My BENEFIT PLAN

Laurentian Graduate Students' Association

Billing Division: 32024, 32025

Revised Effective Date: September 1, 2018

gsc green shield canada

WELCOME TO YOUR BENEFIT PLAN

ABOUT THIS BOOKLET

This booklet provides a summary of your benefits under your benefit plan. 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 benefits 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.

Your Identification Card can be found on the Student Centre website at student.greenshield.ca. Your GSC Identification Number is to be used on all claims and correspondence. Your unique GSC Identification Number is your student identification number with the prefix "LES" and ends with -00 – e.g. LES111222333-00. If you have any eligible dependents, they share the same number as you except their number ends with their own unique dependent code.

YOUR BENEFIT PROVIDERS ARE:

Green Shield Canada (GSC)

- Prescription Drugs, Health and Dental Benefit Plans

Western Life Assurance Company (Western Life)

- Accidental Death and Dismemberment Benefit Plan

THE GSC STUDENT CENTRE

The "Student Centre" is accessed from the GSC website at student.greenshield.ca. This website provides quick and easy access to the information you are looking for, such as:

- Reading and/or downloading your Benefit Plan Booklet
- Locating dental providers in your area who are members of the Student Dental Discount Network (if you have GSC Dental Benefits)
- Locating discount vision and hearing care providers in your area (regardless of whether you have GSC Vision Benefits or not)
- Locating an Rxnet network pharmacy in your area offering discounts on your portion of prescription drug costs

PLAN MEMBER ONLINE SERVICES

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

- View your Benefit Plan Booklet
- Access your personal claims information, including a breakdown of how your claims were processed
- Simulate a claim to instantly find out what portion of a claim will be covered
- Submit claims online
- Arrange for claim payments to be deposited directly into your bank account
- Print personalized claim forms and replacement Identification Cards
- Print personal Explanation of Benefits statements for when you need to co-ordinate benefits
- Search for a drug to get information specific to your own coverage (or coverage for your family)
- Search for eligible dental, paramedical, and vision care providers in a particular location (within Canada)
- Search for vision and hearing care providers who offer discounts to GSC plan members through our Preferred Provider Network

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.

TABLE OF CONTENTS

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.

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

Deductible: Nil	**Overall Maximum:** Unlimited

Your Plan Covers:	**Your Co-Pay:**	**Maximum Plan Pays:**
Prescription Drugs – Pay Direct Drug Card	10% per prescription or refill	$1,000 per benefit year
HPV Vaccines: ▪ Gardasil Vaccine eligible for females from age 14 to 26 and males from age 9 to 26 only ▪ Cervarix Vaccine		Reasonable and customary charges (included in the $1,000 per benefit year Prescription Drugs Maximum)
Emergency Transportation	20%	$250 per benefit year
Professional Services	20%	$20 per visit up to $300 per benefit year for all practitioners combined
• Acupuncturist		
• Chiropractor		
• Registered Massage Therapist (Physician (M.D.) or nurse practitioner recommendation required)		
• Naturopath		
• Physiotherapist		
• Speech Therapist		
• Dietitian		
• Psychologist		
Accidental Dental	20%	$1,000 per benefit year

Your Plan Covers:	Your Co-Pay:	Maximum Plan Pays:
Vision • prescription eye glasses or contact lenses, or medically necessary contact lenses	0%	$100 every 24 consecutive months based on date of first paid claim
• optometric eye exams	20%	$50 every 2 years based on date of first paid claim

For a full description of the Health Benefit, refer to the Benefit Description section.

This plan does not include travel benefits. Looking to plan a trip and need emergency medical coverage? Visit the Student Centre website at student.greenshield.ca for details.

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 Provincial Dental Association Fee Guide for General Practitioners in the province where services are rendered For independent Dental Hygienists, the lesser of, the current Provincial Dental Hygienists' Association Fee Guide and Provincial Dental Association Fee Guide for General Practitioners in the province where services are rendered

Your Plan Covers:	**Your Co-Pay:**	**Maximum Plan Pays:**
Basic Services	10%	$500 per covered person per benefit year (Basic, Comprehensive Basic and Major Services combined)
Basic Restorative Services, Basic Oral Surgery and Comprehensive Oral Surgery	25%	
Comprehensive Basic Services	90%	
Major Services	90%	

For a full description of the Dental Benefit, refer to the Benefit Description section.

