

BENEFIT PLAN

University of Toronto Graduate Students' Union

Billing Divisions: 51000, 51001, 51002

Revised Effective Date: September 1, 2018

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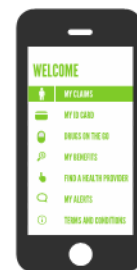
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WELCOME TO YOUR BENEFIT PLAN

ABOUT THIS BOOKLET

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

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

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

Your Identification Card can be found on the Student Centre website at student.greenshield.ca. Your GSC Identification Number is to be used on all claims and correspondence. Your unique GSC Identification Number is your student identification number with the prefix "UTG" and ends with -00 – e.g. UTG111222333-00. If you have any eligible dependents, they share the same number as you except their number ends with their own unique dependent code.

YOUR BENEFIT PROVIDER IS:

Green Shield Canada (GSC)

- Prescription Drugs, Health and Dental Benefit Plans

PLAN MEMBER ONLINE SERVICES

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

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

OUR COMMITMENT TO PRIVACY

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

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

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SCHEDULE OF BENEFITS

HEALTH BENEFIT PLAN

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

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

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

Note: Some benefits shown below are eligible only when they are required as the direct result of an accident. Please refer to the Description of Benefits section for details.

Deductible: Nil	Overall Maximum: Unlimited
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<p>Your Co-pay: Prescription Drugs - 20% of allowed amount per prescription or refill All Other Health Benefits - Nil</p>
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Your Plan Covers:	Maximum Plan Pays:
Prescription Drugs – Pay Direct Drug Card	\$5,000 per benefit year
<ul style="list-style-type: none"> • HPV Vaccines <ul style="list-style-type: none"> ▪ Gardasil Vaccine ▪ Cervarix Vaccine 	Reasonable and customary charges (included in the \$5,000 Prescription Drug Maximum)
Hospital Accommodation	
<ul style="list-style-type: none"> • Public general hospital - semi-private room 	Reasonable and customary charges for a hospital stay due to an accident
Medical Items and Services	
<ul style="list-style-type: none"> • Footwear <ul style="list-style-type: none"> ▪ custom made foot orthotics 	\$350 per benefit year
<ul style="list-style-type: none"> • Other items and services – See the Description of Benefits section for details 	Reasonable and customary charges
Emergency Transportation	Reasonable and customary charges
Private Duty Nursing in the Home	\$25,000 every 3 benefit years

Your Plan Covers:	Maximum Plan Pays:
Professional Services	
<ul style="list-style-type: none"> Chiropractor Naturopath Acupuncturist 	\$15 per visit up to 20 visits per benefit year per practitioner
<ul style="list-style-type: none"> Chiropodist or Podiatrist 	Reasonable and customary charges
<ul style="list-style-type: none"> Registered Massage Therapist (Physician (M.D.) or nurse practitioner recommendation required) 	\$25 per visit up to \$500 per benefit year
<ul style="list-style-type: none"> Physiotherapist 	\$30 per visit up to 20 visits per benefit year
<ul style="list-style-type: none"> Psychologist, Master of Social Work, or Psychotherapist 	\$500 per benefit year combined
<ul style="list-style-type: none"> Speech Therapist 	\$1,000 per benefit year
<ul style="list-style-type: none"> Tutorial Benefit Note: Your dependents are not eligible for this benefit 	Private tutorial service of a qualified teacher at \$15 per hour, up to \$1,000 per disability. You must be confined to home or hospital for a minimum of 15 consecutive days to qualify.
Accidental Dental	Reasonable and customary charges
Vision	
<ul style="list-style-type: none"> prescription eye glasses or contact lenses, or medically necessary contact lenses, or laser eye surgery 	\$125 per 24 consecutive months based on date of first paid claim (every 12 months for dependent children 17 years of age and under)
<ul style="list-style-type: none"> Optometric eye exams 	\$75 once every 24 months based on date of first paid claim (every 12 months for dependent children 17 years of age and under)

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

DENTAL BENEFIT PLAN

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

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

Deductible:	Nil
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Fee Guide:	<p>The current Provincial Dental Association Fee Guide for General Practitioners in the province where services are rendered</p> <p>For independent Dental Hygienists, the lesser of, the current Provincial Dental Hygienists' Association Fee Guide and Provincial Dental Association Fee Guide for General Practitioners in the province where services are rendered</p>
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Your Plan Covers:	Your Co-Pay:	Maximum Plan Pays:
Basic Services and Comprehensive Basic Services	30%	\$550 per covered person per benefit year

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

DEFINITIONS

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

Accident means a bodily injury that has occurred solely as a direct result of a violent, sudden and unexpected action from an outside source, including injuries resulting from sports.

