PRISM® INDIVIDUAL HEALTH AND DENTAL BENEFIT PLANS

Coverage provided by Green Shield Canada

This is your policy.
Please read it carefully and keep it in a safe place.

In this policy, “you” and “your” refer to the owner of this policy. “We”, “us”, “our” and “GSC” refer to Green Shield Canada. Special Benefits Insurance Services Agency Inc. (SBIS): is the exclusive Managing General Agent (MGA) for the Prism Health and Dental Benefit Programs for Individuals. SBIS markets and administers the Prism plans while billings, claims and the underwriting risks are managed by GSC.

Your contract is with GSC and includes this policy and the documents you received in your Welcome package. Your contract also includes any amendment or counter-offer agreed upon before your application for coverage is approved and this policy issued. No agent has the authority to change or waive any of its provisions.

We’ve issued this policy to you based upon:

- the statements you made in your application;
- any other correspondence or information you provided in connection with your application, including your answers to the medical questionnaire, if you completed one; and
- payment of the required premiums.

We’ve italicized words throughout this policy that have a specific meaning. You’ll find a list of these defined terms in the **Definitions** section.

Your Prism coverage (the benefits you’re entitled to claim) is designed to supplement, not duplicate, your provincial/territorial government health insurance coverage.

This policy contains a provision removing or restricting the right of the *policy owner* to designate persons to whom or for whose benefit insurance money is to be payable. It is payable to you or your *service provider*.

Enclosures: Contact Sheet
Schedule of Benefits
A copy of your completed application form (including a counter-offer, if one exists)

Green Shield Canada, 8677 Anchor Drive, P.O. 1606, Windsor, ON N9A 6W1 Phone toll-free: 1.888.711.1119

Contents

How your policy works

This section outlines important information about how your policy works including who is covered and your obligations under the policy. It also contains information about premium payments, benefits and getting reimbursed. Any words in italics are defined in the **Definitions** section.

Questions about your benefits and getting reimbursed?

You can contact GSC by:

- calling our Customer Service Centre at 1.888.711.1119;
- visiting **greenshield.ca**
- emailing customer.service@greenshield.ca

Questions about who is covered and how to make changes?

You can contact SBIS by:

- calling 1.800.667.0429
- emailing general@sbis.ca

Who is covered

To be eligible, and continue to be eligible, for coverage under this policy, a person must be:

- a resident of Canada, and
- covered under a provincial/territorial government health insurance plan.

Quebec residents must also have, and continue to have, coverage through RAMQ (Régie de l'assurance maladie du Québec). This policy cannot be used in place of RAMQ.

You (the *policy owner*) and your eligible *dependents*, who are listed on your application, are covered under this policy. Each person covered may be referred to as a *covered person* and everyone, collectively, as *covered persons*.

To be eligible for coverage, your *dependents* must be your spouse or dependent children.

You can include only one person at a time as your spouse. Your spouse is:

- the person to whom you're legally married; **or**
- your partner with whom you've lived continually in a common-law relationship for more than 12 months and who you publicly represent as your spouse/partner.

Your dependent children include:

- your unmarried children under age 21, including your natural children, stepchildren, common-law children, legally adopted children and children under your legal guardianship; and
- your children age 21 and over if they became dependent upon you due to a mental or physical disability that occurred before they turned 21. They must have been continuously disabled since that time and you must be able to claim a disability tax credit for them under the Income Tax Act.

When a dependent child covered under this policy turns age 21 during the calendar year, you'll be notified in writing in October of their removal from the policy. We'll then adjust your premiums on the December withdrawal, if needed. When a dependent child turns 21, we'll give them the opportunity to transfer to a separate GSC individual plan.

To be eligible for coverage under Continuum plans, a person must also have been covered under a group health insurance plan before this policy's *effective date* but no more than 90 days before the day you submitted your application.

When coverage starts

Your coverage starts on the *effective date* shown in the approval letter SBIS sends you. You won't be reimbursed for any charges incurred for services provided before the *effective date*.

Your obligations

Your key obligations under this policy include the following:

- You are responsible for ensuring your premiums are paid on time and kept up to date. We won't reimburse *eligible services/supplies* unless premiums have been paid in full at the time the services/supplies were provided.
- You and your *dependents* must be covered under the *government health insurance plan* of the Canadian province/territory where you and your *dependents* live.
- You are responsible for telling SBIS when a *covered person* no longer meets the eligibility requirements for coverage.
- You can be covered under only **one** of GSC's individual health and dental benefit plans at any given time.
- Everyone covered under this policy will be covered for the same category of benefits. Although the maximum payable for each category of benefits will be the same, prescription medications eligible for coverage under medically underwritten plans may differ due to an individual's exclusions based on pre-existing medical conditions as specified on their Counter-Offer/Authorization to Proceed.
- In cases of third-party liability, you must tell your lawyer that we retain the right of subrogation. This means we can recover payment from a third party if they should have paid or provided benefits on your behalf. We can also recover payment from you if you've received full or partial reimbursement from both us and the third party.
- You must authorize the release of any information that is reasonably necessary for GSC and SBIS to confirm eligibility for benefits and for GSC to adjudicate claims. GSC and our *service providers* have the authority to get medical records or information from any *health practitioner* or *dental practitioner*, *hospital*, clinic or *service provider*.

For this policy to remain in force, you must always be accurate and complete in your dealings with us and SBIS:

- If within 2 years of your policy's *effective date* or of a plan change's *effective date* you, intentionally or unintentionally, misrepresented, hid or failed to give us information when applying for coverage, we will, in certain circumstances, terminate this policy and return your premiums minus the claim amounts we've previously paid. But we won't terminate the policy if your coverage has been in force for 2 years, unless we have evidence of fraud.
- If you, intentionally or unintentionally, misrepresent, hide or fail to give us information when you're making a claim, we can choose not to pay the claim. If we've already paid it, you must pay us back any amounts we've paid to you. Under certain circumstances, we may terminate your policy and you'll have to pay us back. If we investigate you for fraud, you must provide, at your own cost, all information that we need to investigate and adjudicate the claim.
- We may conduct a claims assessment. This may require you to complete a medical questionnaire or provide us with additional medical information. You're responsible for any costs you incur to get the information we need. The results of the assessment and investigation may cause us to limit your coverage due to pre-existing conditions.
- We'll suspend the reimbursement of benefits while we conduct a claims assessment and investigation.

- You must provide satisfactory proof of identity, age, or other eligibility related information for any *covered person* if asked. If, for example, you provided an incorrect date of birth, the correct date of birth will be used to calculate the *covered person's* age. Then premiums and coverage will be adjusted according to the correct age.

We won't reimburse you for any claims you make if you do not comply with all these obligations.

Your premium payment requirements

This policy will remain in force from month to month as long as premiums are paid when due. You must pay premiums one month in advance. Your initial payment for the first two months of coverage is due on the coverage effective date. We'll take further payments on or about the first business day of every month, through monthly pre-authorized payments.

> For example, if your coverage is effective on March 1st, payment is taken on or about March 1st for coverage in March and April. Then on April 1st, payment will be taken for coverage in May, and so on.

Your coverage depends upon the payment of premiums. Your coverage will end at the end of the month for which we've received a full premium payment. If a payment can't be processed for any reason, we may charge an administration fee.

As the *policy owner*, you're responsible for making sure that premium payments are made. If another person or entity is making your payments and the arrangement changes, you must start making the payments yourself for your coverage to continue. If you don't, your coverage will end on the last day of the last month for which premiums were paid.

Getting reimbursed

- We'll reimburse you for *reasonable and customary* charges that you or your covered *dependents* incur for *eligible services/supplies* received subject to the exclusions, limitations, conditions in the policy and subsequent amendments and counter-offer (if applicable) made to the benefits described in this policy while this policy is in effect. These must be:
    - prescribed by and given under the direction of a *health practitioner* or *dental practitioner*;
    - *medically necessary*, in our opinion, for treating an illness or injury, taking all factors into account;
    - reasonable in the circumstances; and
    - the amount remaining after any contribution made by your provincial/territorial *government health insurance plan*. (We'll apply the standard co-pay for your plan before we reimburse you).
- We'll reimburse you by:
    - making a direct deposit to your personal bank account; or
    - mailing a cheque payable to you through Canada Post.

  When we can reimburse your *service provider*, we'll make a direct payment to them.
- We'll reimburse you or your *service provider* in Canadian or U.S. dollars, depending on the home country of who we're paying. All dollar amounts stated in this policy are in Canadian dollars.
- You'll find information on how to submit a claim in the **How to make a claim** section. We must receive claims within 12 months of the date you bought the eligible item or received the service.
- Claim eligibility and amounts available for reimbursement are based on plan maximums and the date that the service is received or the supplies are delivered, and not the order date or payment date.
- If you haven't paid the premiums you owe in full at the time the *eligible services/supplies* were provided, we won't reimburse you.

Your benefits

This policy document includes a description of all the benefits offered by the various Prism individual health and dental plans:

- Prescription Drug Benefits
- Dental Benefits
- Vision Benefits
- Extended Health Benefits
- Emergency Medical Travel Benefits
- Hospital Accommodation Benefits

There may be some benefits described here that are not included in the plan you bought. It is very important that you check your Schedule of Benefits carefully to understand which benefits are included in your plan. You can find your Schedule of Benefits in the Welcome package you received along with this policy.

Your Schedule of Benefits shows:

- the plan you bought;
- the benefits provided by that plan; and
- the corresponding dollar maximums for each covered benefit for which you've been approved. (We provide benefit maximums on a per *covered person* basis.)