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 means the 12 consecutive months September 1st to August 31st. of each year.

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 his or her enrolled dependents.

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

Dependent means

a) your spouse, if you are legally married or if not legally married, you have lived in a common-law relationship for 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 under age 25, if enrolled and in full-time attendance at an accredited college, university or educational institute;
d) your unmarried child (regardless of age) who became totally disabled while eligible under b) or c) above, and has been continuously so disabled since that time and is considered a dependent as defined under the Income Tax Act, also qualify as a dependent.

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

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

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

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

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

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

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

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

ELIGIBILITY

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

a) a resident of Canada;
b) covered under your provincial health insurance plan;
c) a member or staff member of the student association shown on the cover of this booklet.

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

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

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

Your 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.

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

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

a) the date you are no longer a member or staff member of the student association shown on the cover of this booklet;
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 calendar year 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.

Group Conversion – GSC Health Assist LINK Program

The GSC Health Assist LINK program offers guaranteed coverage (no medical questionnaire) for you and your family for day-to-day medical, dental and travel expenses, as well as unforeseen health expenses.

This program may be your solution if you, your spouse or your dependent children are losing or have lost group health and/or dental benefits within the last 90 days and are looking for coverage.

Click **here** to apply, or contact Prosum Health Benefits Inc. at 1.855.751.6590 for assistance.

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); and
c) are paid on a Pay Direct basis.

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

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

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.

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

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: The Student is responsible for complying with RAMQ rules, your student drug plan does not replace the RAMQ (The Regie de l'assurance maladie du Quebec) provincial plan, **you are required to enrol for RAMQ.** The Student Health and Dental plan pays only to the stated maximums noted in this booklet.

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

a) Drugs for the treatment of obesity, erectile dysfunction and infertility;
b) Vitamins that do not legally require a prescription;
c) Smoking cessation drugs and Nicotine replacement products, such as patches, gum, lozenges, and inhalers;
d) 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;
e) 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;
f) Mixtures, compounded by a pharmacist, that do not conform to GSC's current Compound Policy.

Extended Health Services

1. **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.

2. **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.

3. **Accidental Dental:** Reimbursement for the services of a licensed dental practitioner for dental care to natural teeth when necessitated by a direct blow to the mouth and not by an object wittingly or unwittingly placed in the mouth. The accident must occur while the coverage is in force. When natural teeth have been damaged eligible services are limited to one set of artificial teeth. You must notify GSC immediately following the accident and the treatment must commence within 180 days of the accident.

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

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

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

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

4. **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) 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).
   d) Replacement parts for prescription eyeglasses.
   e) Plano sunglasses prescribed by a legally qualified medical practitioner for the treatment of specific ophthalmic diseases or conditions.

   Eligible benefits do not include and no amount will be paid for:
   a) Medical or surgical treatment;
   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.

Health Exclusions

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

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

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

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

4. The completion of any claim forms and/or insurance reports;

5. Any form of medical cannabis for the treatment of any medical condition, regardless of whether it is authorized by way of a medical document from a legally-authorized medical practitioner and obtained from a Health Canada-licensed producer pursuant to the *Access to Cannabis for Medical Purposes Regulations*;

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

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

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

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 based on date of first paid claim
   - emergency and specific oral examinations
   - full series X-rays and panoramic X-rays once every 3 years based on date of first paid claim
   - bitewing X-rays once per benefit year
   - recall examinations once per benefit year
   - cleaning of teeth (up to 1 unit of polishing plus up to 1 unit of scaling) once per recall period
   - denture cleaning once per recall period
   - pit and fissure sealants on molars only, for covered persons 14 years of age and under
   - space maintainers
   - mouth guards once every 12 months based on date of first paid claim

2. Basic Restorative Services:
   - amalgam, tooth coloured filling restorations (paid to full metal on molars), 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. General anaesthesia, deep sedation, and intravenous sedation in conjunction with eligible oral surgery only

Comprehensive Basic Services

1. Standard denture services:
   - denture repairs and/or tooth/teeth additions
   - standard relining and rebasing of dentures, once every 3 years based on date of first paid claim, only after 6 months have elapsed from the installation of a denture
   - denture adjustments and remount and equilibration procedures, only after 3 months have elapsed from the installation of a denture
   - soft tissue conditioning linings for the gums to promote healing
   - remake of a partial denture using existing framework, once every 5 years

