

My BENEFIT PLAN

City of Vancouver

Classification: City of Vancouver – CUPE 1004

Billing Division: 120

Effective Date: May 1, 2018

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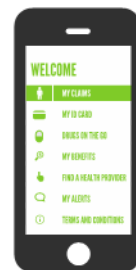
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WELCOME TO YOUR BENEFIT PLAN

This summary contains information about your group benefits with **City of Vancouver**, your plan sponsor, available through the group contract with Green Shield Canada (GSC), effective May 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.

| | |
|--|---|
| Calendar Year Deductible: (per person/per family) Claims incurred in the last 3 months of a calendar year may be used to satisfy the deductible for the following year | \$100 every calendar year (excluding Psychologist, Social Worker/Counsellor or Master of Social Work) |
| Maximums Overall Health Maximum: | \$1,000,000 per lifetime |
| Your Co-insurance All Health Benefits: | 80%, until \$1,000 in paid claims per covered person per calendar year, thereafter 100% |
| Your Plan Covers Prescription Drugs | Maximum Plan Pays Subject to the Overall Health Maximum as stated above |
| Dispensing Fee Cap: | \$10 per prescription or refill |
| Hospital Accommodation | Semi-private or private room |
| Hearing Care | \$700 every 5 calendar years |
| Orthotics/Orthopedic Footwear Custom boots or shoes, and modifications and repairs to orthopedic shoes: | \$400 every calendar year combined (\$200 for dependent children) |
| Custom orthotics and modifications and repairs to custom orthotics | \$300 every 5 calendar years combined |
| Paramedical Practitioners Chiropractor, Naturopath | \$500 every calendar year for all practitioners combined |
| Registered Massage Therapist, Physiotherapist | \$800 every calendar year for all practitioners combined |
| Speech Therapist | \$100 every calendar year |
| Podiatrist | \$350 every calendar year |
| Acupuncturist | \$250 every calendar year |
| Psychologist, Social Worker/Counsellor, Master of Social Work | \$600 every calendar year for all practitioners combined |
| Vision Eyeglasses or contact lenses or medically necessary contact lenses, contact lens fitting or laser eye surgery | \$650 every 24 months |
| Optometric eye exams (Covered persons age 19 to 64 for BC residents) | \$100 every 24 months |

TRAVEL SUMMARY

The [travel benefits](#) are 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 medically necessary for the treatment of an illness or injury and reimbursement will be limited to [reasonable and customary](#) charges for the area in which they are incurred.

| | |
|--|---|
| Calendar Year Deductible: (per person/per family) | No deductible |
| Your Co-insurance: Emergency Services: Referral Services: | 100% 80% |
| Maximum Number of Days per Trip: | Equal to number of days under the Provincial Plan |
| Your Plan Covers | Maximum Plan Pays |
| Emergency and Referral Services: | Included in the Overall Health Maximum |

Before you travel, visit greenshield.ca for important information you will need to know if you experience a medical emergency while you are travelling.

DENTAL SUMMARY

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

| | |
|--|-------------------------------|
| Calendar Year Deductible: (per person/per family) | No deductible |
| Dental Fee Guide: (General Practitioners and Specialists) | Current province of treatment |
| Your Co-insurance | |
| Basic Services : | 80% |
| Comprehensive Basic Services : | 80% |
| Major Services : | 50% |
| Orthodontics : | 50% |
| Your Plan Maximums | |
| Basic Services | Unlimited |
| Comprehensive Basic Services | |
| Major Services | |
| Orthodontics | \$3,000 per lifetime |
| Summary of Covered Benefits | |
| <p>Basic Services include recall visits twice every calendar year, fillings and extractions Comprehensive Basic Services include root canal therapy, periodontal scaling/root planing and denture relining/rebasing, repairs, or adjustments Major Services include crowns, dentures and/or bridgework (replacements of each limited to once every 5 years) Orthodontics includes treatment to straighten teeth/correct the bite.</p> | |

ABOUT THIS SUMMARY

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

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

You are covered for only those specific benefits for which you have applied and for which your plan sponsor has certified you are eligible. You must be covered in order for your dependents to be covered. Your coverage will terminate upon the earlier of the end of the month in which you retire 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.

