My BENEFIT PLAN

Sysco Canada Inc.

Classification:	Retirees Ontario – Produce Union
Billing Division:	24661
Revised Effective Date:	May 1, 2022

WELCOME TO YOUR BENEFIT PLAN

This summary contains information about your group benefits with **Sysco Canada Inc.**, your plan sponsor, available through the group contract with Green Shield Canada (GSC), effective July 1, 2018.

HEALTH SUMMARY

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

Benefit Year Deductible: **(per person/per family)**	No Deductible
Maximums Overall Health Maximum (excluding Vision): Smoking cessation program:	 $25,000 every 3 benefit years One course of treatment in any 12 month period
Your Co-pay Prescription Drugs, Hospital Accommodation and Vision: All Other Health Benefits:	 0% 20%
Your Plan Covers	**Maximum Plan Pays**
Prescription Drugs	Unlimited, except as stated above
Hospital Accommodation	Semi-private room
Hearing Care	$300 every 60 months
Orthotics/Orthopedic Footwear Custom boots and shoes and orthopedic shoes (including modifications/repairs): Custom orthotics:	 $200 per benefit year combined Reasonable and customary charges
Private Duty Nursing	Reasonable and customary charges
Paramedical Practitioners Chiropractor, Registered Massage Therapist, Naturopath, Osteopath, Physiotherapist, Homeopath Psychologist Speech Therapist, Chiropodist/Podiatrist	 $20 per visit, up to $225 per benefit year per type of practitioner, plus $15 per benefit year for X-rays by a Chiropractor or Osteopath $20 per half hour for the initial visit, $25 for each subsequent visit, up to $225 per benefit year $25 per visit, up to $225 per benefit year per type of practitioner, plus $15 per benefit year for X-rays by a Podiatrist
Vision Eyeglasses or contact lenses or medically necessary contact lenses Visual Training	 $150 every 24 months 10 occurrences every 12 months

DENTAL SUMMARY

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

Benefit Year Deductible: **(per person/per family)**	No deductible
Dental Fee Guide: **(General Practitioners and Specialists)**	Current province of treatment
Your Co-pay	
Basic Services:	0%
Comprehensive Basic Services:	20%
Major Services:	20%
Orthodontics:	20%
Your Plan Covers	
Basic Services	$1,100 per benefit year combined for all Basic, Comprehensive Basic and Major Services
Comprehensive Basic Services	
Major Services	
Orthodontics	$2,000 per lifetime for covered persons age 20 and under
Summary of Covered Benefits	
Basic Services include recall visits once every 6 months, fillings and extractions **Comprehensive Basic Services** include root canal therapy, periodontal scaling/root planing and denture relining/rebasing, repairs, or adjustments **Major Services** include crowns, dentures and/or bridgework (replacements of each limited to once every 5 years) **Orthodontics** includes only in-person orthodontic treatment to straighten teeth/correct the bite.	

ABOUT THIS SUMMARY

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

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

You are covered for only those specific benefits for which you have applied and for which your plan sponsor has certified you are eligible. You must be covered in order for your dependents to be covered. Your coverage will terminate upon the date of your death or the date your plan sponsor advises GSC that you are no longer eligible for coverage. Coverage for your dependents will terminate upon the earlier of termination of your coverage or the date your dependent no longer satisfies the definition of a dependent.

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

GSC everywhere – INFORMATION YOUR WAY

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

- View your Benefit Plan Booklet
- Access your claims history, including a breakdown of how your claims were processed
- Check your eligibility and coverage for health services or items to instantly find out what portion of a claim will be covered
- Submit claims online (some claims can even be processed instantly if you are signed up for direct deposit)
- Search for a drug to get information specific to your own coverage (or coverage for your family)
- Search GSC-vetted health providers in a particular location (within Canada) that will submit your claims for you
- Arrange for claim payments to be deposited directly into your bank account
- Print personalized claim forms and access your digital ID Card
- Print personal Explanation of Benefits statements for when you need to co-ordinate benefits

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

OUR COMMITMENT TO PRIVACY

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

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

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DEFINITIONS

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

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

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.

Benefit year means the 12 consecutive months commencing on July 1st to June 30th of each year.

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

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

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 benefit 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 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, if enrolled and in full-time attendance at an accredited college, university or educational institute; and
d) your unmarried child (regardless of age) who became totally disabled while eligible under b) or c) above, and has been continuously so disabled since that time and is considered a dependent as defined under the Income Tax Act, also qualify as a dependent.

Your child (your or your spouse's natural, legally adopted or stepchildren) must reside with you in a parent-child relationship or be dependent upon you (or both) and not regularly employed.