Each benefit listed above has its own section in this policy. In each benefit section, we outline the coverage that benefit provides, under what conditions, what is not covered (also called exclusions) and any limitations that may apply.

There are other exclusions, limitations and conditions that apply to all benefits under this policy. These are explained in the **General Provisions & Exclusions** section.

Prescription Drug Benefits

Please check your Schedule of Benefits to confirm that the plan you bought includes prescription drug benefits. If they're included, your Schedule of Benefits will also show the maximum coverage amounts.

This section outlines what's covered and not covered under the Prescription Drug Benefit, along with additional relevant details you'll find helpful. All words in italics are defined in the **Definitions** section.

What is covered

- Prescription drugs prescribed by a legally qualified *health practitioner* or *dental practitioner*, as permitted by law, that:
    - require a prescription by law;
    - have a Drug Identification Number (DIN);
    - we've approved through our drug review process; and
    - are dispensed by a pharmacist.

- Drugs that don't legally require a prescription, including nitroglycerin, diabetic syringes, needles, testing agents, insulin and other approved injectables and certain vaccines, if:
    - they have a DIN;
    - we've approved them; and
    - a pharmacist dispenses them.

- Co-pays and deductibles under the relevant provincial/territorial *government health insurance plan*. The standard co-pay for your plan applies.

Limitations

We maintain a list of the drugs we've approved. We manage this list through an evidence-based review process that evaluates drugs based on their overall value. This process considers clinical efficacy, safety, unmet need and plan affordability. At any time, we may:

- add to the list or exclude a drug from the list, even if Health Canada has approved it or it's covered by a provincial/territorial *government health insurance plan*; or
- restrict a drug that we've already approved by, for example, requiring you to:
    - get pre-approval from us before we reimburse you for the claim;
    - get it through an approved provider; and
    - get a lower-cost alternative of the same treatment such as a generic or *biosimilar drug*.

Mandatory generic substitution: When a drug has a generic equivalent, based on specific provincial/territorial *government health insurance plan* regulations, we'll reimburse you up to the cost of the lowest priced equivalent drug. If a *health practitioner* indicates a brand name drug is medically required due to a serious medical reaction to at least two generic equivalent drugs, we'll need a copy of the "Health Canada Vigilance Adverse Reaction Reporting Form" (available on Health Canada's website), completed by the legally qualified *health practitioner*. We'll use this Form to decide if you're eligible to be reimbursed for the cost of the prescribed drug.

When coverage is ending, the maximum amount dispensed for any drug will not be more than a 30-day supply of a prescription at any one time.

Special Timing Provisions

For residents of all provinces/territories, excluding Quebec:

- We may require maintenance drugs, needed to treat lifelong chronic conditions that develop and are diagnosed after this policy is effective, to be bought in a 90-day supply of a prescription at any one time, except for the first time the prescription is filled.
- You can't receive more than a 3-month (90-day) supply of a prescription for non-maintenance drugs at any one time.
- For all drugs, you can receive a 6-month supply for a vacation, but not more than a 13-month supply in any 12 consecutive months.

For Quebec residents only:

- The amount dispensed can never be more than a 3-month supply (6 months if it's for a vacation) of a prescription at any one time. It also can't be more than a 13-month supply in any 12 consecutive months.

Special rules for submitting claims:

- We'll pay prescription drug benefits on a pay-direct basis. Your pharmacy can bill us directly.
- Certain drugs require pre-approval from us before we can reimburse your drug claim. You can find out if your drug requires pre-approval by either:
    - using the online drug search tool available through GSC *everywhere*, our online services; or
    - contacting our Customer Service Centre.

For residents of Quebec, there are different rules:

- To be eligible for prescription drug coverage under this policy, you must be registered under the RAMQ (Régie de l'assurance maladie du Québec) Public Prescription Drug Insurance Plan.
- You must submit all drug claims to RAMQ first.
    - For drugs covered under RAMQ, the unpaid balance (including co-payments and deductibles) will be coordinated so that you may be reimbursed up to 100%.
    - For drugs not covered under RAMQ, the standard co-pay applies.
- If a drug listed on the RAMQ drug formulary requires pre-approval, you need to satisfy RAMQ conditions first before submitting the claim to us for any unpaid balances.

What is not covered – Exclusions

i. Drugs that treat erectile dysfunction, infertility or obesity.

ii. *Biologic drugs* (produced using living cells or microorganisms and often manufactured using DNA technology) that have an approved *biosimilar drug* (demonstrated to be similar to a drug already authorized for sale by Health Canada).

iii. Any medication identified and in the medical conditions or categories shown on the Counter-Offer/Authorization to Proceed, if applicable. You would've received this only if you applied for a medically underwritten plan, had medical conditions at the time you applied, and you chose to proceed with the plan with exclusions for medications that treat those pre-existing medical conditions.

iv. Smoking cessation oral drugs to help someone quit smoking and nicotine replacement products, such as patches, gum, lozenges and inhalers.

v. Administration of serums, vaccines or injectable drugs.

vi. Cannabis.

vii. Ingredients or products, either in the testing stage or considered experimental, that Health Canada hasn't approved for the treatment of a medical condition or disease.

viii. Mixtures compounded by a pharmacist that don't conform to our current compound policy (available by calling our Customer Service Centre).

ix. Treatments or drugs that are not dispensed by a pharmacist.

Dental Benefits

Please check your Schedule of Benefits to confirm that the plan you bought includes dental benefits. If they're included, your Schedule of Benefits will show the dental benefit categories as well as the maximum coverage amounts for each category of service covered.

This section outlines the dental care, services and treatment available for coverage, within the amounts stated in the relevant *fee guide* at the time service was provided, in the province/territory where it was provided:

- Dental Association Fee Guide for General Practitioners;
- Dental Hygienists' Association Fee Guide or Dental Hygienists' Association Fee Guide for Independent Dental Hygienists; and
- Dental Association Fee Guide Treatment for a specialist.

Where multiple *fee guides* exist, we'll apply the lesser fee.

This section also explains what is not covered (exclusions) under this policy and the limitations. All words in italics are defined in the **Definitions** section.

What is covered

Basic preventive and restorative services

1. **Basic diagnostic services**:
    a) complete oral examinations;
    b) emergency and specific oral examinations;
    c) full series x-rays and panoramic x-rays; and
    d) bitewing x-rays.

2. **Basic preventive services**:
    a) recall examinations once per recall period, as defined in your Schedule of Benefits;
    b) preventive cleaning of teeth (up to 1 unit of polishing plus up to 1 unit of scaling), once per recall period;
    c) topical application of fluoride for *covered persons* aged 19 and under, once per recall period;
    d) pit and fissure sealants on molars only, for dependent children aged 16 and under; and
    e) space maintainers that replace prematurely lost teeth for dependent children aged 16 and under.

3. **Basic restorative services**:
    a) amalgam, tooth coloured filling restorations and temporary sedative fillings; and
    b) inlay restorations, as these are considered basic restorations and will be paid to the equivalent non-bonded amalgam.

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

5. **General anaesthesia, deep sedation and intravenous sedation:** eligible only if they're performed with eligible oral surgery.

Comprehensive basic services

1. **Endodontic treatment**:
    a) root canal therapy;
    b) pulpotomy (removes the pulp from the crown portion of the tooth)
    c) pulpectomy (removes the pulp from the crown and root portion of the tooth)
    d) apexification (closes the end of an open root tip)
    e) apical curettage, root resections and retrograde fillings (cleans and removes diseased tissue from the root tip);
    f) root amputation and hemisection (removing half of an injured tooth);
    g) bleaching of non-vital teeth; and
    h) emergency procedures including opening or draining of the gum/tooth.

2. **Periodontal treatment**:
    a) periodontal scaling and/or root planing; and
    b) occlusal equilibration (selective grinding of tooth surfaces to adjust a bite).

    The fees for periodontal treatment are based on units of time (15 minutes per unit) and number of teeth in a surgical site, as set out in the Fee Guide for General Practitioners.

3. **Standard denture services**:
    a) denture cleaning;
    b) denture repairs and tooth additions;
    c) standard relining and rebasing of dentures (at least 6 months after installation of a denture);
    d) denture adjustments, remount and equilibration procedures (at least 3 months after installation of a denture);
    e) soft tissue conditioning linings for the gums to promote healing; and
    f) remake of a partial denture using existing framework.

Major services

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

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

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

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

Special rules for submitting claims: You must get pre-approval from us for crowns and onlays before treatment. Please see **Predetermination of benefits** below. You can also contact our Customer Service Centre if you have questions.

Orthodontic services

- **Orthodontic treatment:** to straighten teeth and/or correct the bite.

If orthodontic treatment is terminated for any reason before it's finished, we won't be obliged to pay benefits after the date of termination. If the services start again, we'll also restart this benefit for the remaining services. We'll only pay benefits for orthodontic services received during the months that your coverage is in force.

Special rules for submitting claims:

- You must get pre-approval from us before any orthodontic treatment begins. Please see **Predetermination of benefits** below. You can also contact our Customer Service Centre if you have questions.
- You must submit your receipts for payment no later than 12 months from the date the service is received while treatment is in progress and not at the end of the treatment.
- When a lump sum fee has been paid towards orthodontic treatment, we'll split the total amount of the claim into separate portions to allow for payment of an initial fee (approximately one-third of the total lump sum). We'll then divide the balance of the claim into equal monthly fees that we'll reimburse over the duration of the treatment.

Alternate benefit clause

When two or more professionally accepted courses of treatment are provided as benefits under your policy, we'll reimburse the amount shown in the *fee guide* for the least expensive service or supply. If the *covered person* chooses to have a more expensive treatment performed, we'll only reimburse you for the cost of the least expensive alternative.

