My BENEFIT PLAN

Saskatchewan Teachers' Superannuation Commission (TSC)

Classification: Saskatchewan Teachers

Billing Division: 1

Effective Date: January 1, 2023

WELCOME TO YOUR BENEFIT PLAN

This summary contains information about your group benefits with The Saskatchewan Teachers' Superannuation Commission (TSC), your employer, available through the group contract between The Government of Saskatchewan, As Represented By The Minister of Finance your plan sponsor and Green Shield Canada (GSC), effective January 1, 2023.

DENTAL SUMMARY

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.

Calendar Year Deductible (per person/per family):	No deductible
Dental Fee Guide (General Practitioners)	Current province of Saskatchewan
Your Co-insurance Basic Services:	100%
Comprehensive Basic Services:	85%
Major Services:	60%
Orthodontics:	50%
Your Plan Covers	
Basic Services	Unlimited
Comprehensive Basic Services	
Major Services	
Orthodontics	$2,000 per lifetime

Summary of Covered Benefits

Basic Services include recall visits twice every calendar year, fillings and extractions
Comprehensive Basic Services include root canal therapy, periodontal scaling/root planing and denture relining/rebasing, repairs, or adjustments
Major Services include crowns, dentures and/or bridgework (replacements of each limited to once every 5 years)
Orthodontics includes treatment to straighten teeth/correct the bite.

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 for which your plan sponsor has certified you are eligible. You must be covered in order for your dependents to be covered. Your coverage will terminate upon the earliest of the dates appearing in the Termination section or the date your plan sponsor advises GSC that you are no longer eligible for coverage. 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.

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.

GSC everywhere – 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
- Check your eligibility and coverage for health services or items to instantly find out what portion of a claim will be covered
- Submit claims online (some claims can even be processed instantly if you are signed up for direct deposit)
- Search for a drug to get information specific to your own coverage (or coverage for your family)
- Search for GSC-vetted health providers in a particular location (within Canada) that will submit your claims for you
- Arrange for claim payments to be deposited directly into your bank account
- Print personalized claim forms and access your digital ID card
- 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.

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DEFINITIONS

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

Allowed amount means, as determined by GSC:

- 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 are 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 their enrolled dependents.

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

Dependent means

- your spouse, if you are legally married or if not legally married, you have lived in a common-law relationship for more than 12 continuous months. Only one spouse will be considered at any time as being covered under the group contract;
- your unmarried child who:
  - is under age 21;
  - is under age 26 (age 26 for RAMQ drugs for Quebec residents) and is enrolled and in full-time attendance at an accredited college, university or educational institute;
  - regardless of age became totally disabled while eligible and enrolled in this plan, and who 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 child (your or your spouse's natural, legally adopted or stepchildren) must reside with you in a parent-child relationship or be dependent upon you (or both) and not regularly employed.

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 or country, 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.

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.

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.

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.

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 as a plan member, you must be:

- a resident of Canada; and
- covered under your provincial health insurance plan;
- actively at work and have been certified as an eligible plan member by the plan sponsor.

For Your Dependents

To be eligible for coverage:

- you must be covered under this plan;
- each dependent must satisfy the definition of Dependent, and
- 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.

You will be eligible for coverage on the first school day of your contract following completion of 20 full or partial days of teaching service (the qualification period).

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

Your plan sponsor is solely responsible for submitting enrolment information 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:

- the date your employment ends;
- the date you are no longer actively working;
- the date you are no longer eligible as a plan member as defined by the plan sponsor;
- the end of the period for which rates have been paid to GSC for your coverage;
- the date the group contract terminates.

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

- the date your coverage terminates;
- the date your dependent is no longer an eligible dependent;
- the date on which your dependent child attains the age limit specified in the definition of Dependent;
- the end of the period for which rates have been paid for dependent coverage;
- the date the group contract terminates.

Continuation of Coverage for Disabled Dependent Children

While you are covered under this plan, any child whose coverage would end because they have reached the specified age limit may qualify for continued coverage, subject to the following conditions:

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

Continuation of Coverage for Surviving Dependents

In the event of your death while covered by this plan, coverage will continue for your eligible covered dependents until the earliest of the following dates:

- 24 months after the date of your death;
- the date the covered person would no longer be considered a dependent under the plan if you were still alive, or
- the date the benefit under which your dependent is covered terminates.