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

Fee guide means the list of dental procedure codes developed by and maintained by the Canadian Dental Association, adopted by the provincial or territorial dental association of the province or territory in which the service is provided (or your province of residence if any dental service is provided outside Canada) and in effect at the time the service is provided.

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

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

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.

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

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

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

ELIGIBILITY

For You

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

a) a resident of Canada; and
b) covered under your provincial health insurance plan.

For Your Dependents

To be eligible for coverage you must be:

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

Coverage Effective Date

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

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

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.

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

Termination

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

a) the date of your death;
a) the end of the period for which rates have been paid to GSC for your coverage;
b) 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 end of the month 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

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.

Losing your Group Benefits?

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

SureHealth™ LINK Plans– Buying directly from GSC

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

DESCRIPTION OF BENEFITS

HEALTH BENEFIT PLAN

The benefits 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.

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 approved under GSC's drug review process; and
d) are paid on a Pay Direct basis.

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

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

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

Certain drugs require prior approval from GSC before your drug claim can be reimbursed. Further, certain drugs defined by GSC as specialty, high cost drugs may be required to be purchased from an approved pharmacy that is a member of GSC's Specialty Drug Preferred Provider Network (PPN) before your claim can be reimbursed. You can find out if your drug requires prior approval or is included in the PPN either by checking your coverage under "Your Health Benefits" on *GSC everywhere*, or by contacting GSC's Customer Service Centre.

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

Mandatory generic drug substitution

Based on specific provincial health insurance plan regulations, where a generic equivalent drug exists, reimbursement will only be made up to the cost of the lowest priced equivalent drug.

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.

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

a) Vitamins that do not legally require a prescription;
b) Nicotine replacement products, such as patches, gum, lozenges, and inhalers;
c) Products which may lawfully be sold or offered for sale other than through retail pharmacies, and which are not normally considered by practitioners as medicines for which a prescription is necessary or required, unless specifically identified and included as eligible in "Prescription Drugs";
d) Ingredients or products which have not been approved by Health Canada for the treatment of a medical condition or disease and are deemed to be experimental in nature and/or may be in the testing stage;
e) Mixtures, compounded by a pharmacist, that do not conform to GSC's current Compound Policy.

Extended Health Services

Hospital Accommodation: Reimbursement, as shown in the Summary of Benefits, of reasonable and customary charges in the area where received, for accommodation in a:

- public general hospital (including program treatment), 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

- Long-Term Care Facility
  For residents of Ontario: Reimbursement for the residential co-payment expense, (difference between the allowance paid to the facility by the province and the amount charged to the resident) as set by the Ministry of Health and Long-Term Care for a standard ward or semi-private room, for each day a covered person resides in an approved facility.

  For residents outside Ontario: Reimbursement, for the covered person's co-payment expense in an approved facility for the lesser of:
  a) the usual charge payable by the covered person; or
  b) the co-payment amount, up to the level that would have been paid had such covered person resided in a licensed facility in the Province of Ontario.

  The covered person must reside in and receive daily care in an approved facility which is licensed or registered under the laws of the province in which it is located, and benefits will be payable:
  a) for each day the covered person is certified as meeting the same requirements necessary to receive long-term care benefits under the Health Insurance Act of Ontario;
  b) on submission of satisfactory proof that if the covered person had resided in the Province of Ontario, such covered person would have been eligible to receive long-term care, and a payment of an allowance for such care would have been made to the facility for the covered person by the Ontario Ministry of Health for each day benefits are claimed;
  c) provided the covered person's provincial health plan agrees to pay the ward or standard rate portion.

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

a) long-term care in a facility outside Canada;
b) a covered person eligible for or receiving same or similar benefits from any branch of any federal, provincial or municipal government or any other third party, regardless of whether the covered person has or has not contributed toward providing such benefit;
c) any expenses incurred in a rest home or retirement home;
d) any expenses incurred for a covered person admitted to an approved Long-Term Care Facility under 'Spousal Accompaniment'; or
e) an expense incurred while a covered person is absent from the Long-Term Care Facility; however, they may continue to receive benefits for up to 3 calendar days following admission to a public general hospital (day of admission to hospital plus 2 additional calendar days).

