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Health & Dental

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POLICY BOOKLET

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Coverage provided by:

GreenShield

Green Shield Canada, 8677 Anchor Drive, PO Box 1606, Windsor, ON N9A 6W1

Reimbursement

If a covered person incurs charges for eligible services or supplies as described in this booklet, Green Shield Canada (GSC) will pay for those charges subject to the exclusions, limitations and conditions stated in this booklet and/or subsequent amendments made to the benefit plan described in this booklet.

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

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

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

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

    a) a reimbursement cheque;

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

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

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

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

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

6. Reimbursement will not be made for any eligible services unless the premiums due by you have been paid in full at the time the eligible benefit was rendered. Benefits are not eligible for charges incurred prior to the effective date of coverage.

Description of Benefits

The following is a description of the benefits available. Some benefits described in this booklet may not apply to you.

You are covered for only the benefits for which you applied, were approved, and for which your premium has been received. Please refer to your Schedule of Benefits for confirmation of the details of the coverage for the specific plan you selected and for which you were approved.

Coverage provided under this benefit plan is supplementary to your provincial coverage, and cannot be used instead of your provincial coverage. Benefits are subject to exclusions, limitations, conditions and reductions of coverage which may appear in either the description of the benefit or under a separate heading within this booklet, or on your Schedule of Benefits.

Extended Health Benefits

1. **Accidental dental:** *Subject to the maximum stated in your Schedule of Benefits.*
    - Reimbursement for the services of a licensed dental practitioner for dental care to natural teeth by an accidental direct blow to the mouth and not by an object wittingly or unwittingly placed in the mouth. The accident must occur while the coverage is in force. When natural teeth have been damaged eligible services are limited to one set of artificial teeth.
    - You must notify GSC of the injury no later than 30 days from the date of the accident
    - Treatment must commence within 180 days following the injury and be completed within 365 days following the injury.
    - No payment will be made for services performed after the date that you or your dependent(s) cease to be covered under this benefit plan.
    - This benefit excludes periodontal or orthodontic treatments and/or the repair or replacement of artificial teeth.
    - Payment will be based on the current Provincial Dental Association suggested Fee Guide for General Practitioners in the province where the services are rendered. Approval will be based on the current status and/or benefit level of the covered person at the time that we are notified of the accident. Any change in coverage will alter GSC's liability. Where multiple fee guides exist, the lesser will be applied

- Pre-determination: A Dental Accident Report Form, along with your dental X-rays must be submitted to GSC for prior approval.

2. Ambulance transportation: Reimbursement for medically necessary emergency professional ambulance services by land or air to the nearest hospital equipped to provide the required treatment. Payment is limited to the difference in amount between the provincial government health plan allowance and the reasonable and customary charges for such services, as determined by GSC.

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

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

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

- Reimbursement for the services of a Registered Nurse (R.N.) or Registered Practical Nurse/Licensed Practical Nurse (R.P.N./L.P.N.) or Personal Support Worker (PSW) in the home only on a visit or shift basis.
- No amount will be paid for services which are custodial and/or services which do not require the skill level of a R.N. or R.P.N./L.P.N. or PSW.
- A Pre-Authorization Form for Home support services must be completed by the attending physician and submitted to GSC. Contact our Customer Service Centre at 1.888.711.1119 to confirm eligibility and to obtain detailed claiming procedures.

5. **Medical items:** *Subject to the maximum and limitations stated in your Schedule of Benefits.*

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

b) **Braces, casts**;

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

d) **Compression stockings** with a pressure measurement of 15 mmgh or higher;

e) **Diabetic equipment:** such as blood glucose meters and lancets;

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

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

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

h) **Standard prosthetics:** such as an arm, breast, ear, eye, foot, hand, larynx, leg, nose; prosthetic eyewear (glasses or contact lenses) is limited to once per lifetime following cataract surgery; prosthetic accessories, modifications and repairs; surgical brassieres following a mastectomy; wigs for temporary or permanent hair loss as a result of a medical condition;

i) **Respiratory/Cardiology:** such as automatic and continuous positive airway pressure pumps (CPAP, BiPAP and APAP machines and supplies) and required modifications and/or repairs, breathing and heart monitor for infants, compressor, inhalant devices, tracheotomy supplies, oxygen.

Submit a Pre-Authorization Form to GSC to confirm eligibility prior to purchasing or renting medical items or equipment. Failure to comply may result in non-payment.

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

7. **Professional services/Registered therapists**: *Subject to the maximum stated in your Schedule of Benefits.*

   Reimbursement for the services of the following practitioners, when the practitioner is licensed, certified or registered by their provincial regulatory agency or a registered member of a professional

association, and that association is recognized by GSC. Please contact the GSC Customer Service Centre to confirm practitioner eligibility.

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

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

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

- Reimbursement for the services performed by a licensed Optometrist, Optician or Ophthalmologist for prescription eyeglasses, contact lenses or laser eye surgery.
- Commencement of the allowable 24-month benefit period is based on the initial date that vision benefits are paid; subsequent vision benefits are only eligible 24 months after the prior claim.
- Optometric eye examinations for visual acuity performed by a licensed optometrist, ophthalmologist or physician limited to one eye exam in a 24-month period. This benefit is only available for residents in provinces where eye exams are not covered by the provincial health insurance plan.

Limitations

i. 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 which has been refurbished by the supplier for resale is not an eligible benefit.

ii. 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.

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

Exclusions

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

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

ii. Medical or surgical audio and visual treatment.

iii. Any special or unusual procedures such as, but not limited to, orthoptics, vision training, subnormal vision aids and aniseikonic lenses.

iv. Follow-up visits associated with the dispensing and fitting of contact lenses.

v. Charges for eyeglass cases.

vi. Incontinence diapers.

vii. Insulin pumps and supplies.