Predetermination of benefits

Before treatment begins:

- For all proposed treatment for crowns, onlays, and orthodontics you **must** submit an estimate completed by your legally qualified *dental practitioner* to us for assessment. Our assessment of the proposed treatment may result in a lesser benefit being payable to you or we may deny benefits. If you don't submit an estimate before beginning treatment, this will delay our assessment.
- If the total cost of any other proposed treatment is expected to be more than $500, we recommend that you submit an estimate completed by your legally qualified *dental practitioner*.

Limitations

i. Laboratory services must be completed with other services. We'll limit them to the reimbursement percentage of these other services. We'll reduce laboratory charges that are greater than 40% of the price stated in the Fee Guide for General Practitioners that applies. We'll then apply the reimbursement percentage.

ii. We'll reimburse you for standard or basic services, supplies or treatment. You'll be responsible for any related expense beyond the standard or basic services, supplies or treatment.

iii. For complete or partial denture services, standard relining and rebasing, crowns and bridges, we'll reimburse you for the percentage of the cost of standard services that applies. If you and your *dentist* decide on personalized restorations or specialized techniques such as precision attachments, stress-breakers or prosthesis over implants, you'll be responsible for the balance of any cost.

iv. We'll pro-rate and reduce reimbursement accordingly when time spent by the *dentist* is less than the average time assigned to the relevant dental service procedure code in the Fee Guide for General Practitioners.

v. We'll reimburse you for the cleaning of a standard denture but not for an implant retained prosthesis. We'll reduce reimbursement accordingly for the cleaning of a standard denture that includes an implant retained prosthesis.

vi. We'll reimburse you for root canal therapy once per tooth, and once for any follow-up procedures such as apicoectomies, root resections, retrofillings and extractions. This doesn't include extra charges for difficult access, exceptional anatomy, calcified canals and retreatments. The total fee for root canal includes all pulpotomies and pulpectomies performed on the same tooth.

vii. We'll assess common surfaces on the same tooth on the same day as one surface. If individual surfaces are restored on the same tooth on the same day, we'll assess payment according to the procedure code representing the combined surface. We'll reimburse you up to a maximum of 5 surfaces in any 36-month period.

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

ix. Core build-ups are eligible only if they're performed with crown treatment to retain and preserve a tooth. The need to perform core build-ups must be evident on mounted pre-treatment x-rays. We'll include core build-ups that facilitate impression taking or block out undercuts in the cost of the crown.

x. Root planing isn't eligible if it's done at the same time as gingival curettage.

xi. For dental *accidents*, you must submit claims under the extended health benefit before submitting them under this dental benefit.

What is not covered - Exclusions

i. Any dental service that is not:

- included in the procedure codes developed and maintained by the Canadian Dental Association;
- adopted by the provincial or territorial dental association of the province/territory in which the service is provided (or the province/territory where the *covered person* lives if any dental service is provided outside Canada); and
- in effect at the time the service is provided.

ii. Implants and implant related services.

iii. Restorations necessary for wear, acid erosion, vertical dimension or restoring occlusion.

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

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

vi. Removal of an amalgam restoration and its replacement with a composite restoration unless there is evidence of recurrent decay or significant breakdown.

vii. Service and charges for sleep dentistry.

viii. Diagnostic or intraoral repositioning appliances including maintenance, adjustments, repairs and relines related to treatment of temporomandibular joint (TMJ) dysfunction.

Vision Benefits

Please check your Schedule of Benefits to confirm the maximum coverage amounts.

This section outlines what's covered and not covered under the Vision benefit, along with additional relevant details you'll find helpful. All words in italics are defined in the **Definitions** section.

What is covered

- When prescribed by a licensed optometrist, optician or ophthalmologist, limited to a 24-month benefit period for:
    - prescription eyeglasses;
    - prescription contact lenses; or
    - laser eye surgery.
- Optometric eye examinations for visual acuity performed by a licensed optometrist, ophthalmologist or *physician*, limited to one eye exam in a 24-month benefit period.

Limitations

In provinces/territories where the government health insurance plans provide coverage for eye exams, you or your health care provider must submit the claim to the government plan first. Only amounts not covered by the government health insurance plan are eligible for consideration by this policy.

Special Timing Provisions

- The allowable 24-month benefit period starts on the date the initial service was received. Further services are eligible 24 months after the previous service was received.

What is not covered – Exclusions

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

Extended Health Benefits

This section outlines what's covered and not covered under the Extended Health benefit, along with additional relevant details you'll find helpful. All words in italics are defined in the **Definitions** section.

Accidental dental

Please check your Schedule of Benefits to confirm the maximum coverage amounts.

What is covered

- The services of a licensed *dental practitioner* for dental care for natural teeth when required due to a direct blow to the mouth.

Payment is based on the current Dental Association Fee Guide for General Practitioners in the province/territory where the services are provided. We'll base our approval on the current status and benefit level of the *covered person* at the time that we're notified of the *accident*. Any change in coverage will change our liability. Where multiple *fee guides* exist, we'll apply the lesser fee.

Limitations

i. The *accident* must occur while the coverage is in force.
ii. You or your dental provider must notify us of the injury within 90 days of the date of the *accident*.
iii. Treatment must begin within 180 days of the injury and be completed within 365 days of the injury.
iv. When natural teeth have been damaged, *eligible services* are limited to one set of artificial teeth.

This policy must be in effect when the treatment or services are received.

Special rules for submitting claims:

- You must get pre-approval from us before treatment for a dental *accident* begins by submitting a completed Dental Accident Report Form.
- You should submit claims for treatment for dental *accidents* under this benefit rather than under dental benefits, if your plan includes them. Check your Schedule of Benefits.

What is not covered – Exclusions

- The services of a licensed *dental practitioner* for dental care that's required because an object was placed, intentionally or unintentionally, in the mouth.
- Periodontal or orthodontic treatments and the repair or replacement of artificial teeth.

Ambulance transportation

What is covered

- Licensed ambulance services, by land or air, to the nearest hospital equipped to provide the required treatment when *medically necessary* in emergency situations.

Limitations

We'll limit reimbursement to the difference between the amount allowed under your provincial/territorial *government health insurance plan* and the *reasonable and customary charges* for these services.

What is not covered - Exclusions

- Transportation for non-emergency situations.

Hearing aids

Please check your Schedule of Benefits to confirm the maximum coverage amounts.

What is covered

- Hearing aids, repairs or replacement parts, recommended or approved by the attending legally qualified *health practitioner*.

Special Timing Provisions

- The allowable benefit period starts on the initial date that hearing aids/services are received.
- Further hearing aids/services are eligible based on the time period set out in your Schedule of Benefits.

What is not covered – Exclusions

- Batteries.

Home support services

Please check your Schedule of Benefits to confirm the maximum coverage amounts.

What is covered

- The services of a Registered Nurse (RN), Registered Practical Nurse/Licensed Practical Nurse (RPN/LPN) or Personal Support Worker (PSW) in the home, but only on a visit or shift basis.

Special rules for submitting claims:

- You must submit a Pre-Authorization Form completed by the attending *physician*.
- To find out if a home support service is eligible for coverage and get detailed information on making claims, please contact our Customer Service Centre.

What is not covered – Exclusions

- Custodial services that are provided by anyone other than an RN, RPN/LN or PSW.

Medical items

Please check your Schedule of Benefits to confirm the maximum coverage amounts. We'll reimburse you for *reasonable and customary* charges, up to these maximum amounts.

What is covered

The items below must be prescribed by a legally qualified *health practitioner* unless we specify otherwise:

1. Aids for daily living such as:
    a) hospital style beds (including rails and mattresses);
    b) standard commodes;
    c) decubitus (bedridden) supplies;
    d) IV stands;
    e) trapezes/transfer poles;
    f) bedpans;
    g) raised toilet seats; and
    h) urinals.
2. Casts and *braces* (rigid or semi-rigid supporting devices or appliances that fit on and are attached to the body).
3. Incontinence/ostomy supplies, including catheter supplies.
4. Compression stockings.
5. Diabetic equipment such as:
    a) blood glucose meters and lancets; and
    b) glucose monitoring systems (GMS) such as continuous and flash type monitors, reimbursed to the cost of a blood glucose meter.
    c) disposable GMS supplies (e.g. sensors, transmitters) used with the monitor.
6. Custom footwear, when prescribed by your attending *physician*, nurse practitioner, podiatrist or chiropodist and dispensed by your podiatrist, chiropodist, chiropractor, orthoptist or pedorthist:
    a) *custom-made foot orthotics* or repairs to them. These devices, composed from raw materials, are made from a 3-dimensional model of an individual's foot an used to relieve foot pain related to biomechanical misalignment of the feet and lower limbs.
    b) *custom-made boots or shoe*s used by someone whose condition can't be accommodated by existing footwear products. A unique cast is made of the feet, using 100% raw materials. (This footwear accommodates the bony and structural abnormalities of the feet and lower legs resulting from trauma, disease or congenital deformities.)

    The allowable benefit period starts on the initial date that footwear benefits are received. You must get a medical pre-authorization from us first.
7. Mobility aids such as:
    a) canes;
    b) crutches;
    c) walkers; and
    d) wheelchairs (including wheelchair batteries).

