prism®

Health and dental benefit programs with a focus on individuals

CONTRACT

This Contract has been issued in consideration of the statements made by you in your application (a copy of which is attached) and payment of the required premiums.

This Contract, which includes your application, these provisions and all amendments provided in connection with this Contract, all of which are incorporated into, form an integral part of and together constitute the entire Contract between Green Shield Canada (GSC) and the Plan Member/Applicant.

This Contract is governed by and administered in accordance with the laws of your province or territory of residence.

The initial premium is due in advance of the effective date and thereafter one (1) month in advance on the 1st of the month, through monthly pre-authorized bank withdrawal.

Prism® is offered through GSC. Trademarks are held by Special Benefits Insurance Services Agency Inc (SBIS).

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Separate Sheets

PART A – REIMBURSEMENT

If a covered person incurs charges for care, services or supplies as described in this Contract, GSC will pay for those charges subject to the exclusions, limitations and conditions stated in this Contract and/or amendments to this Contract.

1. Reimbursement will be made for eligible expenses incurred, paid for and received by you or your dependent(s) provided such services and supplies are:
   a) prescribed by and given under the direction of your attending legally qualified medical or dental practitioner; and
   b) in the opinion of GSC, medically necessary for the treatment of an illness or injury and reasonable and customary, taking all factors into account.
2. Reimbursement will be made by one of the following methods:
   a) GSC cheque drawn in your favour;
   b) direct deposit to your personal bank account when requested; or
   c) payment to the provider of services (where applicable).
3. All maximums and limitations stated are in Canadian currency and no amount payable will bear interest. Reimbursement will be made in Canadian or U.S. funds for both providers and plan members, based on the country of the payee.
4. Claims for eligible benefits must be received by GSC no later than 12 months from the date the eligible expense was incurred.
5. Reimbursement will be made according to standard and/or basic services, supplies or treatment. Related expenses beyond standard and/or basic services, supplies or treatment will remain your responsibility.
6. Reimbursement will not be made for any eligible benefits unless the premiums due by you have been paid in full at the time the eligible benefit was rendered. Benefits are not eligible for charges incurred prior to the effective date of coverage.

PART B – DESCRIPTION OF BENEFITS

- The following is a description of the benefits available under this Contract.
- Benefits are subject to exclusions, limitations, conditions and reductions of coverage which may appear in the description of the benefit or under a separate heading within this Contract.
- Not all benefits described in this Contract may be included in your coverage. Please refer to your Schedule of Benefits for details of the coverage you have selected and been approved for.

Extended Health Benefits including Vision and Travel (Items 1-9)

1. **Accidental dental**: *Subject to the maximum stated in your Schedule of Benefits.*
   - Charges for dental treatment of natural teeth by a licensed dental practitioner when required as a result of an accident to the mouth and not by an object placed wittingly or unwittingly into the mouth, provided the injury is sustained while this coverage is in force.
   - You must notify GSC of the injury immediately and no later than 90 days from the date of the accident.
   - Treatment must commence within 180 days following the injury and be completed within 365 days following the injury.
   - No payment will be made for services performed after the date that you or your dependent(s) cease to be covered under this Contract.
   - This benefit excludes periodontal or orthodontic treatments and/or the repair or replacement of artificial teeth.
   - Payment will be based on the dentist's reasonable and customary fee, not to exceed the Dental Association Suggested Fee Guide for General Practitioners where services are rendered, in effect on the date of treatment. Where multiple fee guides exist, the lesser will be applied.
   - Pre-determination: A Dental Accident Report Form, along with your dental x-rays must be submitted to GSC for prior approval.

2. **Ambulance transportation**: Charges for medically necessary emergency professional ambulance services by land or air to the nearest hospital equipped to provide the required treatment. Payment is limited to the difference in amount between the provincial government health plan allowance and the reasonable and customary charges for such services, as determined by GSC.

3. **Hearing aids**: *Subject to the maximum stated in your Schedule of Benefits.*
   Charges for hearing aids, repairs or replacement parts, if recommended or approved by the attending legally qualified medical practitioner. Commencement of the allowable benefit period specified in your Schedule of Benefits is based on the initial date that hearing aid benefits are received; subsequent hearing aid benefits are only eligible after the end of the benefit period following the prior claim. Batteries are not eligible.

4. **Home support services**: *Subject to the maximum stated in your Schedule of Benefits.*
   - Charges for the services of a Registered Nurse (R.N.) or Registered Practical Nurse/Licensed Practical Nurse (R.P.N./L.P.N.) or Personal Support Worker (PSW), in the home on a visit or shift basis.
   - No payment will be made for services which are custodial in nature and/or services which do not require the skill level of a R.N. or R.P.N./L.P.N. or PSW.
   - A Pre-Authorization Form for Home support services must be completed by the attending physician and submitted to GSC. Contact our Customer Service Centre at 1.888.711.1119 to confirm eligibility and to obtain detailed claiming procedures.

5. **Medical items:** *Reimbursement for reasonable and customary charges, up to the maximums, where applicable, as stated in your Schedule of Benefits.*
   a) **Aids for daily living:** hospital style beds (including rails and mattresses), standard commodes, decubitus supplies, IV stands, trapezes, bedpans, raised toilet seats, urinals;
   b) **Braces, casts, catheter supplies, ostomy supplies;**
   c) **Compression stockings**
   d) **Diabetic equipment:** blood glucose monitor, lancets;
   e) **Footwear:** custom made boots or shoes, a medical pre-determination is required; custom made foot orthotics, when prescribed by your attending physician, podiatrist or chiropodist. Commencement of the allowable benefit period is based on the initial date that footwear benefits are received.
   f) **Mobility aids:** canes, crutches, traction equipment, walkers, wheelchairs;
   g) **Prosthetics:** arm, breast, ear, eye, foot, hand, larynx, leg, nose; prosthetic eyewear (glasses or contact lenses) is limited to once per lifetime following cataract surgery; prosthetic accessories, modifications and repairs; surgical brassieres following a mastectomy; wigs for temporary or permanent hair loss as a result of a medical condition;
   h) **Respiratory/Cardiology equipment:** continuous positive airway pressure pump (CPAP), breathing and heart monitor for infants, compressor, inhalant devices, tracheotomy supplies, oxygen.

