My BENEFIT PLAN

Public Service Pension Plan – Retired Members

Billing Division: 1000

Effective Date: April 1, 2017

gsc green shield canada

WELCOME TO YOUR BENEFIT PLAN

This summary contains information about your voluntary benefits with **Public Service Pension Board of Trustees**, your plan sponsor, available through the group contract with Green Shield Canada (GSC), effective April 1, 2017.

Enrolment

To enrol, you must apply for coverage using the approved application forms enclosed within your Retirement Application Package no later than 60 days of your pension being approved or 60 days of losing a comparable coverage. Coverage will commence on the first of the month following the month in which your application has been received by BC Pension Corporation, the Plan Administrator.

You are eligible to elect the Health Benefit, or the Dental Benefit (Essential or Enhanced), or you can elect both the Health Benefit and one of the Dental Benefits.

For the Dental Benefit:

- If you elect to enrol in either the Essential Dental Benefit or Enhanced Dental Benefit, you must be covered for a minimum of 12 months.
- If you elect to enrol in the Essential Dental Benefit, you will be locked into this plan for 24 months before you are eligible to upgrade to the Enhanced Dental Benefit.
- If you elect to enrol in the Enhanced Dental Benefit, you may not downgrade to the Essential Dental Benefit.

If you have waived eligibility due to having coverage through your spouse's benefit plan or other comparable coverage under another plan, you must request coverage from BC Pension Corporation within 60 days after termination of the coverage under that plan. Coverage will commence on the first day of the month in which proof of continuous and comparable coverage has been received by BC Pension Corporation.

BC Pension Corporation is solely responsible for submitting all required forms to GSC as of the Effective Date of this plan or as of the first date that you become eligible.

HEALTH SUMMARY – IN CANADA ONLY

The health benefits are intended to supplement your provincial health insurance plan. The benefits shown below will be eligible if they are medically necessary for the treatment of an illness or injury, and reimbursement will be limited to reasonable and customary charges, in addition to any specific limitations and maximums stated below.

Calendar Year Deductible: (per person)	$250 (excluding auto injector, insulin gun, insulin pen injector, Hearing Care and Vision) If in any calendar year, the eligible expenses do not exceed the deductible, claims incurred in the last 3 months of the calendar year may be used to satisfy the deductible in the following year
Maximums Overall Health Maximum:	$200,000 per lifetime Reinstatement of this maximum and eligibility for benefits will be considered when GSC receives satisfactory evidence of full recovery. You and your dependents continue to be covered even if you reach your lifetime maximum above. You will have to continue payment of rates for your dependents only, because you will not be eligible for reimbursement for any of your own Health claims.
Co-insurance **In-Province (includes non-emergency expenses out-of-province/territory in Canada only):** Auto injector, insulin gun, insulin pen injector, Hearing Care and Vision: Prescription Drugs and all other Health Benefits:	 100% 70%* of eligible expenses until $2,000 of paid claims has been reached per person per calendar year, then 100% co-insurance will apply * 80% for drugs dispensed at Costco Pharmacy

Out-of-Province/Territory (in Canada only):	100% of emergency medical expenses for hospital, physician, ambulance and prescription drugs
Your Plan Covers	**Maximum Plan Pays**
Prescription Drugs **(Mandatory Generic)** - Includes certain generic drugs that legally require a prescription and have a Drug Identification Number (DIN) Dispensing Fee Cap:	Subject to Overall Health Maximum 8% markup over the manufacturer's drug cost for B.C. residents only Current PharmaCare Cap per prescription or refill
Hospital Accommodation	Semi-private or private room
Hearing Care	$700 per ear every 4 calendar years (every 2 calendar years for dependent children)
Orthotics/Orthopedic Footwear Custom boots or shoes, adjustments to orthopedic shoes, custom orthotics including adjustments:	$400 every calendar year combined
Paramedical Practitioners Chiropractor, Chiropodist/Podiatrist, Registered Massage Therapist, Naturopath, Physiotherapist, Psychologist, Acupuncturist	$500 every calendar year combined for all practitioners X-rays are not covered
Vision Eyeglasses or contact lenses or medically necessary contact lenses (in or outside Canada) Laser eye surgery or eye examinations	$200 every 2 calendar years combined (every calendar year combined for dependent children)

DENTAL SUMMARY – IN CANADA ONLY

The dental benefits shown below will be eligible if they are necessary for the prevention of dental disease or treatment of dental disease or injury and reimbursement will be limited to the amount stated in the Provincial Dental Association Fee Guide indicated below.

