My BENEFIT PLAN

OACAS Aftercare Benefits Initiative

Classification: All Plan Members

Billing Divisions: 100 and 200

Revised Effective Date: April 1, 2021

Ontario Association of Children's Aid Societies

Ontario

WELCOME TO YOUR BENEFIT PLAN

ABOUT THIS BOOKLET

This booklet contains important information you will need about your group benefits with **OACAS Aftercare Benefits Initiative**, your plan sponsor, available through the group contract with Green Shield Canada (GSC). It includes:

- a Table of Contents, to allow easy and quick access to the information you are looking for
- a Schedule of Benefits, listing all the deductibles, co-pays and maximums that may impact the amount paid to you
- a Definitions section, to explain common terms used throughout the booklet
- detailed benefit descriptions for each benefit in your group benefit plan
- information a provider needs to submit a claim

You are encouraged to read this booklet carefully; please keep it in a safe place so that you may refer to it at any time.

You will receive Identification Card(s) showing your GSC Identification Number to be used on all claims and correspondence. Your number will appear on the front of the card and end in -00, while each of your dependent children's with their numbers will be shown on the back.

PLAN MEMBER ONLINE SERVICES

In addition to this booklet 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 today 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
- 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
- Print replacement Identification Cards
- Print personal Explanation of Benefits statements

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.

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SCHEDULE OF BENEFITS

HEALTH BENEFIT PLAN

This schedule describes the deductibles, co-pays and maximums that may be applicable if you are included in one of the Billing Divisions shown on the cover of this booklet.

Complete benefit details are provided in the Description of Benefits section of this booklet. Be sure to read these pages carefully. They show the conditions, limitations and exclusions that may apply to the benefits. All dollar maximums are expressed in Canadian dollars. You are covered for only those specific benefits for which you have applied.

This group benefit plan is intended to supplement your provincial health insurance plan. The benefits shown below will be eligible, if they are reasonable and customary, and are medically necessary for the treatment of an illness or injury.

Deductible:	Nil

Maximums	
Overall Maximum:	Unlimited
Professional Services:	$1,000 per calendar year combined for all types of practitioners

Your Co-pay:	Nil

Your Plan Covers:	**Maximum Plan Pays:**
Prescription Drugs – Pay Direct Drug Card	
▪ Smoking cessation program	One course of treatment in any 12 month period
▪ All other covered drugs	Subject to the Overall Maximum
Hearing Care	Reasonable and customary charges
Medical Items and Services	
• Pharmacogenetic testing (through GenXys Health Care Systems only)	Once per lifetime
• Footwear	Reasonable and customary charges
▪ custom made boots or shoes	Reasonable and customary charges
▪ custom made foot orthotics	$700 per calendar year
• Optometric eye exams	$100 once per 24 months, based on date of first paid claim
• Other items and services – See the Description of Benefits section for details	Reasonable and customary charges
Emergency Transportation	Reasonable and customary charges

Your Plan Covers:	Maximum Plan Pays:
Professional Services	
• Chiropractor	$100 for initial visit, $50 each subsequent visit, up to $500 per calendar year, subject to the Professional Services maximum stated above
• Chiropodist or Podiatrist	$90 for initial visit, $60 each subsequent visit, up to $500 per calendar year, subject to the Professional Services maximum stated above
• Registered Massage Therapist	$95 per hour, up to $500 per calendar year, subject to the Professional Services maximum stated above
• Naturopath	$195 for initial visit, $110 each subsequent visit, up to $500 per calendar year, subject to the Professional Services maximum stated above
• Osteopath	$115 for initial visit, $100 each subsequent visit, up to $500 per calendar year, subject to the Professional Services maximum stated above
• Physiotherapist	$90 for initial visit, $75 each subsequent visit, up to $500 per calendar year, subject to the Professional Services maximum stated above
• Psychologist • Master of Social Work	$200 for initial visit, $88 each subsequent visit, up to $500 per calendar year including Master of Social Work $100 per hour up to $500 per calendar year including Psychologist
• Psychiatrist	$88 per hour, up to $500 per calendar year
• Speech Therapist	$155 per hour, up to $500 per calendar year, subject to the Professional Services maximum stated above
Accidental Dental	Reasonable and customary charges
Vision	
• Prescription eye glasses or contact lenses or medically necessary contact lenses	$350 every 24 months based on date of first paid claim

DENTAL BENEFIT PLAN

This schedule describes the deductibles, co-pays and maximums that may be applicable if you are included in one of the Billing Divisions shown on the cover of this booklet.

