ProBenefits Inc.
employer benefit solutions

Frequently Asked Questions

1. How do I submit and check on the status of my claims?

a) Dental claims can be submitted electronically by your dental provider, should they participate in electronic submission. If you are submitting your dental expense, please have your dental office complete a standard dental claim outlining the procedures completed and forward it to our office via claims@probenefitsinc.ca or mail. You can also submit it at ProBenefits Inc. or on the *My Health Benefits* mobile app.
b) Healthcare and visioncare expense receipts MUST be attached to the healthcare/visioncare claim form if submitted via email at claims@probenefitsinc.ca or mail.
c) A claim form is not required if submitting on-line.
d) The status of your claim can be explored on the *My Health Benefits* mobile app via the DASHBOARD (for recent claims) or the HISTORY tab.
e) Most claims take 5 to 10 business days to process.

2. Can I submit claims electronically?

Yes, claims can be submitted electronically. Sign in at ProBenefits Inc. and use the SUBMIT A CLAIM button on the dashboard or the "+" symbol on the *My Health Benefits* app. Step by step instructions for online submission.

3. Can my claims be sent directly to ProBenefits Inc. from my provider?

Each healthcare or visioncare provider has their own policy in place regarding payment options. If the provider allows you to assign your benefit payable to their office, please have them email, fax, or mail ProBenefits Inc. the AOB (Assignment of Benefits), healthcare/visioncare claim form, and their invoice.

Dental providers can submit claims via CDAnet and pharmacy's submit claims via ASSURE.

4. Can I sign up for Direct Deposit?

Yes, use the Direct Deposit form and then email it to us at claims@probenefitsinc.ca .

5. What does my plan cover?

The Employee Benefit Booklet will outline the benefit coverage you have in place. Benefit booklets can be found through your online access at ProBenefits Inc. or on the *My Health Benefits* app or contact your plan administrator for a copy.

If the service/product you are looking for is not found in the Benefit Booklet, then please contact our office at 1-800-375-3360 for further clarification.

6. How long do I have to submit a claim?

Your Employee Benefit Booklet will have the details. Submit as soon as possible with ProBenefits but no later than 3 months into the new calendar year after the treatment is provided.

7. Where do I find my group and certificate numbers?

This information is located on your benefit id card, which you would have received from your plan administrator at the time you became effective on the program. Your benefit card can also be found under the person icon at ProBenefits Inc. or under the My Profile icon on the *My Health Benefits* app.

8. My plan covers 100% for basic dental services, yet I sometimes must pay out of pocket for some of these services, why?

Each province has its own official dental fee guide for the current year. Your dentist may charge more than what the suggested fee guide is; thus, you will have to pay the difference. To avoid surprises, call your dental office in advance to have them submit a treatment plan for verification.

9. When should I get a pre-authorization on health and dental treatments?

a) For dental services, have your dentist submit a pre-authorization when your services are expected to be a large sum or for services you may not be certain are covered under your program.

The statement will be mailed to your dental office. It can also be found through your on-line access at ProBenefits Inc. under the HISTORY tab and PREDETERMINATION or the *My Health Benefits* app under the HISTORY tab and FILTER.

b) Certain health expenses may require pre-authorization. Contact our office for details.

10. Does my dental plan cover braces (orthodontics)?

Check the BENEFIT SUMMARY in your benefit booklet. Orthodontic coverage will be listed under DENTAL CARE if there is coverage. The age limit for coverage may be listed there or it can be found further in the document under DENTAL CARE and TREATMENT PLAN.

It is suggested that an orthodontic treatment plan be forwarded to our office before beginning treatment.

11. When are children no longer eligible to be on my benefit policy?

a) For most policies, dependent children are those under age 21, and age 21 up to age 25 for those that are attending full time studies at a recognized post-secondary institute.
b) If you have a disabled dependent over age 25, please contact our office to discuss further.

Please review your benefit booklet to confirm dependent eligible age.

12. I submitted a till receipt for my purchase/service, but it was declined, why?

A till receipt is declined for coverage as it does not identify what the purchase/service was, does not include the drug identification number (required for prescriptions only), is missing the claimant's name, and the date of service. Please ensure you are submitting official receipts for assessment.

13. When should I use my Health Care Spending Account (HCSA)?

HCSA funds are used to supplement any unpaid portion from a dental, health, or vision claim through another plan.

Claims are submitted through your primary dental/health/vision plan first. If you have a secondary traditional plan and there is an unpaid balance, then submit the claim through that plan. After all your other coverage is exhausted and there is still an unpaid balance, claims are eligible for reimbursement through your HCSA. You may have to submit a HCSA claim form to request reimbursement, depending on your plan design.

Items accepted through a HCSA are the same type of expenses that you would be able to submit to the Canada Revenue Agency if you were to claim them for Income tax purposes.

14. Can I purchase an item/service today and use my next years HCSA funds to reimburse it?

If your group carries forward funds you can only use the available credits in the benefit year that the item/service was purchased to reimburse the claim.