergency Discretionary Dental/Denture Plans.

Ontario Works will consider coverage required due to extenuating medical situations deemed a medical necessity. Written medical rationale substantiating the requirement must be submitted to Great West Life for “consideration”.

Examples of extenuating medical circumstances are but not limited to the following:

- Diabetes;
- Developmental disabilities (such as Down Syndrome);
- HIV/AIDS;
- Radiation of head/ neck;
- Pre dental treatment prior to heart surgery;
- Other illnesses that directly impact on the oral health of a client.

Princess Margaret Hospital

Ontario Works has entered into an agreement with Princess Margaret Hospital, Department of Dentistry, approving complete oral examinations, cleaning and fluoride trays for patients receiving chemotherapy, radiation or bone marrow transplant for their cancer treatment.

Effective Date of Coverage

Coverage takes effect on the date the person became eligible to receive Ontario Works assistance.

Termination of Coverage

Coverage for a client terminates on the earlier of the following dates:

1. The date this program terminates; and
2. The last day of the month in which the Ontario Works benefits cease.

Coverage for the mandatory dental plan ceases:

1. The 1st month after a dependents 18th birthday.

CLAIMS SUBMISSIONS

All claims for discretionary dental procedures are to be submitted to Great West Life on a Regional Municipality of Peel Mandatory and Discretionary claim form. **A supply of the Region of Peel's Dental Claim forms can be obtained by contacting Great West Life at (416) 440-1348.**

This claim form has been customized to include the group policy number. The client's information must be completed in its entirety. Once the claim form has been completed with both the dentist's signature and the signature of the client, spouse, guardian and/or dependent child 18 years of age or older the form can be sent to Great West Life Assurance Company for payment.

In all cases, benefits will be paid to the provider of service, not to the client. In order for dental providers to receive payment, the client who requires the service must sign the claim form. The signature of the client, spouse, guardian and or dependent child 18 and over who is an eligible member in the benefit unit is an acknowledgement of services rendered.

IMPORTANT:

- **Claims must be received by Great West Life Assurance Company within 90 days of the services being rendered; otherwise it cannot be guaranteed that benefits will be considered.**
- **If a code is listed on a claim form that does not appear in the schedule, the service provider will not be reimbursed.**
- **Corrections to codes after they have been submitted to Great West Life will not be accepted.**
- **Great West Life will not approve or verify payment over the phone.**
- **Claim forms not completed correctly will be returned to the service provider and must be re-submitted and received by Great West Life within the 90-day time limit.**
- **Requests for appeal of a claim declined beyond the 90-day submission period must be submitted to Great West Life in writing providing the reasons for the extension.**

RECONSIDERATION FOR CLAIMS DENIED BY GREAT WEST LIFE

If a claim has been denied by Great West Life a dental provider may submit a request to Ontario Works for reconsideration of the claim. The dental provider must submit the following:

- Reasons for reconsideration;
- The Claimant's Explanation of Benefits/Denial letter from Great West Life;
- Applicant's member ID#, applicant's name, patient's member ID# and name; and
- Dental provider's name, phone #, and address.

Requests for reconsideration of claims denied by Great West Life may be granted on a case by case basis. **Requests for payments because of the difference in costs paid by Great West Life and the actual cost charged by the dental provider will not be considered.**

Requests for reconsideration must be submitted to:

Integrated Business Support – Dental Claim

10 Peel Centre Dr., Suite B
PO Box 2604, STN B
Brampton, Ontario
L6T 0E4

Once a decision to deny a claim has been made by Ontario Works in Peel, the decision is final.

Inquiries

All inquiries should be directed to GWL prior to contacting Ontario Works. Please contact Great West Life at (416) 440-1348 or by mail:

The Great West Life Assurance Company
P.O. Box 4076
Station A
Toronto, Ontario
M5W 3A3

Service providers may also direct their inquiries to Ontario Works via email at: ZZG-OW Dental-Vision Request@peelregion.ca or to speak to someone directly call extension (905) 793-9200 ext 8453.