Prescription Drug Benefits

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

- Eligible drug benefits will be paid on a pay-direct basis (your pharmacy can bill GSC directly);
- Benefits include prescription drugs that are prescribed by a legally qualified medical practitioner or dental practitioner as permitted by law and legally require a prescription and have a Drug Identification Number (DIN) and are approved under GSC's drug review process;

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

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

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

Certain drugs require a prior authorization from GSC before your drug claim can be reimbursed. You can find out if your drug requires prior authorization either by checking your coverage under "Your Health Benefits" on GSC everywhere, or by contacting GSC's Customer Service Centre.

Mandatory generic substitution: based on specific provincial health insurance plan regulations, where a generic equivalent drug exists, reimbursement will be made up to the cost of the lowest priced equivalent drug. (Note: If a medical practitioner prescribes a brand

name drug indicating no substitution, you will be required to pay the difference).

NOTES:

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

Limitations

i. With respect to Quebec residents only, in no event will the amount dispensed exceed a 3-month supply (6 months if a vacation supply is required) of a prescription at any one time and not more than a 13-month supply in any 12 consecutive months.

ii. With respect to all other provinces, maintenance drugs required to treat lifelong chronic conditions may be required to 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.

iii. Upon notice of termination, the maximum amount dispensed will not exceed a 30-day supply of a prescription at any one time.

Exclusions

In addition to the General Exclusions section of this booklet, eligible benefits do not include and no amount will be paid for:

i. Drugs for the treatment of erectile dysfunction, infertility, or obesity.

ii. Reference biologic drugs that have an approved biosimilar.

iii. Smoking cessation products.

iv. Natural Health Products, or homeopathic medicine products such as oral vitamins and minerals, herbal remedies, homeopathic medicines, traditional medicines (such as traditional Chinese medicines), probiotics or products such as amino acids and essential fatty acids.

v. Vitamins, other than injectable.

vi. 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.

vii. Mixtures compounded by a pharmacist that do not conform to GSC's current Compound Policy.

viii. An adjunctive drug prescribed in connection with any treatment or drug that is not an eligible service.

ix. Any specific treatment or drug which is not dispensed by the pharmacist in accordance with the payment method shown above.

x. Any exclusions outlined in the Counter Offer/Authorization to Proceed, if applicable.

Dental Benefits

Refer to your Schedule of Benefits to confirm if this coverage is included in your benefit plan.

All coverage is subject to any frequency limitations, terms, and maximums stated in your Schedule of Benefits.

Dental benefits are eligible after a 1 month waiting period following your coverage effective date. This Dental waiting period does not apply to plans under a Multi-Life billing arrangement.

- Reimbursement for charges incurred for dental care or services outlined below, provided the charges do not exceed the amount stated in the current Dental Association suggested Fee Guide for General Practitioners in your province of residence, in effect at the time the services are rendered;
  - In provinces with more than one fee guide, GSC will reimburse according to the least expensive standard fee (or fee range);
  - For independent Dental Hygienists, the current Provincial Dental Hygienists' Association Fee Guide in your province of residence.
- Treatment rendered by a specialist will be reimbursed in accordance with the Fee Guide for General Practitioners.

Basic Services

1. **Diagnostic Services**
   a) Complete oral examinations;
   b) Emergency and specific oral examinations;
   c) Recall examinations (refer to Schedule of Benefits for frequency limitation);
   d) Full series X-rays and panoramic X-rays;
   e) Bitewing X-rays.
2. **Preventive Services**
   a) Cleaning of teeth (up to 1 unit of polishing plus up to 1 unit of preventive scaling) once per recall period;
   b) Topical application of fluoride for covered persons age 19 and under, once per recall period;

c) Pit and fissure sealants on permanent molars only, for dependent children age 16 and under;

d) Space maintainers that replace prematurely lost teeth for dependent children age 16 and under.

3. **Restorative Services**

a) Amalgam, tooth coloured filling restorations and temporary sedative fillings;

b) Inlay restorations – these are considered basic restorations and will be paid to the equivalent non- bonded amalgam.

4. **Basic Oral Surgery** – extractions of teeth and/or residual roots.

5. **General anaesthesia, deep sedation and intravenous sedation** - in conjunction with eligible oral surgery only.

Comprehensive Basic Services

1. **Endodontic treatment** including:

    a) Root canal therapy;

    b) Pulpotomy (removal of the pulp from the crown portion of the tooth);

    c) Pulpectomy (removal of the pulp from the crown and root portion of the tooth);

    d) Apexification (assistance of root tip closure);

    e) Apical curettage, root resections and retrograde fillings (cleaning and removing diseased tissue of the root tip);

    f) Root amputation and hemisection;

    g) Bleaching of non-vital tooth/teeth;

    h) Emergency procedures including opening or draining of the gum/tooth.

2. **Periodontal treatment** including:

    a) Periodontal scaling and/or root planing (refer to Schedule of Benefits for time unit maximum);

    b) Occlusal equilibration – selective grinding of tooth surfaces to adjust a bite (refer to Schedule of Benefits for time unit maximum).

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

3. **Standard denture services** including:

    a) Denture cleaning;

    b) Denture repairs and/or tooth/teeth additions;

    c) Standard relining and rebasing of dentures, but only after 6 months have elapsed from the installation of a denture;

    d) Denture adjustments, remount and equilibration procedures, only after 3 months have elapsed from the installation of a denture;

e) Soft tissue conditioning linings for the gums to promote healing;

f) Remake of a partial denture using existing framework.

4. **Comprehensive oral surgery** including:
(included only with Enhanced Dental)

a) Surgical exposure, repositioning, transplantation, or enucleation of teeth;

b) Alveoplasty, gingivoplasty and/or stomatoplasty;

c) Excision – removal of cysts and tumours;

d) Incision – drainage and/or exploration of soft or hard tissue;

e) Frenectomy - surgery on the fold of the tissue connecting the lip to the gum or the tongue to the floor of the mouth;

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.

