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A Review of Dental Care Services for Adults in Receipt of Social Assistance in Ontario

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About this Report

Converge3 commissioned the Faculty of Dentistry at the University of Toronto to conduct a review of dental care services for adults in receipt of social assistance in Ontario. Converge3 receives funding from the Province of Ontario. The views expressed in this report are those of the authors and do not necessarily reflect those of Converge3 or the Province of Ontario.

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About Converge3

Converge3 is a policy research centre based in the Institute of Health Policy, Management and Evaluation at the University of Toronto that focuses on integrating health, economic and equity evidence to inform policy. The Centre is funded by the Province of Ontario and includes multiple partner organizations, including Li Ka Shing Knowledge Institute at St. Michael's Hospital, McMaster University, Ottawa Hospital Research Institute, ICES, Health Quality Ontario, Public Health Ontario, and the Ontario Ministry of Health.

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Executive Summary

This report was commissioned by Converge3 to address the following question: What is the status of dental care services offered to adults in receipt of social assistance in Ontario? As such, this report describes and compares the discretionary dental benefits that are available to Ontario Works (OW) recipients and their spouse who are 18 years of age or older (adults receiving OW) across Ontario municipalities. In addition, it examines where additional support with denture services are offered to adults receiving OW.

OW is a legislated social assistance program funded by the Ministry of Children, Community and Social Services (MCCSS) and is locally delivered across Ontario by 47 Consolidated Municipal Services Managers (CMSM) or District Services Administration Boards (DSAB). Dental care for adults receiving OW is classified as a "discretionary health benefit," meaning that the CMSM/DSAB (OW administrators) determine the level of health benefit and delivery as part of policy and budget processes of local municipal councils and administrative boards. It also means that the ability to support discretionary benefits is impacted by the financial capacity of the local community.

Over the last 30 years, how social assistance is funded has changed in Ontario. This change has resulted in shifts to funding and cost-sharing formulas and, in general terms, a reduction in dental care benefits for OW recipients towards "basic" and "emergency/urgent" care only. These reductions have also been coupled to restrictions on services (e.g. setting frequency limits and increasing preapprovals) and the gradual elimination of items such as dentures.

From a comparative perspective, programs and/or benefits vary considerably across the province in terms of:

- Transparency, or how readily accessible the information is to clients and providers
- Policy and process elements, or the broad administrative approach to providing and paying for client benefits
- Eligibility, or the broad considerations related to receipt of dental services
- Benefits, or the level of services offered such as "emergency dental plan," "basic dental plan," "denture plan," "relief of pain only," and/or whether contact with the OW administrator or case-worker is required
- Service plan details, or whether there is a readily accessible description or listing of the services that are covered or offered, and
- Pricing, or the differences in fees for the same services across programs and/or when compared to the MCCSS service schedule.

The current state of dental programs and/or benefits for adults receiving OW across the province is defined by substantial variation across all the parameters investigated, including how benefits are accessed, how they are administered, what services are included or excluded, what maximum annual limits apply, and the levels of reimbursement included. From a health equity perspective, such variation represents a target for health policy intervention.

Ultimately, policy questions for decision-makers include: Should these services remain discretionary or become mandatory? What outcomes are governments trying to achieve by funding such services? What ways of organizing, financing and delivering these services are necessary? What services should be funded and for what reasons? And what expertise is needed to deliver efficient and equitable dental care for adults receiving OW?

1.0 Introduction and Background

This report was commissioned by Converge3 to address the following question: What is the status of dental care services offered to adults in receipt of social assistance in Ontario? As such, this report describes and compares the discretionary dental benefits that are available to Ontario Works (OW) recipients and their spouse who are 18 years of age or older (adults receiving OW) across Ontario municipalities. In addition, it examines where additional support with denture services are offered to adults receiving OW, or recipients of the Ontario Disability Support Program (ODSP) and their dependents.[1]

OW is a legislated social assistance program funded by the Ministry of Children, Community and Social Services (MCCSS) and is locally delivered across Ontario by 47 Consolidated Municipal Services Managers (CMSM) or District Services Administration Boards (DSAB).

The OW program objectives are:

1. Provide financial assistance to those who are in need of help with basic items like food, shelter and clothing, as well as assistance with health benefits for the recipient and their dependents.
2. Provide employment assistance to help clients find, prepare and keep a job. This assistance may include: resume writing, interviewing, job counselling workshops, and job specific training to assist clients to improve their language skills or finish high school.
3. Provide emergency assistance for people who are in crisis or an emergency situation.

Ontarians are eligible for OW if they are living in a household that does not have sufficient financial resources to meet basic living expenses and if they are willing to make reasonable efforts to find, prepare for and keep a job (unless specific circumstances temporarily prevent doing so, such as an illness or caregiving responsibilities). To qualify for ODSP, an individual must be at least 18 years old, an Ontario resident, in financial need, and meet the program's definition of a person with a disability or be a member of a Prescribed Class.[2]

1.1 The Historical Perspective

Some historical perspective is useful for understanding the nature of dental benefits available to adults on social assistance in Ontario. Dental care for adults on OW is classified as a "discretionary health benefit," meaning that the CMSM/DSAB (OW administrators) determine the level of health benefit and delivery as part of policy and budget processes of local municipal councils and administrative boards. It also means that the ability to support discretionary benefits is impacted by the financial capacity of the local community. For these reasons, variation in adult dental services across jurisdictions is expected.

Ontario's approach to funding social assistance is unique in Canada wherein local property tax offsets a portion of the costs. Municipalities also deliver social assistance on behalf of the province. Importantly, how social assistance is funded has changed in Ontario across time.[3]

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[1] The MCCSS provides a basic dental plan to ODSP recipients and their dependents, which is centrally administered.

[2] As per MCCSS, "[p]rescribed classes are specific categories of people who do not have to go through the disability adjudication process to qualify for ODSP Income Support." See: Eligibility for ODSP Income Support. Available at: https://www.mcss.gov.on.ca/en/mcss/programs/social/odsp/income_support/IS_Eligibility.aspx

[3] See: Office of the Auditor General of Ontario. Annual Report 2018. Chapter 3. Section 3.11 Ontario Works (pp. 494-546). Toronto: Office of the Auditor General of Ontario, 2018; Association of Municipalities of Ontario (AMO). The 2008 Upload Agreement (Provincial-Municipal Fiscal and Service Delivery Review). Toronto: AMO, August 2017; Béland D, Daigneault PM, editors. Welfare reform in Canada: provincial social assistance in comparative perspective. University of Toronto Press; 2015 Sep 18; Munir S. Report of the Commission for the Review of Social Assistance in Ontario: Taking Stock Two Years Later. SPP Research Paper. 2015 Mar 31;8(8); Quiñonez C, Sherret L, Grootendorst P, Shim MS, Azarpazhooh A,

Prior to 1995, the province funded the full cost of monthly social assistance, 50% of "discretionary health benefits" (including dental), and 50% of the "cost of administration" for social assistance locally. After 1995, municipalities became responsible for 20% of the cost of monthly social assistance; however, the province increased the portion of discretionary benefits it would cost-share to 80%. Municipalities were able to leverage the cost-sharing with the province to attract additional provincial dollars (80 cent dollars) to their communities and therefore offer more services to those in need.

In 1996, the first funding caps on total expenditures for discretionary health benefits and changes to the cost of administration formulas were introduced by the province. The change in funding formulas created local financial shortfalls. As a result, several major jurisdictions, which offered a broad suite of basic dental care services, began adjusting their programs to provide "emergency dental care only" for adult social assistance recipients.

The changes in 1996 were a prelude to the 1998 major restructuring of social assistance into what is known today as OW and ODSP. As part of the changes to legislation, a greater emphasis on employment and training was added and a portion of the cost of social assistance was downloaded to the municipalities. This meant an increased portion of the property tax revenue funded monthly social assistance payments. Municipal administrators were also required to cover a portion (20%) of the monthly cost of ODSP (even though they did not deliver ODSP) and 20% of the health benefits for ODSP.

The year 2008 marked another significant transition, with the province agreeing to assume the cost of all social assistance over 10 years. In 2012, administration of OW was changed to a per case formula rather than the previous 50/50 cost sharing arrangement. OW administrators were also no longer required to cost-share discretionary benefits; however, the province introduced a per capita funding model for all discretionary health benefits at a flat rate of $10 per OW/ODSP recipient per fiscal year, based on its total expenditures in 2010. By fixing the amount per case, municipalities who were investing more than the flat rate under the 80/20 formula tended to receive less provincial funding for discretionary benefits than they were accustomed to, and those who invested less tended to receive more.

Overall, the changes described above have tended to reduce dental care benefits for OW recipients to "basic" or "emergency/urgent level." These reductions have also been coupled to restrictions on services (e.g. setting frequency limits and increasing preapprovals) and the gradual elimination of items such as dentures. Importantly, while specific social assistance dental care expenditures are not available, overall, publicly available information demonstrates variability in provincial government funded dental care expenditures based on the changes outlined above (Figure 1).

Locker D. An environmental scan of provincial/territorial dental public health programs. Ottawa: Office of the Chief Dental Officer, Health Canada, 2007; Herd D, Mitchell A, Lightman E. Rituals of degradation: Administration as policy in the Ontario Works Programme. Social Policy & Administration. 2005 Feb;39(1):65-79; Herd D. Rhetoric and retrenchment 'common sense' welfare reform in Ontario. Benefits. 2002 Jun 1;10(2):105-10; Graham KA, Phillips SD. "Who Does What" in Ontario: The process of provincial-municipal disentanglement. Canadian Public Administration. 1998 Jun;41(2):175-209; Morrison I, Pearce G. Under the axe: social assistance in Ontario in 1995. Journal of Law and Social Policy. 1995;11:1.

