My **Dental** Benefit

Health Association Nova Scotia is a not-for-profit, non-government, membership-based association with over 60 years' experience in delivering shared services. Serving over 130 health and health-related organizations from across Nova Scotia, we are dedicated to achieving service excellence through innovation, outstanding performance, and an exceptional customer experience. One of our core service offerings is Group Benefits Solutions. We provide a range of comprehensive and cost-effective employee benefits plans, designed to help protect plan members and their families. We offer both mandatory and optional (voluntary) coverage. Your employer may offer all or some of the Health Association's benefits.

The Dental Plan is a 'Self-Insured' plan of Health Association Nova Scotia. A Provincial Group Benefits Advisory Committee comprised of equal Union and Employer representation from both health authority and continuing care sectors collaborate with Group Benefits Solutions.
Medavie Blue Cross provide Administration Services Only (ASO)

This is a summary of the Health Association Nova Scotia **Dental Plan.** For more detailed information, visit our website at www.healthassociation.ns.ca or contact your Benefits Administrator. In the event of a discrepancy between this publication and the contracts, the contracts will prevail.

ELIGIBILITY

Who is eligible?

If you have been hired as a **permanent employee** to work at least 40% of a regular work week, you are entitled to coverage for you, your spouse and dependents.

If you have been hired for a **term position** for a period of no less than 12 months, to work at least 40% of a regular work week, you are entitled to coverage for you, your spouse and dependents.

Your spouse is defined as someone to whom you are married legally or common law (defined as having lived with your partner for 12 months or more; the 12 month cohabitation period is waived in the event a child is born of such relationship). This includes a spouse of the same sex.

Your dependent child is defined as an employee's or spouse's child who:

- is either under age 21 or under age 26 and a full-time student at an accredited school, college, or university; and
- is unmarried (legally or common law); and
- is not employed on a full-time basis; and
- is not eligible for benefits as an employee under this or any other group plan.

A child who is incapable of employment due to a mental or physical condition that occurred before reaching the maximum age will continue to be covered if approved by the insurance company.

Note: Dependents between ages 21 and 26 have the same coverage and restrictions as adults and not the same as dependents under age 21.

If you meet the eligibility requirements you MUST participate in this benefit unless you have other group or association plan coverage.

When will coverage begin?

NSH and IWK employees: Dental Coverage starts the first of the pay period following the date of eligibility. If you are eligible on the first of the pay period, your coverage will start immediately.

All other employees: Dental Coverage starts on first of the month following the date you are eligible. If you are eligible on the first of the month, your coverage will start immediately.

If your employer offers this benefit you must enrol unless you have other group or association plan coverage. You must provide proof of coverage elsewhere or you will be enrolled with single coverage.

When will coverage end?

NSH and IWK employees: Coverage ceases when you are no longer eligible, or the end of the pay period that your employment ends, or retirement, whichever comes first.

All other employees: Coverage ceases when you are no longer eligible, or the end of the month that your employment ends, or retirement, whichever comes first.

COVERAGE

What is covered?

The Health Association's Dental plan covers dental services based on the amounts specified in the current Nova Scotia Dental Association Fee Schedule for general practitioner dentists. Specialist fees are not covered. The reimbursement you receive depends on the category of dental services:

- 100% coverage for Basic services
- 80% coverage for Major services
- 50% coverage for Orthodontic services

There is a maximum of $1,500 per person in each calendar year for Basic and Major services combined. There is a lifetime maximum of $2,000 per person for Orthodontic services.

All dental services must be performed in Canada.

Basic Dental Services

The Plan provides 100% coverage to a calendar year maximum of $1,500 per person for all Basic and Major services combined. This includes:

- Complete Oral Examination: Extensive exam including patient history, clinical examination and diagnosis of oral conditions. Limited to one in any 24 consecutive months.
- Recall Examination: Periodic examination to maintain oral health and diagnose oral conditions. Limited to one in any one calendar year for adults and two in any one calendar year for participants under age 21
- Complete Mouth X-rays or Panographic X-rays: Limited to one in any 24 consecutive months.
- Bite-Wing X-rays: Limited to four films in any one calendar year for adults and dependent children.
- Polishing and Fluoride Treatments: Limited to one in any 12 consecutive months for adults, and twice in any 12 consecutive months for dependent children..
- Scaling: Limited to two units in any one calendar year for adults, and two units twice in any one calendar year for dependent children. (a unit of time is based on increments of 15 minutes)
- Pit and Fissure Sealants: Dependent children only.
- Oral Surgery: Includes simple extractions and surgical extractions of teeth, removal of roots, surgical incision or excision and other oral surgical procedures including pre-operative and post-operative care.
- Minor Restorative: Includes sedative dressings, temporary restorations, amalgam acrylic, composite resin, silicate restorations and retentive pins.
- Adjunctive Dental Services: Includes emergency treatment not classified elsewhere in the Dental Fee Guide, conscious sedation (includes intravenous or nitrous oxide) and professional consultation.
- Anaesthesia is eligible provided it is being rendered in conjunction with other dental services.
- Mouth guards: Includes one mouth guard in a calendar year.
- Teeth Extractions: Extractions of any tooth are covered.

