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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 Summary of Benefits.

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

Co-pay means the eligible allowed amount that must be paid by you or your dependent 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 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 12 continuous months. Only one spouse will be considered at any time as being covered under the group contract;
b) your unmarried child under age 21;
c) your unmarried child under age 25 (age 26 for RAMQ Drugs for Quebec residents), if enrolled and in full-time attendance at an accredited college, university or educational institute;
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; and
e) for Health Care Spending Account, in addition to your dependents above, your relative who is a Canadian resident and dependent on you for support and for whom you are claiming a tax deduction on your federal tax return, as outlined in the rules and regulations of the Canadian Income Tax Act.

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, 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. (Please note that the trip duration limit of the Travel plan will still apply.)

Eligible expense means the services and supplies described in the Summary of Benefits and Description of Benefits sections.

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.

Medically necessary means generally recognized by the Canadian medical profession as effective, appropriate and required in the treatment of an illness or injury in accordance with Canadian medical standards.

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.

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.

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 plan member who is:

a) a resident of Canada;
b) covered under your provincial health insurance plan;
c) under age 70; and
d) actively at work and working a minimum of 21 hours per week on a regular basis.

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.

Enrolment

To enroll, you must request coverage in writing by supplying the appropriate enrolment information to your administrator within 31 days of your employment date. You must choose one of the following options: Basic, Coordination, Comprehensive or Enhanced for Health. For Dental, you must choose either Coordination, Comprehensive, Enhanced or Opt Out. If you elect Basic Health, Coordination Health or Dental, or Opt Out Dental, you are eligible for the Health Care Spending Account benefit. If you do not elect coverage within 31 days of your employment, you will be automatically enrolled for the Comprehensive Health and Dental Options, single status only.

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 day following 3 months of continuous active employment.

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

If you have waived eligibility due to having coverage through your spouse's benefit plan, you must request coverage from your plan sponsor within 31 days after termination of the coverage under your spouse's plan.

Re-enrolment

Re-enrolment occurs annually every October/November with your choices effective January 1st. You may elect to change your coverage selection or continue your current coverage selection for the next benefit period (subject to the locked-in restrictions). If you do not re-elect coverage, your existing coverage choices will apply.

Locked-in Coverage

When you join the plan, you must elect an Option shown in the Summary of Benefits, and your coverage selection will be locked-in until the next re-enrolment year (for all Options except the Enhanced Options), unless you have a qualifying life event. The first year lock-in for the Enhanced Options will be for 15 months from October 1, 2015 until December 31, 2016, thereafter the lock-in period is 2 years. If a life event occurs in the middle of a benefit year, the lock-in maximum is 2 years but not less than 1 year.

Life Events

If you have a qualifying life event, you may elect to change your coverage selection, within 31 days of your life event change. A life event is a change in your personal situation that

a) requires a change in your coverage status; or
b) results from a change in your spouse's benefits.

Qualifying life events include:

a) birth or adoption of a child;
b) change in dependent child eligibility;
c) death of a spouse or dependent child;
d) change in marital status; or
e) loss or gain of spouse's coverage under another plan.

Termination

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

a) the date your employment ends;
b) the date you are no longer actively working;
c) the date you attain age 70;
d) the end of the period for which rates have been paid to GSC for your coverage;
e) the date the administrative services agreement or group contract terminates.

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

a) the date your coverage terminates;
b) the date your dependent is no longer an eligible dependent;
c) the date on which your dependent child attains the specified age limit;
d) the end of the period for which rates have been paid for dependent coverage;
e) the date the administrative services agreement or 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 your eligible covered dependents until the earliest of the following dates:

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

Group Conversion - PRISM CONTINUUM® Program

The PRISM CONTINUUM® Program offers three plans that are focused on providing coverage for you if you are leaving a company group plan.

This program may be your solution if you, your spouse or dependent children are losing, or have lost company group health benefits within the last 60 days and are looking for guaranteed coverage.

Call 416.601.0429 in the Toronto area or toll-free at 1.800.667.0429 for an information package or visit our website at greenshield.ca. Coverage is guaranteed if you apply within 60 days of losing your GSC group benefits.

DESCRIPTION OF BENEFITS

HEALTH BENEFIT PLAN

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. Refer to the Summary of Benefits for the specific benefits that you are covered for, based on the option you have chosen.

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); and
c) are paid on a Pay Direct basis.

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, needles and testing agents. In addition, this plan includes all vaccines.

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

In no event will the amount dispensed exceed a 3-month supply (6 months if a vacation supply is required) of a prescription at any one time and not more than a 13-month supply in any 12 consecutive months.

Tiered Drug Formulary

A Tiered Formulary encourages the use of the most cost-effective therapies by assigning lower levels of co-pay to preferred drugs in Tiers 1, 2 and 5 and higher levels of co-pay to non-preferred drugs in Tiers 3 and 4.