	ESSENTIAL DENTAL	ENHANCED DENTAL
Calendar Year Deductible: (per person)	No deductible	No deductible
Dental Fee Guide: **(General Practitioners)** **(Specialist Practitioners)**	Current province where services are rendered 10% above the fee guide for General Practitioners	Current province where services are rendered 10% above the fee guide for General Practitioners
Co-insurance Basic Services:	75%	75%
Comprehensive Basic Services:	75%	75%
Major Services:	Not covered	75%
Your Plan Covers		
Basic Services	$750 per calendar year combined for all Basic and Comprehensive Basic Services	$1,500 per calendar year combined for all Basic, Comprehensive Basic and Major Services
Comprehensive Basic Services		
Major Services		
Summary of Covered Benefits		
Basic Services include recall visits once every 9 months, fillings, and simple extractions **Comprehensive Basic Services** include root canal therapy, periodontal scaling/root planing, complicated extractions, and denture relining/rebasing, repairs, or adjustments **Major Services** include crowns, dentures and/or bridgework (replacements of each limited to once every 5 years)		

ABOUT THIS SUMMARY

This information is intended to provide an overview of the coverage available. Detailed benefit information about your coverage, including limitations and exclusions applicable to the benefits appearing in this summary, which will form part of your Benefit Plan Booklet, will be available online at greenshield.ca.

This summary describes the deductibles, co-insurance and maximums that may be applicable to your coverage if you are included in the Billing Division shown on the cover of this summary. All dollar maximums stated in this summary are expressed in Canadian dollars.

You are covered for only those specific benefits for which you have applied and are eligible. You must be covered in order for your dependents to be covered. Your coverage will terminate as outlined under the Termination provision of this booklet. Coverage for your dependents will terminate upon the earlier of termination of your coverage or the date your dependent no longer satisfies the definition of a dependent.

If you enrol for coverage, you will receive Identification Cards showing your GSC Identification Number to be used on all claims and correspondence, and for identification purposes when speaking with our Customer Service Centre. Your number will appear on the front of the card and end in -00, while each of your dependents with their numbers will be shown on the back.

PLAN MEMBER ONLINE SERVICES – INFORMATION YOUR WAY

In addition to this summary, and our Customer Service Centre, we also provide you with access to our secure website. Self-service through the GSC website makes things quick, convenient and easy. Register with GSC to:

- View your Benefit Plan Booklet
- Access your personal claims information, including a breakdown of how your claims were processed
- Simulate a claim to instantly find out what portion of a claim will be covered
- Submit certain claims online
- Search for a drug to get information specific to your own coverage (or coverage for your family)
- Search for eligible dental, paramedical, and vision care providers in a particular location (within Canada)
- Search for vision and hearing care providers who offer discounts to GSC plan members through our Preferred Provider Network
- Arrange for claim payments to be deposited directly into your bank account
- Print personalized claim forms and replacement Identification Cards
- Print personal Explanation of Benefits statements for when you need to co-ordinate benefits

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

OUR COMMITMENT TO PRIVACY

The GSC Privacy Code balances the privacy rights of our group and benefit plan members and their dependents, and our employees, with the legitimate information requirements to provide customer service.

To read our privacy policies and procedures, please visit us at greenshield.ca.

TABLE OF CONTENTS

DEFINITIONS

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

Allowed amount means**,** as determined by GSC:

a) Drugs – the PharmaCare low cost alternative and reference drug programs for B.C. residents, or, the GSC National Pricing Policy and/or the reasonable and customary charge for all other provinces;
b) Extended Health Services – the reasonable and customary charge for the service or supply but not more than the prevailing charge in the area in which the charge is made for a like service or supply;
c) Dental – the fee guide as specified in the Summary of Benefits.

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

Co-insurance is the percentage of the eligible allowed amount that you or your dependent is entitled to receive for reimbursement of an eligible expense, after the deductible is satisfied.

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

Custom made boots or shoes means footwear used by an individual whose condition cannot be accommodated by existing footwear products. The fabrication of the footwear involves making a unique cast of the covered person's feet and the use of 100% raw materials. (This footwear is used to accommodate the bony and structural abnormalities of the feet and lower legs resulting from trauma, disease or congenital deformities.)