Alternate Benefit Clause

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

Predetermination

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

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

Limitations

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

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

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

iv. Reimbursement will be limited to the cleaning of a standard denture and not for an implant retained prosthesis. Reimbursement for the cleaning of a standard denture which includes an implant retained prosthesis will be reduced accordingly.

v. Reimbursement for root canal therapy will be limited to payment once only per tooth, and thereafter, only once for possible follow-up procedures such as apicoectomies, root resections, retrofillings, and extractions. Extra charges for difficult access, exceptional anatomy, calcified canals, and retreatments are not included. The total fee for root canal includes all pulpotomies and pulpectomies performed on the same tooth.

vi. 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.

vii. 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.

viii. 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%.

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

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

Exclusions

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

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

ii. Implants and implant related services.

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

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

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

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

vii. Service and charges for sleep dentistry.

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

ix. Orthodontia and any services or supplies related to orthodontia.

GSC Travel Plan: Benefit Details

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

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

Important: **This Travel benefit includes requirements, limitations, and exclusions that can affect eligibility and/or reimbursement of incurred expenses. You must be accurate and complete in your dealings with GSC at all times. Please take the time to read through this benefit before you travel to ensure you are aware of the terms and conditions, making note of the following:**

- With the exception of the **"Referral Services"**, this Travel benefit is an **emergency** medical benefit only and provides coverage while you are temporarily outside of your regular province/territory of residence for vacation, education, or business reasons. It does not cover any non-emergency, elective, cosmetic, or experimental treatment, surgery, procedure, or any other service a covered person chooses to have performed outside of his or her home province/territory – whether pre-planned or not.
- GSC reserves the right to review your medical information at the time of claim. Any invasive or investigative procedures must be pre-approved by GSC Travel Assistance. If the covered person is the patient and it is medically impossible for the covered person to call prior to obtaining emergency treatment, it is extremely important to have someone call GSC Travel Assistance on the covered person's behalf within 48 hours. If GSC Travel Assistance is not notified within the first 48 hours, reimbursement of incurred expenses may be limited 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 the covered person will be responsible for all expenses thereafter.

Emergency means a sudden and unforeseen Medical Condition that requires Treatment. An emergency no longer exists when the evidence reviewed by GSC Travel Assistance indicates that no further Treatment is required at destination or you are able to return to your province/territory of residence for further Treatment. If GSC Travel Assistance determines that you transfer to another facility or return to your home province/territory of residence, and you choose not to, the benefits will not be paid for further medical treatment and coverage will be limited for unrelated events.

Emergency excludes Treatment of a **Pre-existing Condition** that was not completely **Stable** for the 90-day period immediately preceding the covered person's departure.

Pre-existing Condition means any Medical Condition that exists prior to the date of the covered person's departure.

Medical Condition means any disease, illness or injury (including symptoms of undiagnosed conditions).

A Medical Condition is considered **Stable** when all of the following statements are true during the 90-day period immediately preceding the date of the covered person's departure.

a) There has not been any new Treatment prescribed or recommended, or change(s) to existing Treatment (including stoppage in Treatment), and

b) The Medical Condition has not become worse, and

c) There has not been any new, more frequent, or more severe symptoms, and

d) There has been no hospitalization or referral to a specialist, and

e) There have not been any tests, investigation or Treatment recommended, but not yet complete, nor any outstanding test results, and

f) There is no planned or pending treatment, and

g) There has not 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. The following are not considered changes to existing prescribed drug Treatment.

   i) Routine dosage adjustments of Coumadin, Warfarin, or insulin, as long as these medications have not been newly prescribed or stopped;

   ii) 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 to a biosimilar product;

   iii) A decrease in the dosage of a medication due to the improvement of a condition

All of the above conditions must be met during the 90-day period prior to the covered person's departure in order for a Medical Condition to be considered Stable.

Treat, Treated, Treatment means 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.

- To qualify for benefits, the claimants must be covered by their respective provincial/territorial government health plan or equivalent at the time the expenses are incurred; otherwise, there is no coverage under this benefit.
- Eligible travel benefits will be considered based on the reasonable and customary charges in the area where they were received, less the amount payable by your provincial/territorial health insurance plan, if your province provides such coverage.
- All dollar maximums and limitations are stated in Canadian currency. Reimbursement will be made in Canadian funds or U.S. funds for both providers and plan members, based on the country of the payee. For payments that require currency conversion, the rate of exchange used will be the rate in effect on the date of service of the claim.
- Eligible benefits are limited to the maximum days per trip shown in the Summary of Benefits commencing with the date of departure from your province/territory of residence. If you are hospitalized on the last day shown in the Summary of Benefits, your benefits will be extended until the date of discharge.

Eligible travel expenses include the following:

1. **Hospital services and accommodation** up to a standard ward rate in a public general hospital;
2. **Medical/surgical services** rendered by a legally qualified physician or surgeon to relieve the symptoms of, or to cure an unforeseen illness or injury;
3. **Emergency Transportation**;
    - **Land ambulance** to the nearest qualified medical facility
    - **Air ambulance -** the cost of air evacuation (including a medical attendant when necessary) between hospitals and for hospital admission into Canada when approved in advance by your provincial/territorial health insurance plan or to the nearest qualified medical facility
4. **Referral services** – (a) hospital services and accommodation, up to a standard ward rate in a public general hospital, and/or (b) medical surgical services rendered by a legally qualified physician or surgeon;

- **Prior to the commencement of any referral treatment, written pre-authorization** from your provincial/territorial health insurance plan and GSC **must be obtained**. Your provincial/territorial health insurance plan may cover this referral benefit entirely. You must provide GSC with a letter from your attending physician stating the reason for the referral, and a letter from your provincial/territorial health insurance plan outlining their liability. **Failure to obtain pre-authorization will result in non-payment;**

5. **Services of a registered private nurse** up to a maximum of $5,000 per calendar year, at the reasonable and customary rate charged by a qualified nurse registered and licensed in the jurisdiction in which treatment is provided. You must contact GSC Travel Assistance for pre-approval;

