Lake of the Woods District Hospital

Classification:	CUPE Local 822
Billing Division:	300
Revised Effective Date:	June 17, 2024

WELCOME TO YOUR BENEFIT PLAN

ABOUT THIS BOOKLET

This booklet contains important information you will need about your group benefits with **Lake of the Woods District Hospital**, your plan sponsor, available through the group contract with GSC Canada (GSC). It includes:

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

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

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

OUR COMMITMENT TO PRIVACY

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

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

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SCHEDULE OF BENEFITS

HEALTH BENEFIT PLAN

This schedule describes the deductibles, co-pays and maximums that may be applicable if you are included in the Billing Division shown on the cover of this booklet.

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

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

Out-of-Province

Medical services are eligible only if your provincial health insurance plan provides payment toward the cost of incurred services.

Deductible: $22.50 per covered person, $35 per family, every 12 months	**Overall Maximum:** Unlimited

Your Co-pay: Nil

Your Plan Covers:	**Deductible Applies:**	**Maximum Plan Pays:**
Prescription Drugs – Pay Direct Drug Card	Yes	
▪ All covered drugs		Unlimited
Hospital Accommodation		
• Public general hospital or convalescent or rehabilitation hospital:		
▪ semi-private room	No	$50 per day
▪ private room	No	Reasonable and customary charges
• Public chronic hospital - semi-private room	No	$3 per day to a maximum of 120 days every 12 months
• Licensed private hospital	Yes	$10 per day to a maximum of 120 days per lifetime
Hearing Care	Yes	one hearing aid per ear every 36 months
Medical Items and Services	Yes	
• Footwear		
▪ custom made boots or shoes		Reasonable and customary charges
▪ custom made foot orthotics		2 pairs per calendar year to a maximum of $400 per pair

Your Plan Covers:	Deductible Applies:	Maximum Plan Pays:
• Bra (mastectomy)		6 per calendar year
• Respiratory/Cardiology		
▪ Mucous suction apparatus, supplies		1 every 48 months
• Optometric eye exams		Once every 24 months
• Compression stockings		6 pairs per calendar year
• Wigs		1 per lifetime
• Other items and services – See the Description of Benefits section for details		Reasonable and customary charges
Emergency Transportation	Yes	Reasonable and customary charges
Private Duty Nursing in the Home	Yes	90 8-hour shifts per calendar year
Professional Services	Yes	
• Chiropractor		$450 every 12 months
• Physiotherapist		$450 every 12 months
• Registered Massage Therapist (Physician (M.D.) recommendation required)		$450 per calendar year
• Psychologist, Psychotherapist or Master of Social Work		$800 combined maximum per calendar year
• Speech Therapist		$200 every 12 months
Accidental Dental	Yes	Reasonable and customary charges
Vision	Yes	
• prescription eyeglasses or contact lenses, or medically necessary contact lenses, or laser eye surgery		$450 per 24 months
Out-of-Province	Yes	
• medical services (including surgical) by a legally qualified physician or surgeon		Reasonable and customary charges

DENTAL BENEFIT PLAN

This schedule describes the deductibles, co-pays and maximums that may be applicable if you are included in the Billing Division shown on the cover of this booklet.

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

Deductible:	Nil

Fee Guide:	The current Ontario Dental Association Fee Guide for General Practitioners

Your Plan Covers:	**Your Co-Pay:**	**Maximum Plan Pays:**
Basic Services and Comprehensive Basic Services	0%	Unlimited
Major Services		
• Crowns, Bridges and Implants	50%	$2,000 per covered person per calendar year
• Dentures	50%	$1,000 per covered person per calendar year
Orthodontic Services	50%	$2,000 per lifetime

HEALTH CARE SPENDING ACCOUNT (applicable to Non-Retired Plan Members only)

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

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

Your Plan Covers:	**Maximum Plan Pays:**
Lump sum per plan member	as determined by your plan sponsor
Benefit Year: January 1 to December 31	

DEFINITIONS

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

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

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

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

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

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

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

Co-pay is the eligible allowed amount that must be paid by you or your dependent before reimbursement of an expense will be made.

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

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

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

Deductible is the amount that must be paid by or on behalf of you and your dependent in any 12 months before reimbursement of an eligible expense will be made.