Allowed amount means, as determined by GSC:

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

Benefit year means the 12 consecutive months starting September 1st and ending August 31st of each year.

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

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

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

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

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

Dependent means

- a) your spouse, if you are legally married or if not legally married, you have lived in a common-law relationship for more than 12 continuous months. Only one spouse will be considered at any time as being covered under the group contract;
- b) your unmarried child under age 22;
- c) your unmarried child under age 25, if enrolled and in full-time attendance at an accredited college, university or educational institute.

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

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

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

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

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

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

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

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

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

ELIGIBILITY

For You

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

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

For your Dependents

To be eligible for coverage you must be:

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

Coverage Effective Date

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

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

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

Termination

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

- a) the date you are no longer a member or staff member of the student association shown on the cover of this booklet;
- b) the end of the period for which rates have been paid to GSC for your coverage;
- c) the date the group contract terminates.

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

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

Dependent Children Continuation of Coverage

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

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

Group Conversion – GSC Health Assist LINK Program

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

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

Click [here](#) to apply, or contact Prosum Health Benefits Inc. at 1.855.751.6590 for assistance.

DESCRIPTION OF BENEFITS

HEALTH BENEFIT PLAN

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

Prescription Drugs

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

- a) are prescribed by a legally qualified medical practitioner or dental practitioner as permitted by law; and
- b) legally require a prescription and has a Drug Identification Number (DIN); and
- c) are paid on a Pay Direct basis.

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

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

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

Generic drug substitution

Reimbursement will be made for the cost of the lowest priced equivalent drug based on specific provincial regulations, unless your medical or dental practitioner has written that there is to be no substitution of the prescribed drug or medicine.

NOTE:

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

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

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

- a) Drugs for the treatment of obesity, erectile dysfunction and infertility;
- b) Vitamins, that do not legally require a prescription;
- c) Smoking cessation drugs and Nicotine replacement products, such as patches, gum, lozenges, and inhalers;
- d) Products which may lawfully be sold or offered for sale other than through retail pharmacies, and which are not normally considered by practitioners as medicines for which a prescription is necessary or required;
- e) Ingredients or products which have not been approved by Health Canada for the treatment of a medical condition or disease and are deemed to be experimental in nature and/or may be in the testing stage;
- f) Mixtures, compounded by a pharmacist, that do not conform to GSC's current Compound Policy.

Extended Health Services

1. **Hospital Accommodation:** When required as a result of an Accident, reimbursement, as shown in the Schedule of Benefits, of reasonable and customary charges in the area where received, for accommodation in a public general hospital, provided your provincial health insurance plan has accepted or agreed to pay the ward or standard rate.
2. **Medical Items and Services:** When required as a result of an Accident (with the exception of Footwear, Diabetic, Incontinence and Ostomy Equipment) and when prescribed by a legally qualified medical practitioner. Unless specified otherwise below, reimbursement will be for reasonable and customary charges, up to the amount, where applicable, as shown in the Schedule of Benefits for:
 - a) Aids for daily living: such as hospital style beds, including rails and mattresses; bedpans; standard commodes; decubitus (bedridden) supplies; I.V. stands; portable patient lifts (including batteries); trapezes; urinals;
 - b) Footwear, when prescribed by your attending physician, nurse practitioner, podiatrist or chiropodist and dispensed by your podiatrist, chiropodist, chiropractor, orthotist, or pedorthist:
 - i) custom made foot orthotics or adjustments to custom made foot orthotics;
 - c) Braces, casts;
 - d) Diabetic equipment, such as:
 - i) blood glucose meters;
 - ii) lancets;
 - iii) glucose monitoring systems (GMS) such as continuous and flash type monitors subject to medical pre-authorization and reimbursed to the cost of a blood glucose meter. Disposable GMS supplies (used with the monitor), such as, but not limited to sensors and transmitters, are included and subject to any overall annual maximum applicable to diabetic testing and monitoring equipment and supplies;
 - e) Medical services, such as diagnostic tests, X-rays and laboratory tests;
 - f) Incontinence/Ostomy equipment, such as catheter supplies and ostomy supplies;
 - g) Mobility aids, such as canes, crutches, walkers and wheelchairs (including wheelchair batteries);
 - h) Standard prosthetics, such as arm, hand, leg, foot, breast, eye and larynx;
 - i) Respiratory/Cardiology equipment, such as compressors, inhalant devices, tracheotomy supplies and oxygen;
 - j) Compression stockings.