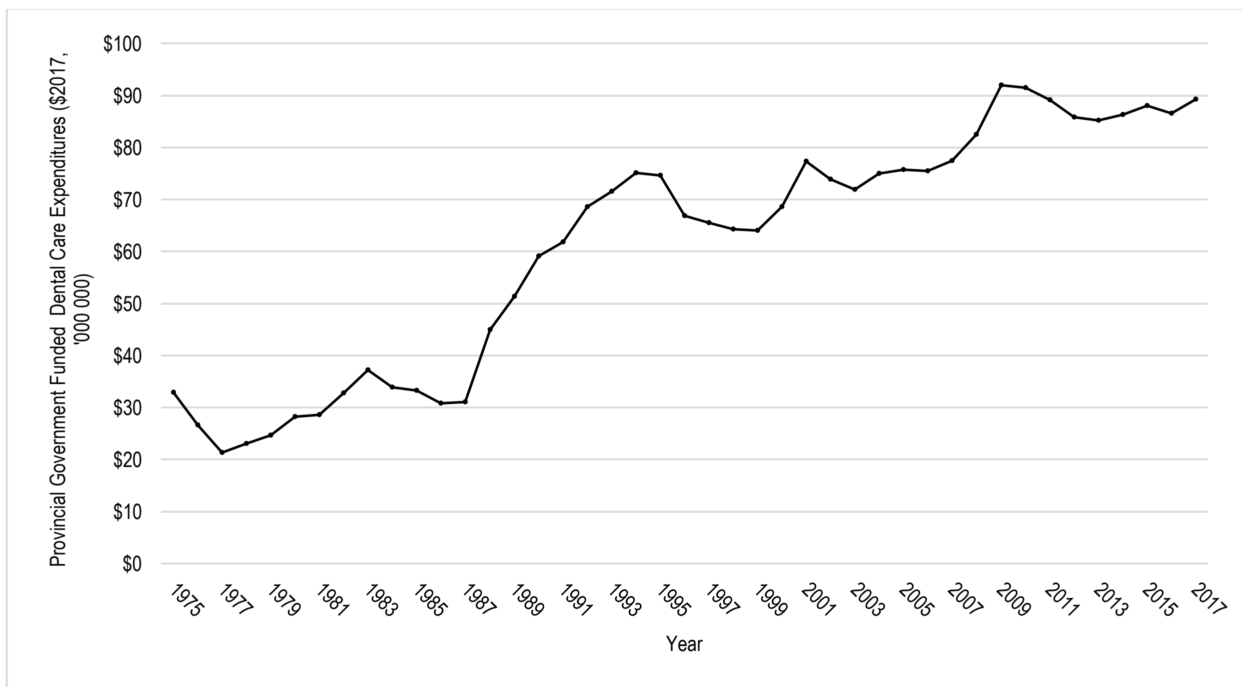

Figure 1. Provincial government funded dental care expenditures, Ontario, 1975 to 2017 ($2017, '000 000). Source: National Health Expenditure Database, Canadian Institute for Health Information

2.0 Methods

This was a descriptive study based on a review of websites, documents, and information sourced from the Internet and through requests to OW administrators. Specifically, information was obtained through an online search of the CMSM or DSAB websites/portals or third-party organizations with which the CMSM or DSAB has partnered (i.e. Public Health Unit [PHU]) or contracted (i.e. AccertaClaim Servicorp Inc. [Accerta], The Great-West Life Assurance Company [Great-West Life]) to administer discretionary dental benefits for OW recipients.

Information was summarized and collated in a variety of ways. An overall descriptive summary by jurisdiction is provided for the following elements:

- Transparency, or how readily accessible the information is to clients and providers
- Policy and process elements, or the broad administrative approach to providing and paying for client benefits
- Eligibility, or the broad considerations related to receipt of dental services
- Benefits, or the level of services offered such as "emergency dental plan," "basic dental plan," "denture plan," "relief of pain only," and/or whether contact with the OW administrator or case-worker is required and any annual limit
- Service plan details, or whether there is a readily accessible description or listing of the services that are covered or offered, and
- Notes, or additional relevant details.

A more detailed analysis based on the above elements is provided beyond just simple description. A review of the public (direct delivery) clinics and approaches taken in these clinics is included. A

convenience sample of dental benefit plans is reviewed to determine and compare the level of services being offered by municipal administrators. The broad areas reviewed include:

- The annual level of benefits available
- Whether predetermination or preauthorization for services is required
- Whether procedures in common categories are covered
- Specific limitations for reimbursement (service codes, frequency and other limitations), and
- The general construction of the plan and coverage for dentures.

And an assessment tool was also developed that considers 30 different parameters, which are used to compare jurisdictions in Appendix A -- Comparison of Dental Coverage. Table 1 below provides a description for each of the parameters.

Table 1. Parameters to compare details of a convenience sample of dental benefit plans offered by municipal administrators

Parameter	Assessment parameter description
Dollar limit	Payment limit or dollar limit of the plan in a 12-month period
Predetermination/preauthorization (PD)	Dentists are required to submit information for approval for specific services or when treatment costs are expected to exceed a certain dollar limit level
MCCSS Fees	Are the reimbursement levels in the plan the same as found January 2018 MCCSS Schedule of Dental Services and Fees (yes or no)?
Amalgam & composite	Does the plan reimburse composite restorations to the same rate?
Complete	Refers to a comprehensive dental examination, which is done when a patient sees their dentist for the first time or periodically (generally every five years)
Emergency	Refers to an emergency examination to investigate an urgent dental problem when the patient presents with pain or infection
Specific	Like an emergency examination, reimbursed at the same level; some plans place limitations on how many specific or emergency exams can be claimed while others are open ended, for example, a plan that indicates any combination of an emergency exam and specific exams up to three during a six-month period (described as 3/6 in the chart)
Recall	Refers to reimbursement for a periodic re-examination of existing patient; not considered as comprehensive as a complete exam; usually not included in plans where the focus is the immediate relief of pain and discomfort (emergency dental plan)
Film	Refers to radiographs (x-rays), or the number that will be reimbursed in a given period
Panoramic	General full-face or survey (x-ray) of the entire teeth and jaws
Biopsy	Refers to assessing growths or lesions in the mouth that are suspicious and removing the suspect tissue and sending for analysis
Preventative	Refers to three elements defined under prevention: polishing, scaling and topical fluoride treatments; emergency dental plans typically do not include this component
Caries, Trauma and Pain Control (CTPC)	Refers to the placement of various dressings in the teeth and gums to stop pain
Amalgam	Plan reimburses amalgam (silver) fillings
Comp (A)	Plan reimburses white (composite resin) fillings in the front teeth (12 front teeth)
Comp (P)	Plan reimburses for white (composite resin) fillings in the back teeth (12 back teeth)
Pulpotomy	Refers to procedures removing part of the nerve of a painful tooth
Pulpectomy	Refers to procedures for removing all the nerve tissue of a painful tooth
Root Canal Therapy	Refers to sealing the canal space left after the nerve tissue has been removed, cleaned and shaped
Perio 42831	Refers to treating a painful infection in the gums (gum abscess)
Basic removals	Refers to removing or extracting teeth or other damaged tissues in the mouth
Replant	Refers to putting a tooth back into place if it is knocked out or moved by a blow
Limited 8's	Refers to limitation in the removal of impacted wisdom teeth
General Anesthetic (GA)	Refers to general anesthetic being a covered service
Sedation	Refers to the administration of intravenous drugs to sedate a patient
Nitrous Oxide (NO)	Refers to nitrous oxide or "laughing gas"
Dentures	Refers to coverage for acrylic dentures either complete or partial
Cast Removal Partial Denture (RPD)	Refers to partial dentures that have cast metal components; usually more expensive than completely plastic dentures
Repairs	Refers to repairing of a denture
Reline	Refers to the addition of new material to a denture to fill in areas where the tissue has shrunk; improves fit of denture

3.0 Findings

3.1 Descriptive Summary

Tables 2 to 4 below provide data keys for interpreting an overall descriptive summary of programs and benefits by jurisdiction. This summary is included in Table 5, which highlights program transparency, policy and process elements, eligibility, benefits, available details of the service plan, and any additional relevant information.

The data presented in Table 5 (also below) indicates that there is variation in the approach to programs and benefits. More specifically, there remain geographic differences in how services are administered, the services that are offered, and how they are offered. For example, some jurisdictions have developed local initiatives to address access to dental care challenges by expanding clinics either within Community Health Centres or as part of the local PHU infrastructure. These clinics are funded through a combination of provincial grants, local grants and/or contributions from charitable organizations.

In some jurisdictions, there is a fixed and transparent commitment to these programs and benefits available to clients for a given period of time, which are clearly outlined in official policies and supported by budget allocations and related tendering processes. However, for some municipal administrators, there is a degree of opacity related to the information available regarding what dental care benefits are offered. This is arguably due to some jurisdictions' need to manage the demand for a range of assistance, and for staff to maintain discretion in the approval process.

The data collected reflects a snapshot in time that continues to evolve as jurisdictions review their programs as part of their policy and annual budget cycles.