Inquiries should include the following information:

- 9 digit Member ID# of the applicant and their first and last name;
- The name of the person who required the dental work;
- The name of the dental provider and their phone #; and
- The reasons for the inquiry.

A copy of this plan can be accessed on the Region of Peel's website at <http://www.peelregion.ca/ow/index.htm>

General Limitations

This program is for all eligible claims incurred on or after August 1, 1999.

1. No other procedures other than what is outlined in the Schedule of Covered Dental/Denture Procedures and Fees will be accepted.
2. Dentists/denturists will be reimbursed on an individual dentist basis for frequency limitation services. The Region of Peel will be applying same dentist to include same dental office.
3. Acceptance of client for service is acceptance of fees for procedures as outlined in the Region of Peel's Fee Schedule of Covered Dental/Denture guide.

No benefits will be paid for:

1. Expenses that are prohibited from coverage by law.
 2. Services that are not listed in the Schedule of Covered Dental Procedures (Appendix I).
 3. Services that are listed in the Schedule of Covered Dental Procedures (Appendix I) rendered in a non-emergency situation.
 4. Expenses arising from war, insurrection or voluntary participation in a riot.
-

Copyright

“The fees for service in the Dental Schedule for the Dental Plan have been established by the Regional Municipality of Peel. The Canadian Dental Association is the owner of the copyright and other intellectual property rights to the USC&LS and the Ontario Dental Association is the owner of the copyright and other intellectual property rights in the selection and arrangement of the dental procedure codes and descriptors in the Dental Schedule.”

ADULT EMERGENCY DISCRETIONARY DENTURE PLAN - POLICY #51616

Benefit Provision

Coverage is provided for the services listed in the Ontario Works Schedule of Covered Denture Procedures (Appendix II) and benefits are limited to the amount indicated for each service.

Coverage Verification

Pre-determination and authorization of the treatment is required under the Denture Service Program.

Coverage is provided for dentures, denture repairs and relines and is strictly limited to the services described in the Ontario Works Schedule of Covered Denture Procedures (Appendix II). If the service is not listed in this section, it is **not** a covered service and no benefits will be paid. Treatment should not commence prior to written approval from Great West Life or burden of cost will be to the providers.

If the client requires denture services, which are not authorized by this program, the dentist/denturist may proceed with work only if the client agrees to pay directly for these services.

Pre-treatment Plan

Service providers may wish to include the following information to expedite processing of the pre-treatment plan:

- The international tooth code numbers for all missing teeth, circling those being replaced by the proposed denture;
- The date(s) of extraction(s), if known, of the teeth being replaced by the proposed denture;
- Indicate if the proposed denture(s) is an initial appliance(s) or replacement appliance(s);
- The age, type and condition of the existing appliance; and
- Restorative treatment necessary to place proposed denture(s) for eligible Ontario Works clients only.

Fee Schedule

Coverage Provision: The Ontario Works fee schedule, as outlined in the Schedule of Covered Denture Procedures (Appendix II), is limited to the listed fees. Lab fees required for the placement, repair, addition or reline of the denture are included in the fees listed.

Great West Life Assurance Company does NOT approve or verify payment by phone as the fee schedule is procedure specific.

Reimbursement Level

Coverage Provision: 100% as per the Ontario Works in Peel Schedule of covered Denture Procedures (Appendix II). **Any other procedures required not covered by the plan will be at the cost to the client.**

Co-ordination of Benefits: Claims for services performed for patients who have dental benefits under a private dental plan, contract or insurance policy, must be submitted through the private plan first. All dental/denturist offices must first request payment through the private plan. Ontario Works coverage is the second payor if the amount paid by the first payor is less than this schedule, or if the first payor declines payment, benefits may be co-ordinated through this plan.

Effective Date of Coverage

Coverage takes effect on the date the person became eligible to receive Ontario Works assistance.