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

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 Summary of Benefits.

Basic Services

Basic Diagnostic and Preventive Services:

- complete oral examinations once every 3 years;
- emergency and specific oral examinations;
- full series X-rays and panoramic X-rays once every 2 years;
- bitewing X-rays twice every calendar year;
- recall examinations twice every calendar year;
- cleaning of teeth:
  - up to 1 unit of polishing once every calendar year; plus
  - up to 2 units of scaling per calendar year, combined with periodontal scaling/root planing;
- topical application of fluoride once every calendar year;
- oral hygiene instruction once every 12 months
- denture cleaning once every calendar year;
- pit and fissure sealants for covered persons under age 16, on molars only;
- space maintainers;
- mouth guards;
- bruxism appliance, limited to one every 24 months.

Comprehensive Basic Services

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.

Basic Oral Surgery:

- extractions of teeth and/or residual roots.

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

Standard Denture Services:

- denture repairs and/or tooth/teeth additions;
- standard relining and rebasing of dentures once every 2 years, only after 6 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;

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 planning 8 time units every 12 months combined with preventive scaling;
- 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, limited to one every 24 months.

Major Services

- Standard onlays or crown restorations (paid to full metal on molar) to restore diseased or accidentally injured natural teeth, once every 5 years;
- Standard bridges, including pontics, abutment retainers/crowns (paid to full metal on molar) 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;
- denture adjustments and remount and equilibration procedures, only after 3 months have elapsed from the installation of a denture;

Note: Dental implants are not covered under this plan.

Orthodontic Services

Reimbursement for orthodontic treatment to straighten teeth and/or correct the bite.

Receipts for payment must be received by GSC no later than 12 months from the date the service is incurred while treatment is in progress, not at the end of the treatment.

If orthodontic treatment is terminated for any reason before completion, the obligation to pay benefits will cease with payment to the date of termination. If such services are resumed, benefit for the remaining services, will be resumed. The benefit payment for orthodontic services will be only for the months that coverage is in force.

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, your dental practitioner must submit an estimate, including supporting materials, such as digital photos and x-rays, for any proposed treatment for which the total cost is expected to exceed $500. Our assessment of the proposed treatment may result in a lesser benefit being payable or in benefits being denied.

Failure to submit an estimate before treatment begins will delay the assessment of your claim.

Limitations

1. Laboratory services that are in excess of 85% for Basic and Comprehensive Basic Services or 60% for Major Services of the dentist's fee in the applicable Fee Guide shown in the Summary of Benefits will be reduced accordingly. Laboratory services must be completed in conjunction with other services and reimbursement is limited to the same percentage as the service for which the laboratory service was received.

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. If this plan includes endodontic services, reimbursement for root canal therapy will be limited to payment once only per tooth. Extra charges for difficult access, exceptional anatomy, calcified canals, and retreatments are not included. The total fee for root canal therapy 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 if this plan covers periodontics, 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, if this plan covers periodontics, 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. If this plan includes coverage for major services (crowns), 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. If this plan includes periodontics, root planning 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. Restorations necessary for wear, acid erosion, vertical dimension and/or restoring occlusion;

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

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

10. Service and charges for sleep dentistry;

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

12. 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).

13. 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.

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)**.

GSC reserves the right to request supplementary claims information. Failure to respond to such requests may result in the denial of the claim.

The intentional omission, misrepresentation or falsification of information relating to any claim constitutes fraud. Submission of a fraudulent claim is a criminal offence and will be reported to the applicable law enforcement and/or regulatory agencies and your plan sponsor. This could result in termination of your coverage under this benefit plan.

Claims Submission Period

All Dental claims must be received by GSC no later than 18 months from the date the eligible benefit was incurred.

Reimbursement

Reimbursement will be made by one of the following methods:

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

All dollar maximums and limitations stated are expressed in Canadian dollars. Reimbursement will be made in Canadian or U.S. funds for both providers and plan members, 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 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 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). 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.

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.

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.