DENTAL PLAN BOOKLET

Government of the Northwest Territories

Billing Division: 24943-24953, 24957, 24959, 24962-24970, 29308, 30113, 30114 & 31045

Effective Date: April 2013

WELCOME TO YOUR DENTAL BENEFIT PLAN

ABOUT THIS BOOKLET

This booklet contains important information you will need about your dental benefits with the **Government of the Northwest Territories**, your plan sponsor, available through the group contract with Green Shield. It includes:

- a Table of Contents, to allow easy and quick access to the information you are looking for
- a Schedule of Benefits, listing all the deductibles, co-pays and maximums that may impact the amount paid to you
- a Definitions section, to explain common terms used throughout the booklet
- detailed benefit descriptions for each benefit in your dental plan
- information you need to submit a claim

You are encouraged to read this booklet carefully; please keep it in a safe place so that you may refer to it when submitting claims.

You will receive Identification Card(s) showing your Green Shield Identification Number to be used on all claims and correspondence. Your number will appear on the front of the card and end in -00, while each of your dependents with their numbers will be shown on the back.

PLAN MEMBER ONLINE SERVICES

In addition to this booklet and Green Shield Customer Service Centre, Green Shield also provides you with access to their secure website. The website will answer those questions most often asked and give you online access to the following:

- A Benefit Plan Booklet
- Printer friendly personalized claim forms
- Benefit eligibility information, such as the date you are eligible for your next dental recall exam
- Explanation of Benefits information and claim history for you and your dependents
- Claim history for tax purposes or Co-ordination of Benefits
- Request your claim payments to be directly deposited into your bank account*
- And much more

Register online at greenshield.ca and see what our website can do for you!

***Please note** that once arrangements have been made for Direct Deposit, claim payments will be deposited directly into the bank account you have chosen. Statements will no longer be mailed to you but will be available for online viewing.

TABLE OF CONTENTS

DENTAL BENEFIT PLAN - 9D

This schedule describes the deductibles, co-pays and maximums that may be applicable if you are included in the Billing Division shown on the cover of this booklet.

Complete benefit details are provided in the Description of Benefits section of this booklet. Be sure to read these pages carefully. They show the conditions, limitations and exclusions that may apply to the benefits. All dollar maximums are based on paid Canadian dollars. You are covered for only those specific benefits for which you have applied.

Deductible:	$25 per covered person, $50 per family, annually beginning April 1st

Fee Guide:	The current Territorial Dental Association Fee Guide for General Practitioners in the territory where services are rendered

Your Plan Covers:	**Your Co-Pay:**	**Deductible Applies:**	**Maximum Plan Pays:**
Basic Services	0%	Yes	$1,500 per covered person per benefit year beginning April 1st (Basic, Comprehensive Basic and Major combined)
Comprehensive Basic Services ▪ Endodontics ▪ Periodontics	 0% 50%	Yes	
Major Services	50%	Yes	
Orthodontic Services	50%	No	$4,000 per covered person per lifetime, eligible only if ongoing treatment commenced by age 19

DEFINITIONS

Unless specifically stated otherwise, the following definitions will apply throughout this booklet.

Allowed amount means**,** as determined by Green Shield:

a) Dental – the territorial dental association fee guide for general practitioners as specified in the Schedule of Benefits.

Benefit Year means the 12 consecutive months April 1st to March 31st.

Calendar year means the 12 consecutive months January 1st to December 31st of each year.

For Dental Benefits

Co-pay is the eligible allowed amount that must be paid by you or your dependent before reimbursement of an expense will be made.

Covered person means the plan member who has been enrolled in the plan or his or her enrolled dependents.

Deductible is the amount that must be paid by or on behalf of you and your dependent in any benefit year before reimbursement of an eligible expense will be made.

Dependent means a person living with you who is:

a) your spouse (including common-law with whom you have lived for a continuous period of at least six months);
b) your child, step-child, adopted child, or foster child who is:
   - under 21 years old and dependant on you for support or is 21 years old or over and is dependent on you because of mental or physical illness.
c) A relative who is wholly dependent on you for support because of mental or physical illness.

