



University of Ottawa Graduate Students' Association

Billing Divisions: 23785 and 32012

Revised Effective Date: September 1, 2024

WELCOME TO YOUR STUDENT HEALTH & DENTAL PLANS

Dear Student,

Welcome to your students' union health and dental plan.

Students here at University of Ottawa Graduate Students' Association have come together to contribute to health and dental plans that provide benefits to us all.

Your health and dental plans have been democratically established by the members of your student union through referenda. Every year, your elected representatives and staff work to negotiate the best value possible. Students who already have coverage are allowed to withdraw from the plan, so that this service can be focused on those who need it.

Your health and dental plans are services of your students' union, underwritten by Green Shield Canada (GSC), the only national non-profit benefits provider in the country, so you can be assured that students' interests are the only priority.

In creating universal health and dental plans, University of Ottawa Graduate Students' Association members have recognized that when we work together, we can save money and provide important services. If any individual student were to seek private and independent health coverage, the cost would be too great and the benefits too limited. However, by pooling our resources, we are able to realize incredible savings and service enhancements through economies of scale.

These benefit plans represent much more! In deciding to offer ourselves health and dental protection, students are working to ensure that no student suffers academically or has to drop out of school because of unexpected and unmanageable health related costs. Some students with chronic illnesses would never be able to see the inside of a classroom without access to affordable treatment and therapies.

That is why it is important to work collectively to provide protection for each other in the most cost-effective way possible. While we hope that this year will be worry free, if your health does falter, we are glad that your health and dental plans will be there to support you. Many of your plan benefits support health promotion and illness prevention, such as annual dental cleaning and maintenance medication. Being proactive about your health and dental needs is as much a worthwhile investment in your future as your education.

This year, please get familiar with the coverage detailed in this brochure and take advantage of the benefits provided by your students' union health and dental plans. After all, we can all benefit from having the peace of mind this coverage brings.

If you have any questions or suggestions, there is a team of people waiting to assist you.

Have a healthy and successful year!

Your University of Ottawa Graduate Students' Association Executive

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 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 “GSA” and ends with -00 – e.g. GSA111222333-00. If you have any eligible dependents, they share the same number as you except their number ends with their own unique dependent code.

GSC STUDENT CENTRE

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

- Locating dental providers in your area who are members of the Student Dental Discount Network (if you have GSC Dental Benefits)
- Locating discount vision providers in your area (regardless of whether you have GSC Vision Benefits or not)
- Access to opt-out and opt-in information

OUR COMMITMENT TO PRIVACY

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

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

TABLE OF CONTENTS

SCHEDULE OF BENEFITS	1
DEFINITIONS	4
ELIGIBILITY	6
For You.....	6
For your Dependents	6
Coverage Effective Date	6
Termination.....	6
Dependent Children Continuation of Coverage	6
Group Conversion – GSC Health Assist LINK Program	6
DESCRIPTION OF BENEFITS	7
HEALTH BENEFIT PLAN	7
Prescription Drugs	7
Extended Health Services.....	8
DENTAL BENEFIT PLAN	13
Basic Services	13
Comprehensive Basic Services	14
Major Services	14
CLAIM INFORMATION	18

SCHEDULE OF BENEFITS

HEALTH BENEFIT PLAN

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

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

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

Deductible: Nil	Overall Maximum: Prescription Drugs - \$2,000 per covered person per benefit year All Other Health Benefits - \$5,000 per covered person per benefit year (excluding Gender Affirmation)
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Prescription Drug Benefit

(The Prescription Drug Benefit does not apply if you have opted out of this coverage)

Your Plan Covers:	Your Co-Pay:	Maximum Plan Pays:
Prescription Drugs – Pay Direct Drug Card		\$2,000 per benefit year
Contraceptives: <ul style="list-style-type: none"> • Oral Contraceptives • Other Contraceptives (injections, IUD's and patch) 	10% per prescription or refill	\$350 per benefit year (included in the Prescription Drug maximum)
HPV vaccines:	20% per prescription or refill	Reasonable and customary charges (included in the Prescription Drugs Maximum)
All other Vaccines:	50% per prescription or refill	
<ul style="list-style-type: none"> ▪ All other covered drugs 	20% per prescription or refill	
Hospital		
<ul style="list-style-type: none"> • Public general hospital or convalescent or rehabilitation hospital or public chronic hospital – semi-private room 	50%	Up to 5 days per disability