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

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

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

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

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

    - GSC Travel Assistance specifies in writing that you immediately return to your province/territory of residence for immediate medical attention, reimbursement will be made for the extra cost incurred for the purchase of a one way economy airfare, plus the additional economy airfare if required to accommodate a stretcher, to return you by the most direct route to the major air

terminal nearest the departure point in your province/territory of residence

This benefit assumes that you are not holding a valid open-return air ticket. Charges for upgrading, departure taxes, cancellation penalties or airfares for accompanying family members or friends are not included;

- GSC Travel Assistance or commercial airline stipulates in writing that you must be accompanied by a qualified medical attendant, reimbursement will be made for the cost incurred for one round trip economy airfare and the reasonable and customary fee charged by a medical attendant who is not your relative by birth, adoption or marriage and is registered in the jurisdiction in which treatment is provided, plus overnight hotel and meal expenses if required by the attendant;

11. **Cost of returning your personal use motor vehicle** to your residence or nearest appropriate vehicle rental agency when you are unable to due to sickness, physical injury or death, up to a maximum of $1,000 per trip. GSC Travel Assistance requires original receipts for costs incurred, i.e. gasoline, accommodation and airfares;

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

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

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

    - identify a deceased prior to release of the body

14. **Return airfare** if the personal use motor vehicle of you or your covered dependent is stolen or rendered inoperable due to an

accident, reimbursement will be made for the cost of a one-way economy airfare to return you by the most direct route to the major airport nearest your departure point in your province/territory of residence. An official report of the loss or accident is required;

15. **Return of deceased** up to a maximum of $5,000 toward the cost of embalming or cremation in preparation for homeward transportation in an appropriate container of yourself or your covered dependent when death is caused by illness or accident. The body will be returned to the major airport nearest the point of departure in your province/territory of residence. The benefit excludes the cost of a burial coffin or any funeral-related expenses, makeup, clothing, flowers, eulogy cards, church rental, etc.

GSC TRAVEL ASSISTANCE SERVICE

The following services are available 24 hours per day, 7 days per week through GSC's international medical service organization.

These services include:

- Access to Pre-trip Assistance (prior to departure): Canada Direct Calling Codes; information about vaccinations; government issued travel advisories; and VISA/document requirements for entry into country of destination
- Multilingual assistance
- Assistance in locating the nearest, most appropriate medical care
- International preferred provider networks
- Medical consultation and monitoring to review appropriateness and quality of medical care
- Assistance in establishing contact with family, personal physician and employer as appropriate
- Monitoring of progress during treatment and recovery and confirming when the patient is medically fit for transportation when a transfer or repatriation Is necessary
- Emergency message transmittal services
- Translation services and referrals to local interpreters as necessary, pertaining to the medical emergency
- Verification of coverage facilitating entry and admissions into hospitals and other medical care providers

- Special assistance regarding the co-ordination of direct claims payment
- Co-ordination of embassy and consular services
- Management, arrangement and co-ordination of emergency medical transportation and evacuation as necessary
- Management, arrangement and co-ordination of repatriation of remains
- Special assistance in making arrangements for interrupted and disrupted travel plans resulting from emergency situations to include:
  - the return of unaccompanied travel companions
  - travel to the bedside of a stranded person
  - rearrangement of ticketing due to accident or illness and other travel related emergencies
  - the return of a stranded personal use motor vehicle and related personal items
- Knowledgeable legal referral assistance
- Co-ordination of securing bail bonds and other legal instruments
- Guidance in replacing lost or stolen travel documents including passports
- Courtesy assistance in securing incidental aid and other travel related services

How Travel Assistance Service Works

For assistance dial **1.800.936.6226** within Canada and the United States or call collect **0.519.742.3556** when traveling outside Canada and the United States. These numbers appear on your GSC Identification Card.

Quote your GSC Identification Number, found on your GSC Identification Card, and explain your medical emergency. **You must always be able to provide your GSC Identification Number and your provincial/territorial health insurance plan number.**

A multilingual Assistance Specialist will provide direction to the best available medical facility or legally qualified physician able to provide the appropriate care.
Upon admission to a hospital or when consulting a legally qualified physician or surgeon for major emergency treatment, GSC Travel Assistance will guarantee the provider (hospital, clinic or physician), that

you have the required provincial/territorial health insurance plan coverage and GSC travel benefits as detailed above.

GSC Travel Assistance will follow your progress to ensure that you are receiving the best available medical treatment. GSC Travel Assistance also keeps in constant communication with your family physician and your family, depending on the severity of your condition.

When calling collect while travelling outside Canada and the United States, you may require a Canada Direct Calling Code. In the event that a collect call is not possible, keep your receipts for phone calls made to GSC Travel Assistance and submit them for reimbursement upon your return to Canada.

Travel Limitations

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

2. GSC Travel Assistance must be notified **before** obtaining Emergency Treatment in order for GSC Travel Assistance to:
   - confirm coverage; and
   - provide pre-approval of treatment.

   If it is medically impossible for the covered person to call prior to obtaining Emergency Treatment, GSC Travel Assistance requires either the covered person or someone on behalf of the covered person to call GSC Travel assistance within 48 hours of commencement of treatment.

   If GSC Travel Assistance is not notified before the Emergency Treatment was received, benefits will be limited 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 mean you will be responsible for all expenses thereafter.

3. After your medical emergency treatment has started, GSC Travel Assistance must assess and pre-approve additional medical treatment. If you undergo tests as part of a medical investigation, treatment or surgery, obtain treatment or undergo surgery that is not pre-approved, your claim will not be paid. This includes invasive

testing, surgery, cardiac catheterization, other cardiac procedures, transplants, MRI.

4. Repatriation is mandatory when GSC Travel Assistance determines that the covered person should transfer to another facility or return to the home province/territory of residence for treatment, or at the end of the emergency. If you choose not to return:
   - no benefits will be paid for any further medical treatment;
   - no benefits will be paid for any recurrence or complications related directly or indirectly to the Medical Condition that caused the emergency; and
   - for the remainder of the trip, coverage will be limited to Medical Conditions completely unrelated to the Medical Condition that caused the emergency.