2. 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
   - maxilofacial deformities - frenectomy - surgery on the fold of the tissue connecting the lip to the gum or the tongue to the floor of the mouth

3. 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

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

   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 once every 12 months based on date of first paid claim

Major Services

1. Standard onlays or crown restorations to restore diseased or accidentally injured natural teeth, once every 5 years based on date of first paid claim

2. Standard bridges, including pontics, abutment retainers/crowns on natural teeth, once every 5 years based on date of first paid claim

3. Standard dentures including complete, immediate, transitional, and partial dentures, once every 5 years based on date of first paid claim

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

Alternate Treatment

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

Predetermination

Before your treatment begins:

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

Limitations

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

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

3. Reimbursement will be pro-rated and reduced accordingly, when time spent by the dentist is less than the average time assigned to a dental service procedure code in the applicable Fee Guide shown in the Schedule of Benefits;

4. Reimbursement for root canal therapy will be limited to payment once only per tooth. Extra charges for difficult access, exception anatomy, calcified canals and retreatments are not included. The total fee for root canal includes all pulpotomies and pulpectomies performed on the same tooth;

5. Common surfaces on the same tooth/same day will be assessed as one surface. If individual surfaces are restored on the same tooth/same day, payment will be assessed according to the procedure code representing the combined surface. Payment will be limited to a maximum of 5 surfaces in any 36 month period;

6. When more than one surgical procedure, including multiple periodontal surgical procedures, is performed during the same appointment in the same area of the mouth, only the most comprehensive procedure will be eligible for reimbursement, as the fee for each procedure is based on complete, comprehensive treatment, and is deemed part of the multiple services factor;

7. The multiple services factor occurs when a minimum of 6 or more restorations (fillings) or multiple periodontal services are performed at the same appointment and the full fee guide price is charged for each restoration or periodontal service, the first service will be paid in full and all remaining services will be reduced by 20%;

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

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

10. In the event of a dental accident, claims should be submitted under the health 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) committing a criminal offence;

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

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

4. The completion of any claim forms and/or insurance reports;

5. Any dental service that is not contained in the procedure codes developed and maintained by the Canadian Dental Association, adopted by the provincial or territorial dental association of the province or territory in which the service is provided (or your province of residence if any dental service is provided outside Canada) and in effect at the time the service is provided;

6. Implants;

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

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

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

10. Service and charges for sleep dentistry;

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

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

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

CLAIM INFORMATION

Inquiries

For detailed inquiries:

- 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 student.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

All claims submitted to GSC require your GSC Identification number. Your GSC Identification Number is your student number with the prefix "**LES**" – e.g. **LES111222333**.

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 certain claims, we may require additional confirmation of payment so we recommend you keep a copy of some other identifiable confirmation of payment, such as a cancelled cheque (copy is acceptable if both sides of the cheque are provided), an authorized electronic credit card receipt and/or statement, direct payment /debit receipt or bank statements.

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.

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.

Submit all Claim Forms to:
Green Shield Canada

Attn: Drug Department	PO Box 1652	Windsor, ON	N9A 7G5
Attn: Professional Services	PO Box 1699	Windsor, ON	N9A 7G6
Attn: 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 dollar maximums and limitations stated are expressed in Canadian dollars. Reimbursement will be made in Canadian funds for both providers and plan members.

Direct Payment to the Provider of Service (where applicable)

Provide your GSC Identification number 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.

DENTAL DISCOUNT NETWORK ARRANGEMENT

In partnership with the National Student Health Network, GSC provides access to the Student Dental Discount Network. The intent of this network is to provide our student plan members access to high quality dental services at an affordable cost.

Features of this great value-added service and how it works:

1. This national program includes more than 800 dental provider locations from coast to coast.
2. Once a dental provider elects to participate in the network, they are added to a list of GSC's participating dental providers. This list is available at student.greenshield.ca.
3. You may visit a dentist from the list of participating dental providers, or you may ask your existing dentist to join this network; the advantage to your dentist of joining the network is the potential of an increase in business. Your dentist can call our Customer Service Centre at 1.888.711.1119 for more information.
4. The discount offer applies to most dental procedures and *may* be up to 30%.
5. Our system will automatically calculate the applicable discount when you visit a dental provider in this network. The applicable discount is dependent on your particular college or university's plan design, and will be subtracted from your co-pay, or share of the cost.
6. Eligible dental claims must be processed electronically; therefore, **you must first be enrolled on GSC's system in order to be eligible for the discount**. GSC will pay your dentist directly; you only have to pay the dentist your share of the cost (if any) for services provided.
7. You will receive professional dental services while incurring lower out-of-pocket expenses and maintain ongoing oral health.