   Submit a Pre-Authorization Form to GSC to confirm eligibility prior to purchasing or renting medical items or equipment. Failure to comply may result in non-payment.

6. **Medical services**
   a) Diagnostic tests and x-rays, dialysis equipment, laboratory tests;
   b) Eye examinations: *Subject to the maximum stated in your Schedule of Benefits.*
      Optometric eye examinations for visual acuity performed by a licensed optometrist, ophthalmologist or physician limited to one (1) eye exam in a 24 month period. This benefit is only available to residents in provinces where eye exams are not covered by their provincial/territory government health.

7. **Professional services/Registered therapists**: *Subject to the maximum stated in your Schedule of Benefits.*
   Charges for treatment by the following practitioners, provided the practitioner rendering the service is licensed, certified or registered by their provincial regulatory agency or a registered member of a professional association, and that association is recognized by GSC. *Note: Payment is based on 1 treatment, per professional service/registered therapist, per day.*

   a) Acupuncturist;
   b) Chiropractor;
   c) Footcare specialist (chiropodist or podiatrist);
   d) Massage therapist (a certificate from your attending physician indicating the medical necessity of the treatment must be provided to GSC);
   e) Naturopath;
   f) Osteopath;
   g) Physiotherapist;
   h) Psychologist;
   i) Registered social worker (RSW)
   j) Speech therapist.

   Ontario and Alberta residents – podiatry services are eligible in co-ordination with the provincial government health plan.

8. **Vision:** *Subject to the maximum stated in your Schedule of Benefits*.

- Reimbursement for the services performed by a licensed Optometrist, Optician or Ophthalmologist for: corrective eyeglasses, contact lenses or laser eye surgery;
- 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.
- Commencement of the allowable 24 month benefit period is based on the initial date that vision benefits are received; subsequent vision benefits are only eligible 24 months after the prior claim.

Limitations

i. The rental price of durable medical equipment will not exceed the purchase price. GSC's decision to purchase or rent will be based on the physician's estimate of the duration of need as established by the original prescription. Rental authorization may be granted for the prescribed duration. Equipment which has been refurbished by the supplier for resale is not an eligible benefit.
ii. 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.
iii. When deluxe medical equipment is a covered benefit, reimbursement will be made only when deluxe features are required in order for the patient to effectively operate the equipment. Items that are not primarily medical in nature or that are for comfort and convenience are not eligible.

Exclusions

In addition to the General Exclusions in Part D of this Contract, eligible benefits do not include and reimbursement will not be made for:

i. Medical examinations, magnetic resonance imaging (MRI), electrocardiogram (ECG/EKG), positron emission tomography (PET) scans, audiometric examinations or hearing aid evaluation tests.
ii. Medical or surgical audio and visual treatment.
iii. Any special or unusual procedures such as, but not limited to, orthoptics, vision training, subnormal vision aids and aniseikonic lenses.
iv. Follow-up visits associated with the dispensing and fitting of contact lenses.
v. Charges for eyeglass cases.
vi. Incontinence diapers.
vii. Insulin pumps and supplies.
viii. Implants and implant related services.
ix. Blood pressure monitor and supplies.

9. **Travel Benefits:** *Subject to the maximum number of days per trip stated in your Schedule of Benefits.*

Eligible travel benefits will be paid at 100% based on reasonable and customary charges in the area where they were received, less the amount payable by your provincial government health plan. "Reasonable and customary" is defined as 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.

All maximums and limitations stated are 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.

ELIGIBLE BENEFITS

Emergency services will be paid to a **maximum of $1,000,000 per calendar year.**

Referral services will be paid to a **maximum of $50,000 per calendar year.**

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

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

- "Emergency" means a sudden, unexpected occurrence (disease or injury) that requires immediate medical attention. This includes treatment (non-elective) for immediate relief of severe pain, suffering or disease which 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 our GSC Assistance Medical Team.

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

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

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

3. **Emergency Transportation**

    - **Land ambulance** to the nearest qualified medical facility.

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

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

- **Prior to the commencement of any referral treatment, written pre-authorization** from your provincial government health plan and GSC **must be obtained**. Your provincial government health 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 government health plan outlining their liability. **Failure to comply in obtaining pre-authorization will result in non-payment.**

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

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

7. **Reimbursement of prescriptions** by GSC 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 the original paid receipt from the pharmacist, physician or hospital outside your province of residence showing the name of the prescribing physician, prescription number, name of preparation, date, quantity and total cost.

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

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

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

    - our 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.

    - our 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 or marriage and is registered in the jurisdiction in which treatment is provided, plus overnight hotel and meal expenses if required by the attendant.

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

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

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

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

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

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

GSC TRAVEL ASSISTANCE SERVICE

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

- Access to Pre-trip Assistance (prior to departure): Canada Direct Calling Codes; information about vaccinations; government issued travel advisories; and VISA/document requirements for entry into country of destination
- Multilingual Assistance
- Assistance in locating the nearest, most appropriate medical care
- International preferred provider networks
- Our Assistance Medical Team's 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 insurance 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 travelling outside Canada and the United States. These numbers appear on your GSC Identification Card.

Quote the GSC travel assist 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 government health 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 government health plan coverage and GSC travel benefits as detailed above.

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

Our 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, a Canada Direct Calling Code may be required. In the event that a collect call is not possible, keep your receipts for phone calls made to GSC's Travel Assistance Service and submit them for reimbursement upon your return to Canada.