Emergency means a sudden, unexpected occurrence (disease or injury) that requires immediate medical attention. This includes treatment (non-elective) for immediate relief of severe pain, suffering or disease that cannot be delayed until you or your dependent is medically able to return to your community of residence.

First paid claim means the actual date of service of the initial or a prior claim paid by Green Shield.

Injury means an unexpected or unforeseen event that occurs as a direct result of a violent, sudden and unexpected action from an outside source.

Plan member means you, when you are enrolled for coverage.

Reasonable and customary means in the opinion of Green Shield, the usual charge of the provider for the service or supply, in the absence of insurance, but not more than the prevailing charge in the area for a like service or supply.

Rendered amount means the amount charged by a provider for a service and submitted for payment of a claim.

ELIGIBILITY

For You
To be eligible for coverage, you must be:

a) a plan member who is a resident of Canada;

For your Dependents
To be eligible for coverage you must be:

a) covered under this plan;

Coverage Effective Date
Your coverage begins on the date you become eligible for coverage, have satisfied the eligibility requirements and you are enrolled under the plan.

You will be eligible for coverage on the first day following 6 months of continuous active employment.

Your dependent coverage will begin on the same date as your coverage.

Termination
Your coverage will end on the earliest of the following dates:

a) the date your employment ends;
b) the date the group contract terminates.

Dependent coverage will end on the earliest of the following dates:

a) the date your coverage terminates;
b) the date your dependent is no longer an eligible dependent;
c) the end of the month in which your dependent child attains the specified age limit;
d) the date the group contract terminates.

Dependent Children Continuation of Coverage
Any child whose coverage would end because they have reached the specified age limit may qualify for continued coverage, subject to the following conditions:

a) your child became dependent upon you by reason of a mental or physical disability prior to reaching this age; and
b) your child has been continuously so disabled since that time.

Group Conversion - PRISM CONTINUUM® Program
The PRISM CONTINUUM® Program offers three plans that are focused on providing coverage for you if you are leaving a company group plan.

This program may be your solution if you, your spouse or dependent children are losing, or have lost company group health benefits within the last 60 days and are looking for guaranteed coverage.

Call 416.601.0429 in the Toronto area or toll-free at 1.800.667.0429 for an information package or visit our website at greenshield.ca. Coverage is guaranteed if you apply within 60 days of losing your Green Shield group benefits.

DESCRIPTION OF BENEFITS

DENTAL BENEFIT PLAN

The benefits shown below will be eligible, if based on the licensed dental practitioner's reasonable and customary charge in accordance with the Fee Guide and the maximum shown in the Schedule of Benefits.

Basic Services

1. Basic Diagnostic and Preventive Services:
   - complete oral examinations once every 3 years
   - emergency and specific oral examinations
   - full series X-rays and panoramic X-rays once every 3 years
   - bitewing X-rays once every 12 months
   - recall examinations once every 9 months
   - cleaning of teeth (up to 1 unit of polishing plus up to 1 unit of scaling) once per recall period
   - topical application of fluoride once per recall period
   - denture cleaning once per recall period
   - pit and fissure sealants on permanent molars only, for dependent children 14 years of age and under
   - space maintainers

2. Basic Restorative Services:
   - amalgam, tooth coloured filling restorations, and temporary sedative fillings
   - inlay restorations – these are considered basic restorations and will be paid to the equivalent non-bonded amalgam

3. Basic oral surgery:
   - extractions of teeth and/or residual roots

4. Anaesthesia and intravenous sedation in conjunction with eligible oral surgery only

5. Standard denture services:
   - denture repairs and/or tooth/teeth additions
   - standard relining and rebasing of dentures
   - denture adjustments and remount and equilibration procedures, only after 3 months have elapsed from the installation of an initial or replacement denture
   - soft tissue conditioning linings for the gums to promote healing
   - remake of a partial denture using existing framework