Complete benefit details are provided in the Description of Benefits section of this booklet. Be sure to read these pages carefully. They show the conditions, limitations and exclusions that may apply to the benefits. All dollar maximums are expressed in Canadian dollars. You are covered for only those specific benefits for which you have applied.

Calendar Year Deductible: (per person/per family)	Nil

Your Copay:	0%

Fee Guide: **(General Practitioners)**	The current Ontario Dental Association Fee Guide for General or Specialist Practitioners For independent Dental Hygienists, the current Ontario Dental Hygienists' Association Fee Guide

Your Plan Covers:	**Maximum Plan Plays:**
Basic Services, Comprehensive Basic Services and Major Services	$5,000 per covered person per calendar year combined

DEFINITIONS

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

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

a) Drugs – the GSC National Pricing Policy and/or the reasonable and customary charge;
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 Schedule of Benefits.

Biologic drug means a drug that is produced using living cells or microorganisms (e.g., bacteria) and are often manufactured using a specific process known as DNA technology.

Biosimilar drug means a biologic drug demonstrated to be similar to a reference biologic drug already authorized for sale by Health Canada.

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

Co-pay is the eligible allowed amount that must be paid by you or your dependent child before reimbursement of an expense will be made.

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

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 a device made from a 3-dimensional model of an individual's foot and made from raw materials. (This device is 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 child in any calendar year before reimbursement of an eligible expense will be made.

Dependent child means

a) your child (natural or legally adopted) must reside with you in a parent-child relationship or be dependent upon you;
b) your unmarried child who became totally disabled 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.

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 (or your province of residence if any dental service is provided outside Canada) and in effect at the time the service is provided.

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.

Off-label use means using a drug for a purpose or to treat a condition other than what Health Canada has approved that drug to be used.

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. The footwear may be modified or adjusted to fit the covered person's feet.

Pharmacogenetic testing means a type of genetic testing that determines whether the covered person has genetic mutations known to influence the way the covered person responds to certain drugs. Based on that information, their health care provider could choose medications better suited to them.

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

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.

Reference biologic drug means a biologic drug that is first authorized for sale by Health Canada.

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

ELIGIBILITY

For You

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

a) a resident of Canada;
b) covered under your provincial health insurance plan;
c) either:
   i) a CAS Youth between 21 and 25 years of age; or
   ii) a CAS Youth adopted on or after June 1, 2016 and between 18 and 25 years of age;
d) not eligible for coverage under any other health plan (e.g. a plan provided by an employer, spouse, or university/college).

For your Dependent Child

To be eligible for coverage your dependent child must be:

a) registered for coverage under this plan; and
b) covered under a provincial health insurance plan.

Coverage Effective Date

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

Your plan sponsor 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.

Termination

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

a) the date you attain age 25, or after 4 consecutive years on the plan;
b) the end of the period for which rates have been paid to GSC for your coverage;
c) the date the group contract terminates.

Your dependent child's coverage will end on the earliest of the following dates:

a) the date your coverage terminates;
b) the date your dependent child is no longer an eligible dependent;
c) the end of the period for which rates have been paid for dependent child's coverage;
d) the date the group contract terminates.

Full eligibility criteria are available at www.oacas.org/abi.

Losing your Group Benefits?

If your coverage terminates under your Plan Sponsor's benefit plan, you may apply for one of GSC's individual Health and Dental plans. Acceptance for these plans is guaranteed as long as GSC receives your application within 90 days of your employee benefits termination date, provided GSC receives the initial payment. There are no health questions and no medical when you apply. These plans offer coverage for medications that treat pre-existing conditions. Best of all, they provide life-time coverage.

SureHealth™ LINK Plans– Buying directly from GSC

Visit SureHealth.ca where you'll find details about the SureHealth™ LINK plan options available. You can request an information package, you can get quotes online, and you can buy completely online. It is quick and easy. You can give us a call at 1.844.753.SURE (7873) –we can answer any questions you have or we can take your application over the phone.

DESCRIPTION OF BENEFITS

HEALTH BENEFIT PLAN

The benefits shown below will be eligible, up to the amount shown in the Schedule of Benefits, if they are reasonable and customary, and are medically necessary for the treatment of an illness or injury.