Tier 1: Preferred generics are most generic drugs and some low-cost brand name drugs, traditional forms of insulin, etc.;

Tier 2: Preferred brands are select brand name drugs with no generic alternatives that are less expensive than other brands but perhaps higher than other generics and can be drugs that are more clinically effective than other options. These drugs are defined on the basis of need, safety, efficacy and cost;

Tier 3: Non-preferred brands are:

- brand name medications that will usually have less costly alternatives within the same therapeutic class;
- brand name drugs that have therapeutically equivalent generics;
- newer non-specialty drugs not yet reviewed for formulary listing by the GSC pharmacy services team;
- medications considered lifestyle in nature.

Tier 4: Non-preferred generics that are higher cost generic drugs than alternative brand name drugs in the same therapeutic class;

Tier 5: Specialty drugs generally prescribed for complex or ongoing medical conditions. Typically high cost medications that are often injected or infused (although some are taken by mouth), or require complicated treatment regimens, unique storage requirements, additional patient support or educational requirements, not typically stocked by most retail pharmacies and are typically prescribed by specialists.

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 (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.

Expenses, incurred for drugs listed in the RAMQ drug formulary and not reimbursed under this plan as a result of the application of the deductible or the co-insurance, are limited in each calendar year to the yearly maximum contribution set by the RAMQ plan. There is an out-of-pocket maximum for you, and another one for your spouse. Any drug expenses incurred for your children are part of the out-of-pocket maximum of the Plan Member.

Eligible benefits do not include and no amount will be paid for:
a) Smoking cessation products (other than smoking cessation oral drugs) and drugs for the treatment of erectile dysfunction;
b) Contraceptives, other than oral;
c) Vitamins that do not legally require a prescription;
d) 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;
e) 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;
f) Mixtures, compounded by a pharmacist, that do not conform to GSC's current Compound Policy.

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:
a) reasonable and customary charges in the area where received, for accommodation in a public general hospital; and
b) reasonable and customary charges in the area where received, limited to 180 days per disability/medical event for accommodation in a convalescent or rehabilitation hospital or a convalescent or rehabilitation wing in a public general hospital, or a public chronic hospital or chronic care in a public general hospital.

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 Summary of Benefits.

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; 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, orthopedic 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, such as blood glucose monitors and lancets;
e) Medical services, such as diagnostic tests, X-rays and laboratory tests;
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, breast;
   ii) post-mastectomy bra, limited to 4 every calendar year;
i) Respiratory/Cardiology equipment, such as compressors, inhalant devices, tracheotomy supplies and oxygen;
j) Compression stockings with a pressure measurement of 15 mmhg or higher, limited to $400 per calendar year;
k) Wigs, for temporary or permanent hair loss as a result of a medical condition, limited to $250 per lifetime.

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.

Private Duty Nursing in the Home: Reimbursement for the services of a Registered Nurse (R.N.) or Registered Practical Nurse/Licensed Practical Nurse (R.P.N./L.P.N.) in the home on a visit or shift basis, up to the amount shown in the Summary of Benefits. No amount will be paid for services which are custodial and/or services which do not require the skill level of a Registered Nurse (R.N.) or Registered Practical Nurse/Licensed Practical Nurse (R.P.N./L.P.N.).

A Pre-Authorization Form for Private Duty Nursing must be completed by the attending physician and submitted to GSC.

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 not eligible until your provincial health insurance plan annual maximum has been exhausted

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 12 months 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 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.

Note: Treatment for dental accidents must be pre-approved by GSC.

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) 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) Laser eye surgery.
e) Plano sunglasses prescribed by a legally qualified medical practitioner for the treatment of specific ophthalmic diseases or conditions.
f) Visual training.
g) 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 by the provincial health insurance plan.

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, 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) intentionally self-inflicted injury while sane or insane;
   b) an act of war, declared or undeclared;
   c) participation in a riot or civil commotion; or
   d) 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 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;

6. 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;
m) are special or unusual procedures such as, but not limited to, orthoptics, subnormal vision aids and aniseikonic lenses;
n) are delivery and transportation charges;
o) are for Insulin pumps and supplies;
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.

TRAVEL

Expenses arising as a result of a medical emergency while you or an eligible dependent are temporarily outside of your regular province of residence for vacation, business, or education will be considered eligible under the Travel benefit.

To qualify for benefits, the claimants must be covered by their respective provincial government health plan or equivalent at the time the expenses are incurred.

Eligible travel 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.

All dollar maximums and limitations are stated in Canadian currency. Reimbursement will be made in Canadian funds or U.S. funds for both providers and plan members, based on the country of the payee. For payments that require currency conversion, the rate of exchange used will be the rate in effect on the date of service of the claim.

Upon notification of the necessity for treatment of an accidental injury or medical emergency, **the patient must contact GSC Travel Assistance within 48 hours of commencement of treatment.**

> **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.
>
> Any invasive or investigative procedures must be pre-approved by GSC Assistance Medical Team.