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

Limitations

- a) The rental price of durable medical equipment will not exceed the purchase price. GSC's decision to purchase or rent will be based on the legally qualified medical practitioner's estimate of the duration of need as established by the original prescription. Rental authorization may be granted for the prescribed duration. Equipment that has been refurbished by the supplier for resale is not an eligible benefit;
- b) Durable medical equipment must be appropriate for use in the home, able to withstand repeated use and generally not useful in the absence of illness or injury;
- c) When deluxe medical equipment is a covered benefit, reimbursement will be made only when deluxe features are required in order for the covered person to effectively operate the equipment. Items that are not primarily medical in nature or that are for comfort and convenience are not eligible.

3. **Emergency Transportation:** Reimbursement for professional land or air ambulance to the nearest hospital equipped to provide the required treatment, when medically required as the result of an injury, illness or acute physical disability.
4. **Private Duty Nursing in the Home:** When required as a result of an Accident, reimbursement for the services of a Registered Nurse (R.N.) or Registered Practical Nurse/Licensed Practical Nurse (R.P.N./L.P.N.) in the home on a visit or shift basis, up to the amount shown in the Schedule of Benefits. No amount will be paid for services which are custodial and/or services which do not require the skill level of a Registered Nurse (R.N.) or Registered Practical Nurse/Licensed Practical Nurse (R.P.N./L.P.N.).
A Pre-Authorization Form for Private Duty Nursing must be completed by the attending physician and submitted to GSC.
5. **Professional Services:** Reimbursement for the services of the practitioners included, up to the amount shown in the Schedule of Benefits, when the practitioner rendering the service is licensed by their provincial regulatory agency or a registered member of a professional association and that association is recognized by GSC. Please contact the GSC Customer Service Centre to confirm practitioner eligibility.

NOTE:

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

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

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

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

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

7. **Vision:** Reimbursement for the services performed by a licensed Optometrist, Optician or Ophthalmologist, up to the amounts shown in the Schedule of Benefits, for:
- a) Prescription eyeglasses or contact lenses;
 - b) Medically necessary contact lenses when visual acuity cannot otherwise be corrected to at least 20/40 in the better eye or when medically necessary due to keratoconus, irregular astigmatism, irregular corneal curvature or physical deformity resulting in an inability to wear normal frames;
 - c) Optometric eye examinations for visual acuity performed by a licensed optometrist, ophthalmologist or physician (available only in those provinces where eye examinations are not covered by the provincial health insurance plan);
 - d) Replacement parts for prescription eyeglasses;
 - e) Laser eye surgery;
 - f) Plano sunglasses prescribed by a legally qualified medical practitioner for the treatment of specific ophthalmic diseases or conditions.

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

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

Health Exclusions

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

1. Services or supplies received as a result of disease, illness or injury due to:
 - a) an act of war, declared or undeclared;
 - b) participation in a riot or civil commotion; or
 - c) committing a criminal offence;
2. Services or supplies provided while serving in the armed forces of any country;
3. Failure to keep a scheduled appointment with a legally qualified medical or dental practitioner;
4. The completion of any claim forms and/or insurance reports;
5. Any form of medical cannabis for the treatment of any medical condition, regardless of whether it is authorized by way of a medical document from a legally-authorized medical practitioner and obtained from a Health Canada-licensed producer pursuant to the *Access to Cannabis for Medical Purposes Regulations*;
6. Any specific treatment or drug which:
 - a) does not meet accepted standards of medical, dental or ophthalmic practice, including charges for services or supplies which are experimental in nature, or is not considered to be effective (either medically or from a cost perspective, based on Health Canada's approved indication for use);
 - b) is an adjunctive drug prescribed in connection with any treatment or drug that is not an eligible service;
 - c) is administered in a hospital or is required to be administered in a hospital in accordance with Health Canada's approved indication for use;
 - d) is not dispensed by the pharmacist in accordance with the payment method shown under the Prescription Drugs benefit;
 - e) is not being used and/or administered in accordance with Health Canada's approved indication for use, even though such drug or procedure may customarily be used in the treatment of other illnesses or injuries;
7. Services or supplies that:
 - a) are not recommended, provided by or approved by the attending legally qualified (in the opinion of GSC) medical practitioner or dental practitioner as permitted by law;
 - b) are legally prohibited by the government from coverage;
 - c) you are not obligated to pay for or for which no charge would be made in the absence of benefit coverage or for which payment is made on your behalf by a not-for-profit prepayment association, insurance carrier, third party administrator, like agency or a party other than GSC, your plan sponsor or you;
 - d) are provided by a health practitioner whose license by the relevant provincial regulatory and/or professional association has been suspended or revoked;
 - e) are not provided by a designated provider of service in response to a prescription issued by a legally qualified health practitioner;
 - f) are used solely for recreational or sporting activities and which are not medically necessary for regular activities;
 - g) are primarily for cosmetic or aesthetic purposes, or are to correct congenital malformations;
 - h) are provided by an immediate family member related to you by birth, adoption, or by marriage and/or a practitioner who normally resides in your home. An immediate family member includes a parent, spouse, child or sibling;