Table 2. Data key 1: Transparency

A	Information available for clients and providers about the benefits offered on the OW administrator's site
B	Information available for clients about the benefits offered on the OW administrator's site
C	Information available for providers through third-party benefits administrator
D	Information available through a secondary website in the local administrative area such as a community or PHU website
E	No information available and clients required to speak with their worker to determine what assistance might be available
F	Indication that assistance may be offered but no details

Table 3. Data key 2: Policy and process elements

Directly administered	OW administrator directly authorizes and pays for services
Third-party administered	OW administrator has contracted with third-party to adjudicate and pay for service claims
PHU administered	OW administrator has partnered with PHU to provide a range of administrative services, from adjudication and payment of service claims, to providing care directly in PHU dental clinics

Table 4. Data key 3: Eligibility

1	Assistance with the cost of emergency dental care: Adults and dependents over the age of 18 up to the last month adult is in receipt of OW
2	Assistance with the cost of dentures: Adults and dependents over the age of 18 up to the last month adult is in receipt of OW
3	Relief of pain only: Adults and dependents over the age of 18 up to the last month adult is in receipt of OW
4	Pre-review by OW administrator to see if assistance may be provided: Adults and dependents over the age of 18 up to the last month adult is in receipt of OW

Table 5. Summary of programs and benefits by jurisdiction

Jurisdiction	Transparency	Policy and process element	Eligibility	Benefits	Service plan details	Notes
Toronto	B/C	Third-party administered, defined benefit claims adjudicated by Great-West Life	1/2	Emergency dental plan and denture plan, no annual dollar limit	Yes	Announcement in 2016 that OW clients could attend Toronto Public Health dental clinics
Cornwall	E	Directly administered	2	Reimburse, to the dental office, $75 dollars per tooth for emergency related work	No	Eastern Ontario Health Unit providing dental services to OW clients on a pro bono basis beyond the $75 dollars for an emergency extraction
Durham	A	PHU administered	1/2	Emergency dental plan and denture plan, predetermination for various other services	Yes	
County of Hastings	F	Directly administered	4	Gateway Community Health Centre dental clinic offers services, $50 per visit	No	Clinic started at Gateway Community Health Centre dental clinic started for OW/ODSP clients as well as low income clients, $50 per visit irrespective of cost of treatment for those without coverage
Kawartha Lakes/Haliburton	C/F	Third-party administered, defined benefit claims adjudicated by Accerta	1/2	Emergency dental and denture plan	Yes	
Kingston	F	Directly administered	1	Emergency dental plan, up to $350 annually	No	Clinic started at Kingston Community Health Centre. Staff dentists provide care. Accept the $350 annually and provide care outside the limit. Additional sources of funding available that some clients can access funded by the municipality, a local charity, as well as block funding from the Local Health

Jurisdiction	Transparency	Policy and process element	Eligibility	Benefits	Service plan details	Notes
						Integration Network. Program and services continue to evolve.
Lanark County	D	Directly administered	1	Emergency dental plan, up to $400 annually	No	
Leeds Grenville	D	No online information	1	Basic dental plan, up to $400 annually	No	
Northumberland	A/C	Third-party administered, defined benefit claims adjudicated by Accerta	1/2	Emergency dental and denture plan	Yes	
City of Ottawa	A/C	PHU administered and direct administration of denture program	1/2	Emergency dental plan within clinics and denture plan which is preauthorized according to clinical need	No	Dental care provided through the Ottawa Public Health clinics. Variable services available year-over-year pending budgetary approval from City Council.
Peterborough	A	Third-party administered, defined benefit claims adjudicated by Accerta and direct administration of denture services	1/2	Accerta basic dental plan up to $600 per treatment plan and up to $1500 for dentures every 5 years	Yes	
Prescott-Russell	F	Directly administered	3	Emergency dental plan, limited to $75	No	Eastern Ontario Health Unit offers clinics in Cornwall and Hawkesbury where clients can attend at no charge. Clinic does accept the limited payment but broader dental needs may be addressed.
Prince Edward/Lennox and Addington	C/D	Third-party administered, defined benefit	1	Accerta emergency dental plan	Yes	

Jurisdiction	Transparency	Policy and process element	Eligibility	Benefits	Service plan details	Notes
		claims adjudicated by Accerta				
County of Renfrew	C/D	Third-party administered, defined benefit claims adjudicated by Accerta	1	Accerta emergency plan up to $500 annually	Yes	
County of Dufferin	D	Directly administered	1	Emergency plan, $300 per 12 months	No	
Halton Region	D	PHU administered	1/4	Up to $200 then preauthorization required	No	
Peel	A	Third-party administered, defined benefit claims adjudicated by Great-West Life	1/2	Emergency dental plan and denture plan	Yes	
Simcoe County	C/D	PHU administered	1/2	Emergency dental and denture benefit plan	Yes	
Waterloo	A	PHU administered	1/2	Emergency dental and denture benefit plan	Yes	
County of Wellington	A	Third party administered, defined benefit claims adjudicated by Accerta	1	Accerta basic dental plan, up to $1000 per calendar year	Yes	
York Region	A	Third-party administered, defined benefit claims adjudicated by Accerta	1/2	Accerta emergency dental plan and denture plan	Yes	

Jurisdiction	Transparency	Policy and process element	Eligibility	Benefits	Service plan details	Notes
Brantford	E	Directly administered	4	Relief of pain, contact with case worker required	No	
Bruce County	F	Directly administered	4	Direct follow-up required to see how OW administrator will assist	No	
Chatham-Kent	F	Directly administered	4	Direct follow-up required to see how OW administrator will assist	No	
County of Grey	C/F	Third-party administered, defined benefit claims adjudicated by Accerta	1	Accerta basic dental plan, up to $1000 per calendar year	Yes	
City of Hamilton	A	Directly administered	1/2	Emergency dental plan and denture plan	Yes	
Huron County	B/C	Third-party administered, defined benefit claims adjudicated by Accerta	1	Accerta basic dental plan, up to $1000 per calendar year	Yes	
Lambton County	B	PHU administered	1	Emergency dental plan	No	
City of London	A	Directly Administered	1	Emergency dental plan	No	Two teeth per six months, filling or extractions only
Niagara	B	Directly administered	1/4	Up to $135 per month, then follow-up with case worker	No	
Norfolk County	F	Directly administered	3	Direct follow-up with OW case	No	

Jurisdiction	Transparency	Policy and process element	Eligibility	Benefits	Service plan details	Notes
				worker, voucher system		
Oxford County	E	Directly administered	3	Direct follow-up required to see how OW administrator will assist	No	
City of St. Thomas	F	Directly administered	3	Direct follow-up required to see how OW administrator will assist	No	
City of Stratford	C/F	Third-party administered, defined benefit claims adjudicated by Accerta	1	Accerta emergency dental plan	Yes	
City of Windsor	A	Directly administered	1	Basic dental plan, $300 per calendar year	Yes	
Algoma	C/E	Third-party administered, defined benefit claims adjudicated by Accerta	1/2	Accerta emergency dental plan and denture plan	Yes	
Cochrane	C/E	Third-party administered, defined benefit claims adjudicated by Accerta	1/2	Accerta emergency dental plan and denture plan	Yes	
Kenora	C/F	PHU administered	1	Basic dental plan	No	
Manitoulin-Sudbury	A	Third-party administered, defined benefit claims adjudicated by Accerta	1	Accerta emergency dental plan	Yes	

Jurisdiction	Transparency	Policy and process element	Eligibility	Benefits	Service plan details	Notes
Muskoka	A	PHU administered	1/2	Emergency dental plan and denture plan	Yes	
Nipissing	E	Directly administered	3	OW administrator provides voucher for relief of pain	No	
Parry Sound	C	PHU administered	1/2	Emergency dental plan and denture plan	Yes	
Rainy River	C/F	PHU administered	1	Indication that benefits are available, but no details	No	
Sault Ste. Marie	B/C	Third-party administered, defined benefit claims adjudicated by Accerta	1/2	Accerta emergency dental and denture plan	Yes	
Sudbury	E	Directly administered	3	Contact with case worked for voucher, limited to pain	No	
Thunder Bay	B/C	Third-party administered, defined benefit claims adjudicated by Accerta	1	Accerta emergency dental plan	Yes	
Timiskaming	C/E	Third-party administered, defined benefit claims adjudicated by Accerta	1/2	Accerta emergency dental plan and denture plan	Yes	

3.2 Program Transparency

Table 6 below summarizes the data related to program transparency, or the ease of finding program information related to the dental program.

Table 6. Program transparency

Category	Description	Count of OW municipal administrators
A	Information available for clients and providers about the benefits offered on the OW administrator's site	13[1]
B	Information available for clients about the benefits offered on the OW administrator's site	6[2]
C	Information available for providers through third-party benefits administrator	1
D	Information available through a secondary website in the local administrative area such as a community or PHU website	7[3]
E	No information available and clients required to speak with their worker to determine what assistance might be available	8[4]
F	Indication that assistance may be offered but no details	12[5]

[1] Two of the 13 municipalities refer and direct dental providers to Accerta for information about the benefits plan.

[2] Four of the six municipalities refer and direct dental providers to Accerta. In the case of Toronto, the information can be obtained from Great-West Life.

[3] For three of seven municipalities, the plans were available electronically and the information posted for dental offices and denturists.

[4] Three of the eight municipalities have contracts with Accerta and the information was found on the Accerta website. The information would be more transparent to dental offices but less to clients in these cases.

[5] For five of the 12 municipalities, although there is no public information easily accessible, information was obtained directly from the Accerta website.

In terms of transparency, an "A" rating is the most desirable. This means that both the client and potential dental provider have a clear indication of what will be covered or paid for by the municipal administrator. For the survey period in 2017, this represented approximately one in four municipal administrators. At the other end of the spectrum, category F, there was only an indication that discretionary dental benefits might be available.

Within each program, there was variation in the level of transparency. The area of least transparency (with the exception of those with published plans) was related to denture plans. In comparison to emergency plans, for denture plans, there was often no information at all or a statement indicating clients could speak with their case worker to see if assistance is available.

The majority of programs do provide information online; however, in a number of cases finding information related to programs was difficult. For these programs, municipal administrators were contacted to seek addition information. While information related to several plans was obtained through their assistance, in many cases the municipal administrators had no information available and indicated that clients would need to speak with an internal case worker to obtain information. And

often, the case worker would only supply information to individuals who were registered in the program.

A significant source of additional information was obtained from PHUs and is reflected in category D, where information related to dental services offered by the municipal administrator could be found through the PHU website. These websites frequently offered summaries of all dental programs and services by category (children, adults, low income and seniors, including adults on OW) that were available in that jurisdiction or surrounding jurisdictions. In these jurisdictions, clients seeking additional information are thus more likely to call the PHU.

As the results demonstrate, the extent to which assistance is available varies and information related to the programs can be opaque. Although all administrators offer some assistance, there is variation in how easy it is to answer a basic question: What help is available to me if I have a toothache and am an adult on Ontario Works?

It is possible to get a clear answer to this question from some municipal administrators. In other cases, a dental office that accepts OW clients in their area will have to provide the information and can assist and explain the entitlements. And in other cases, the municipal administrator states “it depends,” and clients need to speak with an OW case worker directly, where in some cases the client is required to obtain estimates from dental offices prior to assistance being approved.