Prescription Drugs

Prescription drug benefits, up to the amount shown in the Schedule 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 has a Drug Identification Number (DIN); or
c) has a Natural Product Number (NPN) for Nicotine replacement products, such as patches, gum, lozenges, and inhalers, and certain natural health products;
d) are approved under GSC's drug review process; and
e) are paid on a Pay Direct basis.

GSC reserves the right to manage its drug formularies through an evidence-based review process in which drugs are evaluated based on overall value taking into account clinical efficacy, safety, unmet need and plan affordability. Formulary management includes the right to:

- add a drug to GSC's formularies;
- exclude or remove a drug from GSC's formularies regardless of Health Canada approval and/or the existence of provincial coverage;
- place restrictions on a formulary drug as determined by GSC. Restrictions may include, but are not limited to, GSC's pre-approval of the drug before the claim can be reimbursed, requirement to obtain the drug through an approved provider, and requirement to obtain a lower cost alternative of the same treatment such as a generic or a biosimilar drug.

If approved by GSC, this plan includes drugs with a Drug Identification Number (DIN) that do not legally require a prescription, including but not limited to nitroglycerin and all other approved injectables, as well as related supplies such as diabetic syringes, needles, testing agents and some limited access drugs. In addition, this plan includes vaccines.

Certain drugs require prior approval from GSC before your drug claim can be reimbursed. Further, certain drugs defined by GSC as specialty, high cost drugs may be required to be purchased from an approved pharmacy that is a member of GSC's Specialty Drug Preferred Provider Network (PPN) before your claim can be reimbursed. You can find out if your drug requires prior approval or is included in the PPN either by using the online drug search tool available to you through GSC's Plan Member Online Services, or by contacting GSC's Customer Service Centre.

Maintenance drugs required to treat lifelong chronic conditions may be required to 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 at least two generic equivalent drugs, 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:

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) Reference biologic drugs that have an approved biosimilar;
c) 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, excluding Nicotine replacement products, such as patches, gum, lozenges, and inhalers, and certain natural health products;
d) 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;
e) Mixtures, compounded by a pharmacist, that do not conform to GSC's current Compound Policy.

Extended Health Services

1. **Hearing Care:** Reimbursement for hearing aids, batteries, repairs or replacement parts, if recommended or approved by the attending legally qualified medical practitioner, up to the amount shown in the Schedule of Benefits.

2. **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 Schedule of Benefits for:
   a) Aids for daily living: such as hospital style beds, including rails and mattresses; bedpans; standard commodes; decubitus (bedridden) supplies; I.V. stands; portable patient lifts (including batteries); trapezes; urinals;
   b) Footwear, when prescribed by your attending physician, nurse practitioner, podiatrist or chiropodist and dispensed by your podiatrist, chiropodist, chiropractor, orthotist, or pedorthist:
      i) custom-made foot orthotics or adjustments to custom made foot orthotics;
      ii) custom-made boots or shoes, adjustments to orthopedic shoes, or footwear as an integral part of a brace, (subject to a medical pre-authorization);
   c) Braces, casts;
   d) Diabetic equipment and supplies, such as:
      i) blood glucose meters, lancets and diabetic supplies;
      ii) glucose monitoring systems (GMS) such as continuous and flash type monitors subject to medical pre-authorization and reimbursed to the cost of a blood glucose meter. Disposable GMS supplies (used with the monitor), such as, but not limited to sensors and transmitters, are included and subject to any overall annual maximum applicable to diabetic testing and monitoring equipment and supplies;
   e) Medical services, such as pharmacogenetic testing only through GenXys Health Care Systems, subject to prior approval, and limited to once per lifetime, diagnostic tests, X-rays and laboratory tests;
   f) Incontinence/Ostomy, such as catheter supplies, ostomy supplies and diapers;
   g) Mobility aids, such as canes, crutches, walkers and wheelchairs (including wheelchair batteries);

h) Standard prosthetics, such as arm, hand, leg, foot, breast, eye and larynx;
i) Optometric eye examinations for visual acuity performed by a licensed optometrist, ophthalmologist or physician limited to one exam in a 24 month period (available only in those provinces where eye examinations are not covered by the provincial health insurance plan);
j) Respiratory/Cardiology equipment, such as compressors, inhalant devices, tracheotomy supplies and oxygen;
k) Compression stockings (15 mmhg or higher);
l) Wigs, for temporary or permanent hair loss as a result of a medical condition.

