MY BENEFIT PLAN BOOKLET

Classification: High Liner Foods
A – Salaried
B – Part Time Merchandisers
D - Executives

Revised Effective Date: January 1, 2015

gsc green shield canada

WELCOME TO YOUR BENEFIT PLAN

ABOUT THIS BOOKLET

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

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

You are encouraged to read this booklet carefully; please keep it in a safe place so that you may refer to it when submitting claims.

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

PLAN MEMBER ONLINE SERVICES

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

- View your Benefit Plan Booklet
- Access your personal claims information, including a breakdown of how your claims were processed
- Simulate a claim to instantly find out what portion of a claim will be covered
- Submit certain claims online
- Arrange for claim payments to be deposited directly into your bank account*
- Print personalized claim forms and replacement Identification Cards
- Print personal Explanation of Benefits statements for when you need to co-ordinate benefits
- Get the support you need online

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

TABLE OF CONTENTS

SCHEDULE OF BENEFITS

HEALTH BENEFIT PLAN

This schedule describes the deductibles, Co-Insurance and maximums that may be applicable if you are included in the Classification shown on the cover of this booklet.

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

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

PRESCRIPTION DRUG COVERAGE OPTIONS – PAY DIRECT DRUG CARD

Your Plan Covers:	**Level 1**	**Level 2**	**Level 3**
Co-Insurance:	75% of the allowed amount	85% of the allowed amount	95% of the allowed amount until an out of pocket amount of $750 per family has been reached, then 100% thereafter per calendar year
Deductible (per prescription or refill):	$12	$10	$8
Annual Maximum	Unlimited	Unlimited	Unlimited
Smoking cessation drugs	$800 per lifetime	$800 per lifetime	$800 per lifetime
Fertility drugs	Not covered	$1,500 per lifetime	$2,500 per lifetime
Overall Maximum	Unlimited	Unlimited	Unlimited

MEDICAL SERVICES OPTIONS

Your Plan Covers:	Level 1	Level 2	Level 3
Co-Insurance	100%	100%	100%
Hospital Accommodation			
• Public general hospital - semi-private	Reasonable and customary charges	Reasonable and customary charges	Reasonable and customary charges
• Convalescent or rehabilitation hospital - semi-private room	$20 per day up to 180 days per calendar year	$20 per day up to 180 days per calendar year	$30 per day up to 180 days per calendar year
• Public chronic hospital - semi-private room	120 days per calendar year	120 days per calendar year	120 days per calendar year
Private Duty Nursing in the Home • Registered Nurse (R.N.) or Registered Practical Nurse/Licensed Practical Nurse (R.P.N./L.P.N.)	$5,000 every 12 months based on date of first paid claim	$7,500 every 12 months based on date of first paid claim	$10,000 every 3 years based on date of first paid claim
Audio	$500 every 5 years based on date of first paid claim	$700 every 5 years based on date of first paid claim	$700 every 4 years based on date of first paid claim
Emergency Transportation Accidental Dental	Reasonable and customary charges	Reasonable and customary charges	Reasonable and customary charges
Insulin Pumps and supplies	$1,500 per lifetime	$1,500 per lifetime	$1,500 per lifetime
Blood Glucose Monitor	1 every 4 calendar years	1 every 4 calendar years	1 every 4 calendar years
Footwear ▪ custom made boots or shoes, modifications/repair to footwear and footwear as an integral part of a brace ▪ custom made orthotics	$200 combined every 12 months based on date of first paid claim	$300 combined every 12 months based on date of first paid claim	$400 combined every 12 months based on date of first paid claim
Wheelchair Ramp (portable)	$2,000 per lifetime	$2,000 per lifetime	$2,000 per lifetime