Dependent means

a) your spouse, if you are legally married or if not legally married, you have lived in a common-law relationship for more than 12 continuous months. Only one spouse will be considered at any time as being covered under the group contract;
b) your unmarried child under age 21;
c) your unmarried child (regardless of age) who became totally disabled while eligible under b) above, and has been continuously so disabled since that time and is considered a dependent as defined under the Income Tax Act, also qualify as a dependent.

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

Note: A legally adopted child cannot be added to the benefit plan until the adoption has been finalized and permanent custody awarded.

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

Emergency means a sudden, unexpected occurrence (disease or injury) that requires immediate medical attention. This includes treatment (non-elective) for immediate relief of severe pain, suffering or disease that cannot be delayed until you or your dependent is medically able to return to your province of residence.

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

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

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

Orthopedic shoes means off-the-shelf, ready-made footwear prescribed for covered persons diagnosed with a specific medical condition that affects their feet and who require specialized footwear to treat their condition and assist with mobility. The footwear may be modified or adjusted to fit the covered person's feet.

Plan member means you, when you are enrolled for coverage.

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

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

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

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

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

ELIGIBILITY

For You
Non-Retired Plan Members
To be eligible for coverage, you must be:

a) a plan member who is a resident of Canada;
b) covered under your provincial health insurance plan;
c) under age 80; and
d) actively at work and working a minimum of 37 1/2 hours per week on a regular basis or on an approved leave of absence as outlined in your Collective Bargaining Agreement.

Retired Plan Members
To be eligible for coverage, you must be:

a) a retired plan member under age 65, who is a resident of Canada; and
b) covered under your provincial health insurance plan.

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

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

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

If you are a Non-Retired Plan Member, you will be eligible for coverage on the first of the month following 3 months of continuous active employment.

If you are a Retired Plan Member, you will be eligible for coverage when you retire from active employment with your plan sponsor, based on the coverage you had at the time of your retirement.

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

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

Late Entrants
If you decline to enroll for coverage on the date you first become eligible for coverage you will only be eligible to enroll on any subsequent anniversary of the benefit contract effective date.

If you have waived eligibility due to having coverage through your spouse's benefit plan, you must request coverage from your plan sponsor within 31 days after termination of the coverage under your spouse's plan. If you do not request coverage from your plan sponsor within 31 days after termination of this coverage, then you will only be eligible to enroll on any subsequent anniversary of the benefit contract effective date.

Termination
Non-Retired Plan Members
Your coverage will end on the earliest of the following dates:

a) the first of the month following the date your employment ends;
b) the date you are no longer actively working, excluding any approved leave of absence as outlined in your Collective Bargaining Agreement;
c) the date you attain age 80;
d) the end of the period for which rates have been paid to GSC for your coverage;
e) the date the group contract terminates.

Retired Plan Members
Your coverage will end on the earliest of the following dates:

a) the first of the month following the date you attain age 65;
b) the end of the period for which rates have been paid to GSC for your coverage;
c) the date the group contract terminates.

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

a) the date your coverage terminates;
b) the date your dependent is no longer an eligible dependent;
c) the end of the month in which your dependent child attains the specified age limit;
d) the end of the period for which rates have been paid for dependent coverage;
e) the date the group contract terminates.

Dependent Children Continuation of Coverage
Any child whose coverage would end because they have reached the specified age limit may qualify for continued coverage, subject to the following conditions:

a) your child became dependent upon you by reason of a mental or physical disability prior to reaching this age; and
b) your child has been continuously so disabled since that time.

Losing your Group Benefits?
If your coverage terminates under your Plan Sponsor's benefit plan, you may apply for one of GSC's individual Health and Dental Link plans. Acceptance for these plans is guaranteed as long as GSC receives your application and the initial payment within 90 days of your employee benefits termination date. There are no health questions and no medical when you apply. These plans offer coverage for medications that treat pre-existing conditions. Best of all, they provide lifetime coverage. Please contact Selectpath at 1.888.327.5777 where an authorized representative can review the options available to you and advise you on the coverage that best suits your needs.