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

DENTAL BENEFIT PLAN

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

Basic Services

1. Basic Diagnostic and Preventive Services:
 - complete oral examinations once every 3 years based on date of first paid claim
 - emergency and specific oral examinations
 - full series X-rays and panoramic X-rays once every 3 years based on date of first paid claim
 - bitewing X-rays once per benefit year
 - recall examinations once per benefit year
 - cleaning of teeth (up to 1 unit of polishing, plus up to 1 unit of scaling) once per recall period
 - topical application of fluoride once per recall period for covered persons 18 years of age and under
 - oral hygiene instruction once per recall period
 - denture cleaning once per recall period
 - pit and fissure sealants on molars only, for covered persons 14 years of age and under
 - space maintainers
2. Basic Restorative Services:
 - amalgam, tooth coloured filling restorations (paid to full metal on molars), and temporary sedative fillings
 - inlay restorations – these are considered basic restorations and will be paid to the equivalent non-bonded amalgam
3. Basic oral surgery:
 - extractions of teeth and/or residual roots
4. General anaesthesia, deep sedation, and intravenous sedation in conjunction with eligible oral surgery only

Comprehensive Basic Services

1. Standard denture services:
 - denture repairs and/or tooth/teeth additions
 - standard relining and rebasing of dentures once every 12 months based on date of first paid claim, only after 6 months have elapsed from the installation of a denture
 - denture adjustments and remount and equilibration procedures, only after 3 months have elapsed from the installation of a denture
 - soft tissue conditioning linings for the gums to promote healing
 - remake of a partial denture using existing framework, once every 5 years based on date of first paid claim
2. Comprehensive oral surgery:
 - surgical exposure, repositioning, transplantation or enucleation of teeth
 - remodeling and recontouring - shaping or restructuring of bone or gum
 - excision - removal of cysts and tumors
 - incision - drainage and/or exploration of soft or hard tissue
 - fractures including the treatment of the dislocation and/or fracture of the lower or upper jaw and repair of soft tissue lacerations
 - maxillofacial deformities - frenectomy - surgery on the fold of the tissue connecting the lip to the gum or the tongue to the floor of the mouth

3. Endodontic treatment including:
 - root canal therapy
 - pulpotomy (removal of the pulp from the crown portion of the tooth)
 - pulpectomy (removal of the pulp from the crown and root portion of the tooth)
 - apexification (assistance of root tip closure)
 - apical curettage, root resections and retrograde fillings (cleaning and removing diseased tissue of the root tip)
 - root amputation and hemisection
 - bleaching of non-vital tooth/teeth
 - emergency procedures including opening or draining of the gum/tooth
4. Periodontal treatment of diseased bone and gums including:
 - periodontal scaling and/or root planing 8 time units per benefit year
 - occlusal equilibration - selective grinding of tooth surfaces to adjust a bite 2 time units every 12 months based on date of first paid claim

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

- bruxism appliance once every 12 months based on date of first paid claim

Alternate Treatment

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

Predetermination

Before your treatment begins, if the total cost of any proposed treatment is expected to exceed \$300, it is recommended that you submit an estimate completed by your dental practitioner.