Ultimately, for many OW clients in Ontario, it is difficult to know if they can obtain assistance for their dental problems or whether they will be responsible for paying for a portion or all of the costs of care. These two factors are barriers to seeking and receiving dental care. While PHUs can be a key source of information and may help clients navigating the system, this is not consistent across Ontario either.

Transparency in terms of process is also important to providers. Indeed, a provider’s decision to participate in a program and accept OW clients arguably relates to the ease of office staff confirming a client is eligible for the program, clarity around services that are covered with minimal requirement for follow-up with third parties (predetermination or additional requests), availability of information directly related to the levels of reimbursement (fees to be paid), as well as a clear indication of the limitations in the scope of procedures, and prompt payment preferably through an electronic submission and payment system. When these elements are not in place or readily available there is an increased likelihood that a provider will opt not to participate in a government plan.[4]

3.3 Program Administration: Approval of Covered Services, Adjudication and Payment of Claims

Discretionary dental benefits have been available for social assistance recipients in Ontario for at least five decades.[5] Municipal administrators assess an individual’s level of eligibility for dental assistance to address their dental needs and balance the need to provide short-term assistance with available funding.

[4] See: Quiñonez CR, Figueiredo R, Locker D. Canadian dentists' opinions on publicly financed dental care. Journal of public health dentistry. 2009 Mar;69(2):64-73; Quiñonez C, Figueiredo R, Azarpazhooh A, Locker D. Public preferences for seeking publicly financed dental care and professional preferences for structuring it. Community dentistry and oral epidemiology. 2010 Apr;38(2):152-8.

[5] See: Quiñonez C, Sherret L, Grootendorst P, Shim MS, Azarpazhooh A, Locker D. An environmental scan of provincial/territorial dental public health programs. Office of the Chief Dental Officer, Health Canada; 2007.

There are specific mandatory benefits or entitlements for eligible OW recipients (e.g. a defined monthly allowance), and OW clients have a right to appeal the decisions of municipal administrators (generally when the administrator has denied benefits) to the Social Benefits Tribunal (SBT). Importantly, municipal administrators set policies with respect to eligibility for discretionary benefits, which cannot be appealed to the SBT.

Municipal administrators determine the scope of benefits to be offered and generally administer these benefits directly (issue a voucher or requisition for the specified service); however, arrangements with a third-party claims-payer or a PHU (department or Board of Health) also exist. Beyond the administrative arrangements there are also variations in program delivery.

Table 7 below summarizes the administrative approaches to adjudicating and reimbursing providers for covered services. As described, approximately 40% of discretionary dental benefits are administered directly by OW administrators. The percentage is higher for denture plans, as some OW administrators that have third-party arrangements still retain administration of the denture plan component. These are noted in the detailed summary information related to plans found in Appendix A – Comparison of Dental Coverage. Approximately 33% are using thirty-party claim adjudication arrangements, primarily Accerta or in two cases Great-West Life. Approximately 24% have arrangement with a PHUs to oversee their programs. The approach varies, including adjudicating specific dental benefits and reimbursing claims, assessing and authorizing specific treatment, and/or providing care directly through public clinics.

Table 7. Administrative approaches to adjudicating and reimbursing providers

Approach	Description	Count of OW municipal administrators
Directly administered	OW administrator directly authorizes and pays for services	21
Third-party administered	OW administrator has contracted with third-party to adjudicate and pay for service claims	15
PHU administered	OW administrator has partnered with PHU to provide a range of administrative services, from adjudication and payment of service claims, to providing care directly in PHU dental clinics	11

In general terms, the following are the program benefit administration approaches:

1. *Defined benefit and payment.* The dental provider and patient determine the course of treatment and the municipal administrator agrees to reimburse eligible procedures under terms of the contract. The entitlements available may or may not address all treatment needs. No additional consideration for care exits outside of the program limitations. The majority of municipal administrators pay for discretionary dental services directly. One-third has engaged a third-party carrier to adjudicate and pay claims.

2. *Defined benefit and payment with consideration to additional expenses.* Similar to 1; however, the municipal administrator may approve additional assistance on a case-by-case basis. Third-party administrators are not involved in this process and OW administrators authorize the additional expenses directly.

3. *Case worker request/approval.* The client requests assistance with dental care and their case worker provides a "requisition" to cover some portion of the visit. This can take a variety of forms from a requisition that will cover a maximum cost for the visit problem to approving a specific estimate for services that is submitted by the provider or client.

4. *Pre-assessment and authorization.* Clients request assistance and are screened or a submission reviewed by a dental professional and a specific authorization for care is provided to the client that the client can then take to a dentist. In some instances, the assessment is being done in public health clinics that offer "preventive" and "cleanings" but do not provide fillings and extractions, which they authorize and the client can then see a private dentist.

5. *Direct delivery.* OW clients attend public clinics and see a staff dentist. The dentist assesses the client and provides care. Programs like this have a degree of flexibility to expand what is offered based on the client's needs that may be beyond a defined schedule while still consistent with stabilizing an individual's dental condition. These clinics operate on a cost-recovery basis and may or may not have additional government contributions. For example, the City of Ottawa has used this approach for over 30 years and has four clinics to serve adults receiving OW among its patient group.

6. *Mixed delivery.* OW clients are provided emergency level coverage or benefits but can also attend public clinics that may offer additional basic care. For example, the City of Toronto has opened it public clinics to OW recipients specifically for this reason.

Given the above, it is clear that municipal administrators have considerable flexibility in how programs are designed and delivered, particularly because these are completely discretionary benefits. This is reflected in the administrative approaches, variation in program delivery, and the benefits offered. Cost-sharing was an important incentive to providing these services when the province paid 80% of the cost of discretionary health benefits (including dental care). With the introduction of per-capita funding for discretionary benefits, there are indications that the design and delivery of these programs is evolving. For example, third-party administration is increasingly common-place, whether selected through a formal tendering process (Toronto), sole-sourced to a specific provider (Renfrew), or are a continuation of arrangements that have been in place for many years (Ottawa, Waterloo, Hamilton). Engaging a third-party generally signals that the municipal administrator has moved away from making determinations internally on a case-by-case basis to adopting a defined benefit with uniform claims processing. This tends to provide greater clarity to providers and to clients about what care is covered, and is suggested to achieve cost containment through plan design that limits the range and frequency of services. Accerta, for instance, claims that they help "provide [municipal] clients with a comprehensive, high-quality oral healthcare social services program while curtailing costs, reducing fraudulent claims, and increasing overall efficiency."[6]

PHUs also act as third-party processors for some municipal administrators. They perform the same functions as claim processing and payment companies such as Accerta and Great-West Life. Some incorporate additional review and authorization functions and take more of a programmatic approach that incorporates plan design, assessment of clinical circumstances and authorization of additional care that is outside of a defined plan. Plans/programs administered by PHUs have higher levels of pre and post determinations incorporated into the administration in general based on the review of the

[6] See: Accerta. Dental Care Plan Management. Available at: https://www.accerta.ca/dental

documented plans, policies and procedures herein. These added accountability measures are designed to arguably contain costs by limited reimbursement but also have provisions to approve additional care under certain circumstances to address a specific client's health needs. Based on provider discussions conducted by the authors of this report, this does result in added effort, time delays and has the potential for providers to feel they have to unnecessarily justify the care they are providing. Additional administrative burden is a factor in providers electing not to accept government plans.[7]

3.4 Program Eligibility for Dental Benefits

All municipal administrators offer some form of assistance with emergency dental needs to adult clients, between 18 and 65 years of age, while they are eligible for OW. Table 8 below summarizes the typical level of discretionary benefits offered and are reflective of local policy related to relief of pain only, to broader emergency dental care, and whether denture benefits are offered.

Table 8. Level of discretionary benefits offered

Description	Count of OW municipal administrators
Assistance with the cost of emergency dental care: Adults and dependents over the age of 18 up to the last month adult is in receipt of OW	14
Assistance with the cost of emergency dental care and dentures: Adults and dependents over the age of 18 up to the last month adult is in receipt of OW	20
Assistance with the cost of emergency dental care and with a pre-review for assistance with dentures: Adults and dependents over the age of 18 up to the last month adult is in receipt of OW	5
Relief of pain only: Adults and dependents over the age of 18 up to the last month adult is in receipt of OW	7
Pre-review by OW administrator to see if assistance may be provided: Adults and dependents over the age of 18 up to the last month adult is in receipt of OW	1

The OW client statement of benefits serves as proof of eligibility in most jurisdictions. The client presents this statement at the time of a visit to a dental office as proof of eligibility. The main difference in eligibility is whether a provider can proceed and provide care within the scope of benefits available (automatically eligible) or whether a specific request has to be made by the client or the dental provider on behalf of the client before treatment can proceed. For some municipal administrators both emergency dental and dentures benefits are automatically provided to eligible recipients. For other municipal administrators, clients are automatically eligible for the emergency dental plan however denture plan assistance must be preauthorized. Seven municipal administrators provide coverage that addresses relief of pain only where removing a tooth but are less clear as to whether a filling of a tooth might be covered. Case workers are more directly involved in approving the benefit in such cases.

It is difficult to access written internal municipal administrative guidelines; however, an electronic copy was provided by Manitoulin-Sudbury. Manitoulin-Sudbury is an example of a municipal administrator that has a third-party processer contracted to adjudicate and pay claims to dental offices (Accerta). Their

[7] See: Quiñonez CR, Figueiredo R, Locker D. Canadian dentists' opinions on publicly financed dental care. Journal of public health dentistry. 2009 Mar;69(2):64-73; Quiñonez C, Figueiredo R, Azarpazhooh A, Locker D. Public preferences for seeking publicly financed dental care and professional preferences for structuring it. Community dentistry and oral epidemiology. 2010 Apr;38(2):152-8.

policy allows for additional care outside that plan to be authorized and paid for directly by the municipal administrator. The following is an excerpt from the Manitoulin-Sudbury District Services Board, policy and procedure manual last revised January 2009:

> *Emergency is defined as being an unscheduled event where an individual appears in immediate distress and requires care, and immediate appropriate treatment is needed to correct the problem. The Director of Integrated Social Services may approve costs for dental services provided to adult members of the benefit unit for: Emergency dental care (dental services which are necessary to relieve pain or for medical or therapeutic reasons); Dental care which supports the person's employability or participation requirements (e.g. orthodontic and denture services); Any exceptional circumstances where deemed medically necessary at the discretion of the Director of Integrated Social Services taking into consideration the Health and Welfare of the individual. This service is available to participants and beneficiaries who are not dependent children. Dental coverage for dependent children is a mandatory item of assistance under OW.*

Based on a number of conversations with municipal administrators, as well as two of the authors' (AB, CQ) experience treating patients or consulting for different public dental programs across Ontario, many municipal administrators have similar internal procedures to approve additional assistance outside of prescribed benefit plans. The number of programs that provide additional assistance is not possible to determine and would require significant follow-up and discussion with municipal administrators.