LIMITATIONS

i. Benefits will be eligible only if existing or pre-diagnosed conditions are completely stable and you are fit to travel (in the opinion of GSC's Assistance Medical Team) at the time of departure from your province of residence. GSC reserves the right to review your medical information at the time of claim.
ii. The eligible benefits must be 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 which could reasonably be delayed until you return to your province of residence.
iii. Reimbursement for eligible benefits will be made only if your provincial government health plan covers and provides payment toward the cost of the services received.
iv. Coverage becomes effective at the time you or your dependent crosses the provincial border departing from your province of residence and terminates upon crossing the border returning to your province of residence on the return home. If travelling 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.
v. 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 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.

vi. Air ambulance services will only be eligible if:
   - they are pre-approved by GSC
   - 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, and
   - 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, and
   - proof of payment (including air ticket vouchers or air carrier invoices) is submitted to GSC.

vii. If planning to travel in areas of political or civil unrest, or in areas where Foreign Affairs and International Trade Canada (DFAIT) has issued a formal travel warning regarding non-essential travel, contact GSC Travel Assistance for pre-travel advice, as we may be unable to guarantee assistance services;
viii. GSC reserves the right, without notice, to suspend, curtail or limit its services in any area in the event of political or civil unrest, including rebellion, riot, military uprising, labour disturbance or strike, act of God, or refusal of authorities in a foreign country to permit GSC to provide service. This includes travel in any area if at the time of booking the trip (including delay of travel), or before your departure date, Foreign Affairs and International Trade Canada (DFAIT) issued a formal travel warning advising Canadians to avoid all or non-essential travel to that specific country, region or city due to a likely or actual epidemic or pandemic, (non-essential travel will be deemed as anything other than a significant medical or family emergency, such as the death of a family member);
ix. No services shall be provided during any trip undertaken for the purpose of seeking medical treatment or advice unless pre-authorized as outlined in referral services.

TRAVEL EXCLUSIONS

In addition to the General Exclusions found under the General Information section, Eligible Benefits do not include and reimbursement will not be made for:

i. Any claims arising directly or indirectly from any medical condition you suffer or contract in a specific country, region or city due to an epidemic or pandemic, if at the time of booking the trip (including delay of travel), or before your departure date, Foreign Affairs and International Trade Canada (DFAIT) issued a formal travel warning advising Canadians to avoid all or non-essential travel to that specific country, region or city. In this exclusion a medical condition is limited to the reason for which the formal travel warning was issued and includes complications arising from such medical condition;
ii. 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;
iii. 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;
iv. Treatment or service required as a result of suicide, attempted suicide, intentionally self-inflicted injury of you, a traveling companion, or immediate family member while sane or insane;
v. 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);
vi. Amounts paid or payable under any Workplace Safety and Insurance Board or similar plan;
vii. 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;
viii. 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;
ix. Services received from a chiropractor, chiropodist, podiatrist, or for osteopathic manipulation;
x. Cataract surgery or the purchase of eyeglasses or hearing aids;
xi. 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.

Prescription Drug Benefits

Refer to your Schedule of Benefits to confirm if this benefit is included. *Subject to the terms and maximum stated in your Schedule of Benefits.*

- Eligible drug benefits will be paid on a pay-direct basis (your pharmacy can bill GSC directly);
- Benefits include prescription drugs that have been approved for use in Canada and which require a prescription by law and have a Drug Identification Number (DIN), provided they have been prescribed by an authorized medical practitioner;
- Benefits also include charges for diabetic syringes, needles and testing agents, insulin and other approved injectibles;
- Mandatory generic substitution: based on specific provincial health insurance plan regulations, where a generic equivalent drug exists, reimbursement will only be made up to the cost of the lowest priced equivalent drug. If your medical or dental practitioner prescribes a brand name drug indicating no substitution, you will be required to pay the difference.

Limitations

i. The maximum amount dispensed will not exceed a three month supply of a prescription at any one time and not more than a 13 month supply in any 12 consecutive months.
ii. Upon notice of termination, the maximum amount dispensed will not exceed a 30 day supply of a prescription at any one time.

Exclusions

In addition to the General Exclusions in Part D of this Contract, eligible benefits do not include and reimbursement will not be made for:

i. Drugs for the treatment of erectile dysfunction, infertility or obesity;
ii. Smoking cessation products;
iii. Natural Health Products, or homeopathic medicine products such as oral vitamins and minerals, herbal remedies, homeopathic medicines, traditional medicines (such as traditional Chinese medicines), probiotics or products such as amino acids and essential fatty acids;
iv. Serums and vitamins unless injected and medically necessary;
v. 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;
vi. Mixtures compounded by a pharmacist that do not conform to GSC's current Compound Policy;
vii. An adjunctive drug prescribed in connection with any treatment or drug that is not an eligible service;
viii. Any specific treatment or drug which is not dispensed by the pharmacist in accordance with the payment method shown above;
ix. Any exclusion(s) outlined in the Counter Offer/Authorization to Proceed, if applicable.

Dental Benefits

Refer to your Schedule of Benefits to confirm if this benefit is included. *Subject to the terms and maximums stated in your Schedule of Benefits.*

Reimbursement for charges incurred for dental care or services outlined below, provided the charges do not exceed the amount stated in the Dental Association Suggested Fee Guide for General Practitioners for your province/territory, in effect at the time the services are rendered;

- In provinces with more than one fee guide, GSC will reimburse according to the least expensive standard fee (or fee range);
- In provinces with no fee guide, GSC will reimburse according to a fee schedule established by GSC for that province.

Treatment rendered by a specialist will be reimbursed in accordance with the fee guide for General Practitioners.

Basic services

1. Basic diagnostic services

a) Complete oral examinations;
b) Emergency and specific oral examinations;
c) Full series x-rays and panoramic x-rays;
d) Bitewing x-rays.