Termination of Coverage

Coverage for a client terminates on the earlier of the following dates:

1. The date this program terminates; and
2. The last day of the month in which the Ontario Works or ODSP benefits cease.

CLAIMS SUBMISSIONS

All claims for discretionary denture procedures are to be submitted to Great West Life on a Regional Municipality of Peel Mandatory and Discretionary claim form. **A supply of the Region of Peel's Dental Claim forms can be obtained by contacting Great West Life at (416) 440-1348.**

This claim form has been customized to include the group policy number. The client's information must be completed in its entirety. Once the claim form has been completed with both the dentist's signature and the signature of the client, spouse, guardian and/or dependent child 18 years of age or older the form can be sent to Great West Life Assurance Company for payment.

In all cases, benefits will be paid to the provider of service, not to the client. In order for dental providers to receive payment, the client who requires the service must sign the claim form. The signature of the client, spouse, guardian and or dependent child 18 and over who is an eligible member in the benefit unit is an acknowledgement of services rendered.

IMPORTANT:

- **Claims must be received by Great West Life Assurance Company within 90 days of the services being rendered; otherwise it cannot be guaranteed that benefits will be considered.**
- **If a code is listed on a claim form that does not appear in the schedule, the service provider will not be reimbursed.**
- **Corrections to codes after they have been submitted to Great West Life will not be accepted.**
- **Great West Life will not approve or verify payment over the phone.**
- **Claim forms not completed correctly will be returned to the service provider and must be re-submitted and received by Great West Life within the 90-day time limit.**
- **Requests for appeal of a claim declined beyond the 90-day submission period must be submitted to Great West Life in writing providing the reasons for the extension.**

RECONSIDERATION FOR CLAIMS DENIED BY GREAT WEST LIFE

If a claim has been denied by Great West Life a dental provider may submit a request to Ontario Works for reconsideration of the claim. The dental provider must submit the following:

- Reasons for reconsideration;
- The Claimant's Explanation of Benefits/Denial letter from Great West Life;
- Applicant's member ID#, applicant's name, patient's member ID# and name; and
- Dental provider's name, phone #, and address.

Requests for reconsideration of claims denied by Great West Life may be granted on a case by case basis. **Requests for payments because of the difference in costs paid by Great West Life and the actual cost charged by the denture provider will not be considered.**

Requests must be submitted to:

Integrated Business Support – Dental Claim

10 Peel Centre Dr., Suite B
PO Box 2604, STN B
Brampton, Ontario
L6T 0E4

Once a decision to deny a claim has been made by Ontario Works in Peel, the decision is final.

Should you require further information regarding the plan, please contact Great West Life at (416) 440-1348.

Please mail completed claim forms to:

The Great West Life Assurance Company
P.O. Box 4076
Station A
Toronto, Ontario
M5W 3A3

Inquiries

Inquiries regarding Ontario Works denture care services may be sent to:
ZZG-OW Dental-Vision Request@peelregion.ca or to speak to someone directly call
extension (905) 793-9200 ext 8453.

Inquiries should include the following information:

- 9 digit Member ID# of the applicant and their first and last name;
- The name of the person who required the dental work;
- The name of the dental provider and their phone #; and
- The reasons for the inquiry.

A copy of this plan can be accessed on the Region of Peel's website at
<http://www.peelregion.ca/ow/index.htm>

General Limitations

This program is for all eligible claims incurred on or after August 1, 1999.

1. No other procedures than what is outlined in the Schedule of Covered Dental/Denture Procedures and Fees will be accepted.
2. Dentist/denturists will be reimbursed on an individual dentist basis for frequency limitation services. We will be applying same dentist/denturists to include same Dental Office.
3. Acceptance of client for service is acceptance of fees for procedures as outlined in the Region of Peel's Fee Schedule of Covered Dental/Denture guide.