Given the above, it is clear that all municipal administrators offer some form of emergency dental benefit or assistance. Municipal administrators, with formal plans for both emergency dental and denture benefits, have in essence created a quasi-mandatory benefit. Clients can access care as needed and receive treatment and dental offices are reimbursed in accordance with specific service and frequency limitations. The primary objective of this approach is arguably to achieve clarity of benefits reimbursed and to administer plans that are designed to ensure some level of cost-containment.

Other municipal administrators see "dental" as a completely discretionary benefit with the determination made by case workers. Minimal pain relief (for example cost of an extraction) are reimbursed as part of a single emergency appointment with additional services beyond the first appointment requiring pre-approval. This results in uncertainty for both the clients and dental offices. Based on the review of municipal administrators' website materials, factors related to quality of life, health, and employability are part of the overall goals for providing discretionary assistance, which support oral health goals and objectives less directly. Only after pre-approval is received will clients know what services will be provided. Dental offices are required to prepare estimates and wait for notification of authorization prior to proceeding with care. The criteria used to determine what will be authorized or not authorized by municipal administrative staff is generally not publicly available. Importantly, some jurisdictions (Ottawa) have systematic assessment tools and policies that are used by staff dentists to review, perform and approve referral for care.

3.5 Supplemental Public Clinics and Access to Care for Adults Receiving OW

The majority of municipalities use a defined benefit plan where private providers deliver care and are reimbursed for services provided through a claims adjudication and payment process. Adjudication and claims payment processes are increasingly rapid and provided by a number of third-party administrators and insurance carriers. There has been a trend towards centralization of claims payment for social assistance in Ontario (Healthy Smiles Ontario (HSO) and ODSP). The approach relies on a clear set of

procedures that define which procedures are eligible for reimbursement. The major limitation is that, by design, claims adjudicating and payment processes must meet financial parameters while not necessarily addressing the care needs of all clients.

There are a growing number of Ontario communities where, in addition to the defined benefits plans, fixed public clinics have been established (Toronto, Kingston, Hawkesbury, Tweed, North Bay, Cornwall as examples), as have mobile public clinics (Niagara Region, Hamilton and Peel), with the initial capital costs supported by provincial and local initiatives and operating funds derived from various sources. These clinics have programs that serve primarily low-income Ontarians who have difficulty accessing private care (some also include recipients of the Federal Non-Insured Health Benefits (NIHB), ODSP and OW programs).

These clinical programs were developed independently of one another and there is considerable variation in their operations and services offered. The level of integration with the local municipal administrator and other not-for-profit organizations like community health centres and PHUs also varies. In some instances, the host not-for-profit organization has a specific contractual and funding arrangement in place with municipal administrators. In other cases, OW clients are accepted by the clinic and the clinic is reimbursed for services similar to other providers or receives block funding that the clinic shadow-bills against.

Depending on funding, clinics offer services from one to five days or more per week. The clinics generally offer the same level of care to all clients who seek services and function as a direct access clinical program. Demand for services is high and therefore effective management of the services offered is critical to ensure urgent problems are prioritized.

The City of Ottawa is the only municipal administrator that provides direct care to all adults receiving OW. The municipal administrator (a branch of city government) has entered into an agreement with Ottawa Public Health. Under this agreement, Ottawa Public Health is responsible for all dental-related matters for OW clients. OW program staff are not able to generate requisitions related to dental services and direct their clients for all dental-related matters to the closest clinic. Through the clinics, clients are offered dental services with referrals to specialists arranged as required.

Ottawa operates three clinics currently specifically dedicated to adults receiving OW and low-income individuals, as well as children through the HSO program.[8] The financial eligibility for the program is confirmed by the municipal administrator through a centralized financial assessment process. All OW clients are eligible to receive services at any of the three clinics. Dental cards or proof of eligibility for OW are not required because dental clinics are part of the city's integrated information system. The program has well-developed policy and assessment parameters for the care to be provided. The program prioritizes urgent problems, offers same-day or next-day appointments and focuses on measures to help prevent further problems. The program encourages adults receiving OW to take advantage of the two dental hygiene training programs at the two community colleges to help maintain their oral health once the urgent problem or problems have been addressed.

Dentures are offered through a specific partnership program with the Ottawa Dental and Denturist Societies. Staff dentists assess and authorizing specific denture services. This approach was introduced

[8] Ottawa Public Health operates a dental clinic at the Wabano Centre and provides dental services to Indigenous adults including those who are in receipt of OW.

in the late 1990's and resulted in better outcomes because it ensured that clients had all the necessary pre-work completed prior to the patients having their partial or full dentures made. Staff dentists can preauthorize additional services where required to improve outcomes and work directly with external providers.

Overall though, based on a review of the plans obtained for this study, the majority of municipal administrators are using a defined dental benefit plan that functions in a similar manner to employer-sponsored plans, but offer more limited coverage when compared to employer-sponsored plans (which include more covered procedures and opportunity for regular visits and maintenance). Importantly, in many communities the OW adult plans will pay for urgent care that other low-income Ontarians cannot afford. And one of the key issues related to this is the issue utilization, meaning dental plans for low-income Ontarians have higher utilization rates than non-insured populations yet lower utilization rates than employer-sponsored plans.[9]

Given this, a limited number of municipal administrators fund local programs which allow low-income adults to access the same discretionary benefits as adults receiving OW. In addition, OW administrators in communities including Kingston, Cornwall, and Tweed, for example, reported to the researchers that they opened public clinics to assist a growing number of individuals who cannot afford to access care and that are not covered by public programs. The clinics operate based on a combination of fee-for-service, grants, local funding and or local charitable contributions. Although these approaches appear to have increased in recent years, they remain the exception rather than the norm.

3.6 Assessment and Comparison of Benefits Offered to Adults Receiving OW

In Ontario, services performed by dentists (examination, diagnosis, fillings etc.) have specific descriptions and are assigned a specific five-digit numeric code. These service descriptions and their corresponding codes are referred to as the Uniform System of Coding and List of Services (USC&LS). The USC&LS is produced and owned by the Canadian Dental Association. In Ontario, the Ontario Dental Association (ODA) produces the *ODA Suggested Fee Guide for General Practitioners*, which assigns a suggested fee to specific codes from the USC&LS. Speciality associations in Ontario also produce their own schedules for their members. A rule of thumb is that specialist fees are 20% higher than general practitioner fees.

Government dental plans, like OW, HSO or ODSP, use the USC&LS under license. These public plans contain a selection or partial list of codes that appear in the ODA suggested fee guide and are reimbursed under the terms of the public plan (total fee and frequency). The HSO and ODSP plans are commonly referred to as "basic dental plans". As an example, taking and interpreting a panoramic radiographic is described by code 02601, is covered once every five years, is reimbursed at $31.54 for a general dentist or $37.85 for a registered dental specialist licensed by the Royal College of Dentists of Ontario (RCDSO).

OW adult plans (with a couple of exceptions) cover fewer services (codes) or lower allowances or frequency and are commonly referred to as "emergency dental plans". Where municipal administrators

[9] See: Quiñonez C, Sherret L, Grootendorst P, Shim MS, Azarpazhooh A, Locker D. An environmental scan of provincial/territorial dental public health programs. Office of the Chief Dental Officer, Health Canada; 2007; Quiñonez C, Figueiredo R. Sorry doctor, I can't afford the root canal, I have a job: Canadian dental care policy and the working poor. Canadian Journal of Public Health. 2010 Nov 1;101(6):481-5; Ramraj C, Sadeghi L, Lawrence HP, Dempster L, Quiñonez C. Is accessing dental care becoming more difficult? Evidence from Canada's middle-income population. PloS one. 2013 Feb 20;8(2):e57377.

cover services by issuing a requisition in response to an estimate supplied by the client from a dental office, the actual services covered, fees assessed and what is actually reimbursed is less clear.

This review was able to obtain 26 published plans representing 56% of municipal administrators across Ontario. The remaining administrators do not have published plans or schedules that can be referenced. There are no two plans in Ontario that are exactly alike, but an attempt has been made to compare them based on a series of parameters (see methods section). Appendix A – Comparison of Dental Coverage provides a detailed description of the unique features of each of the 26 benefit plans, but in general terms, it can be said that there is variation based on:

- Specific services being covered
- Frequency with which certain services are covered
- Inclusion of certain treatments for all teeth
- Exclusion of certain treatments for certain teeth
- Amount of time reimbursed for services that are billed based on a time basis
- Limits to the total amount that can be reimbursed in a 12-month period or other period
- Reimbursement of fees as outlined in the MCCSS fee guide, and
- Other specific features such as when exceptions can be covered or are specifically not considered.

It cannot be overstated that the variation across and within the parameters makes it difficult to establish and identify commonalities amongst plans. Table 9 below is a descriptive summary that illustrates where there is commonality (likely pointing to the diversity) in the discretionary dental benefits offered by OW administrators through the adult dental plans.