Your Plan Covers:	Level 1	Level 2	Level 3
• Musculo-Skeletal (TENS machine)	$700 per lifetime	$700 per lifetime	$700 per lifetime
• Breast Prosthesis	1 breast prosthesis of any kind every 12 months based on date of first paid claim	1 breast prosthesis of any kind every 12 months based on date of first paid claim	1 breast prosthesis of any kind every 12 months based on date of first paid claim
• Mastectomy Bra	$80 each and up to 2 per calendar year	$80 each and up to 2 per calendar year	$80 each and up to 2 per calendar year
• Myo-electric arm (prosthesis)	$10,000 per prosthesis every 2 years based on date of first paid claim	$10,000 per prosthesis every 2 years based on date of first paid claim	$10,000 per prosthesis every 2 years based on date of first paid claim
• Stump Socks	5 per calendar year	5 per calendar year	5 per calendar year
• Wig	$300 per calendar year	$300 per calendar year	$300 per calendar year
• CPAP, BIPAP, APAP machine	$2,000 every 5 years based on date of first paid claim	$2,000 every 5 years based on date of first paid claim	$2,000 every 5 years based on date of first paid claim
• Compression Stockings (Physician (M.D.) recommendation required once per lifetime)	4 pairs per calendar year	4 pairs per calendar year	4 pairs per calendar year
• Other items and services – See the Description of Benefits section for details	Reasonable and customary charges	Reasonable and customary charges	Reasonable and customary charges

VISION AND PARAMEDICAL SERVICES OPTIONS

Your Plan Covers:	Level 1	Level 2	Level 3
Co-Insurance	100%	100%	100%
Vision			
• prescription eye glasses or contact lenses, or medically necessary contact lenses	Not Covered	$175 every 24 months based on date of first paid claim (every 12 months for dependent children age 18 and under)	$200 every 24 months based on date of first paid claim (every 12 months for dependent children age 18 and under)

Your Plan Covers:	Level 1	Level 2	Level 3
• optometric eye exams	$75 for one eye exam every 2 years based on date of first paid claim (once every 12 months for dependent children age 18 and under)	$75 for one eye exam every 2 years based on date of first paid claim (once every 12 months for dependent children age 18 and under)	$75 for one eye exam every 2 years based on date of first paid claim (once every 12 months for dependent children age 18 and under)
Co-Insurance	50%	50%	50%
Laser Eye Surgery	$500 per lifetime	$500 per lifetime	$700 per lifetime
Co-Insurance	100%	100%	100%
Paramedical Services			
• Acupuncturist • Audiologist • Naturopath • Occupational Therapist • Osteopath • Podiatrist and Chiropodist	$400 per calendar year combined	$500 per calendar year combined	$600 per practitioner per calendar year
• Chiropractor • Massage Therapist • Physiotherapist	$300 per calendar year combined	$400 per calendar year combined	$500 per practitioner per calendar year
• Dietician • Psychologist/Counsellor, Social Worker/Master of Social Work • Speech Therapist	$500 per calendar year combined	$600 per calendar year combined	$700 per practitioner per calendar year

TRAVEL BENEFIT PLAN

This schedule describes the deductibles, Co-Insurance and maximums that may be applicable if you are included in the classification shown on the cover of this booklet.

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

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

Reimbursement of eligible benefits for emergency services will be made only if the services were required as a result of emergency illness or injury that occurred while you were vacationing or traveling for other than health reasons.

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.

Deductible: Nil	**Overall Maximum:** Does not apply

Co-Insurance: Does not apply

Your Plan Covers:	**Level 1** **Level 2** **Level 3**
Maximum Number of Days per Trip	180 days
Emergency Services	$5,000,000 per covered person per incident
Referral Services	$50,000 per covered person per calendar year

For a full description of the Travel Benefit, refer to the Benefit Description section.

DENTAL BENEFIT PLAN

This schedule describes the deductibles, Co-Insurance and maximums that may be applicable if you are included in the Classification shown on the cover of this booklet.