Eligible benefits are limited to the maximum days per trip shown in the Summary of Benefits commencing with the date of departure from your province of residence. If you are hospitalized on the last day shown in the Summary of Benefits, your benefits will be extended until the date of discharge.

Hospital services and accommodation up to a standard ward rate in a public general hospital;

Medical/surgical services rendered by a legally qualified physician or surgeon to relieve the symptoms of, or to cure an unforeseen illness or injury;

Emergency Transportation

- **Land ambulance** to the nearest qualified medical facility
- **Air ambulance -** the cost of air evacuation (including a medical attendant when necessary) between hospitals and for hospital admission into Canada when approved in advance by your provincial health insurance plan or to the nearest qualified medical facility

Referral services – (a) hospital services and accommodation, up to a standard ward rate in a public general hospital, and/or (b) medical surgical services rendered by a legally qualified physician or surgeon;

- **Prior to the commencement of any referral treatment, written pre-authorization** from your provincial health insurance plan and GSC **must be obtained**. Your provincial health insurance plan may cover this referral benefit entirely. You must provide GSC with a letter from your attending physician stating the reason for the referral, and a letter from your provincial health insurance plan outlining their liability. **Failure to comply in obtaining pre-authorization will result in non-payment**

Services of a registered private nurse up to a maximum of $5,000 per calendar year, at the reasonable and customary rate charged by a qualified nurse (R.N.) registered in the jurisdiction in which treatment is provided. You must contact GSC Travel Assistance for pre-approval;

Diagnostic laboratory tests and X-rays when prescribed by the attending physician. Except in emergency situations, GSC Travel Assistance must pre-approve these services (i.e. cardiac catheterization or angiogram, angioplasty and bypass surgery);

Reimbursement of prescriptions for drugs, serums and injectables which require a prescription by law and are prescribed by a legally qualified medical practitioner (vitamins, patent and proprietary drugs are excluded). Submit to GSC Travel Assistance the original paid receipt from the pharmacist, physician or hospital outside your province of residence showing the name of the prescribing physician, prescription number, name of preparation, date, quantity and total cost;

Medical appliances including casts, crutches, canes, slings, splints and/or the temporary rental of a wheelchair when deemed medically necessary and required due to an accident which occurs, and when the devices are obtained outside your province of residence;

Treatment by a dentist only when required due to a direct accidental blow to the mouth up to a maximum of $2,000. Treatments (prior to and after return) must be provided within 90 days of the accident. Details of the accident must be provided to GSC Travel Assistance along with dental X-rays;

Coming Home - when your emergency illness or injury is such that:

- GSC Assistance Medical Team specifies in writing that you should immediately return to your province of residence for immediate medical attention, reimbursement will be made for the extra cost incurred for the purchase of a one way economy airfare, plus the additional economy airfare if required to accommodate a stretcher, to return you by the most direct route to the major air terminal nearest the departure point in your province of residence

  This benefit assumes that you are not holding a valid open-return air ticket. Charges for upgrading, departure taxes, cancellation penalties or airfares for accompanying family members or friends are not included;

- GSC Assistance Medical Team or commercial airline stipulates in writing that you must be accompanied by a qualified medical attendant, reimbursement will be made for the cost incurred for one round trip economy airfare and the reasonable and customary fee charged by a medical attendant who is not your relative by birth, adoption or marriage and is registered in the jurisdiction in which treatment is provided, plus overnight hotel and meal expenses if required by the attendant

Cost of returning your personal use motor vehicle to your residence or nearest appropriate vehicle rental agency when you are unable to due to sickness, physical injury or death, up to a maximum of $1,000 per trip. We require original receipts for costs incurred, i.e. gasoline, accommodation and airfares;

Meals and accommodation up to $1,500 (maximum of $150 per day for up to 10 days) will be reimbursed for the extra costs of commercial hotel accommodation and meals incurred by you when you remain with a travelling companion or a person included in the "family" coverage, when the trip is delayed or interrupted due to an illness, accidental injury to or death of a travelling companion. This must be verified in writing by the attending legally qualified physician or surgeon and supported with original receipts from commercial organization;

Transportation to the bedside including round trip economy airfare by the most direct route from your province of residence, for any one spouse, parent, child, brother or sister, and up to $150 per day for a maximum of 5 days for meals and accommodation at a commercial establishment will be paid for that family member to:

- be with you or your covered dependent when confined in hospital. This benefit requires that the covered person must eventually be an inpatient for at least 7 days outside your province of residence, plus the written verification of the attending physician that the situation was serious enough to have required the visit
- identify a deceased prior to release of the body

Return airfare if the personal use motor vehicle of you or your covered dependent is stolen or rendered inoperable due to an accident, reimbursement will be made for the cost of a one-way economy airfare to return you by the most direct route to the major airport nearest your departure point in your province of residence. An official report of the loss or accident is required;

