Prism®

Health and dental benefit programs with a focus on individuals

Coverage provided by

Green Shield Canada (GSC)

CONTRACT

This Contract has been issued in consideration of the statements made by you in your application and payment of the required premiums.

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

This Contract will not become effective unless Green Shield Canada (GSC) receives your initial premium payment.

Your initial payment for the first two (2) months of coverage is due on the coverage effective date. Subsequent payments will be made thirty (30) days in advance of the month for which coverage is to be provided.

The coverage outlined in this Contract and confirmed in the Schedule of Benefits, starts on the coverage effective date confirmed in your approval communication.

This Contract contains a provision removing or restricting the right of the Plan Member to designate persons to whom or for whose benefit insurance money is to be payable. See Section 2 on page 1 of this Contract ("Reimbursement") for detailed information with respect to this restriction. Further information can also be obtained from your agent or broker, if you purchased this coverage from an agent or broker.

You are the Plan Member under this Contract. Green Shield Canada ("GSC" or "us" or "we") provides the benefits under this Contract.

Green Shield Canada, 8677 Anchor Drive, PO Box 1606, Windsor, ON N9A 6W1 Phone toll-free: 1.888.711.1119

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Enclosures:
CONTACT SHEET
SCHEDULE OF BENEFITS
A COPY OF YOUR COMPLETED APPLICATION FORM

Reimbursement

If a covered person incurs charges for 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 subsequent amendments made to the benefits described in this Contract.

1. Reimbursement of reasonable and customary charges for eligible services received by you or your dependent(s) will be made provided such services and supplies are:

    a) prescribed by and given under the direction of your attending legally qualified health or legally qualified dental practitioner; and

    b) in the opinion of GSC, medically necessary for the treatment of an illness or injury, taking all factors into account.

2. Reimbursement will be made by one of the following methods:

    a) a reimbursement cheque payable to you;

    b) direct deposit to your personal bank account when requested; or

    c) direct payment to the provider of services, where applicable.

3. 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.

4. All claims must be received by GSC no later than 12 months from the date the eligible item was purchased and/or service rendered.

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. Claim eligibility and amounts that accumulate toward plan maximums will be based on the date of service. The date of service is defined as the date the service, treatment, medical equipment or supply is received or delivered (not the order date or payment date for the service, treatment, medical equipment or supply).

7. Reimbursement will not be made for any eligible services unless the premiums due from you have been paid in full at the time the eligible service was rendered. No reimbursement will be made for any charges for services incurred prior to the effective date of this coverage.

Description of Benefits

The following is a description of the benefits available under this Contract.

Benefits are subject to exclusions, limitations and conditions 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 for which you have been approved. Your Schedule of Benefits is included in your welcome package along with this Contract. It provides a summary of the benefits and applicable coverage maximums that pertain to the specific plan you have purchased.

Extended Health Benefits including Vision

1. **Accidental dental:** *Subject to the maximum(s) stated in your Schedule of Benefits.*
   - Reimbursement for the services of a licensed dental practitioner for dental care to natural teeth when necessitated by a direct blow to the mouth and not by an object wittingly or unwittingly placed in the mouth. The accident must occur while the coverage is in force. When natural teeth have been damaged eligible services are limited to one set of artificial teeth.
   - You must notify GSC of the injury 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 current Dental Association Fee Guide for General Practitioners in the province where the 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. 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.
   - In the event of a dental accident, claims should be submitted under the extended health benefit before submitting them under the dental benefit.

2. **Ambulance transportation***:* Reimbursement 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. No amount will be reimbursed for transportation services between hospitals.

3. **Hearing aids***: Subject to the maximum(s) stated in your Schedule of Benefits.*

   Reimbursement for hearing aids, repairs or replacement parts, if recommended or approved by the attending legally qualified health practitioner. Commencement of the allowable benefit period specified in your Schedule of Benefits is based on the initial date that hearing aids/services are received; subsequent hearing aids/services are only eligible after the end of the benefit period following the prior claim. No amount will be paid for batteries.

4. **Home support services**: *Subject to the maximum(s) stated in your Schedule of Benefits.*

- Reimbursement 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 only on a visit or shift basis.
- No amount will be paid for services which are custodial 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:** *Subject to the maximum(s) stated in your Schedule of Benefits.*

When prescribed by a legally qualified health practitioner unless specified otherwise below, reimbursement for reasonable and customary charges, up to the amount, where applicable, as shown in your Schedule of Benefits.