DESCRIPTION OF BENEFITS

HEALTH BENEFIT PLAN

The benefits shown below will be eligible, up to the amount shown in the Schedule of Benefits, if they are reasonable and customary, and are medically necessary for the treatment of an illness or injury.

Prescription Drugs

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

a) are prescribed by a legally qualified medical practitioner or dental practitioner as permitted by law; and
b) legally require a prescription and has a Drug Identification Number (DIN); or
c) are approved under GSC's drug review process; and
d) are paid on a Pay Direct basis.

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

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

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

Certain drugs require prior authorization from GSC before your drug claim can be reimbursed. Further, certain drugs defined by GSC as specialty drugs may be required to be purchased from an approved pharmacy that is a member of GSC's Specialty Care Program before your claim can be reimbursed. You can find out if your drug requires prior authorization or is covered under GSC's Specialty Care Program either by using the online drug search tool available to you through the member portal or by contacting GSC's Customer Service Centre.

In no event will the amount dispensed exceed a 3-month supply (6 months if a vacation supply is required) of a prescription at any one time and not more than a 13-month supply in any 12 consecutive months.

Mandatory generic drug substitution

Reimbursement for prescribed drugs covered by the plan will be based on the cost of the lowest priced therapeutically equivalent drug, unless there is a documented adverse reaction to the drug.

NOTE:

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

Quebec residents only: Legislation requires GSC to follow the RAMQ (The Regie de l'assurance maladie du Quebec) reimbursement guidelines for all residents of Quebec. If you are younger than age 65, you must enroll for the GSC Prescription Drugs benefit plan and GSC will be the only payer. If you are age 65 or older, enrollment in RAMQ is automatic, enrollment in the GSC Prescription Drugs benefit plan is optional, and RAMQ would be first payer.

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

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

a) Smoking cessation products and drugs for the treatment of erectile dysfunction and infertility;
b) Reference biologic drugs that have an approved biosimilar;
c) Products which may lawfully be sold or offered for sale other than through retail pharmacies, and which are not normally considered by practitioners as medicines for which a prescription is necessary or required unless specifically identified and included as eligible in "Prescription Drugs";
d) Ingredients or products which have not been approved by Health Canada for the treatment of a medical condition or disease and are deemed to be experimental in nature and/or may be in the testing stage;
e) Mixtures, compounded by a pharmacist, that do not conform to GSC's current Compound Policy.

Extended Health Services

1. **Hospital Accommodation:** Reimbursement, as shown in the Schedule of Benefits, of reasonable and customary charges in the area where received, for accommodation in a:
   - public general hospital, or a convalescent or rehabilitation hospital or a convalescent or rehabilitation wing in a public general hospital, or a public chronic hospital or chronic care in a public general hospital, provided your provincial health insurance plan has accepted or agreed to pay the ward or standard rate
   - licensed private hospital, not provincially funded

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

3. **Medical Items and Services:** Reimbursement for reasonable and customary charges, up to the amount, where applicable, as shown in the Schedule of Benefits for:
   a) Aids for daily living: such as hospital style beds, including rails and mattresses; decubitus (bedridden) supplies;
   b) Footwear:
      i) custom made foot orthotics (when prescribed by your attending physician, podiatrist or chiropodist);
      ii) custom made boots or shoes, modifications and repairs to orthopedic shoes, or footwear as an integral part of a brace, (subject to a medical pre-authorization);
   c) Braces, trusses, casts;
   d) Diabetic equipment and supplies, such as:
      i) blood glucose meters, lancets, insulin infusion pump supplies;
      ii) glucose monitoring systems (GMS) such as continuous and flash type monitors including sensors and transmitters;
   e) Medical services, such as diagnostic tests, X-rays and laboratory tests;
   f) Incontinence/Ostomy, such as catheter supplies, ostomy supplies;
   g) Mobility aids, such as canes, crutches, walkers and wheelchairs (excluding wheelchair batteries);

h) Prosthetics, such as arm (including a myo-electric arm up to the cost of a standard prosthetic arm), hand, leg, foot, breast, eye and larynx. A sports prosthesis will be paid to the cost of a standard prosthesis. For each type of prosthesis, a sports or standard prosthesis will be allowed, not both;
i) Optometric eye examinations for visual acuity performed by a licensed optometrist, ophthalmologist or physician (available only in those provinces where eye examinations are not covered by the provincial health insurance plan);
j) Respiratory/Cardiology equipment, such as compressors, inhalant devices, tracheotomy supplies and oxygen;
k) Compression stockings with a pressure measurement of 15 mmhg or higher;
l) Wigs, for temporary or permanent hair loss as a result of a medical condition due to chemotherapy or radiation.