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.

4. **Emergency Transportation:** Reimbursement 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, up to the amount shown in the Schedule of Benefits.

5. **Professional Services:** Reimbursement for the services of the practitioners included, up to the amount shown in the Schedule 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 not eligible until your provincial health insurance plan annual maximum has been exhausted

6. **Accidental Dental:** Reimbursement for the services of a licensed dental practitioner for dental care to natural 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. When natural teeth have been damaged eligible services are limited to one set of artificial teeth. You must notify GSC immediately following the accident and the treatment must commence within 180 days of 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 child cease to be covered under this plan.

   No amount will be paid for periodontia or orthodontia treatments or the repair or replacement of artificial teeth.

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.

7. **Vision:** Reimbursement for the services performed by a licensed Optometrist, Optician or Ophthalmologist, up to the amounts shown in the Schedule of Benefits, for:
   a) Prescription eyeglasses or contact lenses.
   b) 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.
   c) Replacement parts for prescription eyeglasses.
   d) Non-prescription sunglasses prescribed by a legally qualified medical practitioner for the treatment of specific ophthalmic diseases or conditions.

   Eligible benefits do not include and no amount will be paid for:
   a) Medical or surgical treatment;
   b) Special or unusual procedures such as, but not limited to, orthoptics, vision training, subnormal vision aids and aniseikonic lenses;
   c) Follow-up visits associated with the dispensing and fitting of contact lenses;
   d) Charges for eyeglass cases.

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) attempting to commit or committing a criminal offence or illegal act;

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. Any treatment, drug, service, or supply received outside of Canada on a non-emergency basis;

5. Charges for the translation or completion of any claim forms and/or insurance reports;

6. Any form of medical cannabis for the treatment of any medical condition, regardless of whether it is authorized by way of a medical document or prescription from a legally-authorized medical practitioner and obtained from a Health Canada-licensed producer pursuant to any federal or provincial legislation or regulation regarding access to and/or distribution of medical cannabis;

7. 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;
   b) is not considered to be effective (either medically or from a cost perspective) as determined by GSC's drug review process regardless if Health Canada's approved the drug;
   c) is an adjunctive drug prescribed in connection with any treatment or drug that is not an eligible service;

d) is administered in a hospital or is required to be administered in a hospital in accordance with Health Canada's approved indication for use;
e) is not dispensed by the pharmacist in accordance with the payment method shown under the Prescription Drugs benefit;
f) 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 (i.e., off-label use);

8. 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, your plan sponsor 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 provided by your plan sponsor and/or a practitioner employed by your plan sponsor, other than as part of an employee assistance plan;
   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 Insulin pumps and supplies (unless otherwise covered under the plan);
   p) are for medical examinations, audiometric examinations or hearing aid evaluation tests;
   q) are batteries, unless specifically included as an eligible benefit;
   r) are a duplicate prosthetic device or appliance;
   s) 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;
   t) 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;
   u) 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;

v) 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);
w) 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;
x) 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;
y) 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

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 Schedule of Benefits.

Basic Services

1. Basic Diagnostic and Preventive Services:
   - complete oral examinations
   - emergency and specific oral examinations
   - full series X-rays and panoramic X-rays
   - bitewing X-rays once every 6 months
   - recall examinations once every 6 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
   - oral hygiene instruction
   - denture cleaning once per recall period
   - pit and fissure sealants on molars for covered persons 14 years of age and under
   - space maintainers
   - mouth guards once every 12 months

2. Basic Restorative Services:
   - amalgam, tooth coloured filling restorations, and temporary sedative fillings
   - inlay restorations – these are considered basic restorations and will be paid to the equivalent non-bonded amalgam

3. Basic oral surgery:
   - extractions of teeth and/or residual roots

4. General anaesthesia, deep sedation, and intravenous sedation in conjunction with eligible oral surgery only

Comprehensive Basic Services

1. Standard denture services:
   - denture repairs and/or tooth/teeth additions
   - standard relining and rebasing of dentures, 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
   - remake of a partial denture using existing framework, once every 5 years

2. 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
   - maxillofacial deformities - frenectomy - surgery on the fold of the tissue connecting the lip to the gum or the tongue to the floor of the mouth

3. Endodontic treatment including:
   - 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

4. Periodontal treatment of diseased bone and gums including:
   - periodontal scaling and/or root planing 8 time units, every 12 months
   - occlusal equilibration - selective grinding of tooth surfaces to adjust a bite 2 time units every 12 months

   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 once every 24 months

Major Services

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

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

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

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

Alternate Benefit Clause

This benefit plan will reimburse the amount shown in the Fee Guide for the least expensive service or supply where two or more professionally accepted courses of treatment are a benefit under the plan. The covered person can choose to have a more expensive treatment performed, however reimbursement will be limited to the cost of the least expensive alternative.