2. Basic preventive services

a) Recall examinations;
b) Preventive cleaning of teeth (up to 1 unit of polishing plus up to 1 unit of scaling);
c) Topical application of fluoride for persons age 19 or under;
d) Pit and fissure sealants on permanent molars only, for children age 16 and under;
e) Space maintainers that replace prematurely lost teeth for children age 16 and under.

3. Basic restorative services

a) Amalgam, tooth coloured filling restorations and temporary sedative fillings;
b) Inlay restorations – these are considered basic restorations and will be paid to the equivalent non-bonded amalgam.

4. Basic oral surgery – extractions of teeth and/or residual roots.

5. General anaesthesia and intravenous sedation in conjunction with extractions or eligible oral surgery only.

Comprehensive basic services

6. Endodontic treatment including:

a) Root canal therapy;
b) Pulpotomy (removal of the pulp from the crown portion of the tooth);
c) Pulpectomy (removal of the pulp from the crown and root portion of the tooth);
d) Apexification (assistance of root tip closure);
e) Apical curettage, root resections and retrograde fillings (cleaning and removing diseased tissue of the root tip);
f) Root amputation and hemisection;
g) Bleaching of non-vital tooth/teeth;
h) Emergency procedures including opening or draining of the gum/tooth.

7. **Periodontal treatment** including**:**

a) Periodontal scaling and/or root planing, up to 8 units every 12 months;
b) Occlusal equilibration up to 8 units every 12 months (selective grinding of tooth surfaces to adjust a bite).

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 Fee Guide for General Practitioners.

8. **Standard denture services** including**:**

a) Denture cleaning once every 12 months;
b) Denture repairs and/or tooth/teeth additions;
c) Standard relining and rebasing of dentures (only after 6 months have elapsed from the installation of an initial or replacement denture) but not more than one standard relining or rebasing in any 3 year period;
d) Denture adjustments, remount and equilibration procedures, only after 3 months have elapsed from the installation of an initial or replacement denture;
e) Soft tissue conditioning linings for the gums to promote healing;
f) Remake of a partial denture using existing framework.

Major services – starting in your 3rd year (25th month) of coverage in the plan, the following will be paid at 50%, subject to the maximum stated in your Schedule of Benefits.

9. **Crowns:** Standard onlays or crown restorations, (paid to full metal on molar) to restore diseased or accidentally injured natural teeth once every 5 years, per tooth;

10. **Bridges**: Standard bridges, including pontics, abutment retainers/crowns (paid to full metal on molar) on natural teeth once every 5 years, per tooth;

11. **Dentures**: Standard dentures including complete, immediate, transitional and partial dentures once every 5 years;

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

Orthodontic services – starting in your 3rd year (25th month) of coverage in the plan, the following will be paid at 50%, subject to the maximum stated in your Schedule of Benefits.

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

When a lump sum fee has been paid toward orthodontic treatment, the total amount of the claim will be split into equal portions to include the initial fee and a monthly fee and will be reimbursed over the duration of the treatment.

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

Treatment plan (pre-determination): If the total cost of any proposed treatment is expected to exceed $300, before your treatment begins you must submit a detailed treatment plan estimate completed by your dentist, including x-rays. If a description of the procedures to be performed and an estimate of the charges are not submitted in advance, GSC may apply an Alternate Benefit Clause. This Alternate Benefit Clause may only be applied if both courses of treatment are a benefit under the plan.

Limitations

i. Laboratory services must be completed in conjunction with other services and will be limited to the reimbursement percentage of such services. Laboratory services that are in excess of 40% of the dentist's fee in the current Fee Guide for General Practitioners will be reduced accordingly and the reimbursement percentage is then applied.
ii. For complete or partial denture services, standard relining and rebasing, crowns and bridges, if you and your dentist decide on personalized restorations or specialized techniques such as precision attachments, stress-breakers or prosthesis over implants, reimbursement of the applicable percentage of the cost of standard services only will be made, and the balance of any cost will remain your responsibility.
iii. When more than one surgical procedure is performed during the same appointment in the same area of the mouth, only the most comprehensive procedure will be eligible for reimbursement.
iv. General anaesthesia is only eligible when medically necessary and administered in conjunction with oral or dental surgery.
v. When periodontal surgery flap approach codes are submitted on a pre-determination or claim form, periodontal surgery graft codes will not be eligible for reimbursement if the grafts are done in the same section of the mouth and during the same appointment.
vi. 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 General Practitioners Fee Guide.
vii. Reimbursement will be limited to the cleaning of a standard denture and not for an implant retained prosthesis. Reimbursement for the cleaning of a standard denture which includes an implant retained prosthesis will be reduced accordingly.
viii. Reimbursement for root canal therapy will be limited to payment once, and thereafter only once for possible follow-up procedures such as apioectomies, root resections, retrofilling and extractions. The total fee for root canal includes all pulpotomies and pulpectomies performed on the same tooth.
ix. 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.
x. Where multiple services are performed at one appointment and the full fee guide price is charged for each service, the first service will be paid in full and all remaining services will be reduced by 20%;
xi. 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 not covered and are considered included in the cost of the crown.
xii. Root planing is not eligible if done at the same time as gingival curettage.
xiii. In the event of a dental accident, claims should be submitted under the health benefits plan before submitting them under the dental plan.

Exclusions

In addition to the General Exclusions in Part D of this Contract, eligible benefits do not include and reimbursement will not be made for:

i. Any dental service that is not contained in the procedure codes developed and maintained by the Canadian Dental Association, adopted by the provincial dental association of the province 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.
ii. Implants and implant related services.
iii. Restorations necessary for wear, acid erosion, vertical dimension and/or restoring occlusion.
iv. Appliances related to treatment of myofacial pain syndrome including all diagnostic models, gnathological determinants, maintenance, adjustments, repairs and relines.
v. Posterior cantilever pontics/teeth and extra pontics/teeth to fill in diastemas/spaces.

vi. Removal of an amalgam restoration and its replacement with a composite restoration unless there is evidence of recurrent decay or significant breakdown.
vii. Service and charges for sleep dentistry.
viii. Diagnostic and/or intraoral repositioning appliances including maintenance, adjustments, repairs and relines related to treatment of temporomandibular joint dysfunction (TMJ).