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

Limitations

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

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

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

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

5. **Private Duty Nursing in the Home:** Reimbursement for the services of a Registered Nurse (R.N.) in the home on a visit or shift basis, up to the amount shown in the Schedule of Benefits. No amount will be paid for services which are custodial and/or services which do not require the skill level of a Registered Nurse (R.N.).

   A Pre-Authorization Form for Private Duty Nursing must be completed by the attending physician and submitted to GSC monthly in the event services are required for more than 30 days.

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

7. **Accidental Dental:** Reimbursement for the services of a licensed dental practitioner for dental care when necessitated by a direct blow to the mouth and not by an object wittingly or unwittingly placed in the mouth. The accident must occur while the coverage is in force. When natural teeth have been damaged eligible services are limited to one set of artificial teeth. You must notify GSC immediately following the accident and the treatment must commence within 90 days of the accident.

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

   If your dependent child is 17 years of age and under at the time of the accident, treatment must be completed prior to their 19th birthday.

   No amount will be paid for periodontia or orthodontia treatments or the repair or replacement of artificial teeth.

   Charges will be based on the current Provincial Dental Association Fee Guide for General Practitioners in the province where services are rendered. Approval will be based on the current status and/or benefit level of the covered person at the time that we are notified of the accident. Any change in coverage will alter GSC's liability.

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

8. **Vision:** Reimbursement for the services performed by a licensed Optometrist, Optician or Ophthalmologist, up to the amounts shown in the Schedule of Benefits, for:
   a) Prescription eyeglasses or contact lenses.
   b) Medically necessary contact lenses when visual acuity cannot otherwise be corrected to at least 20/40 in the better eye or when medically necessary due to keratoconus, irregular astigmatism, irregular corneal curvature or physical deformity resulting in an inability to wear normal frames.
   c) Replacement parts for prescription eyeglasses.
   d) Laser eye surgery.

   Eligible benefits do not include and no amount will be paid for:
   a) Prescription industrial safety eyeglasses;
   b) Medical or surgical treatment, unless specifically identified and included as eligible in "Vision" above;
   c) Special or unusual procedures such as, but not limited to visual training (unless specifically identified and included as eligible in "Vision"), orthoptics, subnormal vision aids and aniseikonic lenses;
   d) Follow-up visits associated with the dispensing and fitting of contact lenses;
   e) Charges for eyeglass cases.

9. **Out-of-Province:** Professional services of a legally qualified physician or surgeon while you are travelling or temporarily residing outside your province of residence when the fees are over the medical association fee guide and are not greater than what would be paid in your province of residence if it were legal to provide such benefits.

Health Exclusions

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

1. Services or supplies received as a result of disease, illness or injury due to:
   a) an act of war, declared or undeclared;
   b) participation in a riot or civil commotion; or
   c) attempting to commit or committing a criminal offence or illegal act;

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

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

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

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

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

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

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

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

DENTAL BENEFIT PLAN

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

Basic Services

1. Basic Diagnostic and Preventive Services:
   - complete oral examinations once every 3 years
   - emergency and specific oral examinations
   - full series X-rays and panoramic X-rays once every 3 years
   - bitewing X-rays once every 9 months
   - recall examinations once every 9 months
   - cleaning of teeth (up to 1 unit of polishing plus up to 1 unit of scaling) once per recall period
   - topical application of fluoride once per recall period
   - consultation 2 time units every 12 months
   - oral hygiene instruction once per recall period
   - denture cleaning once per recall period
   - space maintainers

2. Basic Restorative Services:
   - amalgam, tooth coloured filling restorations and temporary sedative fillings
   - inlay restorations – these are considered basic restorations and will be paid to the equivalent non-bonded amalgam