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

Fee Guide:	The current Provincial Dental Association Fee Guide for General or Specialist Practitioners in the province of residence For independent Dental Hygienists, the lesser of, the current Provincial Dental Hygienists' Association Fee Guide and Provincial Dental Association Fee Guide for General Practitioners in the province of residence For Alberta, with no fee guide, reimbursement will be according to a fee schedule established by GSC for that province

Your Plan Covers:	**Level 1**	**Level 2**	**Level 3**
Co-Insurance			
Basic Services			
▪ Periodontal Services	70%	70%	70%
▪ All Other Services	80%	80%	70%
Major Services	50%	50%	60%
Orthodontic Services	Not Covered	50%	60%
Maximum Plan Pays:			
Basic Services and Major Services	$1,500 per calendar year combined	$1,500 per calendar year combined	$2,000 per calendar year combined
▪ Implants	Not Covered	Not Covered	$500 per calendar year
Orthodontic Services	Not Covered	$1,500 per lifetime (for covered persons age 19 and under only)	$2,000 per lifetime (for covered persons age 19 and under only)

HEALTH CARE SPENDING ACCOUNT

This schedule describes the Health Care Spending Account provided by your plan sponsor and administered by GSC that may be applicable if you are included in the Classification shown on the cover of this booklet.

Complete benefit details are provided in the Description of Benefits section of this booklet. Be sure to read these pages carefully. They show the conditions, limitations and exclusions that may apply to the benefits. All dollar maximums are expressed in Canadian dollars.

Your Plan Covers:	**Maximum Plan Pays:**
Contribution as defined by your flex benefits program	as determined by your plan sponsor
Benefit Year: January 1 to December 31	

PERSONAL SPENDING ACCOUNT

This schedule describes the Personal Spending Account provided by your plan sponsor and administered by GSC that may be applicable if you are included in the Classification shown on the cover of this booklet.

Complete benefit details are provided in the Description of Benefits section of this booklet. Be sure to read these pages carefully. They show the conditions, limitations and exclusions that may apply to the benefits. All dollar maximums are expressed in Canadian dollars.

Your Plan Covers:	**Maximum Plan Pays:**
Contribution as defined by your flex benefits program	as determined by your plan sponsor
Benefit Year: January 1 to December 31	

DEFINITIONS

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

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

a) Drugs – the GSC National Pricing Policy and/or the reasonable and customary charge;
b) Extended Health Services – the reasonable and customary charge for the service or supply but not more than the prevailing charge in the area in which the charge is made for a like service or supply;
c) Dental – the fee guide as specified in the Schedule of Benefits.

Benefit year means the 12 consecutive months commencing on Jan 01 and ending on December 31 of each year for the Health Care Spending Account and Personal Spending Account.

Calendar year means the 12 consecutive months January 01 to December 31 of each year.

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

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

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

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

Deductible is the amount that must be paid by or on behalf of you and your dependent in any calendar 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. 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 26, 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;
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.

Your child (you 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 limitations of the Travel plan still apply).

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.

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

Orthopedic shoes means off-the-shelf, ready-made footwear prescribed for covered persons diagnosed with a specific medical condition that affects their feet and who require specialized footwear to treat their condition and assist with mobility. 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) a plan member who is a resident of Canada;
b) covered under your provincial health insurance plan;
c) actively at work on a regular basis and working a minimum of 30 hours per week or 24 hours per week for a part-time merchandiser.

For your Dependents
To be eligible for coverage you must be:

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

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

You will be eligible for coverage on the first day of active employment.

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

Once you have completed your on line enrolment, your plan sponsor is responsible for providing all required information to GSC as of the Effective Date of this plan or as of the first date that you become eligible for coverage.

Coverage Options
Your Health Benefit Plan consists of three options: Prescription Drug Coverage, Medical Services, and Vision and Paramedical Services. You must choose from all three options and you may select a different level of coverage for each option. For Dental, you may select one of the three different levels of coverage.

Coverage Lock-In Period
Once you have selected your options, you will be permitted to increase or decrease your coverage levels on the benefit enrollment date following one year of coverage.

You can change your level at each re-enrollment period. You can move up as many levels as you wish, for example from Level 1 to Level 3; or move down one level at a time, for example from Level 3 to Level 2 only. This rule does not apply if you change your coverage because of an eligible life event.