8. Standard prosthetics such as:
    a) arm;
    b) breast;
    c) ear;
    d) eye;
    e) foot;
    f) hand;
    g) larynx;
    h) leg;
    i) nose;
    j) prosthetic eyewear (glasses or contact lenses), but limited to once per lifetime after cataract surgery;
    k) prosthetic accessories, modifications and repairs;
    l) surgical brassieres following a mastectomy; and
    m) wigs for temporary or permanent hair loss due to a medical condition.

9. Respiratory/cardiology equipment (and their required modifications and repairs) such as:
    a) continuous, bilevel and automatic positive airway pressure pumps (CPAP, BiPAP, and APAP machines and supplies);
    b) anterior mandibular positioners (AMP devices);
    c) breathing and heart monitors for infants;
    d) compressors;
    e) inhalant devices;
    f) tracheotomy supplies; and
    g) oxygen.

Limitations

i. We'll reimburse diabetic equipment up to our internal limits. Please call our Customer Service Centre to inquire about our diabetic equipment internal limits.
ii. The cost of renting medical equipment should not be more than the cost of buying it. We decide between buying or renting the equipment, based on the legally qualified *health practitioner's* estimate of how long it will be needed, as stated in the original prescription. We may authorize equipment rental for the prescribed length of time. Equipment that the supplier has refurbished for resale is not eligible for coverage.
iii. Medical equipment must be appropriate for use in the home, able to withstand repeated use and generally not be useful if someone isn't ill or injured.
iv. When deluxe medical equipment is eligible for coverage, we'll reimburse you when the patient needs the deluxe features to effectively operate the equipment.

Special rules for submitting claims: We require pre-approval for some medical items. Contact our Customer Service Centre to inquire which medical items require pre-approval. If you don't receive pre-approval from us for those medical items, we may not reimburse you.

What is not covered – Exclusions

i. Incontinence diapers.
ii. Insulin pumps and supplies.
iii. Items that are not primarily medical in nature or that are for comfort and convenience.

Medical services

Please check your Schedule of Benefits to confirm the maximum coverage amounts.

What is covered

- Specific laboratory tests, diagnostic tests and x-rays.

Special rules for submitting claims: Please contact our Customer Service Centre to confirm eligibility of specific laboratory tests, diagnostic texts and x-rays before seeking the service.

What is not covered – Exclusions

i. Laboratory tests and services, diagnostics tests and x-rays or any other services provided by or administered in a private health care clinic.

ii. Medical examinations, magnetic resonance imaging (MRI), CT (computed tomography) scans, electrocardiogram (ECG/EKG), positron emission tomography (PET) scans, audiometric examinations or hearing aid evaluation tests.

iii. Medical or surgical audio and visual treatment.

Professional services/Registered therapists

Please check your Schedule of Benefits to confirm the maximum coverage amounts.

What is covered

This benefit covers services provided by certain practitioners who are licensed, certified or registered by their provincial/territorial regulatory agency as a member in good standing or as an active registered member of a professional association. We must recognize these agencies or associations. We cover services of the following practitioners:

- Chiropractor
- Physiotherapist
- Registered massage therapist
- Acupuncturist
- Registered dietitian
- Footcare specialist (chiropodist or podiatrist)
- Naturopath
- Osteopath
- Speech therapist
- Psychologist
- Psychotherapist
- Registered social worker (RSW), professional with a Master of Social Work

Special rules for submitting claims: Please confirm eligibility of a practitioner by logging onto GSC *everywhere* or by contacting our Customer Service Centre. If you live in Ontario or Alberta, podiatry services are eligible in coordination with your provincial *government health insurance plan*.

Emergency Medical Travel Benefits

Please check your Schedule of Benefits to confirm the maximum number of days per trip as well as the maximum coverage amounts.

This section outlines what's covered and not covered under the Emergency Medical Travel benefit, along with limitations and additional relevant details you'll find helpful. There are some terms used in this section that have a specific meaning for the Emergency Medical Travel benefit. We have identified and defined them directly below. All other words in italics are defined in the **Definitions** section.

Definitions for the Emergency Medical Travel Benefit

The definitions shown here apply every time these terms appear in italics in this benefit:

emergency:	a sudden and unforeseen *medical condition* that requires immediate *treatment*. It doesn't include any *treatment* for a *pre-existing condition* that was not completely *stable* for the 90-day period immediately before departure. An emergency no longer exists when the evidence reviewed by GSC Travel Assistance indicates that no further *treatment* is required at destination or the *covered person* is able to return to their province/territory of residence for further *treatment*. If GSC Travel Assistance decides that the *covered person* should transfer to another facility or return to their home province/territory, and they choose not to, we won't pay the benefits for further medical *treatment* and coverage will be limited for unrelated events.
medical condition:	any disease, illness or injury (including any symptoms of any undiagnosed conditions).
physician	a person who is not you or a member of your immediate family or your traveling companion, licensed in the jurisdiction where the services are provided, to prescribe and administer medical treatment.
pre-existing condition:	any *medical condition* that exists before the date of the *covered person's* departure.
stable:	A *medical condition* is considered stable when **all of the following statements are true** during the 90-day period immediately before the departure date: 1. There hasn't been any new *treatment* prescribed or recommended, or change(s) made to existing *treatment* (including stopping *treatment*); and 2. The *medical condition* hasn't become worse; and 3. There haven't been any new, more frequent, or more severe symptoms; and 4. There hasn't been any hospitalization or referral to a specialist; and 5. There haven't been any tests, investigation or *treatment* recommended, but not yet complete, nor any outstanding test results; and 6. There is no planned or pending *treatment*; and 7. There hasn't been any change to an existing prescribed drug (including an increase, decrease or stoppage to prescribed dosage), or any recommendation or starting of a new prescription drug. We don't consider the following as changes to existing prescribed drug *treatment*: ▪ routine dosage adjustments of Coumadin, Warfarin, or insulin, as long as these medications have not been newly prescribed or stopped;

	▪ a change from a brand name to a generic equivalent product as long as the dosage is the same, including a transition from a *biologic drug* to a *biosimilar drug*; or ▪ a decrease in the dosage of a medication due to the improvement of a condition. **All of the conditions listed above must be met during the 90-day period before the covered person's departure for a *medical condition* to be considered *stable*.**
treat, treated, treatment:	a procedure prescribed, performed or recommended by a *physician* for a *medical condition*. This includes, but is not limited to, prescribed medication, investigative testing and surgery.

Important information about this benefit

Coverage period

Coverage under this benefit begins (becomes effective) when *you* or your covered *dependents* cross the border departing your home province/territory in Canada. The coverage ends when you cross the border returning to your province/territory of residence. If you're travelling by air, coverage begins when the aircraft takes off from the province/territory of residence and ends when the aircraft lands in the province/territory of residence on the return home.

Your plan must be in effect on or before you leave your home province/territory in Canada for this benefit to be available.

Coverage is limited to the maximum number of days per trip stated in your Schedule of Benefits. If you or a covered *dependent* is hospitalized and unable to return to your home province/territory by the end of the maximum days stated in your Schedule of Benefits, we'll extend benefits (as described in **Automatic extension of coverage**).

Automatic extension of coverage

We'll automatically extend coverage for any trip for up to 72 hours (as decided by us at our discretion), for any of the following reasons:

- The *covered person* or their travelling companion is hospitalized on or before the date the regular travel coverage would have expired and the *covered person* was unable to return to the province/territory where they live before the expiry date. In this situation, we'll extend coverage beginning on the date the *covered person* or their travelling companion is discharged from the hospital. Claims must be supported by satisfactory documented proof of the hospitalization that delayed the *covered person's* return.

- The *covered person's* return to the province/territory where they live is delayed, if ordered or directed by GSC Travel Assistance, due to an *emergency*. In this situation, we'll extend coverage beginning on the date determined by GSC Travel Assistance.

- The travel coverage expires and the *covered person's* return to the province/territory where they live is delayed either due to (i) the delay of a common carrier (airplane, bus, taxi, train) on which the *covered person* is a passenger; or (ii) a traffic accident or mechanical failure of a private automobile en route to the departure point. In this situation, we'll extend coverage beginning on the date of the delay. Claims must be supported by satisfactory documented proof of the incident that caused the delay.

- The travel coverage expires and the *covered person's* return to the province/territory where they live is delayed due to extreme weather conditions, causing hazardous driving conditions. In this situation, we'll extend coverage beginning on the date of the delay. Claims must be supported by satisfactory documented proof from the local authorities and weather office at the location of the delay.

Key terms and conditions

Important: This Emergency Medical Travel Benefit includes requirements, limitations and exclusions that can affect eligibility and/or reimbursement of incurred expenses. Please take the time to read through the description of this benefit before you travel to ensure you are aware of the terms and conditions, making note of the following:

- We reserve the right to review all medical information when you submit a claim. GSC Travel Assistance must pre-approve any invasive or investigative procedures. If you're the patient, and it is medically impossible for you to call before getting *emergency treatment*, someone else must call GSC Travel Assistance on your behalf within the first 48 hours of *treatment*. If GSC Travel Assistance is not notified within the first 48 hours, we may limit reimbursement of the expenses you incur to **the lesser of** the amount of only those expenses incurred within the first 48 hours of any and each treatment/incident **or** the plan maximum. This means you'll be responsible for all further expenses.

- To qualify for coverage under this benefit, you and your *dependents* must be covered by your respective provincial/territorial *government health insurance plans* at the time the expenses are incurred. If you're not covered by those plans, you're not covered under this benefit.

- We'll reimburse you for eligible travel expenses based upon the *reasonable and customary* charges in the area where they were incurred, less the amount payable by your provincial/territorial *government health insurance plan*, if your province/territory provides such coverage.