Table 9. Commonality (diversity) in discretionary dental benefits

Parameter	Description of commonality (diversity)
Annual reimbursement levels	Eight of 26 plans have a 12-month total reimbursement maximum: Wellington $1,000, Grey $1000, Huron $1000, Peterborough $600, Renfrew $500, Parry Sound $425, Simcoe Co. $400, and Windsor $300. All remaining plans do not have an annual limit.
Reimbursement per dentist or per client	The limitations are generally per patient per time frame. In some plans and for some services the wording is per dentist.
Full examinations	Three municipal administrators, Peterborough (1/60 months), York Region (1/60 months), and Sault St. Marie (1/36 months), cover a complete examination at different frequencies. Peterborough will provide coverage for a recall examination after nine months and York will match the same level of benefit as ODSP adult recipients. None of the other plans include a recall examination.
Radiographs	Coverage varies significantly between plans. For example, Parry Sound will reimburse three periapical radiographs (PA) per emergency visit, while Thunder Bay or Northumberland reimburse three PA every 12 months. There is variation as whether bitewing (BW) radiographs are included in the counts with PA, in addition to PA, or not included at all. Parry Sound covers two BW every nine months, Toronto reimburses six PA or BW in a 12-month period, whereas Peterborough, York and Thunder Bay allow for eight PA in 12 months and two BW. Durham will reimburse for three films claimed in a three-month period including BW. In contrast, Sault St. Marie provides for five films in a 12-month period. Toronto excludes panoramic radiographs (PAN), while Thunder Bay, Wellington and Grey County include a PAN as part of the total count of three radiographs per 12-months, whereas Sault St. Marie will reimburse for a PAN once every 36 months and Peterborough once every 24 months.

Preventive services	Scaling, polishing and fluoride treatments are included in Peterborough's plan ($600 total plan reimbursement limit per 12 months). York Region's plan covers scaling and fluoride treatment but not polishing. Northumberland includes up to four units of scaling for OW adult women during pregnancy.
Posterior composites	These fillings in the molar teeth are included as a benefit in all plans, except for Toronto, where they are not an included benefit. Toronto will reimburse for silver amalgam fillings in the molar teeth. York and Hamilton include posterior composites but only reimburse the same fee as for an amalgam restoration (fees are lower). Plans administered through Accerta contain a general disclaimer related to only reimbursing silver amalgam fees if a tooth is filled with two separate materials at the same time but do reimburse higher fees for composite restorations.
Root canal therapy (RCT)	Peterborough will cover RCT. York will cover one or two canaled teeth, Sault St. Marie will reimburse for RCT on the front teeth (no coverage for premolar or molar teeth), Durham requires predetermination and covers only the front teeth and limits the reimbursement to the fee for one canal. Parry Sound, Simcoe cover one-canaled teeth. For the remainder of municipalities, including Toronto, Thunder Bay, Wellington, Grey County, Windsor, Stratford, partial RCT (pulpectomy) is covered.
Basic and difficult extractions	All plans cover basic and complex extractions. Durham requires predetermination for removal of wisdom teeth that are impacted. All plans, with the exception of Toronto, pay to re-implant a tooth that has been dislodged or knocked out. The Muskoka and Simcoe OW area plans require the provider to submit an explanation and details of the procedures used when submitting for complex extractions.
Sedation	Most administrators do not offer reimbursement providing general anesthesia, deep sedation or conscious sedation. Peterborough, Huron and Peel cover up to eight units (1.5 hours) of sedation per visit. Toronto will reimburse for conscious sedation up to eight units per year. Sault St. Marie reimburses up to six units (75 minutes) of any combination of general anesthesia, deep sedation or conscious sedation in a 12-month period, whereas Hamilton will reimburse four units in a 12-month period. The Simcoe and Muskoka area plans have provisions to consider sedation under very limited circumstances and require an expert letter justifying the medical need prior to being considered and authorised

In terms of denture plans, of the 46 municipalities, 13 (25%) have published denture plans. This does not necessarily mean that other municipalities do not provide such assistance, as they may be offered on a case-by-case basis directly through contact with a case worker. Like the plans described above, there are no two plans that are the same. An assessment of each plan is also included in Appendix A – Comparison of Dental Coverage. The data highlights the following: some plans are more generous and will provide for new dentures (once every five years), allow for more frequent repairs and maintenance, periodic relining or rebasing to address many denture-related needs and/or extend the life of an existing denture; others contain fewer services (relines or rebases not covered), have longer replacement frequencies, exclude cast partial dentures and cap total reimbursement in different ways.

To illustrate the variation, Northumberland will cover a new pair of dentures every 60 months but not relines or repairs to existing dentures or those constructed under the plan. Toronto covers a set of dentures or partials every five years (covers only acrylic type partials), a reline once every 36 months and $88 dollars reimbursement in a 12-month period for repair. Halton in contrast covers a new full or partial dentures every five years, up to four repairs per year and covers tissue conditioning, which most plans do not include. Sault St. Marie covers a new denture benefit once in a lifetime, one repair and a reline every two years.

There was also no consistency in terms of fees paid for denture-related services. For example, Durham will reimburse a maximum fee of $580.27 per denture and Sault St. Marie $495.00. The opposite is true for relines/rebases, where Durham reimburses $163.86 and Sault St. Marie reimburses a maximum fee of $180.

From the point of view of policy, the following statement from Wellington is reflective of the general policy intent of most plans:

> *The intent of coverage - Plan sponsors do NOT intend to provide on-going, regular dental care for their clients. The intent of this plan is to provide emergency care only with the constraints of this program. An emergency involves bleeding, pain, infection or trauma. It requires treatment of a symptomatic patient when the patient appears in distress and appropriate treatment is instituted for that specific emergency problem(s). Resolution of the problem may require more than one appointment.*

While most of the plan designs emphasize providing a limited course of treatment, all generally reimburse the cost of a basic exam, a radiograph(s) and assistance to remove a tooth, or to place a very basic filling, which is inconsistent with the stated intent of the policies.

Another key issue is the lack of clarity for an OW adult client in terms of the level of assistance they can receive related to a particular dental problem. The information in plans is designed and targeted to dental professionals and the limitations and services covered are complex for the general reader or someone that is not familiar with dental terminology. And in contrast to other discretionary benefits where an OW case worker can, in relative terms, accurately describe the benefit (assistance with eye glasses for example), dental care requires examination and discussion with a provider.

A further and related consideration is that, while extra billing is not permitted for services within the plan, dentists are permitted to charge for services outside the plan. Thus, there is the potential for clients to be unsure about the level of assistance available and concerned about the potential of having to pay for some services. Based on the experience of two of the authors (AB, CQ) in managing and adjudicating dental services for social services adult recipients, this can result in OW clients either delaying or not seeking care.

The diversity in plans also means that in some areas of Ontario, the assistance offered can help OW clients maintain or potentially improve their oral health during the time they are on assistance (Peterborough, York and to a lesser extent Ottawa), whereas in other areas of Ontario (such as Windsor), offers of assistance cover only one dental problem or possibly a second instance if there are funds remaining within their annual dollar value limit. This is consistent with the notion that OW is "short term assistance" and very basic supports are provided to clients to achieve self-sufficiency in the shortest time possible. This also means that plans do not consider an individual's baseline oral health or "time on assistance," specifically cases where individuals return to social assistance repeatedly, or where assistance is ongoing and intergenerational, which as indicators of poverty, also likely means that oral health status is poorer than more socioeconomically stable Ontarians.[10]

Sedation (specifically nitrous oxide, intravenous sedation and general anesthesia) is a policy area which requires careful consideration when designing public programs. There has been considerable expansion

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[10] See: Sadeghi L, Manson H, Quiñonez C. Report on access to dental care and oral health inequalities in Ontario. Public Health Ontario; 2013.

in the promotion and availability of sedation in dental practice in Ontario; while at the same time, there is decline in the number of practitioners who treat very anxious patients because of the additional demands (time and emotion) on the dental team to properly support a client with dental anxiety, which is arguably made worse when coupled with lower reimbursement rates.[11] As was noted in the findings only five municipal administrators include assistance with the costs of sedation and there is variation in the amount covered (two others offer limited reimbursement under exceptional medical circumstances). Sedation costs often equal or exceed the cost of treatment provided during an appointment and are therefore not insignificant. Some of the five plans have language that specifically excludes sedation related to anxiety or fear of the dentist, and require another medically-related justification for it to be reimbursed. During the gathering of information related to case-by-case authorizations, it was evident that in some instances, municipal administrators were approving sedation in exceptional circumstances (removal of an impacted tooth or where there are concurrent medical problems making sedation critical to providing treatment safely). The extent to which adults receiving OW are avoiding care because they cannot access sedation or are paying for sedation services as part of emergency dental care is unclear.

Municipal administrators work within specific financial constraints and policy frameworks that are approved locally. The plans reviewed for this report arguably reflect a range of local policy outcomes that balance financial constraints with the local realities of the composition of OW caseloads and the challenges of geography (rural versus urban for example). The approach to addressing these constraints differs. Plans administered through PHUs such as Simcoe and Parry Sound have care covered annually ($400/$425 per year and include both pre-treatment and post-treatment adjudication requirements, such as supplemental information and radiographs when claiming for the higher fee associated with the extraction of a tooth or preauthorization for removal of more than one wisdom tooth). In this approach, and when compared to those plans that are adjudicated by other third-parties, there can be a broader range of services covered within a similar financial limit likely because of the higher level of accountability for expenditures.

Low-income adults and adults on social assistance have higher dental needs (poor oral health) than the general population.[12] Public dental plans for adults on social assistance have also changed little over the last 30 years in terms of the scope of covered procedures, and generally only address an urgent dental problems.[13] Municipal administrators that have plans that are closer to the ODSP level of benefit have a greater potential to assist clients maintain or improve their oral health while on assistance because the plan includes a broader range of coverage for routine preventive care, restorative, endodontic care, surgical services and anesthesia. Providing an ODSP level of benefit to all OW adult clients would entail a significant increase in expenditures over current levels in Ontario. It is also important to note that even an ODSP benefit level would not allow all OW adult clients' oral health to be maintained and/or restored

[11] See: Chanpong B, Haas DA, Locker D. Need and demand for sedation or general anesthesia in dentistry: a national survey of the Canadian population. Anesthesia progress. 2005 Mar;52(1):3-11; Adams A, Yarascavitch C, Quiñonez C. Use of and Access to Deep Sedation and General Anesthesia for Dental Patients: A Survey of Ontario Dentists. J Can Dent Assoc. 2017;83(h4):1488-2159.