Opting Out
If you have Health or Dental coverage through your spouse's plan, you can choose to opt out and not have benefits through your plan sponsor's benefits program. You must request coverage from your plan sponsor within 31 days after termination of the coverage under your spouse's plan.

Default Coverage
If you do not enrol within 31 days of becoming eligible you will receive the default coverage (Level 2 - single coverage) for all Benefits. Any remaining flex credits will be deposited to your Health Care Spending Account.

Life Event Changes
If you experience an eligible life event, you can make changes to your coverage options outside of the regular open enrollment period only if your status (single, two-person, family) changes because of:

a) marriage or qualifying as a common-law relationship;
b) divorce, legal separation, or the end of a common-law relationship;
c) birth or adoption of a child;
d) death of a dependent;
e) last dependent child is no longer eligible for coverage;
f) dependent child who returns to full-time studies after age 21 but before age 26.

You must change your coverage option within 31 days of the eligible event

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 end of the period for which rates have been paid to GSC for your coverage;
d) the date the 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 day in 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 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
(not applicable to Health Care Spending Account and Personal Spending Account)
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) 12 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 shown below will be eligible, up to the amount shown in the Schedule of Benefits, if they are reasonable and customary, and are medically necessary for the treatment of an illness or injury.

Prescription Drugs

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

a) are prescribed by a legally qualified medical practitioner or dental practitioner as permitted by law; and
b) legally require a prescription and has a Drug Identification Number (DIN); and
c) has a Natural Product Number (NPN) for potassium replacement agents and iron supplements only and
d) 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. limited access drugs and some over-the-counter drugs. In addition, this plan includes vaccines, oral contraceptives, Mirena and Depo-Provera.

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.

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 that 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 are eligible benefits for residents in provinces where legislation permits.

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, enrollment in RAMQ is automatic, enrollment in the GSC Prescription Drugs benefit plan is optional, and RAMQ would be first payer.

If any provisions of this plan do not meet the minimum requirements of the RAMQ plan, adjustments are automatically made to meet RAMQ requirements.

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

a) Drugs used for the treatment of obesity and erectile dysfunction;
b) Drugs for the treatment of infertility (for Level 1 only);

c) Contraceptive devices;
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, excluding smoking cessation products (such as Nicoderm patches and Nicorette gum), and natural health products excluding potassium replacement agents and iron supplements;
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

1. **Hospital Accommodation:** Reimbursement, as shown in the Schedule of Benefits, of reasonable and customary charges in the area where received, for accommodation in a public general hospital, or a convalescent or rehabilitation hospital or a convalescent or rehabilitation wing in a public general hospital or a public chronic hospital or chronic care in a public general hospital, provided your provincial health insurance plan has accepted or agreed to pay the ward or standard rate.

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

3. **Medical Items and Services:** Reimbursement for reasonable and customary charges, up to the amount, where applicable, as shown in the Schedule of Benefits for:
   a) Aids for daily living: such as hospital style beds, including rails and mattresses; bedpans; standard commodes; decubitus (bedridden) supplies; I.V. stands; portable patient lifts (including batteries); trapezes; urinals;
   b) Footwear, when prescribed by your attending physician, podiatrist or chiropodist and dispensed by your podiatrist, chiropodist, chiropractor, orthotist, or pedorthist:
      i) custom-made foot orthotics or adjustments to custom made foot orthotics;
      ii) custom-made boots or shoes, adjustments to orthopaedic 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, lancets, insulin guns, insulin pumps and supplies and diabetic supplies;
   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, wheelchairs (including wheelchair batteries) and portable wheelchair ramps;
   h) Prosthetics, such as arm, hand, leg, foot, breast, eye and larynx;
   i) Optometric eye examinations for visual acuity performed by a licensed optometrist, ophthalmologist or physician;
   j) Respiratory/Cardiology equipment, such as compressors, inhalant devices, tracheotomy supplies oxygen and CPAP, APAP and BPAP machines;
   k) Compression stockings;
   l) Wigs, for temporary or permanent hair loss as a result of a medical condition.