5. Air ambulance services will only be eligible if:
   - they are pre-approved by GSC Travel Assistance
   - there is a medical need for you or your dependent to be confined to a stretcher or for a medical attendant to accompany you during the journey
   - you or your dependent are admitted directly to a hospital in your province/territory of residence, and
   - medical reports or certificates from the dispatching and receiving legally qualified physicians are submitted to GSC Travel Assistance
   - proof of payment (including air ticket vouchers or air carrier invoices) is submitted to GSC Travel Assistance
6. If planning to travel in areas of political or civil unrest, or in areas where the Canadian Government has issued a formal travel warning regarding non-essential travel, contact GSC Travel Assistance for pre-travel advice, as we may be unable to guarantee assistance services;

7. GSC reserves the right, without notice, to suspend, curtail or limit its services in any area if any of the following occurs:
   - 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 includes travel in any area if, when you booked your trip (including delay of travel), or before your 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, region or city due to a likely or actual epidemic or pandemic.

In this limitation, non-essential travel means anything other than a significant medical or family emergency, such as the death of a family member.

Travel Exclusions

In addition to the General Exclusions, Travel claims will not be paid for the following:

1. Any expenses incurred for the treatment related directly or indirectly to a Pre-existing Medical Condition that, at the time of your departure from your province/territory of residence and the 90-day period immediately preceding your departure from your province/territory of residence:
   a) was not, completely stable in the professional opinion of GSC Travel Assistance Team;
   b) where medical evidence suggested a reasonable expectation that treatment or hospitalization could be required while traveling; or
   c) a physician advised the covered person not to travel.

   GSC Travel Assistance reserves the right to review the covered person's medical information at the time of claim. A physician's opinion that the covered person was fit to travel does not override or eliminate the requirement for the covered person to satisfy all the conditions of Stable.

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

3. Any expenses incurred for any services received that:
   a) were not required to treat an Emergency;
   b) were not recommended by a legally qualified physician or surgeon;
   c) are not covered under your provincial/territorial health insurance plan; or
   d) are normally covered under the out-of-Canada benefits of your provincial/territorial health insurance plan's out-of-Canada coverage (where applicable), when the provincial/territorial plan has declined payment;

4. Any expenses incurred for services received after GSC Travel Assistance determined:

a) the covered person was to return to the province/territory of residence for treatment, but the covered person chose not to return to the province/territory of residence;
b) the services could be reasonably delayed until the covered person returned to the province/territory of residence;
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 3.a), b), or c) above.

5. 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, when the trip was booked, or before the departure date:
   - An official travel advisory was issued by the Canadian government advising Canadians to avoid either all travel or all non-essential travel regarding any country, region, city, or other key components of your travel arrangements (e.g., cruise ship).
   - To view the travel advisories, visit the Government of Canada Travel site.

6. 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 whether prior 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 millilitres 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.

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

8. Any expenses incurred for a child born during the trip within the 8-week period before and after the expected date of delivery.

9. Any expenses incurred during any trip made for the purpose of obtaining a diagnosis, Treatment, surgery, palliative care, or any alternative therapy, as well as any directly or indirectly related complication.

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

General Information
Administrative Policies

GSC has administrative policies and has the right, at all times and from time to time, to create, adopt, amend, alter or revise such administrative policies.

Administrative policies refers to those policies and procedures GSC uses to administer benefit plans and adjudicate claims for eligible benefits.

In order to properly administer the benefit plan in which you are enrolled, you must provide The Edge Benefits Inc. with any information required to calculate premiums or pay benefits. The Edge Benefits Inc. has the right to inspect all documents that relate to your coverage and you may be required to provide health information records.

In addition, information will be retained in GSC's records for the purpose of statistical analysis. This information is maintained in accordance with GSC's policies on privacy and confidentiality and will be used only in respect to claims administration and for GSC's statistical and administrative purposes.

Provincial or Territorial Government Plans

Provincial or territorial government health plans may contribute a portion toward the approved cost of certain services or supplies to qualified residents. GSC's system is designed to co-ordinate with provincial government plans. Eligible provincial government claims must first be submitted to the provincial government plan for payment of its portion toward the approved cost, and then to GSC for consideration of the unpaid portion.

Where used throughout this booklet, reference to "province" or "provincial" is deemed to include "territory" or "territorial", as applicable.

Identification Card(s)

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

General Exclusions

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

1. services or supplies received as a result of disease, illness or injury due to:
    a) an act of war, declared or undeclared;
    b) participation in a riot or civil commotion; or
    c) attempting to commit or committing a criminal offence or illegal act.
2. services or supplies provided while serving in the armed forces of any country.
3. failure to keep a scheduled appointment with a legally qualified medical or dental practitioner.
4. any treatment, drug, service, or supply received outside of Canada on a non-emergency basis.
5. charges for the translation or completion of any claim forms and/or insurance reports and/or medical reports for any reason, including the result of a claim audit.
6. any form of medical cannabis for the treatment of any medical condition, regardless of whether it is authorized by way of a medical document or prescription from a legally-authorized health practitioner and obtained from a Health Canada-licensed producer pursuant to any federal or provincial legislation or regulation regarding the access to and/or distribution of medical cannabis.
7. any specific treatment or drug which:
    a) does not meet accepted standards of medical, dental or ophthalmic practice, including charges for services or supplies which are experimental in nature;
    b) is not considered to be effective (either medically or from a cost perspective) as determined by GSC's drug review process, regardless of Health Canada's approval of the drug;
    c) is an adjunctive drug prescribed in connection with any treatment or drug that is not an eligible service;
    d) will be administered in a hospital or is required to be administered in a hospital in accordance with Health Canada's approved indication for use;
    e) is not dispensed by the pharmacist in accordance with the payment method shown under the Prescription Drugs benefit;

f) is not being used and/or administered in accordance with Health Canada's approved indication for use, even though such drug or procedure may customarily be used in the treatment of other illnesses or injuries (i.e. off-label use).