PLAN MEMBER ONLINE SERVICES – INFORMATION YOUR WAY

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

- View your Benefit Plan Booklet
- Access your personal claims information, including a breakdown of how your claims were processed
- Simulate a claim to instantly find out what portion of a claim will be covered
- Submit certain claims online
- Search for a drug to get information specific to your own coverage (or coverage for your family)
- Search for eligible dental, paramedical, and vision care providers in a particular location (within Canada)
- Search for vision and hearing care providers who offer discounts to GSC plan members through our Preferred Provider Network
- 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

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.

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

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

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

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

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

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

Dependent means

- a) your spouse, if you are legally married or if not legally married, you have lived in a common-law relationship for more than 1 year. 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;
- 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, 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.

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.

Private room for hospital accommodation means a room having only one treatment bed.

Reasonable and customary means in the opinion of GSC, the usual charge of the provider for the service or supply, in the absence of insurance, but not more than the prevailing charge in the area for a like service or supply.

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

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

ELIGIBILITY

For You

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

- a) a resident of Canada;
- b) covered under your provincial health insurance plan; and
- c) actively at work and working on a:
 - i. regular full-time basis for at least 17.5 hours per week, including employees participating in job-sharing provided you work at least 50% of the required hours of the full-time position in which you are sharing;
 - ii. temporary full-time basis and have been hired under an employment contract that is a minimum of 6 months in duration;
 - iii. regular part-time basis for at least 17.5 hours per week, including employees participating in job-sharing;

Job Sharing: Regular full-time employees who elect to temporarily reduce their hours and participate in job-sharing with either another regular full-time employee or an auxiliary employee, is subject to the following:

- If two regular full-time employees are participating in the job-sharing both employees will be eligible for benefits;
- If one regular full-time employee and one auxiliary employee are participating in the job-sharing only the regular full-time employee will be eligible for benefits.

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 of the month following;

- the date of employment for regular full-time and regular part-time employees.
- 12 months of continuous active employment for temporary employees.

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 end of the month in which your employment ends;
- b) the date you are no longer actively working;
- c) the end of the month in which you retire;
- d) the end of the period for which rates have been paid to GSC for your coverage;
- e) the date the group contract terminates.

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

- a) the end of the month in which 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) the end of the month following the month in which your death occurs;
- 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.

PRISM CONTINUUM® – Buying from an Advisor

Special Benefits Insurance Services (SBIS) can help. Call 416.601.0429 or 1.800.667.0429 to speak with a specialist about the Prism Continuum program. They can review the options available to you and advise you on the coverage that best suits your needs.

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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 paid on a Pay Direct basis.

If approved by GSC, this plan includes certain 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, lancets, and testing agents.

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

Maintenance drugs required to treat lifelong chronic conditions must 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.

Generic drug substitution

Reimbursement will be made for the cost of the lowest priced equivalent drug based on specific provincial regulations, unless your medical or dental practitioner has written that there is to be no substitution of the prescribed drug or medicine.

NOTE:

Drug Benefit over age 65: The Drug Benefit co-pay and the deductible (where applicable) in your province of residence are eligible benefits.

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

- a) Drugs for the treatment of erectile dysfunction and infertility;
- b) Vitamins that do not legally require a prescription;
- c) Vaccines;
- d) Contraceptives;
- e) Smoking cessation oral drugs and Nicotine replacement products, such as patches, gum, lozenges, and inhalers;
- f) 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";
- g) 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.

Extended Health Services

Hospital Accommodation: Provided your provincial health insurance plan has accepted or agreed to pay the ward or standard rate, reimbursement for hospital accommodation shown in the Summary of Benefits will be limited to [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.