6. Comprehensive oral surgery:
   - surgical exposure, repositioning, transplantation or enucleation of teeth
   - remodeling and recontouring - shaping or restructuring of bone or gum
   - excision - removal of cysts and tumors
   - incision - drainage and/or exploration of soft or hard tissue
   - fractures including the treatment of the dislocation and/or fracture of the lower or upper jaw and repair of soft tissue lacerations
   - maxilofacial deformities - frenectomy - surgery on the fold of the tissue connecting the lip to the gum or the tongue to the floor of the mouth

Comprehensive Basic Services

1. Endodontic treatment including:
   - root canal therapy
   - pulpotomy (removal of the pulp from the crown portion of the tooth)
   - pulpectomy (removal of the pulp from the crown and root portion of the tooth)
   - apexification (assistance of root tip closure)
   - apical curettage, root resections and retrograde fillings (cleaning and removing diseased tissue of the root tip)
   - root amputation and hemisection
   - bleaching of non-vital tooth/teeth
   - emergency procedures including opening or draining of the gum/tooth

2. Periodontal treatment of diseased bone and gums including:
   - periodontal scaling and/or root planing
   - occlusal equilibration - selective grinding of tooth surfaces to adjust a bite 8 time units every 12 months

   The fees for periodontal treatment are based on units of time (15 minutes per unit) and/or number of teeth in a surgical site in accordance with the General Practitioners Fee Guide.

   - bruxism appliance

Major Services

1. Standard onlays or crown restorations (paid to full metal on molar) to restore diseased or accidentally injured natural teeth, once every 5 years

2. Standard bridges, including pontics, abutment retainers/crowns (paid to full metal on molar) on natural teeth, once every 5 years

3. Standard dentures including complete, immediate, transitional, and partial dentures, once every 5 years

4. Standard repair or recementing of crowns, onlays and bridge work on natural teeth

Orthodontic Services

Reimbursement for orthodontic treatment to straighten teeth and correct the bite.

When a lump sum fee has been paid toward orthodontic treatment, the total amount of the claim will be split into equal portions to include the initial fee and a monthly fee and will be reimbursed over the duration of the treatment.

If orthodontic treatment is terminated for any reason before completion, the obligation to pay benefits will cease with payment to the date of termination. If such services are resumed, benefit for the remaining services, will be resumed. The benefit payment for orthodontic services will be only for the months that coverage is in force.

Alternate Treatment

The group benefit plan will reimburse the amount shown in the Fee Guide for the least expensive service or supply, provided that both courses of treatment are a benefit under the plan.

Predetermination

Before your treatment begins:

- for all proposed treatment for crowns, onlays and bridges, an estimate completed by your dental practitioner, **must** be submitted for assessment. Green Shields assessment of the proposed treatment, may result in a lesser benefit being payable or may result in benefits being denied. Failure to submit an estimate prior to beginning your treatment will result in the delay of the assessment.
- if the total cost of any other proposed treatment is expected to exceed $300, it is recommended that you submit an estimate completed by your dental practitioner.

Limitations

1. Laboratory services must be completed in conjunction with other services and will be limited to the co-pay of such services. Laboratory services that are in excess of 40% of the dentist's fee in the current General Practitioners Fee Guide will be reduced accordingly; co-pay is then applied;

2. Reimbursement will be made according to standard and/or basic services, supplies or treatment. Related expenses beyond the standard and/or basic services, supplies or treatment will remain your responsibility;

3. When more than one surgical procedure is performed during the same appointment in the same area of the mouth, only the most comprehensive procedure will be eligible for reimbursement;

4. Reimbursement will be pro-rated and reduced accordingly, when time spent by the dentist is less than the average time assigned to a dental service procedure code in the General Practitioners Fee Guide;

5. Reimbursement for root canal therapy will be limited to payment once only per tooth. The total fee for root canal includes all pulpotomies and pulpectomies performed on the same tooth;

6. Common surfaces on the same tooth/same day will be assessed as one surface. If individual surfaces are restored on the same tooth/same day, payment will be assessed according to the procedure code representing the combined surface. Payment will be limited to a maximum of 5 surfaces in any 36 month period;