8. services, supplies or devices that:

a) are not recommended, provided by or approved by the attending legally qualified (in the opinion of GSC) medical 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 or you;

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

e) are not provided by a designated provider of service in response to a prescription issued by a legally qualified health practitioner;

f) are used solely for recreational or sporting activities and which are not medically necessary for regular activities;

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

h) are provided by an immediate family member related to you by birth, adoption, or by marriage and/or a practitioner who normally resides in your home. An immediate family member includes a parent, spouse, child or sibling;

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

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

k) are delivery and transportation charges;

l) are batteries, unless specifically included as an eligible benefit;

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, the Assistive Devices Program or any other government agency, or which would have been payable under such a plan had proper application for coverage been made, or had proper and timely claims submission been made;

p) were previously provided or paid for by any governmental body or agency, but which have been modified, suspended or discontinued as result of changes in provincial health plan legislation or de- listing of any provincial health plan services or supplies;

q) may include but are not limited to drugs, laboratory services, diagnostic testing or any other service which is provided by and/or administered in any public or private health care clinic or like facility, 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);

r) 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;

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

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

Note: payment 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.

General Provisions

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

   a) A Plan Member may apply to increase benefit coverage at any time, provided that evidence of health satisfactory to GSC is submitted along with a written application for the change in coverage;

   b) A Plan Member who chooses to reduce benefit coverage, must have been covered under their existing plan for a period of at least 12 consecutive months prior to the requested date of change

   c) When a Plan Member transfers from one individual benefit plan (or level of coverage) to another, the value of benefits used to date will be carried forward from the previous plan or level of coverage and applied against the maximums of the new plan or level of coverage selected;

   d) When coverage is in force, a dependent(s) may be added to the benefit plan by submitting written application and medical evidence (if such evidence is required) within 30 days of the dependent first becoming eligible; evidence of health is not required for a newborn child if the application is submitted within 30 days following the date of birth. Upon approval, coverage will become effective on a date to be determined by GSC;

   e) If a Plan Member neglects to submit an application for any person within 30 days, the maximum amount payable for dental benefits will not exceed $150 during the first 12 months that such person's coverage is in force;

   f) Termination of coverage due to death, divorce, or a dependent child becoming married or employed on a full-time basis, must be reported in writing to The Edge Benefits Inc. within 30 days following the date of such event;

   g) Notices other than described in "f)" above, must be made by the Plan Member and must be sent in writing by mail to the appropriate address as indicated in the "Contact Information" section of this booklet.

2. **Benefit levels:** All benefit levels outlined are applied on a per covered person basis. Coverage provided depends on whether the single, couple of family option is purchased.

3. **Change of premiums and/or benefits:**

   All EDGE plans renew annually and premiums may be adjusted at that time for all Plan Members. GSC reserves the right to:

a) change the required premiums for this benefit plan based upon its experience pertaining to the payment of eligible services;

b) alter the benefit coverage in response to change(s) made to the government health plan or for any other reason;

c) adjust monthly premiums for those plan members who change age bands;

d) terminate coverage for a plan member's dependent child(ren) at the end of the year in which such child(ren) no longer satisfy the definition of a child as stated in the definition of "Dependent" in this booklet.

GSC will provide The Edge Benefits Inc. with 90 days' written notice of its intent to execute any of the above.

Notice of any of the above will be mailed to the Plan Member's enrolment address on file with The Edge Benefits Inc.

4. **Eligibility:** The Edge™ Health and Dental benefit plan is available to residents of Canada who are under age 70 and their eligible dependents, provided each person is covered by a provincial government health plan.

5. **Enrolment requirements:**

   For Couple Coverage – both eligible members of a couple must apply for and maintain the same plan

   For Family Coverage – all eligible members of the family unit must apply for and maintain the same plan

6. **Incontestability:** If medical information was submitted as a prior consideration for coverage under this benefit plan, and there was a failure to disclose or a misrepresentation of a fact in respect of the application, coverage under this benefit plan will be voidable, or payment in respect of a claim relating to an undisclosed prior condition, denied. However, after coverage has been in force for a period of 2 years, coverage will not, in the absence of fraud, be voidable or payment for any such claim denied.

7. **Liability:** GSC will not be responsible for any act or omission of anyone providing care, services or supplies. The liability of GSC will be limited solely to the payment of benefits in accordance with the terms and conditions of this benefit plan.

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

   a) In respect of any application made hereunder, any misrepresentation, concealment, or failure to disclose correct information will, if discovered within 2 years of the effective date of this benefit plan, render this coverage under this benefit plan

voidable at the option of GSC or The Edge Benefits Inc., and will limit the liability of GSC to the return of eligible premiums;

b) The reimbursement of benefits will be suspended during a non-disclosure investigation;

c) In addition, GSC will have the right to recover all amounts of claims already paid from the amount of eligible premiums GSC is required to return. However, after coverage has been in force for a period of 2 years, coverage will not, in the absence of fraud, be voidable;

d) In respect of the submission of a claim, any misrepresentation, concealment or failure to disclose correct information, whether intentional or not will, at the option of GSC, result in the Plan Member being responsible for 100% of the amount of the claim, as well as for any costs which may have been incurred by GSC in investigating the claim. The Plan Member will be liable to indemnify GSC in this regard and this obligation will survive the termination of this coverage.

9. **Misstatement of age:** GSC may request satisfactory proof of age for any person covered under this benefit plan. If the date of birth was misstated and affects (a) the date on which coverage becomes effective, reduces or terminates, or (b) the amount or type of coverage, or (c) any rights or benefits provided under this benefit plan, the correct date of birth in computing the person's age will govern and premiums will be adjusted accordingly.

10. **Notices:** Notices from GSC or The Edge Benefits Inc.to the Plan Member or dependent(s) will be sent to the Plan Member's address as it appears on the application for coverage under this benefit plan, or to the enrolment address as it appears on GSC's records. If you change your address, The Edge Benefits Inc. requires specific written notification to change your enrolment address. Please refer to the "Contact Information" section of this booklet.

11. **Premium payment:** The coverage under this benefit plan will remain in force from month to month provided that the required premiums are paid when due. Coverage will terminate at the end of the last month for which full premium payment was made to and accepted by The Edge Benefits Inc. and/or GSC, in which case no notice will be required. In the event that a payment is returned as a result of insufficient funds, you will be charged a $25 administration fee.