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.

a) **Aids for daily living:** such as hospital style beds (including rails and mattresses), standard commodes, decubitus (bedridden) supplies, IV stands, trapezes, bedpans, raised toilet seats, urinals;

b) **Braces, casts**;

c) **Incontinence/Ostomy:** such as catheter supplies and ostomy supplies;

d) **Compression stockings**;

e) **Diabetic equipment,** such as:
   i) blood glucose meters and lancets;
   ii) glucose monitoring systems (GMS) such as continuous and flash type monitors subject to medical pre-authorization and reimbursed to the cost of a blood glucose meter. Disposable GMS supplies (used with the monitor) such as but not limited to sensors and transmitters, are included and subject to the overall annual maximum applicable to diabetic testing and monitoring equipment and supplies.

f) **Footwear**, when prescribed by your attending physician, nurse practitioner, podiatrist or chiropodist and dispensed by your podiatrist, chiropodist, chiropractor, orthotist, or pedorthist:
   i) custom-made foot orthotics or adjustments to custom-made foot orthotics;
   ii) custom-made boots or shoes (subject to a medical pre-authorization);

   Commencement of the allowable benefit period is based on the initial date that footwear benefits are received.

g) **Mobility aids:** such as canes, crutches, walkers, wheelchairs (including wheelchair batteries);

h) **Standard prosthetics:** such as an 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;

i) **Respiratory/Cardiology equipment:** such as continuous positive airway pressure pumps (CPAP), breathing and heart monitors for infants, compressors, inhalant devices, tracheotomy supplies, oxygen.

Limitations

i. The rental price of medical equipment will not exceed the purchase price. GSC's decision to purchase or rent will be based on the legally qualified health 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.

ii. 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.

6. **Medical services:** such as diagnostic tests and x-rays, *subject to the maximum*(s) *stated in your Schedule of Benefits*.

7. **Professional services/Registered therapists**: *Subject to the maximum(s) stated in your Schedule of Benefits. Note: Payment is based on 1 treatment, per professional service/registered therapist, per day*

Contact the GSC Customer Service Centre to confirm practitioner eligibility.

Reimbursement for the services of the following practitioners, when the practitioner 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.

- Acupuncturist;
- Chiropractor;
- Footcare specialist (chiropodist or podiatrist);
- Registered massage therapist (Physician (M.D.) or nurse practitioner recommendation required);
- Naturopath;
- Osteopath;
- Physiotherapist;
- Psychologist;
- Registered social worker (RSW);
- Speech therapist.

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

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

- Reimbursement for the services performed by a licensed Optometrist, Optician or Ophthalmologist for:
  - prescription 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;
  - plano sunglasses prescribed by a legally qualified health practitioner for the treatment of specific ophthalmic diseases or conditions;

- optometric eye examinations for visual acuity performed by a licensed optometrist, ophthalmologist or physician limited to one eye exam in a 24-month benefit period. This benefit is only available for residents in provinces where eye exams are not covered by the provincial health insurance plan.

- Commencement of the allowable 24-month benefit period is based on the initial date the service is received; subsequent services are only eligible 24 months after the prior claim.

Benefits do not include and no amount will be paid for:

a) Medical or surgical treatment, except for laser eye surgery;
b) Special or unusual procedures such as, but not limited to, orthoptics, vision training, subnormal vision aids and aniseikonic lenses;
c) Follow-up visits associated with the dispensing and fitting of contact lenses;
d) Charges for eyeglass cases.

Exclusions

In addition to the General Exclusions of this Contract, 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. Incontinence diapers;

iv. Insulin pumps and supplies.

Hospital Accommodation Benefits

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

If your provincial health insurance plan has agreed to pay the standard or ward rate, GSC will reimburse the reasonable and customary charges in excess of such standard or ward rate, for accommodation in:

- a public general hospital; or
- a convalescent or rehabilitation hospital or a convalescent or rehabilitation wing in a public general hospital (when you are admitted within 14 days of discharge from a public general hospital)

Exclusions

In addition to the General Exclusions of this Contract, 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 10-month period following the covered person's coverage effective date.

Prescription Drug Benefits

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

Prescription drug benefits will be paid on a pay-direct basis (your pharmacy can bill GSC directly).

Benefits include prescription drugs that are prescribed by a legally qualified health practitioner or dental practitioner as permitted by law and legally require a prescription and have a Drug Identification Number (DIN), and have been approved through GSC's drug review process.

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

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

If approved by GSC, this plan also includes drugs with a Drug Identification Number (DIN) that do not legally require a prescription, including but not limited to nitroglycerin, diabetic syringes, needles, testing agents, insulin and other approved injectables. In addition, this benefit includes certain vaccines.

Certain drugs require a prior approval from GSC before your drug claim can be reimbursed. You can find out if your drug requires prior approval either by using the online drug search tool available to you through GSC's Plan Member Online Services, or by contacting GSC's Customer Service Centre.

Mandatory generic substitution: based on specific provincial health insurance plan regulations, where a generic equivalent drug exists, reimbursement will be made up to the cost of the lowest priced equivalent drug. If a health practitioner indicates a brand name drug is medically required due to a serious medical reaction to at least two generic equivalent drugs, GSC must be provided with a copy of the "Health Canada Vigilance Adverse Reaction Reporting Form" (that can be obtained from the Health Canada website) completed by the legally qualified health practitioner, to determine eligibility for payment of the cost of the prescribed drug.