Custom made foot orthotics means devices made from a 3-dimensional model of an individual's foot and made from raw materials. (These devices are used to relieve foot pain related to biomechanical misalignment to the feet and lower limbs.)

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

Dependent means

a) your spouse, if you are legally married or if not legally married, you have lived in a common-law relationship for more than 1 year. Only one spouse will be considered at any time as being covered under the group contract;
b) your unmarried child under age 19;
c) your unmarried child under age 25, if enrolled and in full-time attendance at an accredited college, university or educational institute (minimum 3 courses per semester, including co-op programs, online and correspondence courses); and
d) your unmarried child (regardless of age) who became totally disabled while eligible under b) or c) above, and has been continuously so disabled since that time and is considered a dependent as defined under the Income Tax Act, also qualify as a dependent.

Your unmarried child (your or your spouse's natural, legally adopted, stepchildren, or legal ward, (but does not include a foster child) must reside with you in a parent-child relationship or be dependent upon you (or both). Your child must not be regularly employed more than 30 hours per week on a permanent (year round) basis.

Children who are in full-time attendance at an accredited school do not have to reside with you or attend school in your province. If the school is in another province, you must apply to your provincial health insurance plan for an extension of coverage to ensure your child continues to be covered under a provincial health insurance plan.

Emergency means a sudden, unexpected injury, illness or acute episode of disease that requires immediate medical attention **and could not have been reasonably anticipated based upon the patient's prior medical condition**. This includes treatment (non-elective) for immediate relief of severe pain, suffering or disease that cannot be delayed until you or your dependent is medically able to return to your province of residence.

Fee guide means the list of dental procedure codes developed by and maintained by the Canadian Dental Association, adopted by the provincial or territorial dental association of the province or territory in which the service is provided and in effect at the time the service is provided. For Alberta, with no fee guide, reimbursement will be according to a fee schedule established by GSC for that province.

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

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

Orthopedic shoes means off-the-shelf, ready-made footwear prescribed for covered persons diagnosed with a specific medical condition that affects their feet and who require specialized footwear to treat their condition and assist with mobility. **Note: this plan only covers the adjustment of the orthopedic shoes.**

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

Private room for hospital accommodation means a room having only one treatment bed.

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

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

Semi-private room for hospital accommodation means a room having only two treatment beds.

ELIGIBILITY

For You

To be eligible for coverage, you must be a retired plan member who is:

a) a resident of Canada; and
b) covered under your provincial health insurance plan; and
c) receiving a monthly pension from the Public Service Pension Plan.

For Your Dependents

To be eligible for coverage you must be:

a) covered under this plan; and
b) each dependent must be covered under a provincial health insurance plan.

Coverage Effective Date

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

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

Enrolment

Please refer to the Summary for the enrolment process.

Termination

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

a) the last day of the month in which you:
    i) terminate your coverage; or
    ii) are no longer eligible for a monthly pension benefit; or
    iii) are no longer covered under a provincial health insurance plan; or
    iv) became deceased;
b) the end of the period for which rates have been paid to GSC for your coverage;
c) the date the group contract terminates.

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

a) the last day of the month in which your:
    i) coverage terminates (except as provided under Survivor Continuation of Coverage);
    ii) dependent is no longer an eligible dependent;
    iii) dependent child attains the specified age limit;
b) the end of the period for which rates have been paid for dependent coverage;
c) the date the group contract terminates.

Dependent Children Continuation of Coverage

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

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

Survivor Continuation of Coverage

In the event of your death while covered by this plan, coverage will continue for either your eligible spouse who is receiving a monthly pension or, in the event there is no spouse, your eligible dependent children who are receiving a monthly pension, until the earliest of the last day of the month in which:

a) your spouse or dependent coverage terminates under a provincial health insurance plan;
b) your spouse or dependent children terminates their coverage;
c) the covered person would no longer be considered a dependent under the plan as outlined under Termination; or
d) the benefit under which your dependent is covered, terminates.

DESCRIPTION OF BENEFITS

HEALTH BENEFIT PLAN – IN CANADA ONLY

The benefits described in this section will be eligible, up to the amount shown in the Summary of Benefits, if they are medically necessary for the treatment of an illness or injury. Reimbursement will be limited to reasonable and customary charges in addition to any specific limitations and maximums stated in the Summary of Benefits and as stated in this Description of Benefits.