Your Plan Covers:	Your Co-Pay:	Maximum Plan Pays:
Medical Items and Services		
<ul style="list-style-type: none"> Gender affirmation* *Diagnosis of gender dysphoria from a physician (M.D.) or nurse practitioner is required	0%	Reasonable and customary charges, limited to \$10,000 lifetime
<ul style="list-style-type: none"> Braces and casts 	50%	\$500 per benefit year combined
<ul style="list-style-type: none"> Compression Stockings 	50%	\$500 per benefit year
<ul style="list-style-type: none"> Other items and services – See the Description of Benefits section for details 	0%	Reasonable and customary
Emergency Transportation	0%	\$250 per benefit year
Private Duty Nursing in the Home	0%	Minimum 8 hours per shift (limited to reasonable and customary charges)
Professional Services	0%	
<ul style="list-style-type: none"> Chiropractor Registered Massage Therapist Naturopath Speech Therapist Physiotherapist 		\$50 per visit, limited to \$500 per practitioner per benefit year
<ul style="list-style-type: none"> Psychologist, Psychotherapist, Social Worker, Clinical Counsellor or Master of Social Work 		\$80 per visit, limited to \$1,000 per benefit year combined
<ul style="list-style-type: none"> Holistic Nutritional Consultant 		\$80 per visit combined with the overall maximum of \$1,000 per benefit year for Psychologist, Psychotherapist, Social Worker, Clinical Counsellor and Master of Social Work
Accidental Dental	0%	Reasonable and customary charges
Vision	0%	
<ul style="list-style-type: none"> prescription eyeglasses or contact lenses, or medically necessary contact lenses 		\$150 per 24 months based on date of first paid claim
<ul style="list-style-type: none"> optometric eye exams 		\$75 for one eye exam every 2 years based on date of first paid claim
Tutorial Benefit NOTE: Dependents are not eligible for this benefit	0%	\$15 per hour up to \$1,000 per benefit year for private tutorial service of a qualified teacher. You must be confined to home or hospital for a minimum of 30 consecutive days to qualify (Physician (M.D.) recommendation required)

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

This Plan does not include travel benefits. Looking to plan a trip and need emergency medical coverage? Visit the Student Centre website at [greenshield.ca/student](https://www.greenshield.ca/student) for details.

DENTAL BENEFIT PLAN

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

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

Deductible:	Nil
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Fee Guide:	<p>The current less 1 year 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 less 1 year 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 diagnostic and preventive services, periodontal scaling and basic oral surgery	0%	\$1,000 per covered person per benefit year for all eligible dental services combined
Basic restorative services, standard denture services, comprehensive oral surgery and anaesthesia	25%	
Endodontic services	70%	
Major services	70%	

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

DEFINITIONS

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

Allowed amount means, as determined by GSC:

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

Benefit Year means the 12 consecutive months commencing September 1st to August 31st.

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

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

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

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

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

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

Dependent means

- a) your spouse, if you are legally married or if not legally married, you have lived in a common-law relationship for more than 12 continuous months. Only one spouse will be considered at any time as being covered under the group contract;
- b) your unmarried child under age 21;
- c) your unmarried child under age 25, if enrolled and in full-time attendance at an accredited college, university or educational institute;
- d) your unmarried child (regardless of age) who became totally disabled while eligible under b) or c) above, and has been continuously so disabled since that time and is considered a dependent as defined under the Income Tax Act, also qualify as a dependent.

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

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

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

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

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

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.

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

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.

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

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

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

ELIGIBILITY

For You

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

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

For your Dependents

To be eligible for coverage you must be:

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

Coverage Effective Date

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

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

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

Termination

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

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

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

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

Dependent Children Continuation of Coverage

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

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

Group Conversion – GSC Health Assist LINK Program

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

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

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

DESCRIPTION OF BENEFITS

HEALTH BENEFIT PLAN

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

Prescription Drugs

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

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

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

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

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

Certain drugs require prior authorization from GSC before your drug claim can be reimbursed. You can find out if your drug requires prior authorization either by using the online drug search tool available to you through the member portal or by contacting GSC's Customer Service Centre.

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.

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) Reference biologic drugs that have an approved biosimilar;
- c) Vitamins that do not legally require a prescription;
- d) Smoking cessation drugs and Nicotine replacement products, such as patches, gum, lozenges, and inhalers;
- e) Products which may lawfully be sold or offered for sale other than through retail pharmacies, and which are not normally considered by practitioners as medicines for which a prescription is necessary or required, unless specifically identified and included as eligible in "Prescription Drugs";
- f) 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;
- g) Mixtures, compounded by a pharmacist, that do not conform to GSC's current Compound Policy.

Extended Health Services

Hospital Accommodation: Reimbursement, as shown in the Schedule of Benefits, of reasonable and customary charges in the area where received, for accommodation in a public general hospital, or a convalescent or rehabilitation hospital or a convalescent or rehabilitation wing in a public general hospital, or a public chronic hospital or chronic care in a public general hospital, provided your provincial health insurance plan has accepted or agreed to pay the ward or standard rate.