Predetermination

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 $500, it is recommended that an estimate completed by your dental practitioner be submitted.

Limitations

1. Laboratory services must be completed in conjunction with other services and will be limited to the co-pay of such services. Laboratory services that are in excess of 40% of the dentist's fee in the applicable Fee Guide shown in the Schedule of Benefits will be reduced accordingly; co-pay 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 Schedule of Benefits;

4. Reimbursement for root canal therapy will be limited to payment once only per tooth. Extra charges for difficult access, exception anatomy, calcified and retreatments 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) attempting to commit or committing a criminal offence or illegal act;

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;

4. Any treatment, drug, service, or supply received outside of Canada on a non-emergency basis;

5. Charges for the translation or completion of any claim forms and/or insurance reports;

6. 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 (or your province of residence if any dental service is provided outside Canada) and in effect at the time the service is provided;

7. Implants;

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;
    b) is not considered to be effective (either medically or from a cost perspective) as determined by GSC's drug review process regardless if Health Canada's approved the drug;
    c) is an adjunctive drug prescribed in connection with any treatment or drug that is not an eligible service;
    d) is administered in a hospital or is required to be administered in a hospital in accordance with Health Canada's approved indication for use;
    e) is not dispensed by the pharmacist in accordance with the payment method shown under the Health Benefit Plan Prescription Drugs benefit;
    f) 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 (i.e. off-label use);

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, your plan sponsor 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 primarily for cosmetic or aesthetic purposes, or are to correct congenital malformations;
    g) 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;
    h) are provided by your plan sponsor and/or a practitioner employed by your plan sponsor, other than as part of an employee assistance plan;

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 your Benefits Administrator or 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.

Pre-authorization

For **pre-authorization** forward a pre-authorization form OR a physician's prescription indicating the diagnosis and what is prescribed.

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

The provider must submit all claim forms to:
Green Shield Canada

Attn: Drug Department	P.O. Box 1652	Windsor, ON	N9A 7G5
Attn: Medical Items	P.O. Box 1623	Windsor, ON	N9A 7B3
Attn: Professional Services	P.O. Box 1699	Windsor, ON	N9A 7G6
Attn: Vision Department	P.O. Box 1615	Windsor, ON	N9A 7J3
Attn: Dental Department	P.O. Box 1608	Windsor, ON	N9A 7G1

Direct Payment to the Provider of Service

Present your GSC Identification Card to your provider and, after you pay any applicable co-payment, they will bill GSC directly and payment will be made directly to your provider of service.

Reimbursement

Reimbursement will be made by direct payment to the provider of services.

All dollar maximums and limitations stated are expressed in Canadian dollars. Reimbursement will be made in Canadian or U.S. funds for providers, based on the country of the payee.

Overpayments

GSC reserves the right to recover all amounts resulting from overpaid or unsupported claims for benefits by deducting such amounts from future claims and/or by any other legal means.

Limitation on Legal Action

In Ontario, every action or proceeding against GSC for recovery of benefit payment under the plan is absolutely barred unless commenced within the time set out in the *Limitations Act, 2002.*

In British Columbia, Alberta and Manitoba, every action or proceeding against GSC for recovery of benefit payment under the plan is absolutely barred unless commenced within the time set out in the *Insurance Act.*

Subrogation

GSC retains the right of subrogation if benefits paid on behalf of you or your dependent child are or should have been paid or provided by a third party liability. This means that GSC has the right to recover payment for reimbursement where you or your dependent child receives reimbursement, in whole or in part, in respect of benefits or payments made or provided by GSC, from a third party or other coverage(s). In cases of third party liability, you must advise your lawyer of our subrogation rights.