No benefits will be paid for:

1. Expenses that are prohibited from coverage by law.
 2. Services that are not listed in the Schedule of Covered Denture Procedures (Appendix II).
 3. Expenses arising from war, insurrection or voluntary participation in a riot.
-

Copyright

“The fees for service in the Dental/Denture Schedule for the Dental/Denture Plan have been established by the Regional Municipality of Peel. The Canadian Dental Association is the owner of the copyright and other intellectual property rights to the USC&LS and the Ontario Dental Association is the owner of the copyright and other intellectual property rights in the selection and arrangement of the dental procedure codes and descriptors in the Dental Schedule.”

BENEFIT PROVISION – DC

APPENDIX I - Schedule of Covered Adult Emergency Dental Procedures

The specialist fee is paid to licensed specialists for services performed within their specialty, when patients are referred to a specialist by a general dentist.

<u>CODE</u>	<u>SERVICE</u>	<u>GP</u>	<u>FEE</u>	<u>SPECIALIST</u>
Diagnostic:				
01204	Specific examination	\$ 18.93		\$ 22.73
01205	Emergency examination	\$ 18.93		\$ 22.73
Coverage is limited to one time unit (15 minute interval) only:				
Radiographs:				
02111	Single periapical	\$ 13.30		\$ 15.96
02112	Two periapicals	\$ 16.27		\$ 19.53
02113	Three periapicals	\$ 20.04		\$ 24.05
02141	Single bitewing	\$ 13.30		\$ 15.96
02142	Two bitewings	\$ 16.27		\$ 19.53
02143	Three bitewings	\$ 20.15		\$ 22.18

Only 6 radiographs will be considered in 12 consecutive months

Tests:

Tests, histological, soft tissue

04311	Biopsy, by puncture + L*	\$ 37.87		\$ 45.44
04312	Biopsy, by incision + L*	\$ 37.87		\$ 45.44

Tests, histological, hard tissue

04321	Biopsy, by puncture + L*	\$ 88.36		\$ 106.03
04322	Biopsy, by incision + L*	\$ 88.33		\$ 106.03

The following lab codes below are eligible only in conjunction with codes 04311/04312/04321 04322. For all other procedures, lab costs are included in the procedure fees listed in this schedule.

A copy of the laboratory invoice or receipt of laboratory payment must be submitted with the claim form for Code 99111. The amount listed on the invoice will be paid in full. For 99333, please submit in-office laboratory expenses. Laboratory fees must appear immediately below the procedure codes(s) to which they apply.

99111* Commercial Lab Fee

99333 * In-office Lab Fee

APPENDIX I**BENEFIT PROVISIONS – DC****CODE SERVICE****FEE****GP****SPECIALIST****Restorative – Trauma Control:**

Trauma control, smoothing teeth

20111	First tooth	\$ 31.56	\$ 37.87
20119	Each additional tooth – same quadrant	\$ 31.56	\$ 37.87

Coverage is provided only when treatment is rendered within 30 days of an accident.

Restorative – Restorations:

No coverage is provided for surfaces re-treated within 2 years.

Amalgam Restorations

Non-bonded, permanent bicuspid and anteriors

21211	one surface	\$ 25.25	\$ 30.29
21212	two surfaces	\$ 55.29	\$ 66.34
21213	three surfaces	\$ 63.12	\$ 75.74
21214	four surfaces	\$ 75.74	\$ 90.88
21215	five surfaces or maximum surfaces per tooth	\$ 75.74	\$ 90.88

Non-bonded, permanent molars

21221	one surface	\$ 31.83	\$ 37.87
21222	two surfaces	\$ 63.12	\$ 75.74
21223	three surfaces	\$ 79.02	\$ 94.82
21224	four surfaces	\$ 79.02	\$ 94.82
21225	five surfaces or maximum surfaces per tooth	\$ 79.02	\$ 94.82

Bonded, permanent bicuspid and anteriors

21231	one surface	\$ 25.95	\$ 30.29
21232	two surfaces	\$ 55.29	\$ 66.34
21233	three surfaces	\$ 63.12	\$ 75.74
21234	four surfaces	\$ 75.74	\$ 90.88
21235	five surfaces or maximum surfaces per tooth	\$ 75.74	\$ 90.88