Hospital Accommodation

Refer to your Schedule of Benefits to confirm if this benefit is included. *Subject to the maximum stated in your Schedule of Benefits.*

- Eligible benefits will be based on reasonable and customary charges in the area where they were received, provided your provincial government health plan has accepted or agreed to pay the ward or standard rate.
- Reimbursement for the difference in cost between standard ward charges and semi-private or private accommodation
  - in a public general hospital when you have occupied an active treatment bed, or
  - in a convalescent/rehabilitation hospital or a convalescent/rehabilitation wing in a public general hospital when you have occupied an active convalescent/rehabilitation bed. Reimbursement for rehabilitative therapy in a licensed rehabilitation public hospital (where the rehabilitation is medically necessary and arises from surgery in an active treatment public hospital which does not provide the rehabilitation) is limited to 14 days from the date of surgery.

Exclusions

In addition to the General Exclusions in Part D of this Contract, eligible benefits do not include and reimbursement will not be made for:

i. Accommodation in a private hospital, chronic care hospital, chronic care unit of a hospital, transition ward of a hospital, home for the aged, long term care facility or program treatment facility.
ii. Hospitalization due to pregnancy or pregnancy related conditions which commence during the first ten (10) month period following the covered person's coverage effective date.

PART C – GENERAL INFORMATION

Administrative Policies

Please be aware that GSC has Administrative Policies and has the right, at all times and from time to time, to create, adopt, amend, alter or revise such Administrative Policies.

Administrative Policies refer to those policies and procedures of GSC, whether or not adopted in a manual, which define and create benefit plans and which determine the administration and adjudication of claims for eligible benefits.

We are the administrator of this Contract. You must provide us with any information required to calculate premiums and/or pay benefits. We have the right to inspect all documents that relate to your coverage and you may be required to provide health information records.

In addition, information will be retained in GSC's records for the purpose of statistical analysis. This information is maintained in accordance with GSC's policies on privacy and confidentiality and will be used only in respect to claims administration and for GSC's statistical and administrative purposes.

Provincial or Territorial Government Plans

Provincial or territorial government health plans may contribute a portion toward the approved cost of certain services or supplies to qualified residents. GSC's system is designed to co-ordinate with provincial government plans. Eligible provincial government claims must first be submitted to the provincial government plan for payment of its portion toward the approved cost, and then to GSC for consideration of the unpaid portion.

Where used throughout this Contract, reference to "province" or "provincial" is deemed to include "territory" or "territorial", as applicable.

Identification Card(s)

You will receive your GSC Identification Card(s) showing your GSC Identification Number which is to be used on all claims and correspondence. Your Identification Number will end in –00 while each dependent's Identification Number will end in a sequential number (if applicable).

PART D – GENERAL EXCLUSIONS

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

1. services or supplies received as a result of disease, illness or injury due to:
   a) intentionally self-inflicted injury while sane or insane;
   b) an act of war, declared or undeclared;
   c) participation in a riot or civil commotion; or
   d) committing or attempting to commit 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 and/or medical reports for any reason, including the result of a claim audit.

5. any specific treatment or drug which:
   a) does not meet accepted standards of medical, dental or ophthalmic practice, including charges for services or supplies which are experimental in nature, or is not considered to be effective (either medically or from a cost perspective, based on Health Canada's approved indication for use);
   b) will be administered in a hospital;
   c) is not being used and/or administered in accordance with Health Canada's approved indication for use, even though such drug or procedure may customarily be used in the treatment of other illnesses or injuries.

6. services, supplies or devices that:
   a) are not recommended, provided by or approved by the attending legally qualified (in the opinion of GSC) medical 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;
   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 medical or dental 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 a replacement of lost, missing or stolen items, or items that are damaged due to negligence. Replacements are eligible when required due to natural wear, growth or relevant change in your medical condition but only when the equipment/prostheses cannot be adjusted or repaired at a lesser cost and the item is still medically required;
   j) are video instructional kits, informational manuals or pamphlets;
   k) are delivery and transportation charges;
   l) are batteries, unless specifically included as an eligible benefit;
   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 government health 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;

p) were previously provided or paid for by any governmental body or agency, but which have been modified, suspended or discontinued as result of changes in provincial health plan legislation or de-listing of any provincial health plan services or supplies;

q) 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);

r) 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;

s) relates to treatment of injuries arising out of 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 are not eligible; or
   ii) the financial commitment is complete.
   A letter from your automobile insurance carrier will be required.

PART E – GENERAL PROVISIONS

1. **Additions or changes in coverage or status**:

   a) A Plan Member may apply to increase benefit coverage at any time, provided that evidence of health satisfactory to SBIS is submitted along with a written application for the change in coverage;

   b) A Plan Member who chooses to reduce benefit coverage, must have been covered under their existing plan for a period of at least 12 consecutive months prior to the requested date of change;

   c) When a Plan Member transfers from one individual health plan (or level of coverage) to another, the value of benefits used to date will be carried forward from the previous plan or level of coverage and applied against the maximums of the new plan or level of coverage selected;

   d) When coverage is in force, a dependent(s) may be added to the plan by submitting written application and medical evidence (if such evidence is required) within 30 days of the dependent first becoming eligible; evidence of health is not required for a newborn child if the application is submitted within 30 days following the date of birth. Upon approval, notification will be sent to the Plan Member indicating the coverage effective date as determined by GSC;

   e) If a Plan Member neglects to submit an application for any person within 30 days, the maximum amount payable for dental benefits will not exceed $150 during the first 12 months that such person's coverage is in force;

   f) Termination of coverage due to death, divorce, or a dependent child becoming married or employed on a full-time basis, must be sent in writing to SBIS within 30 days following the date of such event;

   g) Notices by the Plan Member or Account Holder must be sent in writing by mail to the appropriate address as indicated on the enclosed "Contact Information" sheet.