3. Basic oral surgery:
   - extractions of teeth and/or residual roots

4. Anaesthesia and intravenous sedation in conjunction with eligible oral surgery only

5. Standard denture services:
   - denture repairs and/or tooth/teeth additions
   - standard relining and rebasing of dentures
   - denture adjustments and remount and equilibration procedures, only after 3 months have elapsed from the installation of an initial or replacement denture
   - soft tissue conditioning linings for the gums to promote healing
   - remake of a partial denture using existing framework

6. Comprehensive oral surgery:
   - surgical exposure, repositioning, transplantation or enucleation of teeth
   - remodeling and recontouring - shaping or restructuring of bone or gum
   - excision - removal of cysts and tumors
   - incision - drainage and/or exploration of soft or hard tissue
   - fractures including the treatment of the dislocation and/or fracture of the lower or upper jaw and repair of soft tissue lacerations
   - maxillofacial deformities - frenectomy - surgery on the fold of the tissue connecting the lip to the gum or the tongue to the floor of the mouth

Comprehensive Basic Services

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

2. Periodontal treatment of diseased bone and gums including:
   - periodontal scaling and/or root planing
   - occlusal equilibration - selective grinding of tooth surfaces to adjust a bite 8 time units every 12 months

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

   - bruxism appliance

Major Services

1. Standard onlays or crown restorations to restore diseased or accidentally injured natural teeth, once every 5 years. Post and cores, amalgam core build up for a crown and composite core build up for a crown once per tooth every 5 years

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

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

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

5. Implants for covered persons aged 16 and over, limited to once per tooth per lifetime, however, implants are not eligible to replace missing or extracted wisdom teeth

Orthodontic Services

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

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

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

Alternate Benefit Clause

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

Predetermination

Before your treatment begins, your dental practitioner must submit an estimate, including supporting materials, such as digital photos and X-rays, for any proposed treatment for which the total cost is expected to exceed $500. Our assessment of the proposed treatment may result in a lesser benefit being payable or in benefits being denied.

Failure to submit an estimate before treatment begins will delay the assessment of your claim.

Limitations

1. Laboratory services must be completed in conjunction with other services and will be limited to the co-pay of such services. Laboratory services that are in excess of 40% of the dentist's fee in the current General Practitioners Fee Guide will be reduced accordingly; co-pay is then applied;

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

3. When more than one surgical procedure is performed during the same appointment in the same area of the mouth, only the most comprehensive procedure will be eligible for reimbursement;

4. Reimbursement will be pro-rated and reduced accordingly, when time spent by the dentist is less than the average time assigned to a dental service procedure code in the General Practitioners Fee Guide;

5. Reimbursement for root canal therapy will be limited to payment once only per tooth. The total fee for root canal includes all pulpotomies and pulpectomies performed on the same tooth;

6. 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;

7. Where multiple services are performed at one appointment and the full fee guide price is charged for each service, the first service will be paid in full and all remaining services will be reduced by 20%;

8. Core build-ups are eligible only for the purpose of retention and preservation of a tooth when performed with crown treatment. Necessity must be evident on mounted pre-treatment X-rays. Core build-ups to facilitate impression taking and/or block out undercuts are considered included in the cost of a crown;

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

10. In the event of a dental accident, claims should be submitted under the health benefits plan before submitting them under the dental plan.

Dental Exclusions

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

1. Services or supplies received as a result of disease, illness or injury due to:
   a) an act of war, declared or undeclared;
   b) participation in a riot or civil commotion; or
   c) attempting to commit or committing a criminal offence or illegal act;

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

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

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

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

6. Any dental 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;

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

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

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

10. Service and charges for sleep dentistry;

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

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

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

HEALTH CARE SPENDING ACCOUNT (HCSA)
(applicable to Non-Retired Plan Members only)

Your HCSA is governed at all times by the rules and regulations of the Income Tax Act. In the event of a dispute the Income Tax Act shall prevail. The liability for the HCSA lies solely with your plan sponsor.

Your HCSA is provided by your plan sponsor and administered by GSC.

Your HCSA is a spending account funded by your plan sponsor that you can use to pay for health and dental expenses that are not covered by your group benefit plan or your provincial health plan.

At the beginning of each benefit year, a predetermined lump sum amount as shown in the Summary of Benefits will be allocated to your account annually to cover the reimbursement of your eligible expenses incurred during that benefit year. When you submit a claim, you will be reimbursed for eligible expenses up to the balance in your account.