Medical Items and Services: Reimbursement for reasonable and customary charges, up to the amount, where applicable, as shown in the Schedule of Benefits for:

- a) Aids for daily living: such as hospital style beds, including rails and mattresses; bedpans; standard commodes; decubitus (bedridden) supplies; I.V. stands; portable patient lifts; trapezes/transfer poles; urinals;
- b) Braces, casts;
- c) Incontinence/Ostomy equipment, such as catheter supplies and ostomy supplies;
- d) Mobility aids, such as canes, crutches, walkers and wheelchairs (including wheelchair batteries);
- e) Standard prosthetics, such as an arm, hand, leg, foot, breast, eye and larynx;
- f) Respiratory/Cardiology equipment, such as compressors, inhalant devices, tracheotomy supplies and oxygen;
- g) Compression stockings with a pressure measurement of 15 mmhg or higher;

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

Limitations

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

Gender Affirmation: The following services not covered by your provincial/territorial health plan will be considered eligible only when a diagnosis of gender dysphoria from a legally qualified physician (M.D.), or nurse practitioner is provided to GSC. Reimbursement will be limited to reasonable and customary charges, up to the amount shown in the Schedule of Benefits:

- **Foundation (core)** – Transition-related genital and chest/breast surgeries not covered by your provincial/territorial health plan, as well as vocal surgery, tracheal shave, chest contouring/breast construction, vaginal dilators, laser hair removal and facial feminization surgery.
- **Focused** – Non-genital, non-breast/chest enhancement surgeries as follows: nose surgery, liposuction/lipofilling, face/eyelid lift, lip/cheek fillers, hair transplant/implants, and gluteal lifts/implants.

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

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

A Pre-Authorization Form for Private Duty Nursing must be completed by the attending physician and submitted to GSC.

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.

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.

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) Non-prescription 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:

- Medical or surgical treatment;
- Special or unusual procedures such as, but not limited to, orthoptics, vision training, subnormal vision aids and aniseikonic lenses;
- Follow-up visits associated with the dispensing and fitting of contact lenses;
- 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) attempting to commit or committing a criminal offence or illegal act;
2. Services or supplies provided while serving in the armed forces of any country;
3. Failure to keep a scheduled appointment with a legally qualified medical or dental practitioner;
4. Any treatment, drug, service, or supply received outside of Canada on a non-emergency basis;
5. Charges for the translation or completion of any claim forms and/or insurance reports;
6. Any form of medical cannabis for the treatment of any medical condition, regardless of whether it is authorized by way of a medical document or prescription from a legally-authorized medical practitioner and obtained from a Health Canada-licensed producer pursuant to any federal or provincial legislation or regulation regarding access to and/or distribution of medical cannabis;
7. Any specific treatment or drug which:
 - a) does not meet accepted standards of medical, dental or ophthalmic practice, including charges for services or supplies which are experimental in nature;
 - b) is not considered to be effective (either medically or from a cost perspective) as determined by GSC's drug review process regardless if Health Canada approved the drug;
 - c) is an adjunctive drug prescribed in connection with any treatment or drug that is not an eligible service;
 - d) is administered in a hospital or is required to be administered in a hospital in accordance with Health Canada's approved indication for use;
 - e) is not dispensed by the pharmacist in accordance with the payment method shown under the Prescription Drugs benefit;
 - f) is not being used and/or administered in accordance with Health Canada's approved indication for use, even though such drug or procedure may customarily be used in the treatment of other illnesses or injuries (i.e., off-label use);
8. Services or supplies that:
 - a) are not recommended, provided by or approved by the attending legally qualified (in the opinion of GSC) medical practitioner or dental practitioner as permitted by law;
 - b) are legally prohibited by the government from coverage;
 - c) you are not obligated to pay for or for which no charge would be made in the absence of benefit coverage or for which payment is made on your behalf by a not-for-profit prepayment association, insurance carrier, third party administrator, like agency or a party other than GSC, your plan sponsor or you;
 - d) are provided by a health practitioner whose license by the relevant provincial regulatory and/or professional association has been suspended or revoked;
 - e) are not provided by a designated provider of service in response to a prescription issued by a legally qualified health practitioner;
 - f) are used solely for recreational or sporting activities and which are not medically necessary for regular activities;
 - g) are primarily for cosmetic or aesthetic purposes, or are to correct congenital malformations;

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

DENTAL BENEFIT PLAN

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

Basic Services

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 every 6 months based on date of first paid claim
- recall examinations once every 6 months based on date of first paid claim
- cleaning of teeth (up to 1 unit of polishing plus up to 1 unit of scaling) once per recall period
- denture cleaning once every 6 months based on date of first paid claim
- pit and fissure sealants on molars only, for covered persons 14 years of age and under
- space maintainers
- protective mouth guards once every 12 months based on date of first paid claim
- periodontal scaling 3 time-units per benefit year