IN-PROVINCE
(includes non-emergency expenses out-of-province/territory in Canada only)

Prescription Drugs

Prescription drug benefits, up to the amount shown in the Summary of Benefits, that:

a) are prescribed by a legally qualified medical practitioner or dental practitioner as permitted by law; and
b) legally require a prescription and have a Drug Identification Number (DIN).

If approved by GSC, this plan includes drugs with a Drug Identification Number (DIN) that do not legally require a prescription, including insulin and all other approved injectables, as well as related supplies such as diabetic syringes and needles (not eligible within 5 years of a claim for an insulin gun), lancets and testing agents.

Certain drugs may require prior approval. Your Pharmacist is aware of the drugs that fall into this category.

Maintenance drugs required to treat lifelong chronic conditions must be purchased in a 90-day supply of a prescription at any one time. Non-maintenance drugs may be purchased in a supply not exceeding 3-months (90-day) supply of a prescription at any one time. However, for all drugs, 6 months for a vacation supply may be purchased and not more than a 13-month supply in any 12 consecutive months.

Mandatory generic drug substitution

Based on specific provincial health insurance plan regulations, where a generic equivalent drug exists, reimbursement will only be made up to the cost of the lowest priced equivalent drug. If a medical practitioner indicates a brand name drug is medically required due to a serious medical reaction to the generic equivalent, GSC must be provided with a copy of the "Health Canada Vigilance Adverse Reaction Reporting Form" (that can be obtained from the Health Canada website) completed by the medical practitioner, to determine eligibility for payment of the cost of the prescribed drug.

NOTE:

Drug Benefit over age 65:	The Drug Benefit co-pay and the deductible under your provincial health care plan (where applicable) in your province of residence are eligible benefits.
Quebec residents only:	Legislation requires GSC to follow the RAMQ (The Regie de l'assurance maladie du Quebec) reimbursement guidelines for all residents of Quebec. If you are younger than age 65, you must enroll for the GSC Prescription Drugs benefit plan and GSC will be the only payer. If you are age 65 or older, enrolment in RAMQ is automatic, enrolment in the GSC Prescription Drugs benefit plan is optional, and RAMQ would be first payer. If any provisions of this plan do not meet the minimum requirements of the RAMQ plan, adjustments are automatically made to meet RAMQ requirements.

Eligible benefits do not include and no amount will be paid for:

a) Drugs for the treatment of erectile dysfunction and infertility;
b) Contraceptives;
c) All vitamins, other than B12 injectable vitamins;
d) Vaccines;
e) Medications for the treatment or to replace an addiction or habituation;
f) Sclerotherapy agents;
g) Smoking cessation oral drugs and Nicotine replacement products, such as patches, gum, lozenges, and inhalers;
h) Products which may lawfully be sold or offered for sale other than through retail pharmacies, and which are not normally considered by practitioners as medicines for which a prescription is necessary or required;
i) Ingredients or products which have not been approved by Health Canada for the treatment of a medical condition or disease and are deemed to be experimental in nature and/or may be in the testing stage;
j) Mixtures, compounded by a pharmacist, that do not conform to GSC's current Compound Policy. To verify the eligibility of a compound, contact our Customer Service Centre.

Extended Health Services

Hospital Accommodation: Provided your provincial health insurance plan has accepted or agreed to pay the ward or standard rate, reimbursement for hospital accommodation shown in the Summary of Benefits will be limited to reasonable and customary charges in the area where received, for accommodation in a public general hospital, or a convalescent or rehabilitation hospital or a convalescent or rehabilitation wing in a public general hospital.

Hearing Care: Reimbursement for hearing aids, repairs or replacement parts, if recommended or approved by the attending legally qualified medical practitioner, up to the amount shown in the Summary of Benefits. No amount will be paid for batteries.