Return of deceased up to a maximum of $5,000 toward the cost of embalming or cremation in preparation for homeward transportation in an appropriate container of yourself or your covered dependent when death is caused by illness or accident. The body will be returned to the major airport nearest the point of departure in your province of residence. The benefit excludes the cost of a burial coffin or any funeral-related expenses, makeup, clothing, flowers, eulogy cards, church rental, etc;

Trip cancellation up to a maximum of $5,000 per covered person per trip;

Reasons for cancellation: for expenses to be eligible, the trip must be cancelled, delayed, interrupted, or extended due to one of the following causes:

a) An illness or accident suffered by the covered person, a travel companion, a business partner of the covered person, or a member of the covered person's immediate family. The illness or accident must prevent the patient from performing his or her usual activities and must be sufficiently serious (in the opinion of GSC Assistance Medical Team) to justify or force the cancellation or interruption of the covered person's trip. Immediate family is defined as:
   i) Spouse (legal or common-law, including a same-sex partner),
   ii) Children, step-children;
   iii) Parents, step-parents;
   iv) Brothers, step-brothers, sisters, step-sisters;

b) Death of: the covered person, the covered person's spouse, the covered person's or spouse's child, the covered person's travel companion, or the covered person's business partner. The funeral must be scheduled to take place during the planned trip or the preceding 14 days;

c) Death of a family member of any of the following individuals: the covered person, the covered person's spouse, the covered person's child, the covered person's travel companion. The funeral must be scheduled to take place during the planned trip or the preceding 14 days;

d) Death, illness or accident suffered by a person for whom the covered person is the legal guardian;

e) Notwithstanding any other provision of this booklet, suicide or attempted suicide of the covered person's travel companion or a member of the covered person's family;

f) Death of a person for whom the covered person is the testamentary executor;

g) Death or emergency hospitalization of the host at destination;

h) The covered person's or travel companion's summons for jury duty or subpoena to act as a witness in a case scheduled to be heard during the trip, provided the person involved has taken all necessary measures to have the hearing postponed. A summons or subpoena is not considered cause for cancellation, delay, or interruption of a trip when the person involved institutes legal proceedings, or is a defendant in the case, or is a police officer and has been subpoenaed as part of his or her regular duties;

i) Quarantine of the covered person, provided that quarantine ends 7 days or fewer before the scheduled date of departure, or occurs during the time of the trip;

j) Hijacking of the airplane on which the covered person is travelling;

k) Damage rendering the principal residence of the covered person or of the host at destination uninhabitable. The residence must remain uninhabitable 7 days or fewer before the scheduled date of departure, or the damage must occur during the time of the trip;

l) Transfer of the covered person, for the same employer, to a location more than 100 kilometres from the current place of residence, provided the transfer is required by the employer within the 30 days preceding the scheduled date of departure;

m) Notwithstanding any other provision of this booklet, terrorism, war, whether declared or undeclared, or an epidemic in the location which the covered person plans to travel to or leave, provided the Government of Canada issues an advisory not to travel to such location or an advisory to leave such location. The advisory must be in force for the period of the planned trip or stay and was issued after the covered person had finalized the travel arrangements of when they would be staying in such location;

n) Delay of the transportation used by the covered person to reach the point of departure of the planned trip or to the point of departure of a scheduled connection after departure of the planned trip, provided that the means of transport used provides for scheduled arrival at the point of departure at least 3 hours prior to the time of departure or at least 2 hours prior to departure if the distance to be covered is less than 100 kilometres. The delay must be caused by mechanical problems (except for a private automobile), a traffic accident, or an emergency road closure, each of the latter two causes requiring confirmation by a police report;

o) Weather conditions such that:

- the departure of the public carrier used by the covered person, at the point of departure of the planned trip, is delayed by at least 30% (minimum 48 hours) of the planned duration of the trip; or

- the covered person is unable to make a scheduled connection after departure with another carrier, provided the scheduled connection after departure is delayed by at least 30% (minimum 48 hours) of the planned duration of the trip

p) Damage occurring to a commercial establishment or to the location where a commercial activity is to be held. The damage must prevent the activity in question from taking place. A written cancellation notice must be issued by the organization officially responsible for the activity; or

q) Death or hospitalization of the person with whom the covered person had arranged a business meeting or commercial activity. In such case, reimbursement is limited to transportation expenses and a maximum of 3 days' accommodation.

Expenses Covered

To be eligible, expenses must be incurred by the covered person following the cancellation, delay, interruption, or extension of a trip, provided such expenses are related to amounts paid in advance by the covered person and that, at the time travel arrangements were finalized, the covered person was not aware of any event that could reasonably lead to the cancellation, delay, interruption, or extension of the planned trip. Expenses must also be incurred for one of the specified eligible reasons for cancellation. Expenses are reimbursed in accordance with the following provisions.