- Wisdom Teeth Extractions: The wisdom teeth extractions are covered. Specialist consult fees are not eligible. We strongly recommend the submission of a predetermination to confirm coverage and eligibility for wisdom teeth extraction, as this will include the specific procedure codes for the treatment.

Major Dental Services

The Plan provides 80% coverage to a calendar year maximum of $1,500 per person for all Basic and Major services combined. This includes:

- Periodontal Scaling, Preventive Scaling and Root Planing: Limited to 8 (15 minutes) time units (in combination with basic scaling) in 12 consecutive months. More frequent service may be considered on a case-by-case basis for severe periodontal conditions. A treatment plan (pre-determination) should be filled in and approved by the insurer before you have these services carried out.
- Relining or Rebasing of Dentures: Limited to once in any 36 consecutive months.
- Repair of Partial or Complete Dentures and Re-cementing of Crowns, Inlays and Onlays, and Bridgework: Covered.
- Major Restorative: Includes crowns and veneers, inlay and onlay restorations or gold fillings when teeth cannot be treated with other material. Replacements are covered only after five years from the initial placement, and the existing restoration cannot be made serviceable.
- Prosthodontics: Includes fixed bridgework, partial and complete dentures and surgical services associated with placement of prosthodontics listed in the dental fee schedule.
- Replacement of a Denture or Bridge: Covered after five years from the initial placement and the existing prosthodontic appliance cannot be made serviceable.
- Endodontic Services: Includes treatment of pulp chamber, root canal therapy, and periapical services.

Orthodontic Dental Services

The plan provides 50% coverage to a lifetime maximum of $2,000 per person. This includes, orthodontic appliances, orthodontic observations and adjustments.

Predetermination: A treatment plan is required for orthodontic claims.

Exclusions and Limitations

No payment will be made (or payment will be reduced) for:

- Services, treatment, articles or supplies that do not fall within the categories of Eligible Expenses listed in this benefit;
- Services, treatment or supplies covered by any government health care coverage or charges payable under a workers' compensation board/commission, automobile insurance bureau or other similar law or public plan;
- Dental care that was covered under any government health care coverage or charges payable under a workers' compensation board/commission, automobile insurance bureau or other similar law or public plan, when this benefit was issued but has since been modified, suspended or discontinued;
- Services, treatment or supplies the Participant receives free of charge;
- Charges that would not have been made if no coverage had existed;
- Anti-snoring or sleep apnea devices;
- Services rendered by a dental hygienist but not administered under the supervision of a dentist, except in provinces where such supervision is not legally required;
- Services, treatment or supplies that are:
  - not Medically Necessary (except for Preventive Care services);
  - for cosmetic purposes only; or
  - experimental or investigative;
- Services or expenses incurred as a result of:
  - insurrection, war (declared or not), the hostile action of the armed forces of any country or participation in any riot or civil commotion; or
  - participation in a criminal act or attempt to commit a criminal act, regardless of whether charges are laid or a conviction is obtained;

- Expenses incurred after the termination date of the Participant's coverage, even if a detailed treatment plan was submitted and accepted by Blue Cross before this date
- Splinting for periodontal reasons, where cast crowns, inlays or onlays are used for this purpose;
- Treatment related directly or indirectly to full mouth reconstruction, to correct vertical dimension or TMJ (temporomandibular joint)/myofascial pain dysfunction;
- Implants and related services;
- Extra supplies that are spares or alternates;
- Charges for missed appointments or for the completion of forms.

PLAN MEMBER RESOURCES

Plan Member Secure Website

The plan member website is a secure, user-friendly website that is available 24 hours a day, 7 days a week. The website provides additional information regarding your coverage and other useful options including:

- Coverage inquiry: Detailed information about your group benefits plan;
- Forms: Printable versions of Medavie Blue Cross forms;
- Requests for new identification cards;
- Addition/updating of banking information for direct deposit of claim payments;
- Member statements: view claims history for you and your Dependents;
- Record of payments: view transactions issued to yourself or the service provider;
- Submit claims electronically

To register for the plan member website, visit www.medaviebc.ca

Medavie Blue Cross Mobile App

Plan members can download the Mobile App for iOS and Android devices.

- Submit a claim just by taking a photo
- Use and share a mobile ID card
- Search benefit/coverage details
- View past claims
- Find a health professional near you

To download the mobile app, visit www.medaviebc.ca/app

CLAIMING

Blue Cross offers several convenient options to quickly and efficiently submit your benefit claims.

The claimant's insurance must be in force when treatment is rendered for benefits to be payable.

Dentist Direct Submit

Many dentists will bill Medavie Blue Cross directly and bill you for any remaining balance. However, in those instances where you do need to submit a claim, your dental professional should complete the Standard Dental Claim Form.

Provider eClaims

For Approved Providers who have registered to submit claims to Blue Cross through electronic claims submission service, e-claim service allows approved professionals to instantly submit claims at the time of service. This eliminates the need for you to submit your claim to Blue Cross and means you only pay the amount not covered under your group benefits plan (if any).