7. The benefits payable for multiple restorative services in the same quadrant performed at one appointment may be reduced by 20% for all but the most costly service in the quadrant;

8. Core build-ups are eligible only for the purpose of retention and preservation of a tooth when performed with crown treatment. Necessity must be evident on mounted pre-treatment X-rays. Core build-ups to facilitate impression taking and/or block out undercuts are considered included in the cost of a crown;

9. Root planing is not eligible if done at the same time as gingival curettage;

10. In the event of a dental accident, claims should be submitted under the health benefits plan before submitting them under the dental plan.

Dental Exclusions

Eligible benefits do not include and reimbursement will not be made for:

1. Services or supplies received as a result of disease, illness or injury due to:
   a) intentionally self-inflicted injury while sane or insane;
   b) an act of war, declared or undeclared;
   c) participation in a riot or civil commotion; or
   d) committing a criminal offence;

2. Services or supplies provided while serving in the armed forces of any country;

3. Failure to keep a scheduled appointment with a legally qualified dental practitioner;

4. The completion of any claim forms and/or insurance reports;

5. Any dental service that is not contained in the procedure codes developed and maintained by the Canadian Dental Association, adopted by the provincial or territorial dental association of the province or territory in which the service is provided (or your province of residence if any dental service is provided outside Canada) and in effect at the time the service is provided;

6. Implants;

7. Restorations necessary for wear, acid erosion, vertical dimension and/or restoring occlusion;

8. Appliances related to treatment of myofacial pain syndrome including all diagnostic models, gnathological determinants, maintenance, adjustments, repairs and relines;

9. Posterior cantilever pontics/teeth and extra pontics/teeth to fill in diastemas/spaces;

10. Service and charges for sleep dentistry;

11. Diagnostic and/or intraoral repositioning appliances including maintenance, adjustments, repairs and relines related to treatment of temporomandibular joint dysfunction;

12. Any specific treatment or drug which:
    a) does not meet accepted standards of medical, dental or ophthalmic practice, including charges for services or supplies which are experimental in nature, or is not considered to be effective (either medically or from a cost perspective, based on Health Canada's approved indication for use);
    b) is an adjunctive drug prescribed in connection with any treatment or drug that is not an eligible service;
    c) will be administered in a hospital;
    d) is not dispensed by the pharmacist in accordance with the payment method shown under the Health Benefit Plan Prescription Drugs benefit;
    e) is not being used and/or administered in accordance with Health Canada's approved indication for use, even though such drug or procedure may customarily be used in the treatment of other illnesses or injuries;

13. Services or supplies that:
    a) are not recommended, provided by or approved by the attending legally qualified (in the opinion of Green Shield) medical practitioner or dental practitioner as permitted by law;
    b) are legally prohibited by the government from coverage;
    c) you are not obligated to pay for or for which no charge would be made in the absence of benefit coverage; or for which payment is made on your behalf by a not-for-profit prepayment association, insurance carrier, third party administrator, like agency or a party other than Green Shield, your plan sponsor or you;
    d) are provided by a health practitioner whose license by the relevant provincial regulatory and/or professional association has been suspended or revoked;
    e) are not provided by a designated provider of service in response to a prescription issued by a legally qualified health practitioner;
    f) are used solely for recreational or sporting activities and which are not medically necessary for regular activities;
    g) are primarily for cosmetic or aesthetic purposes, or are to correct congenital malformations;
    h) are provided by an immediate family member related to you by birth, adoption, or by marriage and/or a practitioner who normally resides in your home. An immediate family member includes a parent, spouse, child or sibling;
    i) are provided by your plan sponsor and/or a practitioner employed by your plan sponsor, other than as part of an employee assistance plan;
    j) are a replacement of lost, missing or stolen items, or items that are damaged due to negligence. Replacements are eligible when required due to natural wear, growth or relevant change in your medical condition but only when the equipment/prostheses cannot be adjusted or repaired at a lesser cost and the item is still medically required;
    k) are video instructional kits, informational manuals or pamphlets;
    l) are delivery and transportation charges;
    m) are a duplicate prosthetic device or appliance;
    n) are from any governmental agency which are obtained without cost by compliance with laws or regulations enacted by a federal, provincial, municipal or other governmental body;
    o) would normally be paid through any provincial health insurance plan, Workplace Safety and Insurance Board or tribunal, or any other government agency, or which would have been payable under such a plan had proper application for coverage been made, or had proper and timely claims submission been made;
    p) relates to treatment of injuries arising from a motor vehicle accident;
       Note: Payment of benefits for claims relating to automobile accidents for which coverage is available under a motor vehicle liability policy providing no-fault benefits will be considered only if–
       i) the service or supplies being claimed is not eligible; or
       ii) the financial commitment is complete;
       A letter from your automobile insurance carrier will be required;
    q) are cognitive or administrative services or other fees charged by a provider of service for services other than those directly relating to the delivery of the service or supply.