In the event of cancellation prior to departure
In the event of cancellation prior to departure, the trip must be cancelled through the travel agent or carrier within 48 hours of the event causing cancellation. In the event that this period ends on a statutory holiday, notice of cancellation may be submitted on the next working day.

a) The non-refundable portion of prepaid travel expenses;

b) Additional expenses incurred by the covered person if the travel companion who was to share accommodation at destination must cancel due to one of the eligible reasons for cancellation and the covered person decides to proceed with the trip as initially planned. Expenses are eligible up to the amount of the cancellation penalty applicable at the time the travel companion had to cancel;

c) The non-refundable portion of prepaid travel expenses, up to 70% of such expenses, if departure is delayed due to weather conditions and the covered person decides not to proceed with the trip.

In the event of missed departure or temporary trip delay prior to departure
The additional cost of a one-way economy class ticket on a scheduled flight of a public carrier, by the most direct route to the initially-planned trip destination. Departure must be missed due to a delay in the means of transportation used by the covered person, subject to the conditions specified in the eligible reasons for cancellation. In the event of delay of a trip, the delay must be due to an illness or accident suffered by the covered person or travel companion, subject to the conditions specified under the eligible reasons for cancellation.

If the trip is interrupted and the return is earlier than planned
a) The additional cost of a one-way economy class ticket, by the most direct route, for a return trip to the point of departure, by the means of transportation initially planned. If the initially-planned means of transportation cannot be used, whether or not travel expenses have been prepaid, the expenses eligible will be equal to the fees charged by a scheduled public carrier for economy class travel, by the most economical means of transportation, via the most direct route, for the covered person to return to the initial point of departure. These expenses must be pre-approved by GSC Travel Assistance;

b) The unused and non-refundable portion of the ground portion of prepaid travel expenses.

If travel expenses were not paid in advance, the expenses incurred by the covered person are eligible provided that before the scheduled date of departure, the covered person was not aware of any event that could reasonably lead to the interruption of the planned trip.

If the return occurs later than planned
If the return trip is delayed by more than 7 days, the expenses incurred are eligible, provided the covered person was admitted to hospital as an in-patient for more than 48 hours within the seven-day period.

Round-trip transportation
The cost of transportation by the most economical means, following approval by GSC Travel Assistance, for the covered person to return to the province of residence and then back to the trip destination, provided the return is due to one of the following reasons:

a) Death or hospitalization of a member of the covered person's family, a person for whom the covered person is the legal guardian or a person for whom the covered person is the testamentary executor;

b) A disaster that has made the principal residence of the covered person uninhabitable or has caused significant damage to the covered person's business establishment.

Trip Cancellation - Limitations and Exclusions

In addition to the Travel Limitations and Travel Exclusions, trip cancellation does not cover losses due to the following causes or to which such causes have contributed:

a) War, whether declared or not, an epidemic or an act of war or of terrorism, it being understood that this exclusion does not apply to the covered person already present in a place at the time a war or an epidemic breaks out, or an act of war or of terrorism occurs, provided the covered person takes the necessary measures to leave such place as soon as the Government of Canada issues an advisory to do so. This exclusion does not apply to covered person(s) whose travel plans are finalized on or before the day the government advisory is issued;

b) Active participation of the covered person in a riot or insurrection, perpetration or attempted perpetration of a criminal act by the covered person or the covered person's travel companion or participation of the covered person or the covered person's travel companion in a criminal act;

c) Participation in any of the following activities or sports: gliding, hang-gliding, paragliding, mountaineering, bungee jumping, parachuting, skydiving or any other similar activity, all extreme or combat sports, any motorized vehicle competition, as well as any sporting or underwater activity for which a remuneration is paid to the covered person;

d) The reason for which the trip is purchased, in the event that it is purchased for the purposes of obtaining or with the intention of receiving medical treatment, a medical consultation or hospital services, even if the trip is on the recommendation of a physician;

e) In the event that the trip is purchased to visit or be at the bedside of a person who is ill or has suffered an accident, change in medical condition or death of such person;

f) A cause which, beyond any possible doubt, does not prevent the covered person from proceeding with the trip.

If notice of cancellation of a trip prior to departure is not provided within the time specified, GSC's trip cancellation liability is limited to the cancellation expenses that are applicable at the time such notice should have been given. However, this limitation will not apply if the covered person and any adult accompanying the covered person on the planned trip provide proof deemed satisfactory by GSC Travel Assistance, that they were totally incapable of providing notice of cancellation. In such case, the trip must be cancelled as soon as one of these persons is able to do so, and GSC's trip cancellation liability is limited to the applicable cancellation fees at the time of cancellation.

GSC TRAVEL ASSISTANCE SERVICE

The following services are available 24 hours per day, 7 days per week through GSC's international medical service organization.