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) bedpans, standard commodes, and urinals;
 - iii) decubitus (bedridden) supplies, portable patient lifts (including batteries); trapezes, and I.V. stands;
- b) Footwear, when prescribed by your attending physician, nurse practitioner, podiatrist, chiropractor, or physiotherapist (for custom orthotics only), and dispensed by your podiatrist, chiropractor, orthotist, or pedorthist:
 - i) [custom-made foot orthotics](#) or repairs to custom made foot orthotics;
 - ii) [custom-made boots or shoes](#), modifications and repairs to [orthopedic shoes](#), or footwear as an integral part of a brace, (subject to a medical pre-authorization);
- c) Braces, casts, when prescribed by your attending physician, nurse practitioner, chiropractor, or physiotherapist;
- d) Diabetic equipment, such as:
 - i) blood glucose meters, limited to \$50 per claim;
 - ii) insulin pumps, limited to \$6,600 every 60 months and insulin pump supplies, limited to \$2,000 every 3 months;
 - iii) continuous glucose monitor receivers, limited to one every calendar year;
- e) Medical services, such as:
 - i) diagnostic and laboratory tests;
 - ii) x-rays and ultrasounds;
 - iii) medical examinations for employment purposes only;
- f) Medical items such as:
 - i) transcutaneous electrical nerve or muscle stimulators (TENS or TEMS machine), limited to \$250 every 60 months combined;
 - ii) cochlear implant speech processor or headset, limited to one every 5 calendar years;
- g) Incontinence/Ostomy equipment, such as catheter and ostomy supplies;
- h) Mobility aids and medical items, such as:
 - i) crutches, and walkers;
 - ii) canes, limited to \$150 every 24 months;
 - iii) manual wheelchairs, limited to one every 36 months;
- i) Standard prosthetics, when prescribed by your attending physician, nurse practitioner, chiropractor, or physiotherapist, such as:
 - i) arm, hand, leg, foot, eye, larynx;
 - ii) myo-electric arm, limited to the cost of a standard arm;
 - iii) external breast prosthesis limited to one left and one right every calendar year;

- iv) post-mastectomy bra, limited to 2 every calendar year, and subject to a combined maximum of \$1,000 every 2 calendar years with wigs;
- v) stump socks, limited to \$200 every calendar year;
- j) Respiratory/Cardiology equipment, such as:
 - i) compressors and inhalant devices;
 - ii) oxygen and equipment for its administration;
 - iii) tracheotomy supplies;
- k) Wigs and hair pieces for temporary or permanent hair loss as a result of a medical condition, limited to \$1,000 every 2 calendar years combined with a post-mastectomy bra.

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.

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 eligible in coordination with your provincial health insurance plan

Accidental Dental: Reimbursement for the services of a licensed dental practitioner for dental care to natural or prosthetic 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.

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, orthodontia or temporomandibular joint dysfunction treatments.

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) Laser eye surgery.

Optometric eye examinations for visual acuity performed by a licensed optometrist, ophthalmologist or physician, up to the amounts shown in the Summary of Benefits. This benefit is available only in those provinces where eye examinations are not covered by the provincial health insurance plan.

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

- a) Prescription industrial safety eyeglasses;
- b) Medical or surgical treatment, unless specifically identified and included as eligible in "Vision" above;
- c) 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;
- d) Follow-up visits associated with the dispensing and fitting of contact lenses;
- e) 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) 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 form of medical cannabis for the treatment of any medical condition, regardless of whether it is authorized by way of a medical document from a legally-authorized medical practitioner and obtained from a Health Canada-licensed producer pursuant to the *Access to Cannabis for Medical Purposes Regulations*;
6. 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;