Medical Items and Services: When prescribed by a legally qualified medical practitioner, unless specified otherwise below, reimbursement for reasonable and customary charges, up to the amount, where applicable, as shown in the Summary of Benefits for:

a) Aids for daily living: such as hospital style beds, including rails and mattresses; standard commodes;
b) Footwear, when dispensed by your podiatrist, chiropodist, chiropractor, orthotist, or pedorthist:
    i) custom-made foot orthotics when prescribed by your attending physician, podiatrist, chiropractor or physiotherapist, or adjustments to custom made foot orthotics;
    ii) custom-made boots or shoes, adjustments to orthopedic shoes, when prescribed by your attending physician, podiatrist or chiropractor;
c) Braces, casts;
d) Diabetic equipment, such as:
    i) blood glucose monitors, auto injector, insulin pen injector, insulin pumps, and insulin pump supplies;
    ii) insulin gun, limited to $500 every 5 calendar years;
e) Medical items such as:
    i) transcutaneous electric muscle stimulators (TEMS machine), due to an injury or illness, and all muscle tone is lost;
    ii) transcutaneous electric nerve stimulators (TENS machine) and supplies;
    iii) continuous passive motion device, due to cancer;
    iv) heart rate monitor or cardiac screener;
    v) speech aids limited to $4,000 every 5 calendar years;
f) Incontinence/Ostomy equipment, such as catheter supplies and ostomy supplies;
g) Mobility aids such as canes, crutches, walkers and wheelchairs (including batteries);
h) Standard prosthetics, such as:
    i) arm, hand, leg, foot, eye, larynx;

   ii) external breast prosthesis and post-mastectomy bra, limited to $500 every calendar year combined;
   iii) stump socks, limited to $200 every calendar year;

i) Respiratory/Cardiology equipment, such as:
   i) APAP, BIPAP, CPAP machine (and supplies);
   ii) compressors and inhalant devices;
   iii) oxygen;
   iv) tracheotomy supplies;

j) Compression stockings with a pressure measurement of 15 mmhg or higher;

k) Wigs, for temporary or permanent hair loss due to chemotherapy or alopecia, limited to $200 every 2 calendar years.

Some items may require pre-authorization. To confirm eligibility prior to purchasing or renting equipment, submit a Pre-Authorization Form to GSC.

Limitations

a) The rental price of durable medical equipment will not exceed the purchase price. GSC's decision to purchase or rent will be based on the legally qualified medical practitioner's estimate of the duration of need as established by the original prescription. Rental authorization may be granted for the prescribed duration. **Equipment that has been refurbished by the supplier for resale is not an eligible benefit**;

b) Durable medical equipment must be appropriate for use in the home, able to withstand repeated use and generally not useful in the absence of illness or injury;

c) When deluxe medical equipment is a covered benefit, reimbursement will be made only when deluxe features are required in order for the covered person to effectively operate the equipment. Items that are not primarily medical in nature or that are for comfort and convenience are not eligible.

Emergency Transportation: Reimbursement for reasonable and customary charges for professional land or air ambulance to the nearest hospital equipped to provide the required treatment, when medically required as the result of an injury, illness or acute physical disability.

Paramedical Practitioners: Reimbursement for the services of the practitioners included, up to the amount shown in the Summary of Benefits, when the practitioner rendering the service is licensed by their provincial regulatory agency or a registered member of a professional association and that association is recognized by GSC. Please contact the GSC Customer Service Centre to confirm practitioner eligibility.

NOTE:

- Podiatry services are eligible in coordination with your provincial health insurance plan

Accidental Dental: Reimbursement for the services of a licensed dental practitioner for dental care to teeth when necessitated by a direct blow to the mouth and not by an object wittingly or unwittingly placed in the mouth. The accident must occur while the coverage is in force. You must notify GSC immediately following the accident.

GSC will not be liable for any services performed after the earlier of a) 365 days following the accident, or b) the date you or your dependent cease to be covered under this plan.

No amount will be paid for periodontia or orthodontia treatments.

Charges will be based on the current Provincial Dental Association Fee Guide for General Practitioners in the province where services are rendered. Approval will be based on the current status and/or benefit level of the covered person at the time that we are notified of the accident. Any change in coverage will alter GSC's liability.

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

Vision: Reimbursement for the services performed by a licensed Optometrist, Optician or Ophthalmologist, up to the amounts shown in the Summary of Benefits, for:

a) Prescription eyeglasses or contact lenses.
b) Optometric eye examinations for visual acuity performed by a licensed optometrist, ophthalmologist or physician. This benefit is available only in those provinces where eye examinations are not covered in full by the provincial health insurance plan.
c) Medically necessary contact lenses when visual acuity cannot otherwise be corrected to at least 20/40 in the better eye or when medically necessary due to keratoconus, irregular astigmatism, irregular corneal curvature or physical deformity resulting in an inability to wear normal frames.
d) Replacement parts for prescription eyeglasses.
e) Laser eye surgery.