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

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

a) Aids for daily living such as:
   i) hospital style beds, including rails and mattresses;
   ii) decubitus (bedridden) supplies, portable patient lifts (including batteries); trapezes/transfer poles, and I.V. stands;
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 repairs to custom made foot orthotics;
   ii) custom-made boots or shoes, orthopedic shoes, modifications and repairs to orthopedic shoes, or footwear as an integral part of a brace, (subject to a medical pre-authorization);
c) Diabetic equipment and supplies, such as
   i) blood glucose meters, lancets and diabetic supplies;
   ii) glucose monitoring systems (GMS) such as continuous and flash type monitors subject to medical pre-authorization and reimbursed to the cost of a blood glucose meter. Disposable GMS supplies (used with the monitor), such as, but not limited to sensors and transmitters, are included and subject to the overall annual maximum applicable to diabetic testing and monitoring equipment and supplies;
e) Medical services, such as:
   i) diagnostic and laboratory tests;
   ii) x-rays;
f) One back rest, plus one in 24 months after the initial paid claim, limited to 2 every 120 months;
g) Incontinence/Ostomy equipment, such as catheters, diapers and ostomy supplies;
h) Mobility aids and medical items, such as:
   i) canes and walkers;
   ii) wheelchairs and scooters (including batteries, limited to one per benefit year);
i) Standard prosthetics, such as:
   i) arm, hand, leg, foot, eye, larynx;
   ii) myo-electric arm, limited to the cost of a standard prosthetic arm;
   iii) external breast prosthesis;
   iv) post-mastectomy bra, limited to 2 per benefit year;
j) Respiratory/Cardiology equipment, such as:
   i) compressors and inhalant devices;
   ii) oxygen and equipment for its administration;
   iii) tracheotomy supplies;

k) Compression stockings with a pressure measurement of 15 mmhg or higher, limited to $100 per benefit year;
l) Wigs for temporary or permanent hair loss as a result of a medical condition, limited to $100 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 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.
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.

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) Non-prescription sunglasses prescribed by a legally qualified medical practitioner for the treatment of specific ophthalmic diseases or conditions.
e) Visual Training.

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

a) Medical or surgical treatment, unless specifically identified and included as eligible in "Vision" above;
b) Special or unusual procedures such as, but not limited to, visual training (unless specifically identified and included as eligible in "Vision"), 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) an act of war, declared or undeclared;
   b) participation in a riot or civil commotion; or
   c) attempting to commit or committing a criminal offence or illegal act;

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

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

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

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

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

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

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

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

DENTAL BENEFIT PLAN

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

Basic Services

Basic Diagnostic and Preventive Services:

- complete oral examinations once every 12 months
- emergency and specific oral examinations
- full series X-rays and panoramic X.-rays once every 2 years
- bitewing X-rays once every 6 months
- recall examinations once every 6 months
- cleaning of teeth (up to 1 unit of polishing, plus up to 1 unit of scaling) once per recall period
- topical application of fluoride once per recall period
- oral hygiene instruction 2 time units twice per lifetime
- denture cleaning once per recall period
- pit and fissure sealants for covered persons under age 16
- space maintainers

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

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 16 time units, every 12 months
- occlusal equilibration - selective grinding of tooth surfaces to adjust a bite 2 time units every 12 months

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

- bruxism appliance, limited to one every 24 months

Major Services

- Standard onlays or crown restorations (paid to full metal on molar) to restore diseased or accidentally injured natural teeth, once every 3 years

- Standard bridges, including pontics, abutment retainers/crowns (paid to full metal on molar) on natural teeth, once every 5 years

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

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

Orthodontic Services

Reimbursement for in-person orthodontic treatment to straighten teeth and/or correct the bite. This plan does not provide coverage for any virtual/tele-orthodontics.

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

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

Alternate Benefit Clause

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

Predetermination

Before your treatment begins:

- for all proposed treatment for crowns, onlays and bridges, an estimate completed by your dental practitioner, **must** be submitted for assessment. Our assessment of the proposed treatment, may result in a lesser benefit being payable or may result in benefits being denied. Failure to submit an estimate prior to beginning your treatment will result in the delay of the assessment.
- if the total cost of any other proposed treatment is expected to exceed $500, it is recommended that 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) an act of war, declared or undeclared;
   b) participation in a riot or civil commotion; or
   c) attempting to commit or committing a criminal offence or illegal act;

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

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

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

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

6. Any dental treatment, service, or supply not provided in person by a licensed dental practitioner;

7. 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;

8. Implants;

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

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

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

12. Service and charges for sleep dentistry;

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

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

15. 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.

CLAIM INFORMATION

Inquiries

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

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

Submitting Claims

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

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

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

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

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

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.

Overpayments

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

Limitation on Legal Action

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

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

Subrogation

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

Co-ordination of Benefits (COB)

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

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

GSC Plan Member

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

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

Spouse

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

Children

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

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

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

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

Access to Information

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

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

GSC may charge you to provide any additional copies.