2. **Age requirements**: Applicants, including spouse/partner, must be between the ages of 16-74, except if eligible for the Prism Continuum program.

3. **Benefit levels**: All benefit levels outlined are applied on a per covered person basis. Coverage provided depends on whether the single, couple or family option is purchased.

4. **Change of premiums and/or benefits**:

   a) GSC reserves the right to change premiums required for this Contract based on its experience in the payment of benefits, or to alter the benefit coverage consistent with change(s) in the government health plan or for any other reason, upon 30 days written notice to the Plan Member;

   b) Age band changes – Plan Members who attain ages 45, 55 or 65 during the calendar year will have their monthly premium adjusted on the December bank withdrawal. Notice of this change will be mailed in October to the enrolment address on file;

   c) Overage dependent children – Plan Members with dependent children who turn 21 during the calendar year will receive notice in October (to the enrolment address on file) of the removal of those dependents affected. Premiums will be adjusted on the December bank withdrawal, if applicable. These overage dependents will be given the opportunity to transfer to their own individual plan.

5. **Eligibility**: Prism plans are available to residents of Canada and their dependents who are covered by a provincial government health plan.

6. **Enrolment requirements**: Couple coverage - both eligible members of a couple must apply for and maintain the same plan; Family coverage - all eligible members of the family unit must apply for and maintain the same plan.

7. **Facsimile**: A facsimile or photocopy of the application for this Contract and/or medical questionnaire if applicable, will be deemed to be an original and will be as binding on the Plan Member as if it were an original.

8. **Incontestability**: If medical information was submitted as a prior consideration for coverage under this Contract, and there was a failure to disclose, or a misrepresentation of a fact in respect of the application, coverage under this Contract will be voidable, or payment in respect of a claim relating to an undisclosed prior condition, denied. However, after coverage has been in force for a period of two (2) years, coverage will not, in the absence of fraud, be voidable or payment for any such claim denied.

9. **Liability**: GSC will not be responsible for any act or omission of anyone providing care, services or supplies. The liability of GSC will be limited solely to the payment of benefits in accordance with the terms and conditions of this Contract.

10. **Misrepresentation, set off and indemnification**:

    a) In respect of any application made, any misrepresentation, concealment or failure to disclose correct information will, if discovered within two (2) years of the effective date of this Contract, render this Contract voidable at the option of GSC or SBIS, and will limit the liability of GSC to the return of eligible premiums;

    b) The reimbursement of benefits will be suspended during a non-disclosure investigation;

    c) In addition, GSC will have the right to set off against the amount it is required to return on account of eligible premiums the amount of any claims it has already paid. However, after coverage has been in force for a period of two (2) years, coverage will not, in the absence of fraud, be voidable;

    d) In respect of the submission of a claim, any misrepresentation, concealment or failure to disclose correct information, whether intentional or not will, at the option of GSC, result in the Plan Member being responsible for 100% of the amount of the claim, as well as for any costs which may have been incurred by GSC in investigating the claim. The Plan Member will be liable to indemnify GSC in this regard and this obligation will survive the termination of this Contract.

11. **Misstatement of age**: GSC may request satisfactory proof of age for any person covered under this Contract. If the date of birth was misstated and affects (a) the date on which coverage becomes effective, reduces or terminates, or (b) the amount or type of coverage, or (c) any rights or benefits provided under this Contract, the correct date of birth in computing the person's age will govern and premiums will be adjusted accordingly.

12. **Notices**: Notices from GSC or SBIS to the Plan Member or dependent(s) will be sent to the Plan Member's address as it appears on the application for this Contract, or to the enrolment address as it appears on GSC's records. If you change your address, SBIS requires specific written notification to change your enrolment address. Please refer to the "Contact Information" sheet.

13. **Premium payment**: This Contract will remain in force from month to month provided that the required premiums are paid when due. Coverage will terminate at the end of the last month for which full premium payment was made to and accepted by GSC, in which case no notice will be required. In the event that a payment is returned as a result of insufficient funds, an administration fee may apply.

14. **Reapplication for coverage**: If this Contract has been terminated, a period of at least 36 months must elapse before another application for coverage will be considered under any GSC individual (non-group) health program.

15. **Release of information**: As a condition precedent to receiving benefits under this Contract, the Plan Member agrees to authorize the release of any information reasonably necessary for GSC to confirm entitlement to benefits and to adjudicate claims. GSC and its service providers have the authority to obtain the covered person's medical records or information from any medical or dental practitioner, hospital, clinic or service provider.

16. **Special Benefits Insurance Services Agency Inc**. **(SBIS):** is the exclusive Managing General Agent (MGA) for the Prism Health and Dental Benefit Programs for Individuals. SBIS markets and administers the Prism plans while the billings, claims and risk are managed by GSC.

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

18. **Term of agreement**: This Contract may be terminated by GSC, the Plan Member or the Account Holder for any other reason upon giving written notice at least ten (10) business days prior to the next premium withdrawal date.

PART F – OUR COMMITMENT TO PRIVACY

The GSC Privacy Code balances the privacy rights of our benefit Plan Members and their dependents, and our employees, with the legitimate information requirements to provide customer service. It consists of the following key principles:

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

2. **Consent**

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

   You and/or your dependents consent can be either express or implied. Express consent can be verbal or written.

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

3. **Withdrawal of Consent**

   You and/or your dependents can withdraw consent any time after you have given it to us, provided there are no legal or regulatory requirements to prevent this.