NOTES:

Drug Benefit over age 65:	In all provinces other than Québec, co-pays and deductibles under your provincial plan are eligible for coverage.
Québec residents only:	To be eligible for prescription drug coverage under this benefit plan, residents of Québec are required to enroll in the public drug plan, RAMQ (Régie de l'assurance maladie du Québec). As a resident of Quebec, you must submit all your drug claims to RAMQ first. The unpaid balances (including co-payments and deductibles) for drugs eligible for coverage under RAMQ, as well as claims for drugs not covered by RAMQ, may then be submitted to GSC for consideration. In the case of drugs requiring special authorization, claims may be submitted to GSC for consideration according to the terms of your Contract, only when the RAMQ criteria has been met.

Limitations

i. With respect to Quebec residents only, in no event will the amount dispensed exceed a 3-month supply (6 months if a vacation supply is required) of a prescription at any one time and not more than a 13-month supply in any 12 consecutive months.
ii. With respect to all other provinces, maintenance drugs required to treat lifelong chronic conditions that develop and are diagnosed after this policy is effective, may be required to be purchased in a 90-day supply of a prescription at any one time, except for the first time the prescription is filled. 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.
iii. 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 of this Contract, benefits do not include and no amount will be paid for:

i. Drugs for the treatment of erectile dysfunction, infertility, or obesity;
ii. Reference biologic drugs that have an approved Biosimilar drug;
iii. Smoking cessation oral drugs and nicotine replacement products, such as patches, gum, lozenges and inhalers;
iv. The administration of serums, vaccines or injectable drugs;
v. Products that may lawfully be sold or offered for sale other than through retail pharmacies, and that 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”;
vi. Vitamins that do not legally require a prescription;
vii. Ingredients or products that 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;
viii. Mixtures compounded by a pharmacist that do not conform to GSC’s current Compound Policy;
ix. Any specific treatment or drug that is not dispensed by the pharmacist;
x. Any exclusions 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 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 current Dental Association Fee Guide for General Practitioners in the province where services are rendered, 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);
  - For independent Dental Hygienists, the current Dental Hygienists' Association Fee Guide in the province where services are rendered.
- Treatment rendered by a specialist will be reimbursed in accordance with the Fee Guide for General Practitioners.

Basic Preventive and Restorative Services

1. **Basic Diagnostic Services** include:
   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** include:
   a) Recall examinations once per recall period; *refer to your Schedule of Benefits for recall frequency*;
   b) Preventive cleaning of teeth (up to 1 unit of polishing plus up to 1 unit of scaling) once per recall period;
   c) Topical application of fluoride for covered persons age 19 and under, once per recall period;
   d) Pit and fissure sealants on molars only, for dependent children age 16 and under;
   e) Space maintainers that replace prematurely lost teeth for dependent children age 16 and under.
3. **Basic Restorative Services** include:
   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** includes extractions of teeth and/or residual roots.
5. **General anaesthesia, deep sedation and intravenous sedation** are eligible in conjunction with eligible oral surgery only.

Comprehensive Basic Services

1. **Endodontic treatment** includes:
   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.

2. **Periodontal treatment** includes:
   a) Periodontal scaling and/or root planing;
   b) Occlusal equilibration (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 General Practitioners Fee Guide.

3. **Standard denture services** include:
   a) Denture cleaning;
   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 a denture);
   d) Denture adjustments, remount and equilibration procedures, only after 3 months have elapsed from the installation of a denture;
   e) Soft tissue conditioning linings for the gums to promote healing;
   f) Remake of a partial denture using existing framework.

Major Services

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

1. **Crowns:** Standard onlays or crown restorations, (paid to full metal on molar) to restore diseased or accidentally injured natural teeth;

2. **Bridges:** Standard bridges, including pontics, abutment retainers/crowns (paid to full metal on molar) on natural teeth;

3. **Dentures:** Standard dentures including complete, immediate, transitional and partial dentures;

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

Orthodontic Services

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

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 Benefit Clause

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

Predetermination

Before your treatment begins:

- For all proposed treatment for crowns, onlays and bridges, an estimate completed by your legally qualified 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 legally qualified dental practitioner.

Limitations

i. Laboratory services must be completed in conjunction with other services and will be limited to the reimbursement percentage of such services. Laboratory charges that are in excess of 40% of the applicable Fee Guide for General Practitioners will be reduced accordingly and the reimbursement percentage is then applied.

ii. 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.

iii. 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.

iv. 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 for General Practitioners.

v. 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.

vi. Reimbursement for root canal therapy will be limited to payment once only per tooth, and thereafter, only once for possible follow-up procedures such as apicoectomies, root resections, retrofillings, and extractions. 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.

vii. 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.

viii. 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.

ix. 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%.

x. 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 the crown.

xi. Root planing is not eligible if done at the same time as gingival curettage.

xii. In the event of a dental accident, claims should be submitted under the extended health benefit before submitting them under the dental benefit.