12. **Reapplication for coverage:** If coverage under this benefit plan has been terminated, a period of at least 24 months must elapse before another application for coverage will be considered under any GSC individual (non-group) health program.

13. **Release of information:** As a condition precedent to receiving

benefits under this benefit plan, the plan member agrees to authorize the release of any information reasonably necessary for GSC to confirm entitlement to benefits and to adjudicate claims. GSC and its service providers have the authority to obtain medical records or information from any medical or dental practitioner, hospital, clinic or service provider.

14. **Termination of agreement:** Coverage under this benefit plan terminates automatically upon attainment of age 75. Coverage may also be terminated by the Plan Member for any other reason upon giving written notice at least 30 days prior to the intended termination date.

Definitions

Where used in this booklet, the terms:

1. **Accident** or **accidental** means an unintentional, sudden or unforeseeable event due exclusively to an external cause inflicting bodily injuries (directly and independently of all other causes).
2. **Benefit year** means the 12 consecutive months commencing on the effective date of coverage, and each 12 month period thereafter.
3. **Biologic drug** means a drug that is produced using living cells or microorganisms (e.g., bacteria) and is often manufactured using a specific process known as DNA technology.
4. **Biosimilar drug** means a biologic drug demonstrated to be similar to a reference biologic drug already authorized for sale by Health Canada.
5. **Brace** means a rigid or semi-rigid supporting device or appliance which fits on and is attached to the body or any part of the body, excluding any brace which is used to correct a dental defect, deficiency or injury.
6. **Calendar year** means the 12 consecutive months January 1st to December 31st of each year.
7. **Consulted** means seeking advice or treatment from any physician and/or health care professional for any condition, injury, disease or disorder. This would include discussion of possible further testing, treatment or surgery.
8. **Coverage** means that you are entitled to make a claim in respect of eligible benefits.
9. **Covered person** means the Plan Member who has been enrolled in the plan or their enrolled dependents.
10. **Custom made boots or shoes** means footwear used by an individual whose condition cannot be accommodated by existing footwear products. The fabrication of the footwear involves making a unique cast of the covered person's feet and the use of 100% raw materials. (This footwear is used to accommodate the bony and structural abnormalities of the feet and lower legs resulting from trauma, disease or congenital deformities.)
11. **Custom made foot orthotic** 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.)
12. **Dentist** means a practitioner of dentistry, lawfully qualified and

licensed to practice in the jurisdiction in which he or she has provided the services or supplies for which the charges are incurred.

13. **Dependent** means:
    a) the plan member's legal or common-law spouse. Only one spouse will be considered at any time as being covered under this benefit plan;
    b) the plan member's unmarried, natural children, legally adopted children, or step children who live with the plan member, are not regularly employed and are under age 21 (age 25 if in full-time attendance at an accredited educational institution.) Child coverage terminates at the end of the year in which the child attains the limiting age;
    c) the plan member's unmarried child over age 21 if the child became dependent upon the Plan Member by reason of a mental or physical disability prior to the child's 21st birthday and has been continuously so disabled since that time and is considered a dependent as defined under the Income Tax Act.
14. **Effective date** means the day on which coverage under this benefit plan begins.
15. **Eligible expenses** means the charges for services or supplies incurred by a covered person that are payable by GSC based on the provisions, terms, limitations and exclusions of this benefit plan.
16. **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.
17. **Government plan** means any plan or arrangement provided by or under the administrative supervision of any government or agency which provides coverage or reimbursement for any health care service or supply, including but not limited to the health insurance plan, home care program, assistive devices program or workplace safety and insurance board or tribunal of the covered person's province of residence.
18. **Hospital** means a public hospital licensed under the Public Hospitals Act or similar legislation of the province in question, or recognized by the Ministry of Health of the province in question as a public hospital, or a duly licensed general active treatment facility in another jurisdiction. Unless expressly stated otherwise herein, the term does not include a federal hospital, private hospital, rest home, nursing home or long term care facility, convalescent home, chronic care facility, health spa or hotel, a home for the aged or an institution used

primarily for the confinement or treatment of alcoholism or drug addiction.

19. **Medically necessary** means a treatment, service or supply which is generally accepted by the medical profession as essential, effective and appropriate in the care and treatment of a medical condition, sickness or injury.

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

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

22. **Plan Member** means the applicant.

23. **Provider of service** means any person, corporation, or other entity authorized to provide eligible benefits in accordance with GSC's administrative policies.

24. **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.

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

GSC everywhere – INFORMATION YOUR WAY

In addition to this booklet and GSC's Customer Service Centre, GSC also provides you with access to their secure website. Self-service through the GSC website makes things quick, convenient and easy. Register with GSC to:

- View your Benefit Plan Booklet
- Access your claims history, including a breakdown of how your claims were processed
- Check your eligibility and coverage for health services or items to instantly find out what portion of a claim will be covered
- Submit most claims online (some claims can even be processed instantly if you are signed up for direct deposit)
- Search for a drug to get information specific to your own coverage (or coverage for your family)
- Search for GSC-vetted health providers in a particular location (within Canada) that will submit your claim for you
- Arrange for claim payments to be deposited directly into your bank account*
- Print personalized claim forms and access your digit ID Card
- Print personal Explanation of Benefits statements for when you need to co-ordinate benefits

* Note - once you've set up direct deposit for your claim payments, the funds will be deposited directly into the bank account you have chosen, and you will receive an email notification from GSC. Statements will no longer be mailed to you, but will be available for online viewing.

Register online at greenshield.ca and see what the GSC website can do for you!

GSC Commitment to Privacy

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

To read GSC's privacy policies and procedures, please visit the GSC web site at greenshield.ca.

About The Edge Benefits Inc.

We exist to safeguard the lifestyle of our clients – simply.

The Edge Benefits has been incorporated since 1985, we have grown to be the largest independent provider of lifestyle protection plans in Canada.