Member eClaims

You can quickly and easily submit your health, drug and dental claims (as applicable) through MBC secure plan member website. Simply take or scan a digital image of your paid-in-full receipts and submit it through the applicable link on the plan member website.

Mobile App

Filing a claim has never been quicker or easier! Submit your claims through the Medavie Mobile app and have your reimbursement deposited directly to your bank account.
Visit www.medaviebc.ca/app for more information or to download the app.

Medavie Benefits (kiosk)

Located in Scotia Square at 1894 Barrington Street
Check with Medavie Blue Cross for service hours.

- Chat with a Medavie Benefits Speciality
- Benefit/coverage inquiries
- Onsite assistance/support self service tools (mobile app, submit a claims)

In determining if an expense is covered, Medavie Blue Cross may require the following information:

- X-rays and a complete dental chart showing any extractions, fillings, or other work performed prior to the date of the incurred expenses for which claim is being made;
- Itemized bills from the dentist or other sources of services or treatments; and
- Laboratory or hospital reports, casts, molds or study models, or other similar evidence of the condition or treatment of the teeth or mouth.

Pre-determination of benefits:
To ensure a smooth claim process, we believe there is value in knowing the cost of planned treatment; therefore we do encourage you and your dentist to consider requesting a pre-determination of benefits.
When a proposed course of treatment is expected to cost more than $500, a treatment plan should be filed with Medavie Blue Cross before treatment begins. Medavie Blue Cross will advise you of the amount covered and you will share this with your dental professional. Dental charges over and above insurance benefits remain the responsibility of the claimant.

If your family has more than one plan, you can coordinate benefits.
Find more information by visiting www.healthassociation.ns.ca and check out Benefits Communication to view our benefits information sheets.

What if my spouse also has coverage?

Canadian insurance companies follow a process called Coordination of Benefits (CoB) when a plan member is covered under more than one health and/or dental plan. CoB ensures you receive the maximum benefit available from your policies. In fact, two policies can be combined to give you up to 100% reimbursement of eligible claims.

When you are covered under your plan and under a spouse's plan, here's how Coordination of Benefits works:

- Submit **your** expenses first to your benefits plan. You can then submit any unpaid portion of your claim to your spouse's plan.
- Submit **your spouse's** expenses first to your spouse's benefits plan. You can then submit any unpaid portion of your spouse's claim to your plan.
- If **your dependent children** are covered under your and your spouse's benefit plans, you must submit all their claims first to the benefit plan of the parent whose birth date falls earliest in the calendar year (the month, then day). Any remaining balance can then be reimbursed from the other plan. When parents are separated or divorced, the custodial parent claims under his or her plan first, then their spouse's plan (where applicable), then the plan of the parent without custody, and then their spouse's plan.
- When you submit a claim for an unpaid balance from another insurance company, you plan will need a copy of the receipt and a copy of the statement (Explanation of Benefits (E0B)) showing the portion of the claim paid by the other company. Although you have 18 months to claim under the HANS plan any remaining balances, your receipts should be submitted as soon as possible.

If you need help determining the order claims should be submitted, call the Medavie Blue Cross Customer Information Contact Centre toll-free at 1-800-667-4511. Alternatively, you can email your questions to inquiry@medavie.bluecross.ca

If you are covered by more than one plan, please call Health Association Nova Scotia toll-free at 1-866-886-7246 regarding any changes or updates to your Coordination of Benefits information.

CONTINUATION OF COVERAGE

What happens during a leave of absence?

If you take an approved paid leave of absence, you must continue coverage for up to 12 months

If you take an approved unpaid leave of absence, you may continue for up to 12 months. If you take an approved maternity or parental leave, you may continue for the duration of the leave. If you choose not to continue the benefit during your leave, coverage is reinstated on your return to work.

If you are approved for your employer sponsored Long Term Disability benefits, you may continue coverage. For cost sharing arrangements, please check your collective agreement or contact your employer for more details.

What happens If I lose coverage under another plan?

If you had opted-out of the dental plan because you were covered under another group plan, you MUST join the Health Association plan if you lose the other coverage. If you apply late, after 60 days, your coverage will be restricted to $125 for the first 12 months.

What happens to coverage if I die before retirement?

In the event of your death before retirement, your spouse and dependent children may continue their coverage for up to 24 months after your death. No premiums are required for this coverage.

What happens to my coverage when I retire?

There is no dental plan for Retirees. Dental Coverage ceases when you retire.

Can I convert my coverage?

You may choose to convert your coverage to an individual policy within 31 days of your coverage ending. To convert to a dental insurance plan, members can call Medavie Blue Cross toll-free at 1-800-873-2583. You can also visit their corporate website at https://www.medaviebc.ca/en/plans/moving-off-an-employers-plan

Questions?

If you have any questions about your benefits, talk to your Benefits Administrator (Employer) or contact Health Association Nova Scotia.

Group Benefits Solutions
Health Association Nova Scotia
2 Dartmouth Road, Bedford, Nova Scotia B4A 2K7
Toll-free: 1-866-886-7246

For more information, visit www.healthassociation.ns.ca and select the Benefits Plan Member Information button

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