All dollar maximums and limitations stated are expressed in Canadian dollars. We'll reimburse *policy owners* and *service providers* in either Canadian or U.S. dollars, depending on their home countries. For payments that require currency conversion, we'll use the rate of exchange that was in effect on the date of service of the claim.

What is covered

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

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

3. **Emergency transportation**:

    a) **Land ambulance**: to the nearest qualified medical facility equipped to provide the required *treatment*, when *medically necessary*.

    b) **Air ambulance**: air evacuation (including a medical attendant when necessary) between hospitals and for hospital admission into Canada or to the nearest qualified medical facility. You must contact GSC Travel Assistance for pre-approval.

4. **Registered private nurse services**, at the *reasonable and customary* rate charged by a qualified Registered Nurse (RN) who is registered in the jurisdiction in which *treatment* is provided up to a maximum of $5,000 per *calendar year*. You must contact GSC Travel Assistance for pre-approval.

5. **Diagnostic laboratory tests and x-rays** when prescribed by the attending *physician*. You must get pre-approval from GSC Travel Assistance for these services except in *emergency* situations such as cardiac catheterization or angiogram, angioplasty and bypass surgery.

6. **Reimbursement of prescriptions** for drugs, serums and injectables that require a prescription by law and are prescribed by a legally qualified *health practitioner*. Vitamins and patent and proprietary drugs are not covered. You must submit to GSC Travel Assistance the original paid receipt from the pharmacist, *physician* or *hospital* outside the province/territory where the *covered person* lives. The receipt must show the name of the prescribing *physician*, prescription number, name of preparation, date, quantity and total cost.

7. **Medical appliances** including casts, crutches, canes, slings, splints and temporary rental of a wheelchair when deemed *medically necessary* and required due to an *accident*. The devices must be obtained outside the province/territory where the *covered person* lives.

8. **Treatment by a *dentist*** only when required due to a direct *accidental* blow to the mouth up to a maximum of $2,000. *Treatments* (before and after the *covered person's* return) must be provided within 90 days of the *accident*. You must provide details of the *accident* and dental x-rays to GSC Travel Assistance.

9. **Returning home**, due to an *emergency* illness or injury when:

    - GSC Travel Assistance tells you or your covered *dependent* in writing that you must **immediately** return to the province/territory where you live for immediate medical attention. We'll reimburse you for the extra cost incurred to buy a one-way economy airfare, plus the additional economy airfare if required to accommodate a stretcher, to return you by the most direct route to the major air terminal nearest your departure point in your home province/territory.
        - This benefit assumes that you or your covered *dependent* does not have a valid open-return air ticket. We won't reimburse you for upgrading charges, departure taxes, cancellation penalties or the cost of airfares for accompanying family members or friends.
    - GSC Travel Assistance or commercial airline tells you in writing that you or your covered *dependent* must be accompanied by a qualified medical attendant. We'll reimburse you for the cost incurred for one round trip economy airfare. We'll also reimburse you for the *reasonable and customary* fee charged by a medical attendant along with any overnight hotel and meal expenses required by the attendant. The attendant must be registered in the jurisdiction where the *covered person* received treatment and can't be your relative by birth or marriage.

10. **Cost of returning a personal use motor vehicle** to a *covered person's* residence or nearest appropriate vehicle rental agency when they're unable to do so due to sickness, physical injury or death, up to a maximum of $1,000 per trip. You must provide original receipts for costs incurred e.g. gasoline, accommodation and airfares, to GSC Travel Assistance.

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

12. **Transportation to the bedside** including round trip economy airfare by the most direct route from your home province/territory, for any one spouse, parent, child, sibling, and up to $150 per day for a maximum of 5 days, for meals and accommodation at a commercial establishment for that family member to:

    a. be with you or your covered *dependent* when confined in hospital. This benefit requires that the *covered person* must eventually be an inpatient for at least 7 days outside the province/territory where they live, plus written verification from the attending *physician* that the situation was serious enough to have required the visit; or

    b. identify a deceased before the body is released.

13. **Return airfare** if a *covered person's* personal use motor vehicle is stolen or made inoperable due to an *accident*. This benefit covers the cost of a one-way economy airfare to return the *covered person* by the most direct route to the major airport nearest their departure point in the province/territory where they live. You must supply an official report of the loss or *accident*.

14. **Return of deceased** up to a maximum of $5,000 towards the cost of embalming or cremation in preparation for transporting a *covered person* home in an appropriate container when death is caused by illness or *accident*. The body will be returned to the major airport nearest the point of departure in the *covered person's* home province/territory. The benefit doesn't cover (excludes) the cost of a burial coffin or any funeral-related expenses, such as makeup, clothing, flowers, eulogy cards or church rental.

Limitations

i. Coverage becomes effective when you or your covered *dependent* cross the border departing from the province/territory where they live. Coverage ends when you or your covered *dependent* cross the border returning home to their province/territory where they live. If travelling by air, coverage becomes effective when the aircraft takes off from the province/territory where you live. Coverage ends when the aircraft lands on the return home in the province/territory of residence.

ii. You must notify GSC Travel Assistance **before** obtaining *emergency treatment* so that GSC Travel Assistance can:

- confirm coverage, and
- pre-approve the *treatment*.

If it's medically impossible for the *covered person* to call before beginning *emergency treatment*, someone else must call GSC Travel Assistance on their behalf within the first 48 hours of *treatment*.

If GSC Travel Assistance is not notified within the first 48 hours of *treatment*, we may limit reimbursement of the incurred expenses to **the lesser of** the amount of only those expenses incurred within the first 48 hours of each *treatment*/incident **or** the plan maximum. This means you'll be responsible for all further expenses.

iii. After a *covered person's* medical *emergency treatment* has started, GSC Travel Assistance must assess and pre-approve additional medical *treatment*. Your claim won't be paid if a *covered person* undergoes tests as part of a medical investigation, *treatment* or surgery, obtains treatment or undergoes surgery that is not pre-approved. This includes invasive testing, surgery, cardiac catheterization, other cardiac procedures, transplants and MRIs.

iv. Repatriation is mandatory when GSC Travel Assistance decides that the *covered person* should transfer to another facility or return to their home province/territory for *treatment*, or at the end of the *emergency*. If the *covered person* chooses not to return:

- We won't pay benefits for expenses associated with any further medical *treatment*.
- We won't pay benefits for expenses associated with recurrence or complications related directly or indirectly to the *medical condition* that caused the *emergency*.
- For the remainder of the trip, coverage will be limited to *medical conditions* completely unrelated to the *medical condition* that caused the *emergency*.

v. Air ambulance services will be eligible if **all the conditions** below are met:

- GSC Travel Assistance pre-approves them.
- There is a medical need for the *covered person* to be confined to a stretcher or for a medical attendant to accompany them during the journey.
- The *covered person* is admitted directly to the nearest qualified medical facility or to a *hospital* in the province/territory where they live.
- You submit medical reports or certificates from the dispatching and receiving legally qualified *physicians* to GSC Travel Assistance.
- You submit proof of payment (including air ticket vouchers or air carrier invoices) to GSC Travel Assistance.

vi. If a *covered person* is planning to travel in areas of political or civil unrest, or in areas where the Canadian government has issued a formal travel warning about non-essential travel, check with us before travelling. We may not be able to guarantee assistance services.

vii. GSC Travel Assistance reserves the right, without notice, to suspend, curtail or limit its services and benefits in any area if any of the following occur:

- political or civil unrest, rebellion, riot or military uprising;
- labour disturbance or strike;
- act of God; or
- refusal of authorities in a foreign country to permit GSC Travel Assistance to provide service.

This limitation includes travel in any area if, when a *covered person* booked their trip (including delay of travel), or any time before the departure date, the Canadian government issued a formal travel warning advising Canadians to avoid either all travel or all non-essential travel to that specific country (or region, city, or other key component of the *covered person's* travel arrangements, such as a cruise ship) due to a likely or actual epidemic or pandemic. For this limitation, non-essential travel means anything other than a significant medical or family emergency, such as the death of a family member.

What is not covered - Exclusions

In addition to this policy's general exclusions, found in the **General Provisions & Exclusions** section, Emergency Medical Travel benefits do not cover the following:

i. Any expenses incurred for *treatment* related directly or indirectly to a *pre-existing medical condition* that, at the time of departure from the province/territory where the *covered person* lives and during the 90-day period immediately before they left their home province/territory:

   a) was not completely *stable* in the professional opinion of GSC Travel Assistance;

   b) where medical evidence suggested a reasonable expectation that *treatment* or hospitalization could be required while travelling; or

   c) a *physician* advised you or your *dependent* not to travel.

   GSC Travel Assistance reserves the right to review all medical information at the time you submit a claim. A *physician's* opinion that a *covered person* was fit to travel doesn't override or eliminate the requirement for a *medical condition* to satisfy all the conditions specified in our definition of *stable* (shown at the beginning of this section).

ii. Any expenses submitted if the *covered person* or anyone acting on behalf of them attempts to deceive GSC Travel Assistance, or makes a fraudulent, false or exaggerated statement or claim.

iii. Any expenses incurred for any services that:

   a) weren't required to treat an *emergency*;

   b) weren't recommended by a legally qualified *physician* or surgeon;

   c) aren't covered under your provincial/territorial *government health insurance plan*; or

   d) are normally covered under the out-of-Canada benefits of your provincial/territorial *government health insurance plan's* out-of-Canada coverage (where applicable), when the provincial/territorial plan has refused to pay.

iv. Any expenses incurred for services received after GSC Travel Assistance decided that:

   a) the *covered person* had to return to the province/territory where they live for *treatmen*t, and they chose not to do so;

   b) the services could be reasonably delayed until the *covered person* could return to their home province/territory;

   c) the *emergency* had ended; or

   d) the services are for a recurrence or complication directly or indirectly related to the *emergency* that GSC Travel Assistance determined in iii. a), b), or c) above.

v. Any expenses incurred for services to treat a *medical condition* or complications of a *medical condition* directly or indirectly related to an epidemic or pandemic if the Canadian government issued an official travel advisory advising all Canadians to avoid either all travel or all non-essential travel to the destination country (or region, city, or other key component of the travel arrangements such as a cruise ship) and the advisory was in effect either:

   a) when the trip was booked; or

   b) before the departure date of the *covered person*.