Limitations

1. Laboratory services must be completed in conjunction with other services and will be limited to the co-pay of such services. Laboratory services that are in excess of 40% of the dentist's fee in the applicable Fee Guide shown in the Schedule of Benefits will be reduced accordingly; co-pay is then applied;
2. Reimbursement will be made according to standard and/or basic services, supplies or treatment. Related expenses beyond the standard and/or basic services, supplies or treatment will remain your responsibility;
3. Reimbursement will be pro-rated and reduced accordingly, when time spent by the dentist is less than the average time assigned to a dental service procedure code in the applicable Fee Guide shown in the Schedule of Benefits;
4. Reimbursement for root canal therapy will be limited to payment once only per tooth. Extra charges for difficult access, exceptional anatomy, calcified and retreatments are not included. The total fee for root canal includes all pulpotomies and pulpectomies performed on the same tooth;
5. Common surfaces on the same tooth/same day will be assessed as one surface. If individual surfaces are restored on the same tooth/same day, payment will be assessed according to the procedure code representing the combined surface. Payment will be limited to a maximum of 5 surfaces in any 36 month period;

6. When more than one surgical procedure, including multiple periodontal surgical procedures, is performed during the same appointment in the same area of the mouth, only the most comprehensive procedure will be eligible for reimbursement, as the fee for each procedure is based on complete, comprehensive treatment, and is deemed part of the multiple services factor;
7. The multiple services factor occurs when a minimum of 6 or more restorations (fillings) or multiple periodontal services are performed at the same appointment and the full fee guide price is charged for each restoration or periodontal service, the first service will be paid in full and all remaining services will be reduced by 20%;
8. Root planing is not eligible if done at the same time as gingival curettage;
9. In the event of a dental accident, claims should be submitted under the health benefits plan before submitting them under the dental plan.

Dental Exclusions

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

1. Services or supplies received as a result of disease, illness or injury due to:
 - a) an act of war, declared or undeclared;
 - b) participation in a riot or civil commotion; or
 - c) committing a criminal offence;
2. Services or supplies provided while serving in the armed forces of any country;
3. Failure to keep a scheduled appointment with a legally qualified dental practitioner;
4. The completion of any claim forms and/or insurance reports;
5. Any dental service that is not contained in the procedure codes developed and maintained by the Canadian Dental Association, adopted by the provincial or territorial dental association of the province or territory in which the service is provided (or your province of residence if any dental service is provided outside Canada) and in effect at the time the service is provided;
6. Implants;
7. Restorations necessary for wear, acid erosion, vertical dimension and/or restoring occlusion;
8. Appliances related to treatment of myofascial pain syndrome including all diagnostic models, gnathological determinants, maintenance, adjustments, repairs and relines;
9. Posterior cantilever pontics/teeth and extra pontics/teeth to fill in diastemas/spaces;
10. Service and charges for sleep dentistry;
11. Diagnostic and/or intraoral repositioning appliances including maintenance, adjustments, repairs and relines related to treatment of temporomandibular joint dysfunction;
12. Any specific treatment or drug which:
 - a) does not meet accepted standards of medical, dental or ophthalmic practice, including charges for services or supplies which are experimental in nature, or is not considered to be effective (either medically or from a cost perspective, based on Health Canada's approved indication for use);
 - b) is an adjunctive drug prescribed in connection with any treatment or drug that is not an eligible service;
 - c) is administered in a hospital or is required to be administered in a hospital in accordance with Health Canada's approved indication for use;
 - d) is not dispensed by the pharmacist in accordance with the payment method shown under the Health Benefit Plan Prescription Drugs benefit;
 - e) is not being used and/or administered in accordance with Health Canada's approved indication for use, even though such drug or procedure may customarily be used in the treatment of other illnesses or injuries;

13. Services or supplies that:

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

CLAIM INFORMATION

Inquiries

For detailed inquiries:

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

Pre-authorization

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

Submitting Claims

All claims submitted to GSC require your GSC Identification number. Your GSC Identification Number is your student number with the prefix "**UTG**" – e.g. **UTG111222333**.

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

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

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

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

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

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

Submit all Claim Forms to:

GSC

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

Reimbursement

Reimbursement will be made by one of the following methods:

- a) Direct deposit to your personal bank account, when requested;
- b) A reimbursement cheque; or
- c) Direct payment to the provider of services, where applicable.

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

Direct Payment to the Provider of Service (where applicable)

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

Subrogation

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

Co-ordination of Benefits (COB)

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

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

GSC Plan Member

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

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

Spouse

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

Children

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

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

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