Bonded, permanent molars

21241	one surface	\$ 31.83	\$ 37.87
21242	two surfaces	\$ 68.12	\$ 75.74
21243	three surfaces	\$ 79.02	\$ 94.82
21244	four surfaces	\$ 79.02	\$ 94.82
21245	five surfaces or maximum surfaces per tooth	\$ 79.02	\$ 94.20

APPENDIX I**BENEFIT PROVISIONS – DC****CODE SERVICE****FEE****GP****SPECIALIST****Tooth-coloured Restorations**

Coverage is provided for permanent anteriors and bicuspid only.

Acid etch/non bonded technique; permanent anteriors

23101 one surface	\$ 44.18	\$ 53.02
23102 two surfaces	\$ 56.80	\$ 68.17
23103 three surfaces	\$ 86.85	\$104.20
23104 four surfaces	\$ 86.85	\$104.20
23105 five surfaces	\$ 97.20	\$116.63

Acid/bond technique; permanent anteriors

23111 one surface	\$ 50.49	\$ 60.59
23112 two surfaces	\$ 63.12	\$ 75.74
23113 three surfaces	\$ 94.67	\$113.61
23114 four surfaces	\$ 94.67	\$113.61
23115 five surfaces	\$106.03	\$127.24

Plastic with/without silver fillings; permanent posteriors

Non bonded permanent bicuspid

23211 one surface	\$ 44.17	\$ 53.02
23212 two surfaces	\$ 79.02	\$ 94.82
23213 three surfaces	\$ 86.85	\$104.20
23214 four surfaces	\$104.27	\$125.11
23215 five surfaces	\$104.27	\$125.11

Plastics with/without silver fillings; permanent posteriors

Non bonded permanent molars

23221 one surface	\$ 50.49	\$ 60.59
23222 two surfaces	\$ 86.85	\$104.20
23223 three surfaces	\$ 94.67	\$113.61
23224 four surfaces	\$113.61	\$136.32
23225 five surfaces	\$113.61	\$136.32

Acid etch/bond technique; permanent bicuspid

23311 one surface	\$ 50.49	\$ 60.59
23312 two surfaces	\$ 86.85	\$104.20
23313 three surfaces	\$ 94.67	\$113.61
23314 four surfaces	\$113.61	\$136.32
23315 five surfaces	\$113.61	\$136.32

APPENDIX I**BENEFIT PROVISIONS – DC**

CODE SERVICE	<u>FEE</u>	
	GP	SPECIALIST
Permanent posteriors – Bonded permanent molars		
23321 one surface	\$ 56.80	\$ 68.17
23322 two surfaces	\$ 94.67	\$113.61
23323 three surfaces	\$102.50	\$123.02
23324 four surfaces	\$123.20	\$147.84
23325 five surfaces	\$123.20	\$147.84

Endodontics – Pulpectomy

No coverage is provided for molar teeth.

Permanent anteriors and bicuspid		
32221 one canal	\$ 63.12	\$ 75.74

Endodontics – Root Canal Therapy:

Only 1 root canal procedure is payable per tooth. Coverage is limited to cases involving the following teeth: 13, 12, 11, 21, 22, 23, 33, 32, 31, 41, 42 and 43.

33111 one canal	\$ 252.45	\$252.45
-----------------	-----------	----------

If a pulpectomy was performed on the tooth by the same dentist in the last 3 months, the amount payable is reduced by the amount paid for the pulpectomy.