These services include:

- Access to Pre-trip Assistance (prior to departure): Canada Direct Calling Codes; information about vaccinations; government issued travel advisories; and VISA/document requirements for entry into country of destination
- Multilingual assistance
- Assistance in locating the nearest, most appropriate medical care
- International preferred provider networks
- GSC Assistance Medical Team consultative and advisory services, including second opinion and review of appropriateness and analysis of the quality of medical care

- Assistance in establishing contact with family, personal physician and employer as appropriate
- Monitoring of progress during treatment and recovery
- Emergency message transmittal services
- Translation services and referrals to local interpreters as necessary
- Verification of coverage facilitating entry and admissions into hospitals and other medical care providers
- Special assistance regarding the co-ordination of direct claims payment
- Co-ordination of embassy and consular services
- Management, arrangement and co-ordination of emergency medical transportation and evacuation as necessary
- Management, arrangement and co-ordination of repatriation of remains
- Special assistance in making arrangements for interrupted and disrupted travel plans resulting from emergency situations to include:
  - the return of unaccompanied travel companions
  - travel to the bedside of a stranded person
  - rearrangement of ticketing due to accident or illness and other travel related emergencies
  - the return of a stranded personal use motor vehicle and related personal items
- Knowledgeable legal referral assistance
- Co-ordination of securing bail bonds and other legal instruments
- Special assistance in replacing lost or stolen travel documents including passports
- Courtesy assistance in securing incidental aid and other travel related services
- Emergency and payment assistance for major health expenses, which would result in payments in excess of $200

How Travel Assistance Service Works

For assistance dial **1.800.936.6226** within Canada and the United States or call collect **0.519.742.3556** when traveling outside Canada and the United States. These numbers appear on your GSC Identification Card.

Quote the GSC travel assist group number and your GSC Identification Number, found on your GSC Identification Card, and explain your medical emergency. **You must always be able to provide your GSC Identification Number and your provincial health insurance plan number.**

A multilingual Assistance Specialist will provide direction to the best available medical facility or legally qualified physician able to provide the appropriate care.

Upon admission to a hospital or when consulting a legally qualified physician or surgeon for major emergency treatment, we will guarantee the provider (hospital, clinic or physician), that you have both provincial health insurance plan coverage and GSC travel benefits as detailed above.

The provider may then bill GSC Travel Assistance directly for these approved services for amounts in excess of $200.

GSC Assistance Medical Team will follow your progress to ensure that you are receiving the best available medical treatment. These physicians also keep in constant communication with your family physician and your family, depending on the severity of your condition.

When calling collect while travelling outside Canada and the United States, you may require a Canada Direct Calling Code. In the event that a collect call is not possible, keep your receipts for phone calls made to GSC Travel Assistance and submit them for reimbursement upon your return to Canada.

Travel Limitations

1. Coverage becomes effective at the time you or your dependent crosses the provincial border departing from their province of residence and terminates upon crossing the border returning to their province of residence on the return home. If traveling by air, coverage becomes effective at the time the aircraft takes off in the province of residence and terminates when the aircraft lands in the province of residence on the return home.

2. Upon notification of the necessity for treatment of an accidental injury or medical emergency, GSC's Assistance Medical Team reserves the right to determine whether repatriation is appropriate if the patient's medical condition will require immediate or scheduled care. Such repatriation is mandatory, where the Assistance Medical Team determines that the patient is medically fit to travel and appropriate arrangements have been made to admit the patient into the provincial government health care system of their province of residence. Repatriation will ensure continued coverage under the plan. Should the patient opt not to be repatriated or elects to have such treatment or surgery outside their province of residence, the expense of such continuing treatment will not be an eligible benefit.

   The patient must contact GSC Travel Assistance within 48 hours of commencement of treatment. Failure to notify us within 48 hours may result in benefits being limited to only those expenses incurred within the first 48 hours of any and each treatment/incident or the plan maximum, whichever is the lesser of the two.

3. Air ambulance services will only be eligible if:
   - they are pre-approved by GSC Travel Assistance
   - there is a medical need for you or your dependent to be confined to a stretcher or for a medical attendant to accompany you during the journey
   - you or your dependent are admitted directly to a hospital in your province of residence, and
   - medical reports or certificates from the dispatching and receiving legally qualified physicians are submitted to GSC Travel Assistance
   - proof of payment (including air ticket vouchers or air carrier invoices) is submitted to GSC Travel Assistance

4. If planning to travel in areas of political or civil unrest, or in areas where Foreign Affairs and International Trade Canada (DFAIT) has issued a formal travel warning regarding non-essential travel, contact GSC Travel Assistance for pre-travel advice, as we may be unable to guarantee assistance services.

5. GSC reserves the right, without notice, to suspend, curtail or limit its services in any area in the event of political or civil unrest, including rebellion, riot, military uprising, labour disturbance or strike, act of God, or refusal of authorities in a foreign country to permit GSC to provide service. This includes travel in any area if at the time of booking the trip (including delay of travel), or before your departure date, Foreign Affairs and International Trade Canada (DFAIT) issued a formal travel warning advising Canadians to avoid all or non-essential travel to that specific country, region or city due to a likely or actual epidemic or pandemic, (non-essential travel will be deemed as anything other than a significant medical or family emergency, such as the death of a family member).