Exclusions

In addition to the General Exclusions of this Contract, 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 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;

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 myofascial 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 (TMJ) dysfunction.

Emergency/Medical Travel Benefits

Emergency services: *Subject to the maximum(s) stated in your Schedule of Benefits.*

Referral services: *Subject to the maximum(s) stated in your Schedule of Benefits.*

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

Expenses arising as a result of a medical emergency while you or your eligible dependent are temporarily outside of your regular province/territory of residence for vacation or travelling for reasons other than health related reasons (unless incurred as described under referral services) will be considered eligible under this Travel benefit.

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

Eligible travel expenses will be reimbursed based upon the reasonable and customary charges in the area where they were received, less the amount payable by your provincial government health plan.

All dollar maximums and limitations stated are expressed in Canadian dollars. 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/territory of residence, but does not include treatment of a pre-existing/pre-diagnosed condition that was not completely stable prior to your departure.

GSC reserves the right to review your medical information at the time of claim. Any invasive or investigative procedures must be pre-approved by our GSC Assistance Medical Team.

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.

Travel benefits are limited to the number of days per trip stated, commencing with the date of departure from your province/territory of residence. If you are hospitalized on the last day shown in 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**

   - 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.

   Prior to the commencement of any non-emergency, referral treatment that is not available in your home province, 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 Travel Assistance for pre-approval.

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

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

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

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

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

    - GSC Assistance Medical Team specifies in writing that you **should immediately** return to your province of residence for immediate medical attention, reimbursement will be made for the extra cost incurred for the purchase of a one way economy airfare, plus the additional economy airfare if required to accommodate a stretcher, to return you by the most direct route to the major air terminal nearest the departure point in your province of residence;
    - 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 or marriage and is registered in the jurisdiction in which treatment is provided, plus overnight hotel and meal expenses if required by the attendant.

    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.

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/territory 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.

16. **Automatic Extension of Coverage**

    Coverage for any trip will automatically be extended, for up to 72 hours (the determination of which is at the discretion of GSC), if:

    - The covered person or the covered person's travelling companion is hospitalized on or before the date the regular travel coverage would have expired and the covered person was unable to return to the province/territory of residence before the coverage for the trip expired. In that case, the coverage will be extended beginning on the date the covered person or covered person's travelling companion is discharged from the hospital, and claims must be supported by satisfactory documented proof of the hospitalization that caused the inability to return;

    - The covered person's return to the province/territory of residence is delayed by order of the GSC Assistance Medical Team due to an emergency. In that case, the coverage will be extended beginning on the date of the order of the GSC Assistance Medical Team;

    - The travel coverage expires and the covered person's return to the province/territory of residence is delayed due to the delay of a common carrier (airplane, bus, taxi, train) on which a person covered under this Contract is a passenger; or the delay is caused by a traffic accident, or mechanical failure of a private automobile en route to the departure point. In that case, the coverage will be extended beginning on the date of the delay, and claims must be supported by satisfactory documented proof of the incident that caused the delay;

    - The travel coverage expires and the covered person's return to the province/territory of residence is delayed due to extreme weather conditions, causing hazardous driving conditions. In that case, the coverage will be extended beginning on the date of the delay, and claims must be supported by satisfactory documented proof from the local authorities and weather office at the location of the delay.

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'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 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 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. The GSC Assistance Medical Team also keeps 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.

Limitations

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

ii. 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/territory 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/territory of residence, the expense of such continuing treatment will not be eligible for coverage.

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.

iii. 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; and
- You or your dependent are admitted directly to a hospital in your province/territory of residence; and
- Medical reports or certificates from the dispatching and receiving legally qualified physicians are submitted to GSC Travel Assistance; and
- Proof of payment (including air ticket vouchers or air carrier invoices) is submitted to GSC Travel Assistance.

iv. 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 for pre-travel advice as we may be unable to guarantee assistance services.

v. GSC reserves the right, without notice, to suspend, curtail or limit its services and benefits 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).

Exclusions

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

i. 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/territory of residence, was not, in the professional opinion of GSC Assistance Medical Team, completely stable, 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.

ii. 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. Benefits will not include reimbursement for treatment or surgery that could reasonably be delayed until you return to your province/territory of residence.

iii. 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.

iv. 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/territory of residence.

v. 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.

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

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

viii. Any expenses for injuries caused by, arising from, or directly or indirectly contributed to by the abuse or excessive consumption or use of medications, drugs, alcohol or other toxic substances or for injuries caused by, arising from, or directly or indirectly contributed to as a result of the consequences of such abuse or excessive consumption. Use of alcohol which gives rise to a blood alcohol level of more than 80 milligrams in 100 millilitres of blood will be deemed to be excessive consumption or use and this exclusion will apply.

ix. Any expenses relating directly or indirectly to an injury sustained as a result of the covered person's operation of a motorized vehicle while legally impaired or intoxicated as a result of the excessive use of a medication, drugs, alcohol or other toxic substances. Use of alcohol which gives rise to a blood alcohol level of more than 80 milligrams in 100 millilitres of blood will be deemed to be intoxication as a result of excessive use and this exclusion will apply. 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.

x. Amounts paid or payable under any Workplace Safety Insurance Board or similar plan.

xi. 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.

xii. 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.