CLAIM INFORMATION

Inquiries

For detailed inquiries, contact your Benefits Administrator or contact Green Shield:

- Call Green Shield's Customer Service Centre at 1.888.711.1119 to determine eligibility for a specific item or service and Green Shield's pre-authorization requirements, or
- Visit their website at greenshield.ca to e-mail your question

Pre-authorization

For **pre-authorization** forward a pre-authorization form.

Submitting Claims

When submitting a claim to Green Shield, you must show the Green Shield Identification Number for the person who has received the benefit. You can find the applicable Green Shield Identification Number for yourself and each of your dependents listed on your Green Shield Identification Card. Original itemized paid receipts are required for claims reimbursement (cash receipts or credit card receipts alone are not acceptable as proof of payment).

For **claims reimbursement** forward an original itemized paid receipt **(cash receipts or credit card receipts alone are not acceptable)** including:

- Covered person's name, address and Green Shield Identification Number
- Provider's name and address
- Date of service
- Charges for each service or supply
- A detailed description of the service or supply

For dental claims, forward a dental claim form, completed by both the plan member and the dentist. If your claim is the result of an accident, a Dental Accident Report Form and your dental X-rays must be submitted to Green Shield for prior approval. Failure to comply may result in non-payment.

When Green Shield is identified as a secondary carrier, submit the original Explanation of Benefits statement from the primary carrier and a copy of the claim form in order to receive any balances owing.

All claims must be received by Green Shield no later than 12 months from the date the eligible benefit was incurred.

Submit all Claim Forms to:
Green Shield Canada

Attn: Dental Department	PO Box 1608	Windsor, ON	N9A 7G1

Reimbursement

Reimbursement will be made by one of the following methods:

a) Direct deposit to your personal bank account, when requested;
b) A reimbursement cheque; or
c) Direct payment to the provider of services, where applicable.

All maximums and limitations stated are in Canadian currency. Reimbursement will be made in Canadian or U.S. funds for both providers and plan members, based on the country of the payee.

Direct Payment to the Provider of Service (where applicable)

Present your Green Shield Identification Card to your provider and, after you pay any applicable co-payment, they may bill Green Shield directly and in many cases, payment will be made directly to your provider of service. Most providers will also have a supply of claim forms.

Subrogation

Green Shield retains the right of subrogation if benefits paid on behalf of you or your dependent are or should have been paid or provided by a third party liability. This means that Green Shield has the right to recover payment for reimbursement where you or your dependent receives reimbursement, in whole or in part, in respect of benefits or payments made or provided by Green Shield, from a third party or other coverage(s). In cases of third party liability, you must advise your lawyer of Green Shield subrogation rights.

Co-ordination of Benefits (COB)

If you are covered for dental benefits under more than one plan, your benefits under this plan will be coordinated with the other plan so that you may be reimbursed up to 100% of the eligible expense incurred.