   If you and/or your dependents do not consent to certain uses of personal information, or if you withdraw your consent, we will no longer be able to administer your benefit coverage. If so, we will explain the situation to you to help you with your decision.

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

PART G – DEFINITIONS

Where used in this Contract, the term;

1. **Accident** or a**ccidental** means an unintentional, sudden or unforeseeable event due exclusively to an external cause inflicting bodily injuries (directly and independently of all other causes).

2. **Account holder** means a person or business designated and authorized by the Plan Member to transact business on their behalf, including entering into a contract with the Bank for the provision of financial services, and/or uses such services.

3. **Benefit year** means the 12 consecutive months following the effective date of coverage, and each 12 month period thereafter.

4. **Brace** means a rigid or semi-rigid supporting device or appliance which fits on and is attached to the body or any part of the body, excluding any brace which is used to correct a dental defect, deficiency or injury.

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

6. **Child(ren)** means natural children, stepchildren, common-law children or legally adopted children.

7. **Consulted** means seeking advice or treatment from any physician and/or health care professional for any condition, injury, disease or disorder. This would include discussion of possible further testing, treatment or surgery.

8. **Coverage** means that you are entitled to make a claim in respect of eligible benefits.

9. **Covered person** means the Plan Member who is enrolled in the plan or his/her enrolled dependents.

10. **Custom made boots or shoes** means footwear used for an individual whose condition cannot be accommodated by existing footwear products. The fabrication of the footwear involves making a unique cast of the patient'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.

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

12. **Dentist** means a practitioner of dentistry lawfully qualified and licensed to practice in the jurisdiction in which he or she has provided the services or supplies for which the charges are incurred.

13. **Dependent** means your spouse/partner and/or unmarried child(ren) under age 21 who live with the Plan Member and are not regularly employed. Child(ren) over age 21 are eligible if they became dependent upon the Plan Member by reason of a mental or physical disability prior to their 21st birthday and have been continuously so disabled since that time and is considered a dependent as defined under the Income Tax Act.

14. **Effective date** means the day on which coverage under this Contract takes effect.

15. **Eligible expenses** means expenses incurred by a covered person that are payable by GSC based on the provisions, terms, limitations and exclusions of this Contract.

16. **Emergency** means a sudden, unexpected occurrence (disease or injury) that requires immediate medical attention. 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.

17. **Experimental** means a service, drug, treatment or medical device which has not been acknowledged as appropriate, acceptable or proven for use by the medical profession and/or approved by Health Canada for use in Canada.

18. **First paid claim** means the actual date of service of the initial or a prior claim paid by GSC.

19. **Government plan** means any plan or arrangement provided by or under the administrative supervision of any government or agency which provides coverage or reimbursement for any health care service or supply, including but not limited to the health insurance plan, home care program, assistive devices program or workers compensation board of the covered person's province of residence.

20. **Hospital** means a public hospital licensed under the Public Hospitals Act or similar legislation of the province in question, or recognized by the Ministry of Health of the province in question as a public hospital, or a duly licensed general active treatment facility in another jurisdiction. Unless expressly stated otherwise herein, the term does not include a federal hospital, private hospital, rest home, nursing home or long term care facility, convalescent home, chronic care facility, health spa or hotel, a home for the aged or an institution used primarily for the confinement or treatment of alcoholism or drug addiction.

21. **Licensed, certified or registered** means licensed, certified or registered by the appropriate authority or professional body in the jurisdiction where the care or services are rendered or the institution exists.

22. **Medically necessary** means a treatment, service or supply which is generally accepted by the medical profession as essential, effective and appropriate in the care and treatment of a medical condition, sickness or injury.

23. **Physician** means a person lawfully qualified and licensed to practice medicine without restriction in the area where the services are rendered.

24. **Plan member** means the applicant for this Contract. Premiums will be charged based on the age of the Plan Member. The Plan Member may or may not be the Account Holder.

25. **Private room** for hospital accommodation means a room having only one (1) treatment bed.

26. **Provider of service** means any person, corporation or other entity authorized to provide eligible benefits in accordance with GSC's Administrative Policies.

27. **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.

28. **Semi-private room** for hospital accommodation means a room having only two (2) treatment beds.

29. **Spouse/partner** means a person to whom you are legally married or with whom you have lived continually in a common-law relationship for more than 12 months and publicly represent as your spouse/partner. Only one spouse/partner will be considered at any time as being covered under this Contract.

PART H – PLAN MEMBER ONLINE SERVICES

GSC's Plan Member Online Services website makes it easier and faster for you to view claims information, check benefit eligibility and receive your claim payments.

In addition to this Contract and our Customer Service Centre, we also provide you with access to our secure website. Our website will answer those questions most often asked and give you online access to the following:

- Your Contract and Schedule posted on-line
- Printer friendly personalized claim forms
- Benefit eligibility information, such as the date you are eligible for your next dental recall exam /optometric eye exam
- Explanation of Benefits information and claim history for you and your dependents
- Claim history for tax purposes or Co-ordination of Benefits
- Request your claim payments to be directly deposited into your bank account *****
- And much more

* **Please note** that once arrangements have been made for Direct Deposit, claim payments will be deposited directly into the bank account you have chosen. Statements will no longer be mailed to you but will be available for online viewing.

Your information is secure

GSC is committed to the protection of any personal information collected by us or in our custody. Our Online Services are password protected. We follow rigorous security procedures and use state-of-the-art technologies to protect your information. To ensure that your confidential information is protected, we will mail an Access Code to the address that we have on file for you. In the meantime, you will have access to basic services within the site. When you receive the letter, simply use the Access Code in it to fully activate your account.

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

PART I – CLAIMING INFORMATION

Pre-determination

If the cost of any proposed treatment is expected to exceed $300, submit a detailed treatment plan to GSC from your provider before your treatment begins. If a description of the procedures to be performed and an estimate of the charges are not submitted in advance, GSC reserves the right to make a determination of benefits payable, taking into account alternate procedures, services, or course of treatment, based on accepted standards of medical/dental practice.