[12] See: Quiñonez C, Figueiredo R. Sorry doctor, I can't afford the root canal, I have a job: Canadian dental care policy and the working poor. Canadian Journal of Public Health. 2010 Nov 1;101(6):481-5; Health Canada. Summary report on the findings of the oral health component of the Canadian Health Measures Survey, 2007-2009. Ottawa: Health Canada, 2010; Canadian Academy of Health Sciences. Improving access to oral health care for vulnerable people living in Canada. Ottawa: Canadian Academy of Health Sciences, 2014.

[13] See: Quiñonez C, Sherret L, Grootendorst P, Shim MS, Azarpazhooh A, Locker D. An environmental scan of provincial/territorial dental public health programs. Office of the Chief Dental Officer, Health Canada; 2007; Shaw J, Farmer J. An environmental scan of publicly financed dental care in Canada: 2015 update. Toronto: Faculty of Dentistry, University of Toronto, 2016.

to full function. Many low-income patients go without dental care for significant periods of time and need more advanced treatment,[14] which is outside the scope of the ODSP or most public plans in Canada.

Finally, clinics like those in Eastern Ontario, Kingston, North Bay, and Ottawa often help close some of the gap in access to care and services by offering care that resembles the care received through HSO or ODSP for a defined period. This type of extended access is not available in every community in Ontario, or not promoted openly due to the community's limited capacity. This reflects the diversity and disparity of approaches of access to care across Ontario.

3.7 MCCSS Fee Comparison

As presented in the previous section, most OW adult dental benefit plans follow the MCCSS schedule of benefits (level of reimbursement). This review found that:

- 17 of the 26 plans reimburse the same fees for the same codes as found as the MCCSS schedule
- Seven plans have payment schedules that exceeded the MCCSS schedule, and
- The current version of the plan for the City of Toronto provided by Great-West Life show fees that are below those of the MCCSS schedule while those in the Region of Peel schedule were very marginally lower.

Appendix B – Comparison of Select Fee Codes contains a summary of the differential in fees for seven commonly used codes in emergency treatment:

1. 01204, specific examination
2. 01205, emergency examination
3. 02112, two PA radiographs
4. 20111, caries, pain and trauma control
5. 21243, large silver amalgam filling in back tooth
6. 23323, large composite resin filling in back tooth
7. 71201, complicated extraction (removal) of a tooth

For the seven plans that exceeded the MCCSS schedule, the difference in fees for the various codes assessed were between 23.2 and 244% greater. Within the seven plans, there were no two fee structures that matched. Code 20111 showed the greatest range compared to the MCCSS schedule, 114.6 to 244% greater. Whereas 01205 varied from 23.2 to 100% greater (double the fee in the MCCSS schedule).

The MCCSS schedule of benefits has remained largely unchanged for many years. The seven of 26 publicly available plans that are paying in excess of the approved schedules are outside of the major urban areas of the province and are administered by Accerta. An assessment of the rational and variation of local plans is beyond the scope of this project, but may warrant further discussions with the

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[14] See: Locker D, Maggirias J, Quiñonez C. Income, dental insurance coverage, and financial barriers to dental care among Canadian adults. Journal of public health dentistry. 2011 Sep;71(4):327-34; Thompson B, Cooney P, Lawrence H, Ravaghi V, Quiñonez C. The potential oral health impact of cost barriers to dental care: findings from a Canadian population-based study. BMC Oral Health. 2014 Dec;14(1):78; Thompson B, Cooney P, Lawrence H, Ravaghi V, Quiñonez C. Cost as a barrier to accessing dental care: findings from a C anadian population-based study. Journal of public health dentistry. 2014 Aug;74(3):210-8; Ramraj C, Azarpazhooh A, Dempster L, Ravaghi V, Quiñonez C. Dental treatment needs in the Canadian population: analysis of a nationwide cross-sectional survey. BMC oral health. 2012 Dec;12(1):46.

specific administrators to verify the methodology used to determine reimbursement levels for specific fees and the basis of the decision to deviate from the MCCSS schedule.

Ultimately, it is a good working assumption that the closer government plans resemble employer-sponsored plans, the more likely these plans are to be accepted by dentists.[15] Also, there is currently no clearly defined social contract with the dentists in Ontario. Dentists are under no obligation to accept government plans and can limit how many clients they will accept in their practice. The current discourse among dentists is that the current MCCSS schedule represents only "30 cents on the dollar" for a dental practice and therefore dentists are personally subsidizing the government plans.[16] Indeed, before the most recent election, the Ontario Dental Association (ODA) had a public campaign arguing for increases to the provincial government's investment in existing public dental plans.

4.0 Conclusions

This report provided a descriptive analysis of the current state of dental programs and/or benefits for adults receiving OW across the province. It demonstrated substantial variation across all parameters compared, including how benefits are accessed, how they are administered, what eligible services are included or excluded, what maximum annual limits apply and the levels of reimbursement included. These findings suggest several policy options.

The wide variation present among municipalities is likely related to the discretionary nature of oral health care delivery for adults receiving social assistance. This variation could be addressed by guidance from the province regarding how these services are to be organized (managed), financed, and delivered. Alternatively, governments could set organizational, financing, and delivery standards for the delivery of oral health care to social assistance populations by making clear what services are mandatory to deliver.

The objectives of providing oral health care to adults receiving OW in Ontario have not been clearly articulated. Identifying specific goals can indicate policy options. For example, if the goal is to incentivize and increase the chances of employment among adults receiving OW, approaches to care could include coordination between caseworkers and other social services or PHU staff that is focused on employment outcomes. Alternatively, if the goal is to achieve improved health, approaches could include coordination between caseworkers and other social services or PHU staff that is focused on health outcomes. Importantly, these are not mutually exclusive strategies. Notably, the evidence of an association between receiving dental services and leaving social assistance for employment is weak,[17] yet individuals do report improvements to employment-related factors when surveyed pre and post dental treatment, including improvements to subjective measures of oral health.[18]

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[15] See: Quiñonez CR, Figueiredo R, Locker D. Canadian dentists' opinions on publicly financed dental care. Journal of public health dentistry. 2009 Mar;69(2):64-73; Quiñonez C, Figueiredo R, Azarpazhooh A, Locker D. Public preferences for seeking publicly financed dental care and professional preferences for structuring it. Community dentistry and oral epidemiology. 2010 Apr;38(2):152-8.

[16] See: CBC News. 'Ugly, awful secret:' Ontario dentists are ducking some patients — and they say they have no choice. Deburary 08, 2018. Available at: https://www.cbc.ca/news/canada/sudbury/healthy-smile-cost-money-1.4525204; The Agenda with Steve Paikin. Ontario's Dental Care: Biting Off Myths. May 14, 2018. Available at: https://www.tvo.org/video/ontarios-dental-care-biting-off-myths.

[17] See Singhal S, Correa R, Quinonez C. The impact of dental treatment on employment outcomes: a systematic review. Health policy. 2013 Jan 1;109(1):88-96 and Singhal S, Mamdani M, Mitchell A, Tenenbaum H, Lebovic G, Quiñonez C. Dental treatment and employment outcomes among social assistance recipients in Ontario, Canada. Health Policy. 2016 Oct 1;120(10):1202-8.

[18] See Singhal S, Mamdani M, Mitchell A, Tenenbaum H, Quiñonez C. An exploratory pilot study to assess self-perceived changes among social assistance recipients regarding employment prospects after receiving dental treatment. BMC oral health. 2015 Dec;15(1):138.

An important policy question is the appropriate mix of public delivery of services, private delivery, or both (mixed delivery). Almost all developed nations work on a mixed delivery model,[19] given that not all service delivery contexts are appropriate for all populations.[20] Economic evaluations may help to determine the efficiency of block funding the organization, management, and delivery of public services (PHU clinics, community health sector clinics), while organizing, financing, and delivering private services through the use of a centralized claims processor, as currently done with the HSO program.

In one sense, the above decisions are structural in nature. They involve questions as to which level of government will assume the funding of such care, whether a local safety net approach will be prioritized or simply the payment of services, whether the goal is to create strong public and private systems around the oral health care delivered to social assistance populations, and whether the focus will be around those with teeth or those without. These are obviously false dichotomies, but they do paint a picture of the types of decisions that are required.

Another important question for Ontario is the level of flexibility that is optimal at the local level. For example, local administrators are often faced with the challenge of what to do for a person who, from experience, will likely only be on OW for a very short time, versus a person who, again from experience, may be headed towards ODSP. Flexibility is particularly important in the former case, as someone may not need to be on OW, but simply needs support for a tooth extraction or some other basic dental care. Block funding of these services provides for this type of flexibility, especially in locations where public clinics are available, or where private clinics are the only option.

From an equity perspective, the wide variation in what is available to whom and through what processes may be particularly concerning. This report has highlighted such variation, which has implications for fair access to services and outcomes across the province, for achieving positive outcomes in these populations in general, and for appropriate and effective use of scarce resources.

From an economic perspective, rationalizing oral health care can help in deciding what services should be covered and at what cost. Dentistry, for good or bad, is arguably unique in that different treatment regimens — often with largely varying prices — can achieve relatively similar outcomes (e.g. implants vs. dentures in the treatment of missing teeth, root canals and fillings to deal with a specific level of disease vs. combining extractions with dentures to deal with the same level of disease). Clinical and value judgments are important for determining how services funded by public programs are best used (e.g. paying for a root canal and crown or paying for extraction for a patient with given prognostic factors).

Finally, formalizing dental public health expertise and leadership centrally may improve decision making processes (currently, there is no provincial chief dental public health officer), and at the regional/local level (many municipalities have no such expertise available). This can help to address concerns about inequity in oral health services and maximize the potential for efficient use of resources in public dental care programming.

[19] See Vujicic M, Bernabé E, Garbin Neumann D, Quiñonez C, Mertz E. (2016) Dental Care. World Scientific Handbook of Global Health Economics and Public Policy, Volume 2 – Health Determinants and Outcomes, Edited by Richard M. Scheffler. Singapore: World Scientific Publishing Company, pp. 83-121.