Eligible benefits do not include and no amount will be paid for:

a) Medical or surgical treatment, except for laser eye surgery;
b) Special or unusual procedures such as, but not limited to, orthoptics, vision training, subnormal vision aids and aniseikonic lenses;
c) Charges for eyeglass cases.

OUT-OF-PROVINCE/TERRITORY (IN CANADA ONLY) ELIGIBLE EXPENSES

Reimbursement for charges while travelling outside your province/territory of residence (in Canada only), for expenses arising as a result of a medical emergency. Eligible benefits will be considered based on the reasonable and customary charges in the area where they were received, less the amount payable by your provincial health insurance plan. Eligible benefits are:

a) Local ambulance services to the nearest qualified medical facility.
b) Hospital services and accommodation while confined in a public general hospital to a maximum of 90 days for:
   i) the difference between the room and board benefit payable by the provincial hospital plan and ward accommodation; and
   ii) hospital services and supplies furnished during hospital confinement.

   GSC should be notified within 5 days of admission to a hospital. Upon the approval of the attending physician, once the covered person's condition has stabilized they will be returned to the nearest hospital to their home by a licensed ambulance for ongoing care. If the transportation would endanger their health, the 90 day limit may be extended upon GSC approval.
c) Professional services of a physician where permitted by law, including laboratory and X-ray services.
d) Prescription drugs which require a prescription by law and are prescribed by a legally qualified medical practitioner.
e) Other services or supplies if they would be considered eligible under your provincial health insurance plan.

Eligible benefits do not include and no amount will be paid for out-of-province/territory (in Canada only) expenses for:

a) Treatment or service that you elect to have performed outside your province/territory of residence (in Canada only), including complications related to such treatment or service;

b) Hospital and medical care for childbirth, including complications within 2 months (8 weeks) of the expected delivery date from the date of departure, or deliberate termination of pregnancy;
c) Treatment or services for ongoing care, rest cures or check-ups that are normally covered under your provincial health insurance plan.

Health Exclusions

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

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

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

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

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

5. Any form of medical cannabis for the treatment of any medical condition, regardless of whether it is authorized by way of a medical document from a legally-authorized medical practitioner and obtained from a Health Canada-licensed producer pursuant to the *Access to Cannabis for Medical Purposes Regulations;*

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

7. Services or supplies that:
   a) are purchased outside Canada, including purchases over the internet (unless specifically included as an eligible benefit);
   b) are not recommended, provided by or approved by the attending legally qualified (in the opinion of GSC) medical practitioner or dental practitioner as permitted by law;
   c) are legally prohibited by the government from coverage;
   d) you are not obligated to pay for or for which no charge would be made in the absence of benefit coverage or for which payment is made on your behalf by a not-for-profit prepayment association, insurance carrier, third party administrator, like agency or a party other than GSC or you;
   e) are provided by a health practitioner whose license by the relevant provincial regulatory and/or professional association has been suspended or revoked;
   f) are not provided by a designated provider of service in response to a prescription issued by a legally qualified health practitioner;

g) are used solely for recreational or sporting activities and which are not medically necessary for regular activities;
h) are primarily for cosmetic or aesthetic purposes, or are to correct congenital malformations;
i) are provided by an immediate family member related to you by birth, adoption, or by marriage and/or a practitioner who normally resides in your home. An immediate family member includes a parent, spouse, child or sibling;
j) are a replacement of lost, missing or stolen items, or items that are damaged due to negligence. Replacements are eligible when required due to natural wear, growth or relevant change in your medical condition but only when the equipment/prostheses cannot be adjusted or repaired at a lesser cost and the item is still medically required;
k) are video instructional kits, informational manuals or pamphlets;
l) are for medical or surgical audio and visual treatment;
m) are special or unusual procedures such as, but not limited to, orthoptics, vision training, subnormal vision aids and aniseikonic lenses;
n) are delivery and transportation charges;
o) are for medical examinations, audiometric examinations or hearing aid evaluation tests;
p) are batteries, unless specifically included as an eligible benefit;
q) are a duplicate prosthetic device or appliance;
r) are from any governmental agency which are obtained without cost by compliance with laws or regulations enacted by a federal, provincial, municipal or other governmental body;
s) would normally be paid through any provincial health insurance plan, Workplace Safety and Insurance Board or tribunal, the Assistive Devices Program or any other government agency, or which would have been payable under such a plan had proper application for coverage been made, or had proper and timely claims submission been made;
t) were previously provided or paid for by any governmental body or agency, but which have been modified, suspended or discontinued as a result of changes in provincial health plan legislation or de-listing of any provincial health plan services or supplies;
u) may include but are not limited to, drugs, laboratory services, diagnostic testing or any other service which is provided by and/or administered in any public or private health care clinic or like facility, medical practitioner's office or residence, where the treatment or drug does not meet the accepted standards or is not considered to be effective (either medically or from a cost perspective, based on Health Canada's approved indication for use);
v) are provided by a medical practitioner who has opted out of any provincial health insurance plan and the provincial health insurance plan would have otherwise paid for such eligible service;
w) relates to treatment of injuries arising from a motor vehicle accident;
   Note: Payment of benefits for claims relating to automobile accidents for which coverage is available under a motor vehicle liability policy providing no-fault benefits will be considered only if–
   i) the service or supplies being claimed is not eligible; or
   ii) the financial commitment is complete;
   A letter from your automobile insurance carrier will be required;
x) are cognitive or administrative services or other fees charged by a provider of service for services other than those directly relating to the delivery of the service or supply.