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

xiv. Cataract surgery or the purchase of eyeglasses or hearing aids.

xv. Any expenses for claims provided during any trip undertaken for the purpose of seeking medical treatment or advice unless pre-authorized as outlined in referral services.

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

General Information

Administrative Policies

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 GSC uses to administer benefit plans and adjudicate claims for eligible items purchased and/or services rendered.

GSC is the administrator of this Contract. You must provide GSC with any information required to calculate premiums and/or pay benefits. GSC has 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 that should be used on all claims and correspondence. Your number will appear on the front of the card and will end in –00 while each of your dependents with their number will be shown on the back.

General Exclusions

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) 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 health 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 form of medical cannabis for the treatment of any medical condition, regardless of whether it is authorized by way of a medical document or prescription from a legally-authorized health practitioner and obtained from a Health Canada-licensed producer pursuant to any federal or provincial legislation or regulation regarding the access to and/or distribution of medical cannabis.
6. Any specific treatment or drug that:
   a) Does not meet accepted standards of medical, dental or ophthalmic practice, including charges for services or supplies which are experimental in nature;
   b) Is not considered to be effective (either medically or from a cost perspective) as determined by GSC's drug review process, regardless of Health Canada's approval of the drug;
   c) Is an adjunctive drug prescribed in connection with any treatment or drug that is not an eligible service;
   d) Is administered in a hospital or is required to be administered in a hospital in accordance with Health Canada's approved indication for use;
   e) Is not dispensed by the pharmacist;
   f) Is not being used and/or administered in accordance with Health Canada's approved indication for use (i.e. off-label use), even though such drug or procedure may customarily be used in the treatment of other illnesses or injuries.
7. Services, supplies or devices that:
   a) Are not recommended, provided by or approved by the attending legally qualified (in the opinion of GSC) health 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 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 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 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 eligible for coverage;

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 a 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, health 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 provided by a health 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;

s) 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;

t) Relates to treatment of injuries arising out of a motor vehicle accident.

Note: Payment 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.

General Provisions

1. 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.**

2. **The Contract**: The application, this document, any document attached to this document when issued, and any amendment to the contract agreed upon in writing after this document is issued, constitute the entire Contract and no agent has the authority to change or waive any of its provisions.

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

   a) A Plan Member may apply to increase benefit coverage under a "Precision and Spectra" plan at any time by submitting a written application for the change in coverage. For "Precision and Spectra" medically underwritten plans, evidence of health satisfactory to SBIS is also required. (Once coverage is in effect, a Plan Member may not increase benefit coverage under a "Continuum"plan.)

   b) A Plan Member who chooses to reduce "Precision or Spectra or Continuum" 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 good health is not required for a newborn child if the application is submitted within 30 days following the date of birth. Upon approval, coverage will become effective on a date to be 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) When coverage is in force, and a dependent must be removed due to death, divorce, or a dependent child becoming married or employed on a full-time basis, the request must be sent in writing to SBIS within 30 days following the date of such event. Any refund of premium resulting from late notification of such events will be limited to a maximum of 3 months premium.

   g) All requests for changes including changes with respect to dependents' coverage and payments, must be made by the Plan Member or Account Holder.

   h) Notices by the Plan Member or Account Holder must be sent in writing to the appropriate address as indicated on the "contact sheet".

4. **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.

5. **Eligibility:** Available to residents of Canada and their dependents who are covered by a provincial government health plan. A covered person may be covered under only one individual health and dental benefit plan issued by GSC at any given time.

6. **Coverage requirements:** All individuals covered under this contract must maintain the same benefits.

7. **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.

8. **Limitations of actions:** Every action or proceeding against an insurer for the recovery of insurance money payable under the Contract is absolutely barred unless commenced within the time set out in the *Insurance Act* (for actions or proceedings governed by the laws of Alberta, British Columbia and Manitoba), the *Limitations Act, 2002* (for actions or proceedings governed by the laws of Ontario), or other applicable legislation.

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

   a) An audit may require that you complete a medical questionnaire or provide GSC and SBIS with additional medical information. You are responsible for costs that may be incurred to obtain the information GSC and SBIS requires. Depending on the results of the audit, exclusions due to pre-existing conditions may be added to your coverage.

   b) In respect of any application made, any misrepresentation, concealment or failure to disclose correct information including without limitation medical information, will, if discovered within 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. However, after coverage has been in force for a period of 2 years, coverage will not, in the absence of fraud, be voidable.

   c) The reimbursement of benefits will be suspended during a non-disclosure investigation.

   d) 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 2 years, coverage will not, in the absence of fraud, be voidable.

   e) 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. The Plan Member must provide, at his/her own cost, all information that GSC requires in order to investigate and adjudicate the claim. The Plan Member will be liable to indemnify GSC and this obligation will survive the termination of this Contract.