Travel Exclusions

In addition to the Health Exclusions, eligible benefits do not include and reimbursement will not be made for:

1. Any expenses incurred for the treatment related directly or indirectly to a pre-existing or pre-diagnosed medical condition that, at the time of your departure from your province of residence, was not completely stable (in the opinion of GSC Assistance Medical Team) and where medical evidence suggested a reasonable expectation that treatment or hospitalization could be required while traveling. GSC reserves the right to review your medical information at the time of claim.

2. Any expenses incurred for treatment or surgery that is not required for the immediate relief of acute pain or suffering as recommended by a legally qualified physician or surgeon. Eligible benefits will not be reimbursed for treatment or surgery that could reasonably be delayed until you return to your province of residence;

3. Any expenses incurred for treatment or surgery not covered under your provincial health insurance plan or for expenses incurred for treatment or surgery towards which your provincial health insurance plan has not provided payment;

4. Any expenses incurred for services, treatment or surgery received once the patient has opted to not be repatriated or elects to have such treatment or surgery outside their province of residence;

5. Any claims arising directly or indirectly from any medical condition you suffer or contract in a specific country, region or city due to an epidemic or pandemic, if at the time of booking the trip (including delay of travel), or before your departure date, Foreign Affairs and International Trade Canada (DFAIT) issued a formal travel warning advising Canadians to avoid all or non-essential travel to that specific country, region or city. In this exclusion a medical condition is limited to the reason for which the formal travel warning was issued and includes complications arising from such medical condition;

6. Treatment or services required for ongoing care, rest cures, health spas, elective surgery, check-ups or travel for health purposes, even if the trip is on the referral of a physician;

7. Treatment or service that you elect to have performed outside Canada when the medical condition would not prevent your return to Canada for such treatment;

8. Treatment or service required as a result of suicide, attempted suicide, intentionally self-inflicted injury of you, a traveling companion, or immediate family member while sane or insane;

9. Abusive or excessive consumption of medication, drugs or alcohol and the ensuing consequences, including, and as a result of, in connection with or in any way associated with driving a motorized vehicle while impaired by drugs, alcohol or toxic substances or an alcohol level of more than 80 milligrams in 100 millilitres of blood. (A motorized vehicle means any form of transportation which is propelled or driven by a motor and includes, but is not restricted to an automobile, truck, motorcycle, moped, snowmobile, or boat);

10. Amounts paid or payable under any Workplace Safety and Insurance Board or similar plan;

11. Hospital and medical care for childbirth occurring within 8 weeks of the expected delivery date from the date of departure, or deliberate termination of pregnancy;

12. Treatment or service provided in a chronic care or psychiatric hospital, chronic unit of a general hospital, Long-Term Care (LTC) Facility, health spa, or nursing home;

13. Services received from a chiropractor, chiropodist, podiatrist, or for osteopathic manipulation;

14. Cataract surgery or the purchase of eyeglasses or hearing aids;

15. Any expenses incurred during any trip taken for the purpose of seeking medical treatment or advice that have not been previously authorized as outlined in referral services.

GSC does not assume responsibility for nor will it be liable for any medical advice given, but not limited to a physician, pharmacist or other healthcare provider or facility recommended by GSC Travel Assistance.

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. Refer to the Summary of Benefits for the specific benefits that you are covered for, based on the option you have chosen.

Basic Services

Basic Diagnostic and Preventive Services:

- complete oral examinations once every 2 calendar years
- emergency and specific oral examinations
- full series X-rays and panoramic X-rays once every 2 calendar 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
- oral hygiene instruction twice per lifetime
- denture cleaning once per recall period
- pit and fissure sealants on molars only, for covered persons 16 years of age and under
- space maintainers
- mouth guards once every 12 months

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

Comprehensive Basic Services

Standard Denture Services:

- denture repairs and/or tooth/teeth additions
- standard relining and rebasing of dentures once every 2 years, only after 3 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

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 8 time units per calendar year
- 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 once every 24 months

Major Services

- Standard onlays or 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

Orthodontic Services
(Applies to dependent children age 17 and under only)

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

When a lump sum fee has been paid toward orthodontic treatment, the total amount of the claim will be split into separate portions to allow for payment of an initial fee (approximately one-third of the total lump sum), and the balance of the claim will be divided into monthly fees of equal amounts to be reimbursed over the duration of the treatment. 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 Treatment
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
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-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 Summary 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 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, calcified canals, 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) intentionally self-inflicted injury while sane or insane;
   b) an act of war, declared or undeclared;
   c) participation in a riot or civil commotion; or
   d) 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;

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

6. Implants and implant related services;

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, 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;

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 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 delivery and transportation charges;
    m) are a duplicate prosthetic device or appliance;
    n) 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;
    o) 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;

p) 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;
q) 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.

HEALTH CARE SPENDING ACCOUNT (HCSA)

(**Applies to the Basic Health, Coordination Health, Coordination Dental and Opt Out Dental Options only)**

Your HCSA is governed at all times by the rules and regulations of the Income Tax Act. In the event of a dispute the Income Tax Act shall prevail. The liability for the HCSA lies solely with your plan sponsor.