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

Limitations

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

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

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

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

5. **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 Schedule of Benefits. No amount will be paid for 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.

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

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

7. **Accidental Dental:** Reimbursement for the services of a licensed dental practitioner for dental care to natural teeth when necessitated by a direct blow to the mouth and not by an object wittingly or unwittingly placed in the mouth. The accident must occur while the coverage is in force. When natural teeth have been damaged eligible services are limited to one set of artificial teeth. You must notify GSC immediately following the accident and the treatment must commence within 180 days of the accident.

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

   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.

8. Vision (Level 2 and 3 only):

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

a) Prescription eyeglasses or contact lenses.
b) Medically necessary contact lenses when visual acuity cannot otherwise be corrected to at least 20/40 in the better eye or when medically necessary due to keratoconus, irregular astigmatism, irregular corneal curvature or physical deformity resulting in an inability to wear normal frames.
c) Replacement parts for prescription eyeglasses.
d) Laser eye surgery. (for Level 1, 2 and 3).
e) Prescription industrial safety eyeglasses.

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

a) Medical or surgical treatment, except for laser eye surgery;
b) Special or unusual procedures such as, but not limited to, orthoptics, vision training, subnormal vision aids and aniseikonic lenses;
c) 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; 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 for medical or surgical audio and visual treatment;
l) are special or unusual procedures such as, but not limited to, orthoptics, vision training, subnormal vision aids and aniseikonic lenses;
m) are delivery and transportation charges;
n) are for medical examinations audiometric examinations or hearing aid evaluation tests;
o) are batteries, unless specifically included as an eligible benefit;
p) are a duplicate prosthetic device or appliance;
q) 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;
r) 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;
s) 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;
t) 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);
u) 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;
v) 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;
w) 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 on the Schedule of Benefits commencing with the date of departure from your province of residence. If you are hospitalized on the last day shown on the Schedule of Benefits, your benefits will be extended until the date of discharge.

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

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

3. **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

4. **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**

5. **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;

6. **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);

7. **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;

8. **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;

9. **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;

10. **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

11. **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;

12. **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;

13. **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

14. **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;

15. **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;

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 for 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 Schedule of Benefits.

Basic Services

1. Basic Diagnostic and Preventive Services:
   - complete oral examinations once every 2 years
   - emergency and specific oral examinations
   - full series X-rays and panoramic X-rays once every 2 years
   - bitewing X-rays:
     - once every 12 months (6 months for dependent children age 18 and under) for Level 1
     - once every 9 months (6 months for dependent children age 18 and under) for Level 2
     - once every 6 months for Level 3
   - recall examinations:
     - once every 12 months (6 months for dependent children age 18 and under) for Level 1
     - once every 9 months (6 months for dependent children age 18 and under) for Level 2
     - once every 6 months for Level 3
   - 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 once every 9 months
   - denture cleaning once per recall period
   - pit and fissure sealants for molars only
   - space maintainers
2. Basic Restorative Services:
   - amalgam, tooth coloured filling restorations and temporary sedative fillings
   - inlay restorations – these are considered basic restorations and will be paid to the equivalent non-bonded amalgam
3. Basic oral surgery:
   - extractions of teeth and/or residual roots
4. General anaesthesia, deep sedation, and intravenous sedation in conjunction with eligible oral surgery only
5. Standard denture services:
   - denture repairs and/or tooth/teeth additions
   - standard relining and rebasing of dentures
   - denture adjustments and remount and equilibration procedures, only after 3 months have elapsed from the installation of an initial or replacement denture
   - soft tissue conditioning linings for the gums to promote healing
   - remake of a partial denture using existing framework, once every 5 years

6. 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

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

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

Major Services

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

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

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

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

Orthodontic Services (Level 2 and 3 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.

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-insurance of such services. Laboratory services that are in excess of 40% of the dentist's fee in the applicable Fee Guide shown in the Schedule of Benefits will be reduced accordingly; the Co-insurance is then applied;

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

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

4. Reimbursement for root canal therapy will be limited to payment once only per tooth. Extra charges for difficult access, exception anatomy, calcified 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 (for Levels 1 and 2);

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

8. Appliances related to treatment of myofacial 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)

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, if eligible, a pre-determined lump sum amount, as defined by your flexible benefits program election, 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.