10. **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 and coverage will be adjusted accordingly.

11. **Notices:** All notices relating to the Contract including notices with respect to dependents' coverage will be sent to the Plan Member at 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 from you to record the change. Refer to the "contact sheet".

12. **Premiums:** Premiums are based on the age of the Plan Member, the plan selected, the number of covered individuals (single, couple, family) and the province of residence.

13. **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 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 withdrawal, if applicable. These overage dependents will be given the opportunity to transfer to their own individual plan..

14. **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 cannot be processed for whatever reason, an administration fee may be charged.

15. **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. 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 under other coverage(s). In cases of third party liability, you must advise your lawyer of our subrogation rights.

16. **Reapplication following cancellation of coverage:** If this Contract, or any other contract for individual coverage with GSC has been terminated, a period of at least 24 months must elapse before an application for any GSC individual health plan will be considered eligible.

17. **Release of information:** As a condition precedent to receiving benefits under this Contract, the applicant 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 medical records or information from any health or dental practitioner, hospital, clinic or service provider.

18. **Termination of agreement:** This Contract may be terminated by the Plan Member or the Account Holder for any reason upon giving written notice at least 10 business days prior to the next premium withdrawal date. Your coverage will terminate at the end of the month for which premiums were paid.

19. **Transfer to surviving spouse:** If at the time of your death, your Contract includes dependent coverage, we will continue the coverage of your dependents following your death and record your spouse as the Plan Member. The benefits under this Contract will be unchanged, but the premium payments may be adjusted. We will issue a new Contract and GSC identification number to your spouse.

Statutory Conditions (not applicable to Quebec residents)

Certain conditions must be included in this policy, by law. They are called "Statutory Conditions" and are set out below.

1. Contract: The application, this policy, any document attached to this policy when issued and any amendment to the Contract agreed on in writing after this policy is issued constitute the entire Contract, and no agent has authority to change the Contract or waive any of its provisions.

2. Waiver: GSC shall be deemed not to have waived any condition of this Contract, either in whole or in part, unless the waiver is clearly expressed in writing signed by GSC.

3. Copy of application: A copy of the application is included as an enclosure. GSC shall, upon request, furnish to the Plan Member or to a claimant under the Contract an additional copy of the application.

4. Material facts: No statement made by the Plan Member or a covered person at the time of application for the Contract shall be used in defence of a claim under or to avoid the Contract unless it is contained in the application or any other written statements or answers furnished as evidence of insurability.

5. Notice and proof of Claim:

   1.) The Plan Member or a covered person, or a beneficiary entitled to make a claim, or the agent of any of them, shall

      (a) Give written notice of claim to GSC
         i. By delivery of the notice, or by sending it by mail, to the head office of GSC, so that GSC receives it no later than 364 days after the date a claim arises under the Contract on account of an accident or sickness,

      (b) Furnish to GSC no later than 364 days after the date a claim arises under the Contract such proof as is reasonably possible in the circumstances of
         i. The happening of the accident or the start of the sickness,
         ii. The loss caused by the accident or sickness,
         iii. The right of the claimant to receive payment,
         iv. The claimant's age and,

      (c) If so required by GSC, furnish a satisfactory certificate as to the cause or nature of the accident or sickness for which claim is made under the Contract and, in the case of sickness, its duration.

   2.) Failure to give notice and proof: Failure to give notice of claim or furnish proof of claim within the time required by this statutory condition does not invalidate the claim if

      (a) Notice or proof is given or furnished as soon as reasonably possible, and in no event later than one year from the date of the accident or the date a claim arises under the Contract on account of sickness, and it is shown that it was not reasonably possible to give the notice or furnish the proof in the time required by this condition, or

      (b) In the case of the death of the covered person, if a declaration of presumption of death is necessary, the notice or proof is given or furnished no later than one year after the date a court makes the declaration.

6. GSC to furnish forms for proof of claim: GSC shall furnish forms for proof of claim within 15 days after receiving notice of claim, but if the claimant has not received the forms within that time the claimant may submit his or her proof of claim in the form of a written statement of the cause or nature of the accident or sickness giving rise to the claim and of the extent of the loss.

7. When moneys payable: All money payable under this Contract shall be paid by GSC within 60 days after it has received proof of claim.

8. Limitations of actions (Applicable in New Brunswick, Nova Scotia, Newfoundland and PEI only): An action or proceeding against GSC for the recovery of a claim under this Contract shall not be commenced more than one year after the date the insurance money became payable or would have become payable if it had been a valid claim.

   Limitation of actions (Applicable in Yukon, NWT and Nunavut only): An action or proceeding against GSC for the recovery of a claim under this Contract shall not be commenced more than two years after the date the insurance money became payable or would have become payable if it had been a valid claim.