7. Services or supplies that:

- a) are not recommended, provided by or approved by the attending legally qualified (in the opinion of GSC) medical practitioner or dental practitioner as permitted by law;
- b) are legally prohibited by the government from coverage;
- c) you are not obligated to pay for or for which no charge would be made in the absence of benefit coverage or for which payment is made on your behalf by a not-for-profit prepayment association, insurance carrier, third party administrator, like agency or a party other than GSC, your plan sponsor or you;
- d) are provided by a health practitioner whose license by the relevant provincial regulatory and/or professional association has been suspended or revoked;
- e) are not provided by a designated provider of service in response to a prescription issued by a legally qualified health practitioner;
- f) are used solely for recreational or sporting activities and which are not medically necessary for regular activities;
- g) are primarily for cosmetic or aesthetic purposes, or are to correct congenital malformations;
- h) are provided by an immediate family member related to you by birth, adoption, or by marriage and/or a practitioner who normally resides in your home. An immediate family member includes a parent, spouse, child or sibling;
- i) are provided by your plan sponsor and/or a practitioner employed by your plan sponsor, other than as part of an employee assistance plan;
- j) are a replacement of lost, missing or stolen items, or items that are damaged due to negligence. Replacements are eligible when required due to natural wear, growth or relevant change in your medical condition but only when the equipment/prostheses cannot be adjusted or repaired at a lesser cost and the item is still medically required;
- k) are video instructional kits, informational manuals or pamphlets;
- l) are for medical or surgical audio and visual treatment;
- m) are special or unusual procedures such as, but not limited to, orthoptics, visual training , subnormal vision aids and aniseikonic lenses;
- n) are delivery and transportation charges;
- o) are for Insulin pumps and supplies (unless otherwise covered under the plan);
- p) are for medical examinations, audiometric examinations or hearing aid evaluation tests;
- q) are batteries, unless specifically included as an eligible benefit;
- r) are a duplicate prosthetic device or appliance;
- s) are from any governmental agency which are obtained without cost by compliance with laws or regulations enacted by a federal, provincial, municipal or other governmental body;
- t) would normally be paid through any provincial health insurance plan, Workplace Safety and Insurance Board or tribunal, the Assistive Devices Program or any other government agency, or which would have been payable under such a plan had proper application for coverage been made, or had proper and timely claims submission been made;
- u) were previously provided or paid for by any governmental body or agency, but which have been modified, suspended or discontinued as a result of changes in provincial health plan legislation or de-listing of any provincial health plan services or supplies;

- v) may include but are not limited to, drugs, laboratory services, diagnostic testing or any other service which is provided by and/or administered in any public or private health care clinic or like facility, medical practitioner's office or residence, where the treatment or drug does not meet the accepted standards or is not considered to be effective (either medically or from a cost perspective, based on Health Canada's approved indication for use);
- w) are provided by a medical practitioner who has opted out of any provincial health insurance plan and the provincial health insurance plan would have otherwise paid for such eligible service;
- x) relates to treatment of injuries arising from a motor vehicle accident;
Note: Payment of benefits for claims relating to automobile accidents for which coverage is available under a motor vehicle liability policy providing no-fault benefits will be considered only if–
 - i) the service or supplies being claimed is not eligible; or
 - ii) the financial commitment is complete;A letter from your automobile insurance carrier will be required;
- y) are cognitive or administrative services or other fees charged by a provider of service for services other than those directly relating to the delivery of the service or supply.

TRAVEL

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

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

Eligible travel benefits will be considered based on the [reasonable and customary](#) charges in the area where they were received, less the amount payable by your provincial health insurance plan.

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

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

Emergency means a sudden, unexpected injury, illness or acute episode of disease that requires immediate medical attention **and could not have been reasonably anticipated based upon the patient's prior medical condition.** This includes treatment (non-elective) for immediate relief of severe pain, suffering or disease that cannot be delayed until you or your dependent is medically able to return to your province of residence.

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

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

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

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

Emergency Transportation

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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 Global Affairs Canada (GAC) 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, Global Affairs Canada (GAC) 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 professional 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.