Claims must be submitted to the primary payor first. Any unpaid balances should then be submitted to the secondary plan(s). Use the following guidelines to identify the primary and secondary plans:

Green Shield Plan Member

Green Shield coverage for you is always primary. If you are the plan member under two group plans, priority goes in the following order:

- The plan where you are a full-time plan member
- The plan where you are a part-time plan member
- The plan where you are a retiree

Spouse

If your spouse is a plan member under another benefit plan, this Green Shield coverage is always secondary. Your spouse must first submit claims to his/her benefit plan.

Children

When dependent children are covered under both your Green Shield plan and your spouse's benefit plan, use the following order to determine where to submit the claims:

- The plan of the parent whose birth date (month and day) occurs earliest in the calendar year
- The plan of the parent whose first name begins with the earlier letter of the alphabet, if the parents have the same birth date
- In cases of separation or divorce with multiple benefit plans for the children, the following order applies:
    - The benefit plan of the parent who has custody of the dependent child
    - The plan of the spouse of the parent who has custody of the dependent child
    - The plan of the parent who does not have custody of the dependent child
    - The plan of the spouse of the parent who does not have custody of the dependent child

    If the parents have joint custody and both have the children listed as dependents under their plans, claims should first be submitted to the plan of the parent whose birth date (month and day) occurs earliest in the calendar year. Balances can then be submitted to the other parent's plan.

PREFERRED PROVIDER VISION NETWORK ARRANGEMENT

As a Green Shield plan member, you have access to Green Shields national preferred provider vision network arrangement where all Green Shield plan members are eligible to receive a discount on eyewear and laser eye surgery.

Features of this great value-added service for either eyewear or laser eye surgery include:

1. Offer applies to any Green Shield plan member, regardless of whether you have Green Shield vision benefits or not;

2. The vision provider may bill Green Shield directly; the plan member just pays any portion of the expense not covered under their vision benefit;

3. Trustworthy retail chains with convenient locations;

4. The discount offer applies to everything such as all extra coatings, upgrades and accessories;

5. Hundreds of the latest frame styles to choose from plus the latest lens and coating technology;

6. Professional opticians to assist in selecting products;

7. For some vendors, this offer applies to non-disposable contact lenses only (excludes disposable contact lenses.

Visit our website at greenshield.ca or call our Customer Service Centre at 1.888.711.1119 for information on the vision providers.

How to Submit Your Vision Claim

1. Present your Green Shield Identification Card as proof of being a Green Shield plan member.

2. The vision provider will apply the appropriate discount(s) to your claim.

3. If no vision benefit exists, you pay your provider the full balance owing after the applicable discounts have been applied.

GREEN SHIELD'S COMMITMENT TO PRIVACY

The Green Shield Canada Privacy Code balances the privacy rights of our group and benefit plan members and their dependents, and our employees, with the legitimate information requirements to provide customer service. It consists of the following key principles:

1. **We ask for your personal information for the following purposes:**
   - To establish your identification
   - To provide you and/or your dependents with the applicable benefit coverage
   - To protect you and us from error and fraud
   - To provide ongoing access to other services at Green Shield

2. **Consent**
   When you enrolled in your group benefit plan as a plan member, your personal information was obtained and used only with your consent. Green Shield obtained your consent before they:
   - Provided benefit coverage
   - Offered you other Green Shield services
   - Obtained, used or disclosed to other persons, information about you unless we were obliged to do so by law or to protect our interests
   - Used your personal information in any way we did not tell you about previously

   Your consent can be either express or implied. Express consent can be verbal or written.

   Consent can be implied or inferred from certain actions. For our existing group and benefit plan members and their dependents, Green Shield will continue to use and disclose your personal information previously collected in accordance with their current privacy code, unless you inform them otherwise and will infer that consent has been obtained by your continued use.

3. **Withdrawal of Consent**
   You can withdraw your consent any time after you've given it to Green Shield, provided there are no legal or regulatory requirements to prevent this.

   If you don't consent to certain uses of personal information, or if you withdraw your consent, Green Shield will no longer be able to administer your benefit coverage. If so, Green Shield will explain the situation to you to help you with your decision.

   For further information on our privacy policies and procedures, please refer to the Green Shield website at greenshield.ca.