Definitions

Where used in this Contract, the terms:

1. **Accident** or **accidental** 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 payment on their behalf.
3. **Benefit year** means the 12 consecutive months commencing on the effective date of coverage, and each 12 month period thereafter.
4. **Biologic drug** means a drug that is produced using living cells or microorganisms (e.g., bacteria) and is often manufactured using a specific process known as DNA technology.
5. **Biosimilar drug** means a biologic drug demonstrated to be similar to a reference biologic drug already authorized for sale by Health Canada.
6. **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.
7. **Calendar year** means the 12 consecutive months January 1st to December 31st of each year.
8. **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.
9. **Coverage** means that you are entitled to make a claim in respect of eligible benefits.
10. **Covered person** means the Plan Member or his or her dependents.
11. **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.)
12. **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.)
13. **Dental practitioner** means a person who is certified to practice dentistry or a specific dental discipline, and holds a valid license to practice that discipline from the applicable provincial regulatory agency or governing body of that discipline. Dental practitioner includes, but is not limited to a general dentist (D.D.S.), dental hygienist, denturist/denture therapist, or dentists specializing in such disciplines as prosthodontics, endodontics, periodontics, oral surgery, or orthodontics.
14. **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.
15. **Dependent** means your spouse to whom you are legally married or partner with whom you have lived continually in a common-law relationship for more than 12 months and publicly represent as your spouse/partner, and/or unmarried natural children, stepchildren, common-law children or legally adopted children under age 21 who live with the Plan Member and are not regularly employed. Child(ren) age 21 and over 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.

    Only one spouse/partner will be considered at any time as being covered under this Contract.
16. **Effective date** means the day on which coverage under this Contract takes effect.
17. **Eligible services** mean services incurred by a covered person that are payable by GSC as set out in, and subject to the exclusions, limitations and conditions of this Contract.

18. **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.

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 provincial government health plan, home care program, Assistive Devices Program or Workplace Safety and Insurance Board or tribunal of the covered person's province of residence.

20. **Health practitioner** means a person who is certified to practice medicine or a specific medical or health care discipline, and holds a valid license to practice that discipline from the applicable provincial regulatory agency or governing body of that discipline. Health practitioner includes, but is not limited to a physician (M.D.), nurse practitioner, chiropractor, podiatrist or chiropodist, registered massage therapist, physiotherapist, psychologist, registered social worker, naturopath, osteopath, or speech therapist.

21. **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.

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

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

25. **Plan Member** means the primary applicant for this Contract who is also the owner of the contract. Premiums will be charged based on the age of the Plan Member. The Plan Member may or may not be the Account Holder.

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

10-Day Satisfaction Guarantee

You as the Plan Member may, within ten (10) days after receiving this Contract, send a request for cancellation to GSC in writing to the address or email address below. The Contract will be considered never to have come into effect and any premium paid up to the end of the 10-day examination period will be refunded, less any claims paid. Where claims paid exceed premiums, the difference must be repaid to GSC immediately. This right of cancellation expires ten (10) days after this Contract is received by the Plan Member.

Special Benefits Insurance Services (SBIS)
366 Bay Street, 7th Floor
Toronto, Ontario M5H 4B2

Email: general@sbis.ca

Plan Member Online Services

Self-service through the GSC Plan Member Online Services website makes things quick, convenient and easy. Register today to:

- Submit certain claims online;
- Access your personal claims information, including a breakdown of how your claims were processed and claims history;
- Simulate a claim to instantly find out what portion of a claim will be covered;
- Arrange for claim payments to be deposited directly into your bank account*;
- Print personalized claim forms and replacement ID cards;
- View and print personal claims statements, including coordination of benefits statements;
- Print your own premium confirmation letter for tax purposes;
- Search for your prescription drug to see if it is covered under your plan, if there are any co-payments or coinsurance, and links to prior authorization information and forms, where applicable;
- 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;
- View a copy of this Contract.

**Note - once arrangements have been made for direct deposit, claim payments will be deposited directly into the bank account you have chosen, along with an email notification from GSC. Statements will no longer be mailed to you, but will be available for online viewing.*

How to register:

1. Visit **greenshield.ca** with your GSC ID card handy.

2. Click the LOGIN button (found in the right corner of every page) and click GO to register as a Plan Member.

3. On the “Welcome to Plan Member Online Services” page, enter your Plan Member ID and registration key in the “REGISTER HERE” section. Click “CONTINUE WITH REGISTRATION”. Skip to Step 5.

4. Don't have a registration key? Your unique, one time use registration key can be found on your Explanation of Benefits (EOB) statement. You can also easily request one by clicking on “GET A REGISTRATION KEY” and following the steps. Once you have your registration key, go back to the Welcome page, enter your Plan Member ID and registration key, and click “CONTINUE WITH REGISTRATION”.