DENTAL BENEFIT PLAN – IN CANADA ONLY

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

Basic Services

Basic Diagnostic and Preventive Services:

- complete oral examinations once every 3 years (not eligible within 6 months of any exam provided by the same provider)
- specific oral examinations twice per calendar year
- emergency oral examinations
- full series X-rays and panoramic X-rays once every 3 years
- bitewing X-rays once every 9 months
- recall examinations once every 9 months
- cleaning of teeth (up to 1 unit of polishing, plus up to 1 unit of scaling) once per recall period
- topical application of fluoride once per recall period
- denture cleaning once per recall period
- pit and fissure sealants once every 2 years per tooth
- space maintainers

Basic Restorative Services:

- amalgam, tooth coloured filling restorations (paid to full metal on molar), and temporary sedative fillings
- inlay restorations – these are considered basic restorations and will be paid to the equivalent bonded amalgam
- standard onlay restorations to restore diseased or accidentally injured natural teeth, once every 5 years

Basic Oral Surgery:

- extractions of teeth and/or residual roots

Comprehensive Basic Services

Standard Denture Services:

- denture repairs and/or tooth/teeth additions
- standard relining and rebasing of dentures (1 upper and 1 lower) once every 2 years, only after 6 months have elapsed from the installation of a denture
- denture adjustments and remount and equilibration procedures, only after 3 months have elapsed from the installation of a denture
- soft tissue conditioning linings for the gums to promote healing, twice every 5 years
- remake of a partial denture using existing framework, once every 5 years

Comprehensive Oral Surgery:

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

Endodontic Treatment

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

Periodontal Treatment

- treatment of diseased bone and gums
- periodontal scaling and/or root planing
- occlusal equilibration - selective grinding of tooth surfaces to adjust a bite 8 time units per calendar year

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

- bruxism appliance twice every 5 years

Major Services (Enhanced Dental Benefit only)

- Standard crown restorations to restore diseased or accidentally injured natural teeth, once every 5 years

- Standard bridges, including pontics, abutment retainers/crowns on natural teeth, once every 5 years

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

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

Alternate Treatment (Essential and Enhanced Dental Benefit)

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

Predetermination (Essential and Enhanced Dental Benefit)

Before your treatment begins:

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

Limitations

1. Laboratory services must be completed in conjunction with other services and will be limited to the co-insurance of such services shown in the Summary of Benefits. Laboratory services that are in excess of 60% of the dentist's fee in the applicable Fee Guide shown in the Summary of Benefits will be reduced accordingly; co-insurance is then applied;

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

3. Reimbursement will be pro-rated and reduced accordingly, when time spent by the dentist is less than the average time assigned to a dental service procedure code in the applicable Fee Guide shown in the Summary of Benefits;

4. Reimbursement for root canal therapy will be limited to payment once only per tooth. Extra charges for difficult access, exceptional anatomy and calcified canals are not included. The total fee for root canal includes all pulpotomies and pulpectomies performed on the same tooth;

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

6. When more than one surgical procedure, including multiple periodontal surgical procedures, is performed during the same appointment in the same area of the mouth, only the most comprehensive procedure will be eligible for reimbursement, as the fee for each procedure is based on complete, comprehensive treatment, and is deemed part of the multiple services factor;

