

Canadian Dental Care Plan

Régime canadien de soins dentaires

Preauthorization under the Canadian Dental Care Plan

Coverage under the Canadian Dental Care Plan

To help improve your oral health, the [Canadian Dental Care Plan](#) (CDCP) helps cover a portion of the cost of a range of [oral health care services](#), but it may not cover all the costs or services recommended by your provider (dentist, denturist, dental hygienist, dental specialist or provider at a school that trains oral health providers).

Some services have a frequency limit, meaning you can only receive the service a certain number of times within a time period. Other services need to be pre-approved by the CDCP **before you receive the treatment so you can know if it will be covered by the plan**. This is called 'preauthorization'.

What is the purpose of a preauthorization?

Preauthorization is needed for some services such as crowns, extra cleanings (additional units of scaling) and some dentures before treatment starts. Only about 2% of services billed to the CDCP require preauthorization.

The CDCP's preauthorization process is not to determine if the proposed treatment is the right treatment, but only whether a service is eligible under the CDCP. Not all requests will be approved.

A preauthorization is an estimate. It tells you and your oral health provider if the service will be covered and estimates how much you will have to pay, if anything, at a specific point in time. It assumes that:

- you receive the treatment before the preauthorization expires and it is the same as the one described in the preauthorization,
- the same rules and fees remain in effect as when the preauthorization was approved,
- you are an active member of the CDCP at the time the treatment is completed.

Any of these may change between the time a preauthorization decision is made and the time the service is received.

A preauthorization decision does not guarantee that a service will be reimbursed at the time it is received. Should any of those factors change, it may make a difference in whether the estimate remains accurate and whether the treatment is still approved. For example, if higher fees are in effect than were in effect when the preauthorization was approved, you may have to pay less than anticipated, but the opposite may also be true.

Process and outcome of preauthorization requests



Your oral health provider must submit preauthorization requests and claims to Sun Life for you. After Sun Life reviews a request, your provider receives the answer. You can also access this information through [my Sun Life](#), a secure online portal where you can review your plan details and claims history – including the outcome of a preauthorization request. You can also contact Sun Life at 1-888-888-8110 for assistance. Please note that Health Canada is not responsible for the adjudication of an individual claim or preauthorization decision, including reconsiderations.

If your preauthorization is **approved**, your provider will receive a cost estimate for the services. In addition to any changes in your eligibility, coverage and the policies that are in effect, if your provider's fees are higher than those established under the CDCP, you may have a difference on your final bill. This may be because of additional fees from your provider that are not reflected on the estimate/Explanation of Benefit (EOB). It is essential that you confirm with your provider that they have verified your member eligibility and service coverage at the time the service is to be received.

Most approved preauthorizations are valid for up to 12 months (with some exceptions for preventive and periodontal services that are valid for up to 24 months), as long as your coverage is active and the requested service is covered under the CDCP on the date of service. You should make sure your coverage is active and the service is covered before you receive the treatment.

If a preauthorization is **denied**, your provider receives an explanation of benefits that explains why the request was denied. If the reason says that the service “did not meet the plan criteria for coverage,” additional details can be found in the relevant sections of the [CDCP Dental Benefits Guide](#).

Reconsideration of a denied preauthorization

If additional or new clinical information becomes available, your provider can submit a request for reconsideration on your behalf within 60 days of the preauthorization denial. More details on this process are available in [Appendix C of the CDCP Dental Benefits Guide](#).

Services identified as exclusions (see [Appendix E: Exclusions](#)) will never be covered and cannot be reconsidered. Exclusions include services such as:

- veneers in composite or ceramic
- all $\frac{3}{4}$ crowns
- cosmetic treatment, including teeth whitening
- fixed prosthodontics (bridges and all bridge-related procedures)
- periodontal appliances, including bruxism appliances (night guards)
- implants and all implant-related procedures
- bone grafts