5. You will be required to confirm a few personal details, create a user name and password, and provide answers to three challenge questions. You can also give authorization for other people to access your account (such as a spouse) and enter your banking information for direct deposit. Sign in as a ‘Plan Member’.

System requirements include Adobe® Reader®, which is a free download directly from our website.

Visit **greenshield.ca** and register today!

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.

Terms and Conditions

All information provided using the Plan Member Online Services web claim submission must be complete and accurate. In the event that information is found to be incomplete or inaccurate, GSC reserves the right to remove online claiming privileges. The information, including personal information provided to GSC about the covered persons, will be used by GSC for claims adjudication and any other services necessary in the administration of benefits which may include the exchange of information with other parties to administer this benefit plan.

By applying for coverage for his/her spouse and/or dependents, the Plan Member represents and warrants to GSC that he/she is authorized by his/her spouse and/or dependents to disclose and receive information about them. This information may be seen by the Plan Member and used by GSC and the other parties referenced in this agreement for the purposes set out in this agreement.

It is understood that when submitting claims online, GSC may select claims for audit. If so requested, the Plan Member is responsible for producing the original receipt(s) within 30 days.

Upon failure to provide receipt(s) to GSC, or provision of false, incomplete or misleading information, GSC reserves the right to classify the claim as an overpayment and will deduct such monies from any future claims payments. Furthermore, coverage may be denied or terminated and/or online submission may be revoked.

It is understood that the Plan Member is responsible for retaining original receipt(s) for 13 months following the date of claim submission(s).

GSC maintains a national database of providers and their association with any regulatory agency, professional, association or educational program. GSC reviews each provider to determine which benefits/services are eligible for reimbursement in conjunction with the Plan Member's health benefits plan. When submitting a claim online, with a provider that has not registered with GSC, the provider's credentials will be verified and claims will be processed accordingly.

Acceptance of the Web Claim Submission Agreement Terms and Conditions applies to all claims submitted within an online session, including multiple claims (for different dependents and/or providers).

Registration for Web Claims Submission and clicking "Accept" indicates that the Plan Member has deemed to have read, understood and agreed to all these Terms and Conditions.

Claiming Information

Inquiries
For detailed inquiries, 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, are available at greenshield.ca.

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).

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

ALL CLAIMS MUST BE RECEIVED BY GSC NO LATER THAN 12 MONTHS FROM THE DATE THE ELIGIBLE BENEFIT WAS INCURRED.

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.

Co-ordination of Benefits (COB)

If you are covered for health and dental benefits under more than one plan and all those plans permit Co-ordination of Benefits, your benefits under this plan will be co-ordinated with the other plan following the 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 order of payment rules allows GSC, as well as other carriers, to identify which plan is the primary payer and which is the secondary payer.

If you are covered under a group plan permitting COB, you should submit your claim to the group plan first.

If you are covered for health and dental benefits under more than one plan, but one of the plans does **not** permit COB, the plan that does not permit COB must be the primary payer.

For additional information about COB, please refer to the GSC website at greenshield.ca.

Our Commitment to Privacy

Protecting your privacy and the confidentiality of your personal information has always been fundamental to the way GSC (“we”, “us” or “our”) does business. We are committed to the protection of personal information that we collect, including information that we transfer to third parties to perform services for us.

Why We Require Personal Information

We require personal information for benefits related purposes such as:

- To establish your identity;
- To provide you and your dependents with benefits coverage, including administering your coverage and processing claims;
- To protect you from error and fraud; and
- To provide you with access to other services we provide.

We do not sell our customer lists for marketing purposes.

Personal Information We Collect, Use and Retain

We collect the personal information necessary to determine your eligibility for our benefits plans and in order to process claims under such plans. That information includes, but is not limited to, your name, contact details, age, sex, health status, health history, family information and financial information.

We retain such information, subject to legal and regulatory requirements, only for so long as is necessary to provide you with the products and services you are using, and for a period of time thereafter in accordance with legal and regulatory requirements. We destroy your personal information when it is no longer required or we remove your name from it. We may also record telephone calls for quality and accuracy assurance purposes.

Your Access To Our Information

You may request to review your personal information in our files. You may also request a correction to such personal information. Requests for access and/or correction should be made by calling us at 1.888.711.1119 or in writing to:

Privacy Officer
Green Shield Canada
P.O. Box 1606
Windsor, ON N9A 6W1
Email: privacyoffice@greenshield.ca

We will grant access to your personal information upon verifying your identity and entitlement to such access. We may not be able to provide information about you from our records if it contains references to another person (even your spouse), is subject to legal privilege, contains information that is proprietary to us or cannot be disclosed for other legal reasons. If you identify information that requires correction, we will assist you in identifying the appropriate means to have the correction made.

For More Information

This is a summary of our Privacy Policy. For a copy of our full Privacy Policy, please call us at 1.888.711.1119 or go to our website at https://www.greenshield.ca/en-ca/Home/privacy-and-confidentiality