Visit student.greenshield.ca or call the Customer Service Centre at 1.888.711.1119 for more information.

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 payor 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

This GSC student plan is always your primary plan. 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.

DISCLAIMER

The Accidental Death & Dismemberment Insurance benefits are provided by Western Life Assurance Company (Western Life). Accidental Death & Dismemberment Insurance is not a benefit if you opt out of the Health Benefits Plan.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT PLAN

BASIC ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

Policy GRE1001

Western Life Assurance Company (Western Life)

When are you Covered?

The Basic Accidental Death and Dismemberment plan covers you 24 hours a day, anywhere in the world, for specified accidental losses. If you suffer any of the eligible losses listed in the policy as the result of an injury caused by an Accident, and the loss occurs within 365 days of the date of the Accident, the benefits indicated in the policy will be paid.

The injury caused by the Accident must be the basis of claim but in no event shall Injury mean Sickness or Disease howsoever caused unless caused by an Accident.

"Accident" means a single sudden and unexpected event, which:
a) occurs at an identifiable time and place;
b) causes unexpected bodily Injury at the time it occurs; and
c) arises from an external source to the Insured Person.

Aircraft Coverage

Insurance includes Injury sustained by you while and in consequence of:

a) riding as a passenger, in or on any aircraft operated on a regular, special or chartered flight by a domestic or international scheduled air carrier, licensed by the Department of Transport of Canada or the governmental authority having jurisdiction over such air carrier in the country of its registry; or

b) riding as a passenger, in or on any aircraft operated by the Canadian Armed Forces or by a similar military service of any duly constituted governmental authority of any other recognized country; or

c) boarding or alighting from or being struck by any aircraft.

Notwithstanding (a) and (b) above, this policy excludes Injury sustained while and in consequence of:

a) riding as a pilot, operator or member of the crew in or on any aircraft; or

b) riding as a passenger, in or on any aircraft owned, operated, or leased by or on behalf of the Policyholder.

Who is Covered?

All active full-time & part-time students, under the age of 70, whose names are on file with the Health Plan Administrator provided the student is actively carrying out their curriculum.

If a student is not actively carrying out their curriculum on the date they become eligible coverage will be delayed until they begin their studies. Coverage also terminates when a student ceases to carry out their curriculum on account of leave of absence, disability, abandoned course of study or is expelled.

SCHEDULE OF BENEFITS

Benefit amounts for each eligible student are shown below. The amount specified shall apply to each student per accident, subject to all terms of the policy.

Accidental Death & Dismemberment Benefit – Benefit Amount: $10,000

Brain Death Indemnity: $10,000

Cosmetic Disfigurement Benefit: $10,000

Additional Benefits	**Maximum Amount**
Repatriation Benefit	$15,000
Rehabilitation Benefit	$15,000
Family Transportation Benefit	$15,000
Occupational Training Benefit (Spouse):	$15,000
Home Alteration & Vehicle Modification Benefit:	$10,000
Education Benefit	$5,000
Day Care Benefit:	$5,000
Seat Belt Benefit:	10% of Principal Sum
Hospital Indemnity (per month)	$2,500
Accidental Dental Expense	$1,000
Accidental Reimbursement Expense	$10,000
Identification	$15,000
Bereavement	$5,000
Funeral Expense	$2,500

SCHEDULE OF LOSSES

Accidental Death and Dismemberment

If you suffer an injury that results in one of the following losses, within one year from the date of the accident, Western Life will pay a percentage as shown below of the Accidental Death and Dismemberment Benefit Amount indicated in the **Schedule of Benefits,** however, not more than one (the largest) shall be paid with respect to all injuries resulting from one accident.**For Loss of:**	**% of Benefit Amount**
Life	100%
Entire Sight of Both Eyes	300%
Speech and Hearing in Both Ears	300%
One Hand and the Entire Sight of One Eye	300%
One Foot And the Entire Sight of One Eye	300%
Entire Sight of One Eye	210%
Speech	150%
Hearing in Both Ears	300%
Hearing in One Ear	150%
All Toes on Same Foot	25%
One Finger	10%
Four Fingers on Same Hand	33.33%

For Loss or Loss of Use of:	**% of Benefit Amount**
Both Hands	300%

Both Feet	300%
Both Arms	300%
Both Legs	300%
One Hand and One Foot	300%
One Arm	225%
One Leg	225%
One Hand	210%
One Foot	210%
Thumb and Index Finger on Same Hand	50%

For Paralysis of:	**% of Benefit Amount**
Both Upper and Lower Limbs (Quadriplegia)	300%
Both Lower Limbs (Paraplegia)	300%
Upper and Lower Limbs of One Side of Body (Hemiplegia)	300%

When Will Benefits Not Be Paid?