Any balance remaining in your account on the last day of the benefit year will be carried forward to, but not beyond the end of, the next benefit year. This balance will be added to your new credits, and claims for the new benefit year will be applied to the combined amount, using the previous benefit year credits first. At the end of the new benefit year, any remaining previous benefit year credits will be forfeited.

ELIGIBLE EXPENSES

Eligible expenses include but are not limited to those that qualify for medical expense tax credits under the Canada Revenue Agency (CRA) Income Tax guidelines. It also includes the amount of the deductible and the percentage not covered by the group benefit plan or the amount in excess of group benefit plan maximums.

For a list of eligible medical expenses, visit our website at greenshield.ca, or for more information about eligible expenses you can consult a CRA office or visit the CRA website.

Exclusions

Expenses not eligible for reimbursement are at all times governed by the non-eligible expenses, restrictions and limitations outlined in the Canadian Income Tax Act. An example of expenses would be:

a) premiums paid to provincial medical or hospitalization plans; and
b) medical costs for which you or your dependent are reimbursed or entitled to be reimbursed under a provincial health insurance plan, your group benefit plan or your spouse's group benefit plan.

Maternity, Adoption or Parental Leave

If you elect to continue benefits under your group plan, you may continue to submit claims for expenses incurred prior to, or during, the period of your leave.

CLAIM INFORMATION

Inquiries

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

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

Pre-authorization

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

Submitting Claims

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

Original itemized paid receipts are required for claims reimbursement **(cash receipts or credit card receipts alone are not acceptable as proof of payment)**.

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

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

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

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

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

Out-of-Province claims must be submitted to your provincial government health plan first. To claim the eligible remaining portion after payment has been made by your provincial government health plan, submit to Mondial the patient name, address and patient number along with:

- Detailed statements showing the services rendered and the fees charged for each service.
- Copies of the allowance and payment made under the provincial government health plan.

Your HCSA does not have automatic coordination with your health and dental benefits. If you would like to enable this functionality, you may do so through the plan member portal (the GSC Customer Service Centre is unable to arrange set up of this function).

Auto-Coordination with HCSA
Once you have accessed the plan member portal and have set up your HCSA auto-coordination, your health and dental claims will automatically be coordinated with your HCSA. You must pay the provider of service the HCSA portion of the claim and you will be automatically reimbursed from your HCSA without having to submit a paper claim. The claim **will not** be re-directed to a secondary plan (COB) before paying out of the HCSA.

Manual Coordination with HCSA
If you choose **not** to have all your traditional health and dental claims automatically coordinated with your HCSA, you must pay the provider of service the HCSA portion of the claim, then complete a HCSA Claim Submission Form and attach proof of payment. You can indicate on this claim form if you want your eligible expenses paid from your GSC health and/or dental plan first, and any unpaid portion of your eligible expenses paid from your HCSA.

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

All HCSA claims must be received by GSC no later than 90 days after the end of the benefit year, or, no later than 90 days after your termination date, your retirement date, your date of death or your leave of absence date (other than a Maternity, Adoption or Parental Leave).

Submit all Claim Forms (other than Out-of-Province) to:
Green Shield Canada

Attn: Drug Department	PO Box 1652	Windsor, ON	N9A 7G5
Attn: Medical Items	PO Box 1623	Windsor, ON	N9A 7B3
Attn: Professional Services	PO Box 1699	Windsor, ON	N9A 7G6
Attn: Hospital/Vision Department	PO Box 1615	Windsor, ON	N9A 7J3
Attn: Dental Department	PO Box 1608	Windsor, ON	N9A 7G1

Reimbursement
Reimbursement will be made by one of the following methods:
a) Direct deposit to your personal bank account, when requested;
b) A reimbursement cheque; or
c) Direct payment to the provider of services, where applicable.

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

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

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

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

Direct Payment to the Provider of Service (where applicable)

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

Subrogation

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

Co-ordination of Benefits (COB)

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

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

GSC Plan Member

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

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

Spouse

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

Children

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

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

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

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

Access to Information

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

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

GSC may charge you to provide any additional copies.