   You can find the Government of Canada's travel advisories at https://www.travel.gc.ca.

vi. Any expenses incurred for services to treat:
    a) any *medical condition*, including symptoms of withdrawal, arising from or in any way related to the chronic use of alcohol, drugs or other intoxicants either before or during the trip;
    b) any *medical condition* arising during the trip resulting from, or in any way related to, the abuse of alcohol that results in a blood alcohol level of more than 80 milligrams in 100 milliliters of blood, drugs or other intoxicants; or
    c) any *medical condition* resulting from not following *treatment* as prescribed, including prescribed or over-the-counter medication.

vii. Any expenses related to pregnancy or delivery, or complications of either, arising during the 8-week period before and after the expected date of delivery.

viii. Any expenses for a child born during the trip.

ix. Any expenses incurred during any trip for getting a diagnosis, *treatment*, surgery, palliative care or any alternative therapy, as well as any complications that are directly or indirectly related.

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

GSC Travel Assistance Service

Available services

The following services are available 24 hours per day, 7 days per week, through GSC Travel Assistance:

- Access to pre-trip assistance (before departure): Canada Direct Calling Codes, information about vaccinations, government-issued travel advisories, and VISA/document requirements for entry into country of destination.
- Assistance in different languages.
- Assistance in locating the nearest, most appropriate medical care.
- International preferred provider networks.
- Medical consultation and advisory services, to review the appropriateness and quality of medical care.
- Assistance in contacting a *covered person's* family, personal *physician* and employer as appropriate.
- Monitoring progress during *treatmen*t and recovery and confirming when the *covered person* is medically fit for transportation when a transfer or repatriation to the home province/territory is necessary.
- *Emergency* message transmittal services.
- Translation services and referrals to local interpreters in connection with the medical *emergency*, as needed.
- Verification of coverage facilitating entry and admissions into hospitals and other medical care providers.
- Special assistance with co-ordinating direct claims payment.
- Co-ordination of embassy and consular services.
- Management, arrangement and co-ordination of *emergency* medical transportation and evacuation as needed.
- Management, arrangement and co-ordination of repatriation of remains to the province/territory where the *covered person* last lived.
- Special assistance in arranging interrupted and disrupted travel plans resulting from *emergency* situations to include:
    - the return of unaccompanied travel companions;
    - travel to the bedside of a stranded person;
    - rearrangement of tickets due to *accident* or illness and other travel-related *emergencies*; and
    - the return of a stranded personal use motor vehicle and related personal items.

- Knowledgeable legal referral assistance.
- Co-ordination of securing bail bonds and other legal instruments.
- Guidance in replacing lost or stolen travel documents including passports.
- Courtesy assistance in securing incidental aid and other travel-related services.

How the Travel Assistance Service works

- For assistance, call **1.800.936.6226** within Canada and the United States or call collect **0.519.742.3556** when travelling outside Canada and the United States. You'll also find these numbers on your GSC Identification Card. Quote your GSC Identification Number, found on your GSC Identification Card, and explain your medical emergency.

- **You must always provide your GSC Identification Number and your provincial/territorial *government health insurance plan* number.**

- A multilingual assistance specialist will direct you to the best available medical facility or legally qualified *physician* able to provide the appropriate care.

- When you're admitted to a *hospital* or *consulting* a legally qualified *physician* or surgeon for major emergency treatment, GSC Travel Assistance will guarantee the provider (*hospital*, clinic or *physician*) that you have the required provincial/territorial *government health insurance plan* coverage and GSC travel benefits, as outlined above.

- GSC Travel Assistance will follow the progress of the *covered person* to make sure they're receiving the best available medical *treatment*. GSC Travel Assistance will also keep in regular communication with their family physician and family, depending on the severity of the condition.

- When calling collect while travelling outside Canada and the United States, you may need a Canada Direct Calling Code. If a collect call isn't possible, keep your receipts for phone calls made to GSC Travel Assistance and submit them for reimbursement when you return to Canada.

Hospital Accommodation Benefits

Please check your Schedule of Benefits to confirm that your plan includes Hospital Accommodation benefits. If they're included, your Schedule of Benefits will show the maximum number of days and coverage amounts.

This section outlines what's covered and not covered under the Hospital Accommodation benefit. All words in italics are defined in the **Definitions** section.

What is covered

When a provincial/territorial *government health insurance plan* agrees to pay the standard or ward rate, we'll reimburse any *reasonable and customary* charges greater than the standard or ward rate for semi-private or private accommodation in:

- a public general hospital; or
- a convalescent or rehabilitation hospital or a convalescent or rehabilitation wing in a public general hospital, when a *covered person* is admitted within 14 days of being discharged from a public general hospital.

What is not covered – Exclusions

i. Accommodation in a private hospital, chronic care hospital, chronic care unit of a hospital, transition ward of a hospital, home for the aged, long-term care facility or program treatment facility.

ii. Hospitalization of the *covered person* due to pregnancy or pregnancy-related conditions that begin during the first 10-month period following the *effective date* of coverage.

Changing your coverage

This section explains the changes you can make to any of the plans, as well as the other changes that may be possible depending on the plan you have. (Check the Schedule of Benefits to confirm your plan.) This section also explains the kind of changes GSC can make. Lastly, it describes how to cancel your policy, and when GSC may terminate your policy. All words in italics are defined in the **Definitions** section.

Changes to your coverage

Changes the policy owner and the payor may make

- Only the *policy owner* may make changes to the coverage, including the *dependents*' coverage.
- The *policy owner* or the *payor* may make changes to the method of payment or payment details.

Please note: all change requests must be received in writing. If you have any questions, contact SBIS at 1.800.667.0429 or **general@sbis.ca**.

Upgrading to another plan

After coverage is in effect, you may apply in writing to upgrade coverage from one plan to another plan at any time. For medically underwritten plans, you must complete a health questionnaire and coverage is subject to approval. Pre-existing conditions will not be covered.

For Continuum plans: Once coverage is in effect, you cannot upgrade coverage from one Continuum plan to another.

Downgrading to another plan

You may choose to downgrade to another plan as long as coverage under your existing plan has been in force for at least 12 consecutive months.

Switching plans

When you're switching from one individual health plan to another, we'll carry forward the value of benefits you've used to date and apply them against the maximums of the new plan you've selected.

Adding a dependent

When coverage is in force, you may add a *dependent* to the same plan by submitting a request in writing. You may be asked for proof of eligibility of those *dependents*. For a medically underwritten plan, you must also complete a health questionnaire and coverage will be subject to approval. A health questionnaire is not required for a newborn child if your request is received within 30 days of the date of birth. The *effective date* of coverage is set once your application is approved.

For Continuum plans: *Dependents* are subject to the same eligibility criteria (i.e. apply within 90 days of losing group coverage or new marriage/common law relationship).

Removing a dependent

While coverage is in force, you may need to remove a *dependent:*

- when a *dependent* child gets married;
- if you get divorced; or
- due to the death of a *dependent*.

You must send SBIS a request in writing within 30 days of this happening. If applicable, refunds of premium due to late notification in this situation are limited to a maximum of 3 months premium.

Changes GSC may make

We'll give you at least 30-days notice in writing of any change we make. We'll email or mail it to the email address or address we have on file for you.

We may change your premiums or benefits when:

- the *government health insurance plan* changes;
- our practices change;
- you move to a different age band (when you turn age 45, 55, or 65 during the calendar year and we'll adjust your premiums on the December withdrawal).
- you move to a new province/territory; or
- you change the number of people covered by this policy (i.e. family, couple/two person, single).

We reserve the right to make other changes that don't appear in the list above, as long as we give you 30 days' notice in writing.

When your coverage ends

Your coverage will remain in force from month to month as long as the required premiums are paid when due.

How to cancel

The *policy owner* may cancel this policy at any time by notifying SBIS in writing. To cancel your coverage at the end of the following month, you must notify SBIS at least 10 business days before the date of your next premium payment.

> For example, if your next premium payment is due August 1st (for September coverage), you must notify SBIS before July 20th to ensure that your last date of *coverage* is August 31st. If you notify us after July 20th, your last premium payment will be on August 1st and the last day of your coverage will be September 30th.

Reapplying after you cancel your policy

If this policy, or any other GSC individual health policy issued to you, is cancelled or terminated (even if it's due to non-payment of premium), you must wait at least 24 months before reapplying for another GSC individual health plan.

What happens if the *policy owner* dies

If, at the time of your death, your policy includes dependent coverage, we'll continue the coverage of your *dependents* and record your spouse as the new *policy owner*. The benefits under this policy will not change. We'll issue a new policy and GSC Identification Number to your spouse and transfer prior claims history. We may adjust the premium, depending on the number of people who remain covered under the policy. If your policy does not include a spouse, your *dependent's* coverage will end on the first of the month following the date we are notified of your death. If your *dependents* are 18 years of age or older, they may be eligible for their own GSC individual health plan. When your death results in an adjustment of premium and/or refund, we'll limit the refund to a maximum of 3 months premium.