If you elect not to continue benefits under your group plan credits will not be allocated to your Health Care Spending Account. You may submit claims for expenses incurred prior to or during the period of your leave.

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PERSONAL SPENDING ACCOUNT (PSA)

Your PSA is provided by your plan sponsor and administered by GSC. Your plan sponsor reserves the right to cancel, alter or amend the terms and provisions of the PSA to ensure the program is reaching the desired goal of increased health and wellness.

Your PSA is a spending account funded by your plan sponsor that you can use to pay for a range of personal wellness related expenses not covered by your group benefit plan or provincial health plan. Expenses claimed are subject to income tax as outlined by the Canada Revenue Agency.

At the beginning of each benefit year, a predetermined lump sum amount as shown in the Schedule 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 benefits 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 for up to 12 months until 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

The following items are covered under the Personal Spending Account. These items are a taxable benefit so all expenses submitted for payment will be shown on your T4A slip received from your plan sponsor.

Fitness/Sports Fees
Recreational Program, Classes, Team Registration Fees
Personal Training, Consultation
Club, Resort, Park, Annual Memberships
Recreational, Individual Event Pass, Registration or Fee
Gym, Fitness Centre, Pool, Annual Memberships

Fitness Equipment
Fitness Equipment
Sports Equipment
Bicycle (Manual)
Heart Rate Monitor
Athletic Sportswear and Accessories
Wii Fit or Xbox Kinect, PlayStation Fitness (entertainment system not included)
Fishing Equipment

Family Care
Child Care
Elder care
Homecare Assistance Services and Products (lifts, supportive aids)
Caregiver Support Programs and Services

Educational and Personal Development
Hobby and General Interest Classes
Education Fees, Tuition, Books
Training, Classes, Tutoring, Language, First Aid, CPR
Professional Designation and Membership Fees and/or dues
Personal Computer and Accessories
Music Equipment

Wellness Services
Smoking Cessation Programs
Safety Equipment
Health Assessments
Weight Loss Programs, Counseling (excluding food)
Nutritional Counseling
Vitamins, Supplements, Natural Products
Maternity Services (Pre-Natal Classes and Mid-Wife Services)
Stress Management Programs
Medical Tests
Alternative Health Practitioners (Examples: Reflexologist, Iridologist, Herbalist, Homeopath, Chinese medicine, Shiatsu therapist, Acupuncturist)
Holistic Health Services

Non-Health Professional Services
Legal Services
Financial Services

CLAIM INFORMATION

Inquiries

For detailed inquiries, contact your Benefits Administrator or contact us:

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

Pre-authorization

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

Submitting Claims

When submitting a claim to GSC, you must show the GSC Identification Number for the person who has received the benefit. You can find the applicable GSC Identification Number for yourself and each of your dependents listed on your GSC Identification Card. Original itemized paid receipts are required for claims reimbursement (cash receipts or credit card receipts alone are not acceptable as proof of payment).

For **claims reimbursement** forward an original itemized paid receipt **(cash receipts or credit card receipts alone are not acceptable)** including:

- Covered person's name, address and GSC Identification Number
- Provider's name and address
- Date of service
- Charges for each service or supply
- A detailed description of the service or supply
- Medical referral/ physician prescription when required
- For Audio, a copy of audiogram and details of provincial funding, if applicable
- For Hospital, admission and discharge dates; daily accommodation charges; number of days in preferred accommodation

For dental claims, forward a dental claim form, completed by both the plan member and the dentist. If your claim is the result of an accident, a Dental Accident Report Form and your dental X-rays must be submitted to GSC for prior approval. Failure to comply may result in non-payment.

For Health Care Spending Account (HCSA), forward a HCSA claim form and indicate on the 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. These claims must first be submitted to any provincial health insurance, or any private health care plan you may have (including another GSC plan, spousal plan, etc.).