We identify the ever growing lifestyle protection needs and challenges faced by our customers and work with key quality insurance partners to continually design solutions that safeguard lifestyle.

We distribute our plans across Canada through a network of advisors who are trained by The Edge Benefits to provide advice and recommend the steps required to safeguard YOUR lifestyle.

We believe the combination of Edge products provide a unique solution in safeguarding your lifestyle, we are a full service company, we issue all policies, collect premiums and provide support when you need us most - in the event of a claim.

The Edge Benefits Inc. is the plan administrator of the Edge™ Health and Dental benefit plan. The Edge Benefits Inc. develops, markets and administers the plans while the claims and risk are managed by GSC.

The Edge Benefits Inc. Privacy Statement

How We Collect Your Information

We collect information from you, either directly or through our representatives. We may also need to collect information about you from sources such as hospitals, doctors and other health care providers, the Medical Information Bureau, the government (including government health insurance plans) and other governmental agencies, other insurance companies, financial institutions, motor vehicle reports, and your current and former employer.

We collect and keep **only** the information about you and your dependents that is required to provide you with the products and services you requested.

How We Use Your Information

We use your information to provide the products and services you request, which includes using it to evaluate insurance risk and manage

claims. We may also share your information with others who work for The Edge Benefits, or with third parties, when it is necessary for the services we provide to you. Third parties may include other insurance companies, the Medical Information Bureau, financial institutions, third party administrators, and any references you provide. We may use your information internally, to prepare statistical reports that help us understand the needs of our customers and that help us understand and manage our business.

If you have given us your social insurance number, we will use it for taxation purposes and to help identify you to Citizenship and Immigration Canada, when necessary.

For further information on the privacy policies and procedures of any of the Insurers that partner with The Edge Benefits Inc. or to access your information or to ask us to correct information, you can contact us at:

The Edge Benefits Inc.
1255 Nicholson Road,
Newmarket, ON,
L3Y 9C3

1-800-908-9917

Contact Information

Notification of Change

To ensure there is no disruption of your benefits, please contact The Edge Benefits Inc. immediately in the event of:

- changes in your status (newborn child, marriage, divorce, death);
- changes in coverage or plan options;
- a change of address or province of residence; or
- a change to your bank account details (financial institution and/or account numbers).

Mail: The Edge Benefits Inc.
1255 Nicholson Road
Newmarket, Ontario
L3Y 9C3

E-mail: HDcustomerservice@edgebenefits.com
Telephone: (905) 836-7135, ext. 301
Toll Free: 1-877-902-EDGE (3343)
Fax: 1-866-273-5557

Notices from GSC or The Edge Benefits Inc. to the Plan Member or dependent(s) will be sent to the Plan Member's address as it appears on the application for coverage, or to the enrollment address in GSC's records. If you change your address, The Edge Benefits Inc. requires specific written notification to change your enrollment address.

Claiming Information

Submitting Claims

Claim forms, including pre-authorization forms and valuable claims submission information, are available at greenshield.ca.

Note that in addition to a completed claim form, claims reimbursement requires the original itemized paid receipt **(cash receipts or credit card receipts alone are not acceptable)**.

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

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

Emergency Travel

GSC Travel Assistance must be contacted by phone within 48 hours of commencement of treatment.

For assistance and to obtain the proper claim form, dial 1.800.936.6226 within Canada and the United States or call collect 0.519.742.3556 when traveling outside Canada and the United States. These numbers appear on your GSC Identification Card.

If you have incurred out of pocket expenses, make sure you tell GSC Travel Assistance about all the travel coverage you have when submitting claims. Claims must be submitted 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 plans that provide out-of-Canada coverage, a spousal plan, travel coverage provided through your credit card, etc.).

When submitting your Emergency Medical claim, please include:

- Completed and signed claim form provided to you by GSC Travel Assistance when notice of claim has been given, which you must complete and sign for the purpose of allowing GSC Travel Assistance to recover payment from any other insurance contract or health plan (group, individual or government).
- A fully completed and signed claim form with all original bills and receipts from commercial organizations for any claims you paid out of pocket.
- Medical records including an emergency room report and diagnosis from the medical facility or a Medical Certificate completed by the treating physician. Any fee for completion of the certificate is not a benefit under this insurance.
- Completed appropriate Government Health Insurance Plan forms; see claim form for details.
- Proof of date of departure from your province or territory of residence.
- Any other documentation that may be required and/or requested by GSC Travel Assistance.

Claim forms must be sent to Green Shield Canada:

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: Dental Department	P.O. Box 1608	Windsor, ON	N9A 7G1

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

Reimbursement

Reimbursement will be made by one of the following methods:

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

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

Overpayments

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

Limitation on Legal Action

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

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

Subrogation (recovering damages from a third party)

GSC retains the right of subrogation of benefits. This means that if GSC paid benefits on behalf of you or your dependent, but the benefits either should have been paid or are subsequently paid or provided in whole or in part, by a third party liability or other coverage(s), GSC has the right to recover such payment or reimbursement. In cases of third party liability, you must advise your lawyer of GSC's subrogation rights. The covered person must notify GSC of any planned legal action and when payments are received. This right of subrogation applies only in provinces where subrogation is legally permitted.

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 co-ordinated with the other plan so that you may be reimbursed up to 100% of the eligible expense incurred.

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

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

1. the plan where you are a full-time plan member;
2. the plan where you are a part-time plan member;
3. 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:

1. the plan of the parent whose birth date (month and day) occurs earliest in the calendar year,
2. 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:

1. the plan of the parent who has custody of the dependent child;
2. the plan of the spouse of the parent who has custody of the dependent child;
3. the plan of the parent who does not have custody of the dependent child;
4. 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.

Travel Benefits
In the event of a travel claim, all plans equally share the cost of the claim.

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

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

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

GSC may charge you to provide any additional copies.

1255 Nicholson Road
Newmarket ON L3Y 9C3
Tel: 1-877-902-EDGE (3343)
Fax: 1-866-273-5557