Carleton University TA Plan CUPE 4600 (Unit 1)

Billing Division: 32031

Revised Effective Date: September 1, 2024

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.

Green Shield Canada (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 “CTA” and ends with -00 – e.g. CTA111222333-00. 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:

- View information that describes programs, services, or benefits you can access as a GSC plan member
- Locating dental providers in your area who are members of the Student Dental Discount Network (if you have GSC Dental Benefits)
- Locating discount vision and hearing care providers in your area (regardless of whether you have GSC Vision Benefits or not)
- 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.

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SCHEDULE OF BENEFITS

HEALTH BENEFIT PLAN

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

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

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

Deductible: Nil	**Overall Maximum:** Unlimited

Your Co-pay 0%

Your Plan Covers:	**Maximum Plan Pays:**
Professional Services	
• Chiropractor	$300 per benefit year
• Physiotherapist • Registered Massage Therapist (Physician (M.D.) or Physiotherapist recommendation required)	$300 combined per benefit year
• Psychologist, Social Worker, Clinical Counsellor, Master of Social Work or Psychotherapist	$200 combined per benefit year
Vision • prescription eye glasses or contact lenses, or medically necessary contact lenses or optometric eye exams	$300 every 24 consecutive months based on date of first paid claim

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 for details.

DENTAL BENEFIT PLAN

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

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

Deductible:	Nil

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

Your Plan Covers:	**Your Co-Pay:**	**Maximum Plan Pays:**
Basic Restorative Services and Basic Oral Surgery (excluding wisdom teeth extractions) All Other Basic and Comprehensive Basic Services (excluding wisdom teeth extractions) Wisdom Teeth Extractions	75% 80% 50%	$1,000 per benefit year for all eligible dental services combined
Major Services	80%	

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) 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;
b) Dental – the fee guide as specified in the Schedule of Benefits.

Benefit Year means the 12 consecutive months September 1st to August 31st of each year commencing on the date a plan member's coverage becomes effective.

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

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

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

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

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

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

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

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

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

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

ELIGIBILITY

This GSC benefit plan provided for academic employees represented by CUPE 4600 (Unit 1) is intended to supplement your primary benefits plan (CUSA, GSA, or parental plan). To process a claim, you are required to submit the Explanation of Benefits statement from your primary benefits carrier and a copy of the claim form. Plan members will be reimbursed for the remaining amount, if eligible, under the GSC benefit plan.

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 or equivalent;
c) an active member as shown on the cover of this booklet.

For your Dependents
This plan does not provide coverage for your dependents.

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.

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

a) the date your employment ends;
b) the end of the academic year (August 31st) in which you were hired;
c) the end of the period for which rates have been paid to GSC for your coverage;
d) the date the group contract terminates.

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 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.

Extended Health Services

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.

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.

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

- Medical or surgical treatment, unless specifically identified and included as eligible in “Vision” above;
- Special or unusual procedures such as, but not limited to, orthoptics, vision training (unless specifically identified and included as eligible in “Vision”), 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 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 has 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 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;
s) 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;
t) 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;
u) may include but are not limited to, 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 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);
v) 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;
w) 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;
x) 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 benefit years
- consultation once per benefit year
- emergency and specific oral examinations
- full series X-rays and panoramic X-rays once every 3 benefit years
- bitewing X-rays once per benefit year
- recall examinations once per benefit year
- cleaning of teeth (up to 1 unit of polishing plus up to 1 unit of scaling) once per benefit year
- denture cleaning once per benefit year
- pit and fissure sealants on molars only, for covered persons 14 years of age and under
- space maintainers, for covered persons 15 years of age and under
- mouth guards once every 12 months based on date of first paid claim

Basic Restorative Services:

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

Basic oral surgery:

- extractions of teeth and/or residual roots
- maximum of 4 wisdom teeth extractions every 12 months based on date of first paid claim

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

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 and/or root planing 2 time units per benefit year
- occlusal equilibration - selective grinding of tooth surfaces to adjust a bite 2 time units per benefit year

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

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

Major Services

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

- Standard dentures including complete, immediate, transitional, and partial dentures, 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, 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;

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

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

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

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

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

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

Dental Exclusions

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

1. Services or supplies received as a result of disease, illness or injury due to:
   a) an act of war, declared or undeclared;
   b) participation in a riot or civil commotion; or
   c) 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 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) or 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 has 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 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 "**CTA**" – e.g. **CTA111222333**.

Original itemized paid receipts are required for claims reimbursement **(cash receipts or credit card receipts alone are not acceptable as proof of payment).**

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 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, 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 1.888.525.7587for 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

As 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.