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.

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.

All PSA claims must be received by GSC no later than 90 days after the end of the benefit year or no later than 12 months from the date the eligible benefit was incurred after your termination date.

Submit all Claim Forms to:
GSC

Attn: Drug Department	PO Box 1652	Windsor, ON	N9A 7G5
Attn: Medical Items	PO Box 1623	Windsor, ON	N9A 7B3
Attn: Professional Services	PO Box 1699	Windsor, ON	N9A 7G6
Attn: Hospital/ Vision Department	PO Box 1615	Windsor, ON	N9A 7J3
Attn: Out-of-Country Department	PO Box 1606	Windsor, ON	N9A 6W1
Attn: Dental Department	PO Box 1608	Windsor, ON	N9A 7G1
Attn: Personal Spending Account	PO Box 1699	Windsor, ON	N9A 7G6
Attn: Health Care Spending Account	Applicable P.O. Box shown above		

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 maximums and limitations stated are in Canadian currency. Reimbursement will be made in Canadian or U.S. funds for both providers and plan members, based on the country of the payee.

Direct Payment to the Provider of Service (where applicable)

(not applicable to Health Care Spending Account or Personal Spending Account)

Present your GSC Identification Card to your provider and, after you pay any applicable co-pay, they may bill GSC directly and in many cases, payment will be made directly to your provider of service. Most providers will also have a supply of claim forms.

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

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

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.

PREFERRED PROVIDER VISION NETWORK ARRANGEMENT

As a GSC plan member, you have access to our national preferred provider vision network arrangement where all GSC plan members are eligible to receive a discount on eyewear and laser eye surgery.

Features of this great value-added service for either eyewear or laser eye surgery include:

1. Offer applies to any GSC plan member, regardless of whether you have GSC vision benefits or not;

2. The vision provider may bill GSC directly; the plan member just pays any portion of the expense not covered under their vision benefit;

3. Trustworthy retail chains with convenient locations;

4. The discount offer applies to everything such as all extra coatings, upgrades and accessories;

5. Hundreds of the latest frame styles to choose from plus the latest lens and coating technology;

6. Professional opticians to assist in selecting products;

7. For some vendors, this offer applies to non-disposable contact lenses only (excludes disposable contact lenses).

Visit our website at greenshield.ca or call our Customer Service Centre at 1.888.711.1119 for information on the vision providers.

How to Submit Your Vision Claim

1. Present your GSC Identification Card as proof of being a GSC plan member.

2. The vision provider will apply the appropriate discount(s) to your claim and may submit the claim directly to GSC for payment. You pay your vision provider any balance not covered under your vision benefit.

3. If no vision benefit exists, you pay your provider the full balance owing after the applicable discounts have been applied.

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. It consists of the following key principles:

1. **We ask for your personal information for the following purposes:**
   - To establish your identification
   - To provide you and/or your dependents with the applicable benefit coverage
   - To protect you and us from error and fraud
   - To provide ongoing access to other services at GSC

2. **Consent**
   When you enrolled in your group benefit plan as a plan member, your personal information was obtained and used only with your consent. We obtained your consent before we:
   - Provided benefit coverage
   - Offered you other GSC services
   - Obtained, used or disclosed to other persons, information about you unless we were obliged to do so by law or to protect our interests
   - Used your personal information in any way we did not tell you about previously

   Your consent can be either express or implied. Express consent can be verbal or written.

   Consent can be implied or inferred from certain actions. For our existing group and benefit plan members and their dependents, we will continue to use and disclose your personal information previously collected in accordance with our current privacy code, unless you inform us otherwise and will infer that consent has been obtained by your continued use.

3. **Withdrawal of Consent**
   You can withdraw your consent any time after you've given it to us, provided there are no legal or regulatory requirements to prevent this.

   If you don't consent to certain uses of personal information, or if you withdraw your consent, we will no longer be able to administer your benefit coverage. If so, we will explain the situation to you to help you with your decision.

   For further information on our privacy policies and procedures, please refer to the GSC website at greenshield.ca.