GSC may terminate your coverage

GSC may terminate your coverage if we are unable to obtain full payment of premiums. We will make attempts to contact you prior to terminating your coverage. If a payment can't be processed for any reason, we may charge an administration fee.

If it is discovered that you don't meet the eligibility criteria, GSC will terminate your coverage.

10-Day Satisfaction Guarantee

You can send a request in writing to cancel this policy within 10 days of receiving it. You must send your request to the address or email address shown below. We'll treat the policy as if it never came into effect. We'll refund any premiums paid up to the end of the 10 days, minus any claims we've paid. If the claims we've paid are more than the premiums paid, you must pay us the difference right away. Your right to cancel expires 10 days after you receive this policy.

Special Benefits Insurance Services (SBIS)
20 Toronto Street, Suite 860,
Toronto, ON, M5C 2B8

email: general@sbis.ca

How to make a claim

This section outlines how to submit a claim to us. Please note that we must receive your claim within 12 months from the date the charge for the eligible benefit was incurred. All words in italics are defined in the **Definitions** section.

Questions?

You can get detailed information about making claims by:

- visiting the **Support Centre** at **greenshield.ca**; or
- logging into **gsceverywhere.ca**; or
- calling our Customer Service Centre at 1.888.711.1119

Submitting claims

Many claims for prescription drugs, dental services and vision care can be submitted directly by your health care provider and processed automatically. You can also submit claims through GSC *everywhere.* Visit www.gsceverywhere.ca to register. You'll find it quick, easy and efficient.

Alternatively, you can complete, and mail a paper claim form to us. Claim and pre-authorization forms are available on www.greenshield.ca for you to download, print, complete and mail.

When submitting a claim, you must always give the GSC Identification Number for the *covered person* who has received the benefit. You'll find your GSC Identification Number, ending in –00, on the front of your GSC Identification Card. Numbers for your eligible *dependents* are shown on the back of your card. You should include these GSC Identification Numbers on all claims and correspondence with us.

You'll also need to include copies of the original itemized paid receipts. **We do not accept cash receipts or credit card receipts on their own as proof of payment**.

We reserve the right to ask you for supplementary claims information. If you don't respond to our requests, we may deny your claim.

If you intentionally omit, misrepresent or falsify information relating to a claim, this constitutes fraud. It is a criminal offence to submit a fraudulent claim and we may report it to the relevant law enforcement and regulatory agencies. We may also terminate your coverage under this policy.

When GSC is identified as a secondary carrier, you must submit the original Explanation of Benefits statement from the primary carrier along with a copy of the claim form to receive any balances that you're owed.

We must receive your claim within 12 months from the date the charge for the eligible benefit was incurred.

Overpayment of claims

We reserve the right to recover all amounts resulting from overpaid or unsupported claims for benefits by deducting these amounts from any future claims you make 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 begun within the time set out in the *Limitations Act, 2002*.

In all other provinces and territories, every action or proceeding against GSC for recovery of benefit payment under the plan is absolutely barred unless begun within the time set out in the *Insurance Act*, or other legislation that applies in the province or territory where you live.

Emergency Medical Travel claims

You must contact GSC Travel Assistance by phone within 48 hours of beginning *treatment* (as defined in the **Emergency Medical Travel Benefits** section).

You can call our Customer Service Centre at 1.888.711.1119 for detailed claims submission instructions.

If you've incurred out-of-pocket expenses, make sure you tell GSC Travel Assistance about your travel coverage when submitting claims. You must submit claims together with supporting original receipts to GSC Travel Assistance who will then co-ordinate reimbursement of those approved, eligible expenses from all sources (e.g. provincial/territorial *government health insurance plans* that provide out-of-Canada coverage, a spousal plan, travel coverage provided through your credit card, etc.).

To make a claim, you must submit the patient's name, provincial/territorial *government health insurance plan* number, address and GSC Identification Number, along with a detailed statement of the services provided and the fees charged for each service.

Co-ordination of Benefits (COB)

If you're covered for health and dental benefits under another plan as well as this plan, and both plans permit Co-ordination of Benefits (COB), your benefits under this plan will be co-ordinated with the other plan following the standard industry guidelines developed by the Canadian Life & Health Insurance Association: the total amount payable cannot be greater than 100% of the eligible expense incurred.

Applying COB allows all benefit carriers to identify which plan is the primary payor and which is the secondary payor. We work together with other carriers or benefit plans to make sure you receive the maximum dollar value from all plans that you and your family are entitled to. For example, if you have less than 100% coverage on any one plan, co-ordinating with other carriers/plans may provide you with up to 100% combined coverage overall. However, you can never be reimbursed for more than 100% of the value of services rendered or benefits received.

Spouse

If your spouse is covered under another benefit plan, they must submit claims to that benefit plan first and then submit any remaining balances to this plan. Coverage under this plan will be secondary.

Children

When your dependent children are covered under both your benefit plan and your spouse's benefit plan, you should first submit claims under the plan for the parent whose birth month and day come earlier in the calendar year.

For example:

- Policy Owner: Arthur Smith, born September 1, 1990
- Spouse (ABC Insurance): Gail Smith, born December 10, 1988
- Dependents: Dean Smith, Jack Smith

Since Arthur's birth month is September and Gail's birth month is December, both Dean and Jack would have primary coverage under this benefit plan. Although Gail is older than Arthur, the year of birth is ignored. When both parents have the same birth date, the primary carrier would be the plan of the parent whose initial comes first in the alphabet (Arthur comes before Gail).

General Provisions & Exclusions

This section outlines the general terms and conditions that apply to this policy along with the general exclusions. These are the charges, in addition to what is outlined for each benefit, that aren't covered by your policy. All words in italics are defined in the **Definitions** section.

General Provisions

- **GCS's limitation of liability:** We won't be responsible for any act or omission of any third party providing care, services or supplies. We'll only be liable for the payment of benefits under the terms and conditions of this policy.
- **Time limit for starting a lawsuit**: Any lawsuit against us to recover insurance money payable under the policy is absolutely barred unless it is started within the time set out in the Insurance Act (for actions or proceedings governed by the laws of Alberta, British Columbia and Manitoba), the Limitations Act, 2002 (for actions or proceedings governed by the laws of Ontario), or any other legislation that applies.

Notices: We'll send all notices about the policy, including coverage for *dependents*, to (i) the *policy owner* at the *policy owner's* mailing address or email address that appears on the application for this policy, or (ii) the enrolment mailing address or email address that appears on our records. If you change your mailing address or email address, you must tell SBIS in writing by mail or email so the change can be recorded. Contact SBIS at 1.800.667.0429 or **general@sbis.ca** with any questions.

- **Premiums:** Premiums are based on the age of the *policy owner*, the plan selected, the number of people covered (single, couple, family) and the province/territory of residence.
- **Applicable law:** This policy is governed by and administered under the laws of the province/territory where you live.
- **Administrative policies**: Administrative policies are the policies and procedures that we use to administer benefit plans and adjudicate claims for eligible items purchased and services provided.
    - We always have the right to create or adopt new administrative polices or to amend, alter or revise existing policies.
    - We are the administrator of this policy. You must provide us with the information we need to calculate your premiums and pay your benefits. We have the right to inspect all documents that relate to your coverage and we may ask you to provide us with health information records.
    - We'll keep all your information in our records, according to our policies on privacy and confidentiality. We'll only use it for claims administration and for statistical and administrative reasons.

General Exclusions

In addition to the exclusions listed for individual benefits, shown in the **What is not covered – Exclusions** sections throughout this policy, your benefits also don't include any of the items listed below. That means we won't reimburse you for expenses related to any of the following:

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 *health practitioner* or *dental practitioner*.

4. Charges for translating or completing any claim forms, insurance reports or medical reports for any reason, including if required for a claim audit or non-disclosure investigation.

5. Any form of medical cannabis for the treatment of any medical condition, even if a medical document or prescription from a legally authorized *health practitioner* has authorized it, or you got it from a Health Canada-licensed producer under federal or provincial/territorial legislation or regulation on the access to or distribution of medical cannabis.

6. Any specific treatment or drug that:

   a) doesn't meet accepted standards of medical, dental or ophthalmic practice, including charges for experimental services or supplies;

   b) our drug review process does not consider to be effective (either medically or from a cost perspective) even if Health Canada has approved it;

   c) is an adjunctive (secondary) drug prescribed in connection with any primary treatment or drug that is not an *eligible service*;

   d) is administered in a *hospital* or is required to be administered in a *hospital* according to Health Canada's approved indication for use;

   e) is not dispensed by the pharmacist; or

   f) is being used or administered for a purpose that Health Canada has not approved for its use, even though it may customarily be used in the treatment of other illnesses or injuries (i.e. *off-label use*).