[20] See Quiñonez C, Figueiredo R, Azarpazhooh A, Locker D. Public preferences for seeking publicly financed dental care and professional preferences for structuring it. Community dentistry and oral epidemiology. 2010 Apr;38(2):152-8.

Appendix A – Comparison of Dental Coverage

Abbreviation	Description
GWL	Great-West Life Assurance Company
Accerta	AccertaClaim Servicorp Inc.
NC	Not covered
X	Included in the plan
PD	Pre-determination
R	3 periapical radiographs (PA) or 1 panoramic radiograph per 12 months
-	No plan

	Toronto	Durham	Thunder Bay	S. St Marie	Wellington	Grey County	Peterborough	Windsor[i]	Stratford	Waterloo[ii]	Halton[iii]
Admin	GWL	PHU	Accerta	Accerta	Accerta	Accerta	Accerta & OW admin[iv]	Accerta & OW admin[v]	Accerta	PHU[vi]	PHU
$ limit	none	none	none	none	$1000	$1000	$600	$300	none	PD 4 teeth/year[vii]	none
PD	NO	YES[viii]	NO	NO	NO	NO	NO	YES (Dentures)	NO	Dentures and RCT	Screening for non emerg[ix]
MCCSS Fees	NO	YES	YES	NO	NO	YES	YES	YES	YES	YES	YES
Amalgam & composite	NO	NO	NO	NO	NO	NO	NO	NO	NO[x]	NO	NO
Complete	NC	NC	NC	1/36	NC	NC	X[xi]	NC	NC	NC	PD 1 per 60 mo
Emergency	X[xii]	3/12	3/6	3/12	3/6	3/6	X	2 exams/year	3/12 mo combined	X	Unlimited
Specific	X	X	X	NI	X	X	X	2 exams/yr	3/12 mo combined[xiii]	X	1 /12 mo
Recall	NC	NC	NC	NC	NC	NC	X	NC	NC	NC	NC
Film	6/12	3/12	3/12	5/12	3/12	3/12	8/12 + 2BW/9	3 PA/3 yrs	3 PA/12 mo combined[xiv]	X	5/12 mo

	Toronto	Durham	Thunder Bay	S. St Marie	Wellington	Grey County	Peterborough	Windsor[i]	Stratford	Waterloo[ii]	Halton[iii]
Panoramic	NC	X	R[xv]	1/36	R	R	1/24	1/3 yrs[xvi]	R	X	1/24 mo
Biopsy	X	X	X	X	X	X	X	X	X	X	X
Prevention	NC	NC	NC	NC	NC	NC	YES[xvii]	NC	NC	NC	PD up to 4 units scaling[xviii]
CTPC	NC[xix]	X	X	X	X	X	X	X	X	X	X
Amalgam	X	X	X	X	X	X	X	X	X	X	X
Comp (A)	X	X	X	X	X	X	X	X	X	X	X
Comp (P)	NC	X	X	X	X	X	X	X	X	X	X
Pulpotomy	NC	NC	NC	13 to 43	NC	NC	YES	X	-	See RCT	See RCT
Pulpectomy	X	PD	X	13 to 43	X	X	YES	X	X	See RCT	See RCT
RCT	NC	PD[xx]	NC	13 to 43	NC	NC	YES	NC	NC	PD[xxi]	PD 3 per 5 years
Perio 42831	NC	X	X	X	X	X	X	NC	X	X	4 units including scaling
Basic removals	X	X/PD 8's	X	X	X	X	X	X	X	X	X
Replant	X	X	X	X	X	X	X	X	X	X	X
GA	NC	NC	NC	X[xxii]	NC	NC	8 units/appt	NC	X	NC	NC
Sedation	NC	NC	NC	X	NC	NC	8 units/visit	NC	X	NC	NC
NO	X	NC	NC	X	NC	NC	8 units/visit	NC	NC	NC	NC
Dentures[xxiii]	1/5 yrs	PD[xxiv]	-	ONCE	-	-	YES	1/10 yrs	-	1/5 yrs[xxv]	1/5 yrs
Cast RDP	NC	NC	-	ONCE	-	-	YES	1/10 yrs	-	1/5 yrs	1 / 5 yrs
Repairs	$88/12 mo	PD	-	1/2 yrs	-	-	yes	1 per appliance/year	-	1/3 years	4/year
Reline	1/36[xxvi]	PD	-	½ yrs	-	-	yes	1 per appliance/year	-	1/3 yrs[xxvii]	1/3 yrs[xxviii]

Appendix B – Comparison of Select Fee Codes

Fee code	01204	01205	02112	20111	21243	23323	71201
MCCSS GP	$19.00	$19.00	$16.33	$31.68	$79.32	$102.88	$88.69
Toronto	$13.29 (-30.1%)	$13.29 (-30.1%)	$11.88 (-27.3%)	N/A	$55.40 (-30.2%)	N/A	$62.04 (-30.0%)
Algoma	$28.08 (+51.6%)	$28.08 (+51.6%)	$24.00 (+47.0%)	$68.00 (+114.6%)	$128.80 (+62.4%)	$171.20 (+66.4%)	$161.60 (+82.2%)
Kawartha Lakes	$38.00 (+100.0%)	$38.00 (+100.0%)	$34.00 (+108.2%)	$109.00 (+244.1%)	$128.80 (+62.4%)	$171.20 (+66.4%)	$217.00 (+144.7%)
Northumberland	$29.60 (+55.8%)	$29.60 (+55.8%)	$26.40 (+61.7%)	$83.20 (+162.6%)	$152.80 (+92.6%)	$152.80 (+48.5%)	$167.20 (+88.5%)
Peel	$18.93 (-0.4%)	$18.93 (-0.4%)	$16.27 (-0.4%)	$31.56 (-0.4%)	$79.02 (-0.4%)	$102.50 (-0.4%)	$88.36 (-0.4%)
Sault St Marie	N/A	$23.40 (+23.2%)	$19.50 (+19.4%)	$55.25 (+74.4%)	$125.45 (+58.2%)	$128.70 (+25.1%)	$131.30 (+48.0%)
Manitoulin Sudbury	$38.00 (+100.0%)	$38.00 (+100.00)	$33.00 (+100.00)	$108.00 (+240.9%)	$208.00 (+162.2%)	$239.00 (+132.3%)	$210.00 (+136.8%)
Huron	$33.30 (+75.3%)	$33.30 (+75.3%)	$29.70 (+81.9%)	$93.60 (+195.5%)	$171.90 (+116.7%)	$202.50 (+96.8%)	$188.10 (+112.1%)
Wellington	$32.40 (+70.5%)	$32.40 (+70.5%)	$27.00 (+65.3%)	$76.50 (+141.5%)	$144.90 (+82.7%)	$192,60 (+87.2%)	$181.80 (+105.0%)

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[i] Plan in the preamble indicates relief of pain only for the dental plan and specifically indicated that no extra billing is permitted.

[ii] The Waterloo plan covers up to 4 extractions or 3 fillings per the schedule. Treatment beyond that level has to be preauthorized.

[iii] "Halton Region does not intend to provide on-going regular dental care to adults in the OW program. The OW Adults dental program is not an insurance plan. This program provides three types of care: Emergency care for conditions involving pain, infection, or trauma. Denture care to restore chewing ability and/or speech. Non-emergency dental services will only be covered under special circumstances."

[iv] Dentures are $750 for upper / $750 for a lower per 5 years; case worker determined.

[v] The municipal administrator processes claims for dentures internally but the Discretionary Dental Benefits Program claims processing is done by Accerta.

[vi] Adults and their dependent children, 18 years and older, can receive emergency care. As an Ontario Works client, you will receive a dental card with your statement each month. If you have a specific dental problem you can go to a dental care provider and have it checked. You can have an exam, limited number of x-rays and up to three teeth filled or up to four teeth removed.

[vii] Preamble for the plan indicates where dentist can send their authorizations for care and provides a number for dental offices to call.

[viii] "Predetermination of Benefits if required for any treatment other than that provided at the time of the initial appointment to relieve pain or beyond the two teeth treatable […]."

[ix] Non-emergencies; adults with non-emergency dental conditions must first be screened by Halton Region Oral Health staff.

[x] The preamble indicates that if a tooth is restored with more than one material than the amalgam rate applies.

[xi] Includes any 2 examinations per 12 months for emergency. A complete exam every 60 months and a recall examination every 9 months or 9 months after a complete exam.

[xii] For either emergency or specific exam covers only 1 unit of time (fee adjusted accordingly).

[xiii] Plan allows for any combination of 3 exams (specific or emergency per 12-month period).

[xiv] The plan allows for either 3 PA's or 1 panorex per 12 months.

[xv] The benefit is either 3 films per 12 months or 1 panorex (BW's excluded).

[xvi] Plan limits either 3 PA's or 1 panorex per 3 years.

[xvii] Includes polishing 1per 9 months, scaling 4 units per 12 months, fluoride treatment.

[xviii] Plan also has 1 unit of smoking counseling as a covered benefit.

[xix] The plan lists 20131/9, which are for trauma control.

[xx] Set maximum fee of $253.39 anterior teeth only.

[xxi] Waterloo plan: 1 time per tooth: 3 teeth per patients per 60 months excluding the anterior teeth 1-2 to 2-3.

[xxii] 6 units per dentist per year for all three combined GA, Sedation or NO.

[xxiii] Information for those municipal administrators with public plans. Those not indicating a plan does not meant that it may not be available and typically clients have to request assistance.

[xxiv] All denture services are PD. The plan reimburses fee that includes professional and lab components.

[xxv] Plan also covers immediate dentures.

[xxvi] Relines are limited to once every 36 months, are not covered until after 3 months if a new denture has been paid for and dentures will not be replaced if a reline fee has been pain within 6 months. Repairs are limited to $88 per denture per 12 consecutive months

[xxvii] Also covers a soft reline once per denture.

[xxviii] Plan also covers up to 4 times per year tissue conditioning.

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