Claiming Instructions

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

For claims inquiries, to determine eligibility for a specific item or service, or to obtain GSC's pre-authorization requirements, contact our Customer Service Centre at 1.888.711.1119 or visit greenshield.ca to email your question.

For pre-authorization forward a Pre-Authorization Form OR physician prescription indicating the diagnosis and what is prescribed.

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

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

1. Covered person's name, address and GSC Identification Number;
2. provider's name and address;
3. date of service
4. charges for each service or supply;
5. a detailed description of the service or supply;
6. a medical referral or physician prescription, when required;

☐ **Mail all claim forms to: GSC**

Attn: Dental	PO Box 1608	Windsor, ON	N9A 7G1
Attn: Drug	PO Box 1652	Windsor, ON	N9A 7G5
Attn: Medical Items	PO Box 1623	Windsor, ON	N9A 7B3
Attn: Out-of-Country	PO Box 1606	Windsor, ON	N9A 6W1
Attn: Professional Services	PO Box 1699	Windsor, ON	N9A 7G6
Attn: Vision/Hospital	PO Box 1615	Windsor, ON	N9A 7J3

Direct payment to the provider of service (where applicable)

Present your GSC Identification Card to your provider and, after you pay any applicable share of the cost, your provider may bill GSC directly. In most cases, payment will be made directly to your provider of service. Most providers will have a supply of claim forms.

In addition to pharmacy and dental providers where claims are adjudicated online in real time, we also offer online claim submission for an increasing number of other health care providers. Authorized providers of physiotherapy services, massage therapy services, chiropractic services, vision services and some medical items can submit claims online through the GSC website. Before you leave a provider's office, you and the provider will know what is covered by GSC on your behalf.

Claiming instructions by type of benefit

1. **EXTENDED HEALTH BENEFITS**

   a) HEARING AIDS: Providers may contact GSC for prior approval and will generally bill GSC directly. *For claim reimbursement*, forward a completed Audio Claim Form, a copy of audiogram and details of provincial funding, if applicable, OR an original itemized paid receipt including the following: audiologist name and address, date and service received, a breakdown of the charges, (i.e. acquisition cost, fee, mold), the patient's name, address and GSC Identification Number.

   b) HOME SUPPORT SERVICES: A Pre-Authorization Form must be completed by the attending physician and forwarded to GSC. Contact our Customer Service Centre at 1.888.711.1119 for detailed claim submission instructions.

   c) MEDICAL ITEMS: Some providers may bill GSC directly. *For claim reimbursement*, forward an original itemized paid receipt including the following: provider's name and address, date and charge for each service, a detailed description of the equipment, patient's name, address and GSC Identification Number.

   d) PROFESSIONAL SERVICES/REGISTERED THERAPISTS: Some providers may bill GSC directly. *For claim reimbursement*, forward a completed Claim Form along with an original itemized paid receipt including the following: provider's name and address, date and nature of treatment, charge for each service rendered, patient's name, address and GSC Identification Number.

   e) VISION: Providers may contact GSC for prior approval. Generally, vision providers will bill GSC directly. *For claim reimbursement*, forward a completed Vision Claim Form OR an original itemized paid receipt including the following: provider's name and address, date of service (date glasses/contact lenses were picked up), vision prescription, breakdown of charges for lenses and frames (if applicable), patient's name, address and GSC Identification Number.

2. **TRAVEL BENEFITS**

GSC must be contacted by phone within 48 hours of commencement of treatment. Contact our Travel Assistance Service at 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 for assistance. These numbers appear on your GSC Identification Card.

For complete details on your travel benefits, contact our Customer Service Centre at 1.888.711.1119.

For claim reimbursement, if you have incurred out of pocket expenses, claims must be submitted together with original supporting receipts to our Travel Assistance Service who will then co-ordinate reimbursement of approved, eligible expenses with the provincial government health plan. To make a claim, submit the patient's name, provincial government health plan number, address and GSC Identification Number with a detailed statement showing the services rendered and the fees charged for each service.

3. **DRUG BENEFITS**

Present your GSC Identification Card with your prescription to a participating pharmacist. When your prescription has been filled you pay the pharmacist any applicable share of the cost. The pharmacist will forward the balance directly to GSC.

For claim reimbursement, forward all itemized prescription drug receipts from your pharmacist to GSC along with your name, address and GSC Identification Number.

4. **DENTAL BENEFITS**

Your dental provider may bill GSC directly.

For claim reimbursement, forward a completed standard Dental Claim Form. If your claim is the result of an accident, a Dental Accident Report Form and your dental x-rays must be submitted to GSC for prior approval.

5. **HOSPITAL ACCOMMODATION**

Generally, hospitals will bill GSC directly. For direct payment to a hospital, you must present your GSC Identification Card when admitted.

For claim reimbursement, forward an original itemized paid receipt which provides the number of days in private or semi-private accommodation, the daily private or semi-private accommodation charges, date of admission, date of discharge, patient's name, address and GSC Identification Number.

Co-ordination of Benefits (COB)

If you are covered for health and dental benefits under more than one plan, your benefits under this plan will be co-ordinated with the other plan following standard industry guidelines developed by the Canadian Life & Health Insurance Association (CLHIA) such that the total amount payable does not exceed 100% of the eligible expense incurred. Applying the standard COB rules allows GSC, as well as other carriers, to identify which plan is the primary payor and which is the secondary payor.

For complete details on COB, please refer to the GSC website at greenshield.ca.

Vision Preferred Provider Network Arrangement

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

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

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

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

3. Trustworthy retail chains with convenient locations;

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

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

6. Professional opticians to assist in selecting products;

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

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

How to Submit Your Vision Claim

1. Present your GSC Identification Card as proof of being a GSC Plan Member.

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

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