This policy does not cover any Loss, fatal or non-fatal, caused or contributed to by:

a) suicide or intentionally self-inflicted Injury while sane or insane;

b) war or civil war, whether declared or undeclared

c) active full-time, part-time or temporary service in the armed forces of any country;

d) riding as a passenger or otherwise in any vehicle or device for aerial navigation, other than as provided in Aircraft Coverage;

e) medical treatment or Surgery, except if the medical treatment or Surgery was needed because of an Accident.

Beneficiary Designation

The policy contains a provision removing or restricting the right of the group person insured (the student) to designate persons to whom benefit insurance money is to be payable.

a) On your Effective Date under this plan your beneficiary is the executors or administrators of your estate or your heirs, unless you forward a written declaration to the Administrator designating a beneficiary. Any designation or change in beneficiary shall be effective on the date your written declaration is received at the office of the Administrator.

b) you will be considered the beneficiary for all other indemnities payable.

c) If, at your death, there is no designated beneficiary, benefit payments shall be made to the executors or administrators of your estate, or your heirs.

d) If more than one (1) beneficiary is designated with no indication of their respective interests, they shall share equally in the benefit payments.

e) The rights of a beneficiary who predeceases you shall revert to yourself

Reserving Rights

As a condition precedent to recovery of insurance money under this contract the Insurer reserves the right to:

a) examine the full details regarding the claim;

b) require the Insured Person to undergo a medical examination at the Insurer's expense;

c) examine the Insured Person when and so often as it reasonably required while the claim hereunder is pending;

d) require an autopsy to be performed on the Insured Person in the event of death, unless prohibited by law or religious belief;

e) disallow the claim based on information developed from the attending Physician's report, medical examination, payroll records, or other sources of pertinent data.

Fraudulent Claims

Any claim for benefits under the policy which is based on false or incorrect information on an application, claim form or other documents required to verify benefits will result in the benefits being denied or the liability assumed by the Beneficiary if the benefit has already been provided or performed.

Limitation of Action

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 (*Alberta and B.C.).

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* (Manitoba).

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 *Limitations Act, 2002* (Ontario).

Otherwise, in Quebec every action must be brought within three (3) years after the date evidence is furnished, and in all other provinces within one (1) year from the date of loss or such longer period as may be required under the law applicable in such province.

Subrogation

The Insurer is subrogated in all the rights of Insured Persons against the third party liable for the damage that has given rise to an entitlement to payment of benefits under this policy up to the limitation of amounts paid by the Insurer.

The Insurer may, in the exercise of its right of subrogation and if it deems that a third party is liable, require that the Insured Person sign, if applicable, an act of subrogation in its favor at the time of paying any benefits.

Insured Right of Access

As required by your provincial legislation, or if you reside in Alberta or B.C., the Insured Person and any claimant may request a copy of the Insured Person's application, any written evidence of insurability and the Group Policy (other than confidential commercial information or other information exempted from disclosure by applicable law).

For further plan information please contact your plan administrator.

HOW TO CLAIM

In the event of a claim, contact your Health Plan Administrator.

Notice of claim must be given to the Insurer within 30 days from the date of the accident, and subsequent proof of claim must be submitted to the insurer within 90 days from the date of the accident.

Failure to give notice of claim or furnish proof of claim within the time prescribed in the policy condition will not invalidate the claim if the notice or proof is given or furnished as soon as reasonably possible and if it is shown that it was not reasonably possible to give notice or furnish proof within the time so prescribed. In no event, will the insurer accept notice of claim beyond one (1) year.

This summary of coverage has been prepared in connection with a group plan underwritten by Western Life Assurance Company. For ease of reference it contains only a brief description and does not mention every provision of the contract issued. Please remember that rights and obligations are determined in accordance with the contract and not this summary of information. For the exact provisions applicable, please consult your Health Plan Administrator.