7. Services, supplies or devices that:

   a) the attending legally qualified (in the opinion of GSC) *health practitioner* or *dental practitioner* has not recommended, provided or approved, as permitted by law;

   b) the government has legally prohibited from coverage;

   c) either you're not obligated to pay for; or for which there wouldn't be a charge if you didn't have coverage; or for which a not-for-profit prepayment association, insurance carrier, third party administrator (e.g. agency), or someone other than GSC or you makes a payment on your behalf;

   d) are provided by a *health practitioner* whose license by the relevant provincial/territorial regulatory or professional association has been suspended or revoked;

   e) aren't provided by a designated service provider in response to a prescription issued by a legally qualified *health practitioner* or *dental practitioner*;

   f) are used solely for recreational or sporting activities and aren't *medically necessary* for regular activities;

   g) are primarily for cosmetic or aesthetic purposes, or to correct congenital malformations;

   h) are provided by an immediate family member (parent, spouse, child or sibling) who is related to you by birth, adoption or marriage, or by a practitioner who normally lives in your home; or are provided in a facility that you own or are employed through.

   i) are a replacement for lost, missing or stolen items, or items that are damaged due to negligence. Replacements are eligible only when they're required due to natural wear, growth or relevant change in your medical condition and when the equipment/prostheses can't be adjusted or repaired at a lesser cost and the item is still medically required;

   j) are video instructional kits, informational manuals or pamphlets;

   k) are delivery and transportation charges;

   l) are batteries, unless specifically included as eligible for coverage;

   m) are a duplicate prosthetic device or appliance;

n) are obtained for free from any governmental agency by complying with government laws or regulations (enacted by a federal, provincial/territorial, municipal government or other government body);

o) would normally be paid through any provincial/territorial *government health insurance plan*, Workplace Safety and Insurance Board or tribunal, the Assistive Devices Program or any other government agency; or would have been payable under such a plan if you'd made proper application for coverage or proper and timely claims submission;

p) were previously provided or paid for by any government body or agency, but have been modified, suspended or discontinued due to changes in provincial/territorial *government health insurance plan* legislation or de-listing of any provincial/territorial *government health insurance plan* services or supplies;

q) may include but are not limited to drugs, laboratory services, diagnostic testing or any other service provided by or administered in any public or private health care clinic or similar facility, health practitioner's office or residence, where the treatment or drug doesn't meet the accepted standards or isn't considered to be effective (either medically or from a cost perspective, based on Health Canada's approved indication for use);

r) are provided by a health practitioner who has opted out of a provincial/territorial *government health insurance plan* that would have otherwise paid for that *eligible service*;

s) are cognitive or administrative services or other fees charged by a *service provider* for services other than those directly relating to the delivery of the service or supply; or

t) relate to treatment of injuries caused by a motor vehicle accident.

Automobile accidents: We'll only consider paying claims relating to automobile accidents where coverage is available under a motor vehicle liability policy providing no-fault benefits if:

- the services or supplies you're claiming aren't eligible; or
- the financial commitment is complete.

You'll need to send us a letter from your automobile insurance carrier when you submit your claim.

Statutory Conditions

Legally, we have to include certain conditions, called “Statutory Conditions”, in this policy. These conditions do not apply if you are a resident of Quebec.

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

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

3. **Copy of application**: A copy of the application is included as an enclosure. GSC shall, upon request, furnish to the *policy owner* or to a claimant under the contract an additional copy of the application.

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

5. **Notice and proof of claim**:

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

      (a) Give written notice of claim to GSC

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

      (b) Furnish to GSC no later than 364 days after the date a claim arises under the contract such proof as is reasonably possible in the circumstances of

         i. The happening of the *accident* or the start of the sickness,

         ii. The loss caused by the *accident* or sickness,

         iii. The right of the claimant to receive payment,

         iv. The claimant’s age and,

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

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

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

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

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

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

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

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

Definitions

These definitions apply every time these terms appear in *italics* in this policy.

accident* or *accidental:	an unintentional, sudden or unforeseeable event due exclusively to an external cause inflicting bodily injuries (directly and independently of all other causes).
biologic drug:	a drug produced using living cells or microorganisms (e.g. bacteria) and often manufactured using a specific process known as DNA technology.
biosimilar drug:	a *biologic drug* demonstrated to be similar to a *reference biologic drug* already authorized for sale by Health Canada.
brace:	a rigid or semi-rigid supporting device or appliance that fits on and is attached to the body. It doesn't include any brace used to correct a dental defect, deficiency or injury.
calendar year:	the 12 consecutive months from January 1st to December 31st of each year.
consulting:	seeking advice or treatment from any *physician* or health care professional for any condition, injury, disease or disorder, including discussion of possible further testing, treatment or surgery.
covered person:	the *policy owner* or your *dependents*.
custom-made boots or shoes:	Footwear used by a *covered person* whose condition can't be accommodated by existing footwear products. Making this footwear involves making a unique cast of the person's feet using 100% raw material. (This footwear is used to accommodate bony and structural abnormalities of the feet and lower legs caused by trauma, disease or congenital deformities.)
custom-made foot orthotics:	a device made, using raw materials from a 3-dimensional model of a *covered person's* foot. (This device is used to relieve foot pain related to biomechanical misalignment of the feet and lower limbs.)
dental practitioner:	a person certified to practice dentistry or a specific dental discipline, who holds a valid license to practice that discipline from the applicable provincial/territorial regulatory agency or governing body of that discipline. *Dental practitioner* includes a general dentist (DDS), dental hygienist, denturist/denture therapist, or dentists specializing in such disciplines as prosthodontics, endodontics, periodontics, oral surgery, or orthodontics.
dentist:	a practitioner of dentistry who is lawfully qualified and licensed to practice in the jurisdiction in which he or she has provided the services or supplies for which the charges are incurred.

dependent: This can be your spouse or dependent children. Your spouse is the person to whom you're legally married or partner with whom you've lived continually in a common-law relationship for more than 12 months and publicly represent as your spouse/partner. This policy can cover only one spouse/partner at any time. Dependent children are your unmarried children under age 21 including natural children, stepchildren, common-law children, legally adopted children and children under your legal guardianship. Children age 21 and over are eligible if they became dependent upon you due to a mental or physical disability before they turned 21 and have been continuously disabled since that time and you must be able to claim disability tax credit for them under the Income Tax Act.

***effective date*:** the date the coverage under this policy starts.

eligible services/supplies: services and supplies incurred by a *covered person* that are payable by us, as set out in this policy and subject to its exclusions, limitations and conditions (and any later amendments).

fee guide: the list of dental procedure codes developed by and maintained by the Canadian Dental Association, adopted by the provincial/territorial dental association of the province/territory in which the service is provided (or the province/territory where you live if any dental service is provided outside Canada) and in effect at the time the service is provided.

government health insurance plan: any plan or arrangement provided by or under the administrative supervision of any government or agency that provides coverage or reimbursement for any drug, health care service or supply, including the provincial/territorial government health plan, provincial/territorial public drug benefit plan, home care program, Assistive Devices Program or Workplace Safety and Insurance Board or tribunal of the *covered person's* province/territory of residence.

***health practitioner*:** a person who is certified to practice medicine or a specific medical or health care discipline and holds a valid license to practice that discipline from the applicable provincial/territorial regulatory agency or governing body of that discipline. This includes a *physician* (M.D.), nurse practitioner, chiropractor, podiatrist or chiropodist, registered dietitian, registered massage therapist, physiotherapist, psychologist, psychotherapist, registered social worker (RSW), naturopath, osteopath or speech therapist.

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

medically necessary: a treatment, service or supply generally accepted by the medical profession as essential, effective and appropriate in the care and treatment of a medical condition, sickness or injury.

off-label use: using a drug for a purpose or treatment of a condition that Health Canada has not approved for that drug.

payor:	a person or entity who pays the premiums for the coverage or pays the claims for this policy.
physician:	a person who is lawfully qualified and licensed to practice medicine without restriction in the area where the services are rendered.
policy owner:	the primary applicant for this policy who is also the owner of the contract. We charge premiums based on the policy owner's age but the policy owner doesn't have to be the person who makes the premium payments.
reasonable and customary:	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 usual charge in the area for a similar service or supply.
reference biologic drug:	a biologic drug that is first authorized for sale by Health Canada.
service provider:	any person, corporation or other entity authorized to provide eligible benefits under GSC's administrative policies.

Our Privacy Policy

We respect your privacy and are committed to protecting it by complying with our publicly accessible Privacy Policy. We'll only use your personal information in accordance with this policy unless otherwise required by any laws that apply. We take steps to make sure that the personal information that we collect about you is accurate, relevant, not excessive, and used for limited purposes.

Why we need personal information

We need personal information to administer your benefits plan, such as:

- providing you with benefits coverage;
- confirming your identity and the accuracy of your information;
- processing claims and administering the products and services we provide including, if needed, communicating with you and *service providers* about the services they provide;
- protecting you and us from errors, misrepresentations, fraud, and contravention of laws or criminal activity; and
- giving you access to other services we provide.

We don't sell or distribute our customer lists for marketing purposes.

Collecting, using and keeping your personal information

We collect the personal information we need to decide your eligibility for our benefits plans and to process claims under these plans. That information includes your name, contact details, age, sex, health status, health history, family information and financial information.

We only keep this information, subject to legal and regulatory requirements, for as long as we need it to provide you with the products and services you're using, and for a period of time afterwards in line with legal and regulatory requirements. We destroy your personal information or remove your name from it when we no longer need it. We may also record telephone calls with you for quality and accuracy assurance purposes.

Accessing your personal information

You may ask to review or correct your personal information that we keep in our files by calling us at 1.888.711.1119 or writing to us at:

Privacy Officer
Green Shield Canada
P.O. Box 1606
Windsor, ON N9A 6W1

email: privacyoffice@greenshield.ca

We'll give you access to your personal information once we verify your identity and your right to this access. We may not be able to provide information about you from our records if it:

- refers to another person (even your spouse or dependent child);
- is subject to legal privilege; or
- contains information that is proprietary to us or that we can't disclose for other legal reasons.

If you identify information that needs to be corrected, we'll help you identify the appropriate way to make the correction.

Need more information?

This is a summary of our full Privacy Policy. You can get a copy of it by calling us at 1.888.711.1119 or visiting our website at **www.greenshield.ca**.