Access to Information

If you live in a province where the law permits you to request copies of your records, GSC will provide one copy of the following at no charge:

a) any enrollment form you completed for coverage under this plan that was submitted to GSC;
b) any written statements or other record about your health that you submitted to GSC during the course of applying for coverage under this plan;
c) one copy of the group contract.

GSC may charge you to provide any additional copies.

ADDITIONAL SERVICES

Pharmacogenetic Testing

If specific criteria are met, you and your eligible dependents will be able to access pharmacogenetic testing provided through GenXys Health Care Systems. Their TreatGx^{Plus} all-in-one product includes the myPGx pharmacogenetic test and a subscription to TreatGx, a medication decision-support software that provides personalized and optimized medication options based on your pharmacogenetic insights, current drug regimen, and other health information.

For details, visit: genxys.com/gsc

VIRTUAL SERVICES

The following service are included in your benefits plan, but are not provided by GSC. GSC has arranged for this coverage and provides administration only on behalf of your plan sponsor.

PocketPills

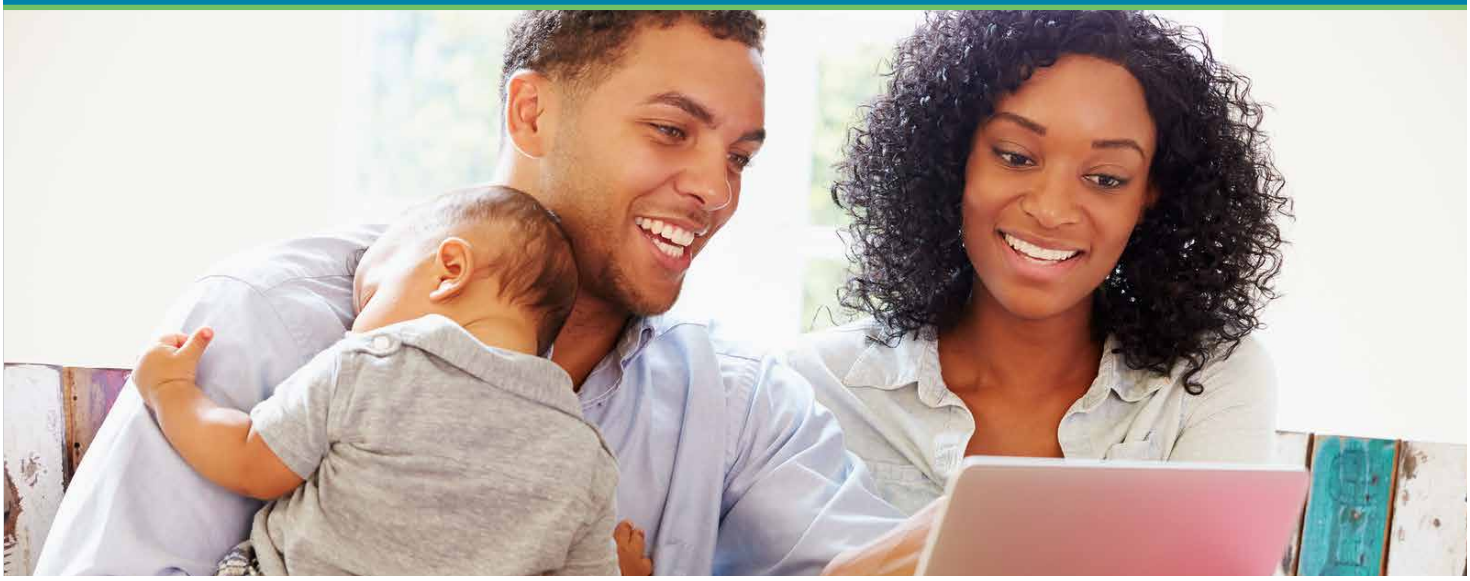
You and your eligible dependents have access to PocketPills – Canada's leading digital pharmacy. With PocketPills as your pharmacy, you will enjoy free delivery of your pre-sorted prescription medications and vitamins. Easy-to-open PocketPacks help you remember to take the right medication at the right time. PocketPacks are convenient to bring with you wherever you go.

For details and to register, visit https://app.pocketpills.com/gsc.

Homewood Health

Your Member and Family Assistance Program

Get to know your MFAP



Everyone faces challenging and stressful events in their lives. Most of the time we can handle these situations ourselves; other times we could benefit from some support.