Your HCSA is provided by your plan sponsor and administered by GSC.

Your HCSA is a spending account funded by your plan sponsor that you can use to pay for health and dental expenses that are not covered by your group benefit plan or your provincial health plan.

At the beginning of each benefit year, a predetermined lump sum amount as shown in the Summary of Benefits will be allocated to your account annually to cover the reimbursement of your eligible expenses incurred during that benefit year. When you submit a claim, you will be reimbursed for eligible expenses up to the balance in your account.

Any balance remaining in your account on the last day of the benefit year will be carried forward to, but not beyond the end of, the next benefit year. This balance will be added to your new credits, and claims for the new benefit year will be applied to the combined amount, using the previous benefit year credits first. At the end of the new benefit year, any remaining previous benefit year credits will be forfeited.

ELIGIBLE EXPENSES

Eligible expenses include but are not limited to those that qualify for medical expense tax credits under the Canada Revenue Agency (CRA) Income Tax guidelines. It also includes the amount of the deductible and the percentage not covered by the group benefit plan or the amount in excess of group benefit plan maximums.

For a list of eligible medical expenses, visit our website at greenshield.ca or for more information about eligible expenses you can consult a CRA office or visit the CRA website at http://www.cra-arc.gc.ca/tx/ndvdls/tpcs/ncm-tx/rtrn/cmpltng/ddctns/lns300-350/330/llwbl-eng.html

Exclusions

Expenses not eligible for reimbursement are at all times governed by the non-eligible expenses, restrictions and limitations outlined in the Canadian Income Tax Act. An example of expenses would be:

a) premiums paid to provincial medical or hospitalization plans; and
b) medical costs for which you or your dependent are reimbursed or entitled to be reimbursed under a provincial health insurance plan, your group benefit plan or your spouse's group benefit plan.

Maternity, Adoption or Parental Leave

If you elect to continue benefits under your group plan, you may continue to submit claims for expenses incurred prior to, or during, the period of your leave.

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 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)**.

Your HCSA does not have automatic coordination with your health and dental benefits. If you would like to enable this functionality, you may do so through Plan Member Online Services (the GSC Customer Service Centre is unable to arrange set up of this function).

Auto-Coordination with HCSA

Once you have accessed Plan Member Online Services and have set up your HCSA auto-coordination, your health and dental claims will automatically be coordinated with your HCSA. You must pay the provider of service the HCSA portion of the claim and you will be automatically reimbursed from your HCSA without having to submit a paper claim. The claim **will not** be re-directed to a secondary plan (COB) before paying out of the HCSA.

Manual Coordination with HCSA

If you choose **not** to have all your traditional health and dental claims automatically coordinated with your HCSA, you must pay the provider of service the HCSA portion of the claim, then complete a HCSA Claim Submission Form and attach proof of payment. You can indicate on this claim form if you want your eligible expenses paid from your GSC health and/or dental plan first, and any unpaid portion of your eligible expenses paid from your HCSA.

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

All HCSA claims must be received by GSC no later than 90 days after the end of the benefit year, or, no later than 90 days after your termination date, your retirement date, your date of death or your leave of absence date (other than a Maternity, Adoption or Parental Leave).

Reimbursement

Reimbursement will be made 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.

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.

Emergency Travel

GSC Travel Assistance must be contacted by phone within 48 hours of commencement of treatment.

Call our Customer Service Centre at 1.888.711.1119 for detailed claims submission instructions.

If you have incurred out of pocket expenses, claims must be submitted together with supporting original receipts to GSC Travel Assistance who will then co-ordinate with the provincial health insurance plan reimbursement of those approved, eligible expenses.

To make a claim, submit the patient name, provincial health insurance plan number, address and GSC Identification Number with a detailed statement showing the services rendered and the fees charged for each service.

Subrogation

Where you or your dependent have rights against a third party for payment of all or part of the cost of any expenses covered under this plan, these eligible expenses are covered under this plan only to the extent you are not compensated for these expenses by the third party. The plan sponsor (and GSC as agent for the plan sponsor) has the right to recover amounts paid under this plan where you or your dependent receives reimbursement, in whole or in part, from a third party in respect to eligible expenses under this plan. The plan sponsor (and GSC as agent for the plan sponsor) may exercise any and all common law right of subrogation in relation to such amounts paid by a third party or any claims you or your dependent may have against a third party in relation to eligible expenses under this plan. In cases of third party liability, you must advise your legal advisor of the subrogation provisions under this plan.

In the case of rights under a prescription drug insurance program described under the Co-ordination of Benefits (COB) provision of this plan, the rights of contribution and subrogation will be subject to the rules set out under that section and the Canadian Life and Health Association (CLHIA) Co-ordination of Benefit Guidelines, as published from time to time.

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.

Travel Benefits
In the event of a travel claim, all plans equally share the cost of the claim.

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.