8. Surgical:

Removals; erupted teeth; uncomplicated		
71101 single tooth	\$ 37.87	\$ 45.44
71109 additional tooth, same quadrant	\$ 18.93	\$ 22.73
Removals, erupted teeth; complicated		
71201 single tooth	\$ 88.36	\$106.03
71209 additional tooth, same quadrant	\$ 88.36	\$106.03
Removal; impactions; soft tissue coverage		
72111 single tooth	\$ 88.36	\$106.03
72119 additional tooth, same quadrant	\$ 88.36	\$106.03

APPENDIX I**BENEFIT PROVISIONS – DC**

CODE SERVICE	<u>FEE</u>	
	GP	SPECIALIST
Removals; impactions; bone coverage - either removal of bone and tooth or sectioning and removal of tooth		
72221 single tooth	\$176.72	\$212.06
72229 additional tooth, same quadrant	\$176.72	\$212.06
Removals, impactions; bone covered, requiring sectioning - removal of bone and sectioning of tooth for removal		
72231 single tooth	\$201.96	\$242.35
72239 additional tooth, same quadrant	\$201.96	\$242.35
Removals; residual roots; soft tissue coverage		
72321 first tooth	\$ 75.74	\$ 90.89
72329 additional tooth, same quadrant	\$ 75.74	\$ 90.89
Removals; residual roots; bone tissue coverage		
72331 first tooth	\$ 88.36	\$106.03
72339 additional tooth, same quadrant	\$ 88.36	\$106.03
75112 Intraoral incision and drainage	\$ 38.08	\$ 38.08
9. Adjunctive Services:		
Conscious sedation; nitrous oxide and oxygen		
92411 one unit of time	\$ 16.92	\$ 20.31
92412 two units of time	\$ 29.55	\$ 35.45
92413 three units of time	\$ 42.19	\$ 50.62
92414 four units of time	\$ 54.80	\$ 65.76
92415 five units of time	\$ 67.44	\$ 80.94
92416 six units of time	\$ 80.07	\$ 96.09
92417 seven units of time	\$ 92.69	\$111.23
92418 eight units of time	\$105.33	\$126.38

APPENDIX II - Schedule of Covered Denture Procedures

CODE SERVICE	<u>FEE</u>	
	GP	SPECIALIST
1. Dentures:		
51103 Complete upper and lower dentures	\$685.33	\$685.33
51101 Complete upper denture	\$418.33	\$418.83
51102 Complete lower denture	\$533.04	\$533.04
52301 Partial upper denture*	\$304.59	\$304.59
52302 Partial lower denture*	\$320.65	\$320.65
52303 Partial upper and lower dentures*	\$573.73	\$573.23
53301 Complete upper and partial lower dentures	\$723.41	\$723.41
53302 Complete lower and partial upper dentures	\$723.41	\$723.41

No coverage is provided for replacement dentures provided within 5 years of a previous denture.

No coverage is provided for a replacement denture if a denture repair/addition or reline procedure was performed on the existing denture within the last 6 months.

No coverage is provided for complete or partial overdentures.

The amount payable for partial upper and lower dentures combined also applies when one of the dentures was inserted within the last 9 months.

2. Denture Repairs:

55101 Minor repair to existing upper denture	\$ 42.36	\$ 42.36
55102 Minor repair to existing lower denture	\$ 42.36	\$ 42.36

The maximum amount payable is \$88 every 12 months, for each denture.

3. Denture Repairs/Additions:

55301 Add 1 tooth	\$ 30.92	\$ 30.92
55302 Add 2 teeth or more	\$ 30.92	\$ 30.92
55401 Add 1 tooth and clasp	\$ 95.16	\$ 95.16
55402 Add 2 teeth or more and clasp	\$ 95.16	\$ 95.16

CODE SERVICE	<u>FEE</u>	
	GP	SPECIALIST
4. Denture Relines		
56211 Complete upper denture	\$126.92	\$126.92
56212 Complete lower denture	\$126.92	\$126.92
56221 Partial upper denture	\$126.92	\$126.92
56222 Partial lower denture	\$126.92	\$126.92

A denture reline is covered once every 36 months.

No coverage is provided for a reline provided within 3 months of the date the denture was inserted.

The fees shown include lab fees. For commercial or in-office lab fees shown separately, the maximum allowable fee is \$25.73.