Your MFAP is a professional, confidential, and proactive service to support you with a wide range of personal, family, and work-related concerns.

What benefits are available to me?

Your MFAP is here for you whenever you need it, 24 hours a day, seven days a week, 365 days of the year.

Within a confidential environment you can receive counselling for any challenge — whether it's a first step in facing a possible addiction, or managing day-to-day stress.

We guarantee your confidentiality.

We are Homewood Health, a trusted company with years of experience delivering the best possible support for clients like you. Everyone is guaranteed confidentiality within the limits of the law. You won't be identified to anybody — including your employer.

People frequently use an MFAP for personal challenges such as relationship concerns, family or parenting issues, anxiety, depression, addictions, grief, coping with health issues, or work-related challenges.

We will match you with a counsellor who suits your needs and provide you with short-term solutions.

If you are identified as requiring additional, longer-term treatment or specialized support, our counsellors will refer you to community-based resources and programs which suit your unique needs.

How does the counselling program work?

Counselling services can be offered face-to-face, over the phone, through video, or online. Offices are local and appointments are made quickly, with your convenience in mind. If you have a preference for location, gender, or appointment time, we'll do our best to accommodate your preferences.

When you need to speak with someone, simply call Homewood Health — staff will ask you for some basic information (to establish your eligibility for this benefit)

Contact us to learn more.

1-800-663-1142 | **TTY:** 1-888-384-1152 | **International** (Call Collect): 604-689-1717

Numéro sans frais - en français : 1-866-398-9505

Homeweb.ca

Homewood Health | Santé

and will help set up an initial appointment at a time that is convenient for you. An experienced counsellor will assess your concerns and help you develop practical solutions.

Life Smart Coaching

Life Smart Coaching is a suite of telephonic services that offers assessments, coaching, and resources; each service has been developed to allow you to take a proactive approach to managing everyday challenges.

A Life Smart intake counsellor will contact you within 72 hours to offer you an appointment with an appropriate specialist.

Life Smart Coaching Services include three major components with service options for each area:

Life Balance Solutions

- New Parent Support
- Childcare and Parenting
- Elder and Family Care
- Relationship Solutions
- Financial Coaching
- Legal Advisory Services
- Grief and Loss
- Stress Solutions

Health Smart Coaching Services

- Nutritional Coaching
- Lifestyle Changes
- Jumpstart your Wellness
- Smoking Cessation

Career Smart Coaching Services

- Career Planning
- Workplace Issues
- Pre-Retirement Planning
- Shift Worker Support

Online Services – Homeweb

Homeweb is part of your Member and Family Assistance Program. You can access Homeweb on your phone, tablet, or desktop. Homeweb offers you the ability to create an individual profile, receive personalized content recommendations, and access lots of helpful resources—anywhere, anytime.

Access Homeweb for interactive tools, health and wellness assessments, child and elder care resource locators, and a library of health, life balance, and workplace articles.

i-Volve: Online CBT. i-Volve is an online, self-paced treatment program for depression and anxiety using the best practice treatment approach, cognitive behavioural therapy (CBT).

This innovative treatment program will guide you through exercises that examine and test how you interpret and perceive external stimulation. These insights will help you change and adapt the ways in which you think, feel, and react in various situations. i-Volve will help you to identify, challenge and overcome your anxious and/or depressive thoughts, behaviours and emotions.

How do I register for Homeweb?

Step One: Visit **www.homeweb.ca** and click 'Sign Up'.

Step Two: Enter information into the required fields, choose

an email and password, and click 'Next Step'. Then, type in your company name and click 'Find it!' Select the correct company from the list provided. If you do not see your company listed, check the spelling and try again.

Step Three: Let us know how you are covered by Homewood, (e.g. through your organization or the organization of a family member), and let us know your relationship to the organization (e.g. employee, spouse, dependent, etc.). Submit the additional information required and click 'Sign In' at the bottom of the page.

Search, browse, and get expert support.

What if I'm in crisis?

Homewood Health staff are prepared to take your call 24 hours a day, seven days a week. **Help is always available.**

Who do I contact?

To speak to someone in confidence, for crisis services (24 hours a day) or to book an appointment contact us today by calling the number below.

Contact us to learn more.

1-800-663-1142 | TTY: 1-888-384-1152 | **International** (Call Collect): 604-689-1717

Numéro sans frais - en français : 1-866-398-9505

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