Basic Restorative Services:

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

Basic oral surgery:

- extractions of teeth (2 wisdom teeth extractions per benefit year) and/or residual roots

General anaesthesia, deep sedation, and intravenous sedation in conjunction with eligible oral surgery only

Comprehensive Basic Services

Standard denture services:

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

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

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

Periodontal treatment of diseased bone and gums including:

- periodontal scaling 3 time units per benefit year

The fees for periodontal treatment are based on units of time (15 minutes per unit) in accordance with the General Practitioners Fee Guide.

Major Services

- Standard onlays or crown restorations to restore diseased or accidentally injured natural teeth, once every 5 years based on date of first paid claim
- Standard repair or recementing of crowns, onlays and bridge work on natural teeth

Alternate Benefit Clause

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

Predetermination

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

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

Limitations

1. Laboratory services must be completed in conjunction with other services and will be limited to the co-pay of such services. Laboratory services that are in excess of 40% of the dentist's fee in the applicable Fee Guide shown in the Schedule of Benefits will be reduced accordingly; co-pay is then applied;
2. Reimbursement will be made according to standard and/or basic services, supplies or treatment. Related expenses beyond the standard and/or basic services, supplies or treatment will remain your responsibility;
3. Reimbursement will be pro-rated and reduced accordingly, when time spent by the dentist is less than the average time assigned to a dental service procedure code in the applicable Fee Guide shown in the Schedule of Benefits;
4. Reimbursement for root canal therapy will be limited to payment once only per tooth. Extra charges for difficult access, exception anatomy, calcified canals and retreatments are not included. The total fee for root canal includes all pulpotomies and pulpectomies performed on the same tooth;
5. Common surfaces on the same tooth/same day will be assessed as one surface. If individual surfaces are restored on the same tooth/same day, payment will be assessed according to the procedure code representing the combined surface. Payment will be limited to a maximum of 5 surfaces in any 36-month period;
6. When more than one surgical procedure, is performed during the same appointment in the same area of the mouth, only the most comprehensive procedure will be eligible for reimbursement, as the fee for each procedure is based on complete, comprehensive treatment, and is deemed part of the multiple services factor;
7. The multiple services factor occurs when a minimum of 6 or more restorations (fillings) or multiple periodontal services are performed at the same appointment and the full fee guide price is charged for each restoration or periodontal service, the first service will be paid in full and all remaining services will be reduced by 20%;
8. Core build-ups are eligible only for the purpose of retention and preservation of a tooth when performed with crown treatment. Necessity must be evident on mounted pre-treatment X-rays. Core build-ups to facilitate impression taking and/or block out undercuts are considered included in the cost of a crown;
9. In the event of a dental accident, claims should be submitted under the health benefits plan before submitting them under the dental plan.

Dental Exclusions

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

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

14. 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 1.888.525.7587 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 "**GSA**" – e.g. **GSA111222333**.

Please 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 your plan sponsor. This could result in termination of your coverage under this benefit plan.

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 funds for both providers and plan members.

Overpayments

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

Limitation on Legal Action

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

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

Direct Payment to the Provider of Service (where applicable)

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

Subrogation

GSC retains the right of subrogation of benefits. This means 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 our subrogation rights.

DENTAL DISCOUNT NETWORK ARRANGEMENT

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

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

1. This national program includes more than 800 dental provider locations from coast to coast.
2. Once a dental provider elects to participate in the network, they are added to a list of GSC's participating dental providers. This list is available at greenshield.ca/student.
3. You may visit a dentist from the list of participating dental providers, or you may ask your existing dentist to join this network; the advantage to your dentist of joining the network is the potential of an increase in business. Your dentist can call our Customer Service Centre at 1.888.525.7587 for more information.
4. The discount offer applies to most dental procedures and *may* be up to 30%.
5. Our system will automatically calculate the applicable discount when you visit a dental provider in this network. The applicable discount is dependent on your particular college or university's plan design, and will be subtracted from your co-pay, or share of the cost.
6. Eligible dental claims must be processed electronically; therefore, **you must first be enrolled on GSC's system in order to be eligible for the discount.** GSC will pay your dentist directly; you only have to pay the dentist your share of the cost (if any) for services provided.
7. You will receive professional dental services while incurring lower out-of-pocket expenses and maintain ongoing oral health.

Visit greenshield.ca/student or call the Customer Service Centre at 1.888.525.7587 for more information.

Co-ordination of Benefits (COB)

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

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

GSC Plan Member

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

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

Spouse

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

Children

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

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

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

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

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.