Stable means that during the 90 days immediately preceding your departure:

- a) your pre-existing/pre-diagnosed medical condition:
 - i) has been controlled by the consistent use of the same medications and dosages (excluding changes in medication that regularly occur as part of your ongoing treatment, or decreases in dosage resulting from an improvement in your pre-existing or pre-diagnosed medical condition) prescribed by a legally qualified medical professional;

- ii) has not, in the reasonable opinion of a legally qualified medical professional, required additional treatment for a recurrence, complications or any other reason related either directly or indirectly to your pre-existing or pre-diagnosed medical condition;
 - b) you have not consulted a legally qualified medical professional for, or had investigated or diagnosed, a new medical condition for which you have not received medical treatment;
 - c) you have not scheduled/are not awaiting any future appointments for non-routine examinations, consultations, tests or investigations (including results) for an undiagnosed medical condition;
 - d) you have not scheduled/are not awaiting any exploratory surgical procedures for an undiagnosed medical condition or surgical procedures for a diagnosed medical condition
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, Global Affairs Canada (GAC) 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. 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);
 9. Amounts paid or payable under any Workplace Safety and Insurance Board or similar plan;
 10. 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;
 11. 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;
 12. Services received from a chiropractor, chiropodist, podiatrist, or for osteopathic manipulation;
 13. Cataract surgery or the purchase of eyeglasses or hearing aids;

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

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

DENTAL BENEFIT PLAN

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

Basic Services

Basic Diagnostic and Preventive Services:

- complete oral examinations once per lifetime each by a General Practitioner or Specialist
- specific oral examination twice every calendar year
- emergency and specific oral examinations
- full series X-rays once every 3 years
- panoramic X-rays once every 5 years
- bitewing X-rays twice every calendar year
- recall examinations twice every calendar year
- cleaning of teeth (up to 1 unit of polishing, plus up to 1 unit of scaling combined with periodontal scaling and/or root planing) twice every calendar year
- topical application of fluoride twice every calendar year
- denture cleaning twice every calendar year
- pit and fissure sealants on molars only, once per tooth every 2 years
- space maintainers

Basic Restorative Services:

- amalgam fillings, composite* (tooth coloured) fillings, and temporary sedative fillings
 - * a composite filling on a permanent molar or any primary tooth will be reimbursed only to the cost of the equivalent bonded amalgam filling
- inlay restorations – these are considered basic restorations and will be paid to the equivalent non-bonded amalgam
- pre-fabricated full coverage restorations once per tooth every 2 years

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 6 months have elapsed from the installation of a denture
- denture adjustments and remount and equilibration procedures, only after 3 months have elapsed from the installation of a denture
- soft tissue conditioning linings for the gums to promote healing, limited to two upper and two lower every 5 years
- 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 13 time units (combined with preventive scaling), every calendar year
- occlusal equilibration - selective grinding of tooth surfaces to adjust a bite 8 time units (combined with functional recontouring) every 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, limited to 2 every 5 years

Major Services

- Standard onlays or crown restorations to restore diseased or accidentally injured natural teeth, once every 5 years
- Standard bridges, including pontics, abutment retainers/crowns on natural teeth, once every 5 years
- Standard dentures including complete, immediate, transitional, and partial dentures, once every 5 years
- Standard repair or recementing of crowns, onlays and bridge work on natural teeth

Orthodontic Services

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

When a lump sum fee has been paid toward orthodontic treatment, the total amount of the claim will be split into separate portions to allow for payment of an initial fee (approximately one-third of the total lump sum), and the balance of the claim will be divided into monthly fees of equal amounts to be reimbursed over the duration of the treatment. Receipts for payment must be received by GSC no later than 12 months from the date the service is incurred while treatment is in progress, not at the end of the treatment.

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

Alternate Treatment

The group benefit plan will reimburse the amount shown in the [Fee Guide](#) for the least expensive service or supply, provided that both courses of treatment are a benefit under the plan.

Predetermination

Before your treatment begins:

- for all proposed treatment for crowns, onlays and bridges, an estimate completed by your dental practitioner, **must** be submitted for assessment. Our assessment of the proposed treatment, may result in a lesser benefit being payable or may result in benefits being denied. Failure to submit an estimate prior to beginning your treatment will result in the delay of the assessment.
- if the total cost of any other proposed treatment is expected to exceed \$300, it is recommended that you submit an estimate completed by your dental practitioner.