7. The multiple services factor occurs when a minimum of 6 or more restorations (fillings) or multiple periodontal services are performed at the same appointment and the full fee guide price is charged for each restoration or periodontal service, the first service will be paid in full and all remaining services will be reduced by 20%;

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

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

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

Dental Exclusions

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

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

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

3. Failure to keep a scheduled appointment with a legally qualified dental practitioner, oral hygiene or nutritional instruction;

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

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

6. Implants;

7. Anaesthesia;

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

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

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

11. Service and charges for sleep dentistry;

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

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

14. Services or supplies that:
    a) are not recommended, provided by or approved by the attending legally qualified (in the opinion of GSC) medical practitioner or dental practitioner as permitted by law;
    b) are legally prohibited by the government from coverage;
    c) you are not obligated to pay for or for which no charge would be made in the absence of benefit coverage; or for which payment is made on your behalf by a not-for-profit prepayment association, insurance carrier, third party administrator, like agency or a party other than GSC or you;
    d) are provided by a health practitioner whose license by the relevant provincial regulatory and/or professional association has been suspended or revoked;
    e) are not provided by a designated provider of service in response to a prescription issued by a legally qualified health practitioner;

f) are used solely for recreational or sporting activities and which are not medically necessary for regular activities;
g) are primarily for cosmetic or aesthetic purposes, or are to correct congenital malformations;
h) are provided by an immediate family member related to you by birth, adoption, or by marriage and/or a practitioner who normally resides in your home. An immediate family member includes a parent, spouse, child or sibling;
i) are a replacement of lost, missing or stolen items, or items that are damaged due to negligence. Replacements are eligible when required due to natural wear, growth or relevant change in your medical condition but only when the equipment/prostheses cannot be adjusted or repaired at a lesser cost and the item is still medically required;
j) are video instructional kits, informational manuals or pamphlets;
k) are delivery and transportation charges;
l) are a duplicate prosthetic device or appliance;
m) are from any governmental agency which are obtained without cost by compliance with laws or regulations enacted by a federal, provincial, municipal or other governmental body;
n) would normally be paid through any provincial health insurance plan, Workplace Safety and Insurance Board or tribunal, or any other government agency, or which would have been payable under such a plan had proper application for coverage been made, or had proper and timely claims submission been made;
o) relates to treatment of injuries arising from a motor vehicle accident;
   Note: Payment of benefits for claims relating to automobile accidents for which coverage is available under a motor vehicle liability policy providing no-fault benefits will be considered only if–
   i) the service or supplies being claimed is not eligible; or
   ii) the financial commitment is complete;
   A letter from your automobile insurance carrier will be required;
p) are cognitive or administrative services or other fees charged by a provider of service for services other than those directly relating to the delivery of the service or supply.

CLAIM INFORMATION

Inquiries

For detailed inquiries, contact us:

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

Submitting Claims

Claim forms, including Pre-Authorization forms, and valuable claims submission information, is available at greenshield.ca.

Please note that in addition to a completed claim form, claims reimbursement requires the original itemized paid receipt **(cash receipts or credit card receipts alone are not acceptable)**.

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

All Health claims, including those incurred outside your province of residence (in Canada only), must be received by GSC no later than June 30th of the calendar year following the year in which the eligible benefit was incurred.

Out-of-Province/Territory (in Canada only)

If you have incurred out of pocket expenses for claims incurred outside your province/territory of residence (in Canada only), claims must be submitted to your provincial government health plan first. To claim the eligible remaining portion after payment has been made by your provincial government health plan, submit to GSC's out-of-province travel provider Allianz Global Assistance, the patient name, address and patient number along with:

- Detailed statements showing the services rendered and the fees charged for each service.
- Copies of the allowance and payment made under the provincial government health plan.

Allianz Global Assistance
4273 King Street East
Kitchener, ON
N2P 2E9

Reimbursement

Reimbursement will be made in Canadian funds by one of the following methods:

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

Subrogation

GSC retains the right of subrogation of benefits. This means if GSC paid benefits on behalf of you or your dependent, but the benefits either should have been paid or are subsequently paid or provided, in whole or in part, by a third party liability or other coverage(s), GSC has the right to recover such payment or reimbursement. In cases of third party liability, you must advise your lawyer of our subrogation rights.

Co-ordination of Benefits (COB)

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

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

GSC Plan Member

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

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

Spouse

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

Children

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

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

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

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