Limitations

1. Laboratory services must be completed in conjunction with other services and will be limited to the co-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 Summary of Benefits will be reduced accordingly; 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 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) 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;
7. Restorations necessary for wear, acid erosion, vertical dimension and/or restoring occlusion;
8. Appliances related to treatment of myofascial pain syndrome including all diagnostic models, gnathological determinants, maintenance, adjustments, repairs and relines;
9. Posterior cantilever pontics/teeth and extra pontics/teeth to fill in diastemas/spaces;
10. Service and charges for sleep dentistry;
11. Diagnostic and/or intraoral repositioning appliances including maintenance, adjustments, repairs and relines related to treatment of temporomandibular joint dysfunction;
12. Any specific treatment or drug which:
 - a) does not meet accepted standards of medical, dental or ophthalmic practice, including charges for services or supplies which are experimental in nature, or is not considered to be effective (either medically or from a cost perspective, based on Health Canada's approved indication for use);
 - b) is an adjunctive drug prescribed in connection with any treatment or drug that is not an eligible service;
 - c) is administered in a hospital or is required to be administered in a hospital in accordance with Health Canada's approved indication for use;
 - d) is not dispensed by the pharmacist in accordance with the payment method shown under the Health Benefit Plan Prescription Drugs benefit;
 - e) is not being used and/or administered in accordance with Health Canada's approved indication for use, even though such drug or procedure may customarily be used in the treatment of other illnesses or injuries;

13. Services or supplies that:

- a) are not recommended, provided by or approved by the attending legally qualified (in the opinion of GSC) medical practitioner or dental practitioner as permitted by law;
- b) are legally prohibited by the government from coverage;
- c) you are not obligated to pay for or for which no charge would be made in the absence of benefit coverage; or for which payment is made on your behalf by a not-for-profit prepayment association, insurance carrier, third party administrator, like agency or a party other than GSC, your plan sponsor or you;
- d) are provided by a health practitioner whose license by the relevant provincial regulatory and/or professional association has been suspended or revoked;
- e) are not provided by a designated provider of service in response to a prescription issued by a legally qualified health practitioner;
- f) are used solely for recreational or sporting activities and which are not medically necessary for regular activities;
- g) are primarily for cosmetic or aesthetic purposes, or are to correct congenital malformations;
- h) are provided by an immediate family member related to you by birth, adoption, or by marriage and/or a practitioner who normally resides in your home. An immediate family member includes a parent, spouse, child or sibling;
- i) are provided by your plan sponsor and/or a practitioner employed by your plan sponsor, other than as part of an employee assistance plan;
- j) are a replacement of lost, missing or stolen items, or items that are damaged due to negligence. Replacements are eligible when required due to natural wear, growth or relevant change in your medical condition but only when the equipment/prostheses cannot be adjusted or repaired at a lesser cost and the item is still medically required;
- k) are video instructional kits, informational manuals or pamphlets;
- l) are delivery and transportation charges;
- m) are a duplicate prosthetic device or appliance;
- n) are from any governmental agency which are obtained without cost by compliance with laws or regulations enacted by a federal, provincial, municipal or other governmental body;
- o) would normally be paid through any provincial health insurance plan, Workplace Safety and Insurance Board or tribunal, or any other government agency, or which would have been payable under such a plan had proper application for coverage been made, or had proper and timely claims submission been made;
- p) relates to treatment of injuries arising from a motor vehicle accident;
Note: Payment of benefits for claims relating to automobile accidents for which coverage is available under a motor vehicle liability policy providing no-fault benefits will be considered only if–
 - i) the service or supplies being claimed is not eligible; or
 - ii) the financial commitment is complete;A letter from your automobile insurance carrier will be required;
- q) are cognitive or administrative services or other fees charged by a provider of service for services other than those directly relating to the delivery of the service or supply.

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**).

All Health and Travel claims incurred in the calendar year must be received by GSC no later than December 31 of the following calendar year.

All Dental 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.

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 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.

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.