STELCO

RETIREE BENEFITS TRUST

My BENEFIT PLAN

Stelco Non-USW Retiree Life and Health Trust

Classification: Retired Employees

Billing Divisions:

5002 USSC/Stelco salaried retirees
5007 USSC/Stelco Lake Erie Works salaried retirees
5012 Stelpipe salaried retirees
5014 Stelpipe bargaining unit retirees
5016 Welland Pipe salaried retirees
5018 Welland Pipe bargaining unit retirees
5020 USSC/Stelco Hamilton Work retirees

Revised Effective Date: January 1, 2021

gsc green shield canada

WELCOME TO YOUR BENEFIT PLAN

ABOUT THIS BOOKLET

This booklet contains important information you will need about your group benefits with **Stelco Non-USW Retiree Life and Health Trust**, your plan sponsor, available through the group contract with Green Shield Canada (GSC). 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-insurance 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 benefit 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.

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

PLAN MEMBER ONLINE SERVICES

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

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

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

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

HEALTH BENEFIT PLAN

This schedule describes the deductibles, co-insurance and maximums that may be applicable if you are included in one of the Billing Divisions 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.

This group benefit plan is intended to supplement your provincial health insurance plan. The benefits shown below will be eligible, if they are reasonable and customary, and are medically necessary for the treatment of an illness or injury.

Deductible: Nil	**Overall Maximum:** Unlimited

The Plan Covers:	**The Plan Pays:**	**Maximum the Plan Pays:**
Vision	100%	
• prescription eye glasses or contact lenses, or medically necessary contact lenses, or laser eye surgery		$325 per 24 consecutive months based on date of first paid claim (if change in prescription, new $325 benefit period begins)
• optometric eye examinations		1 every 24 months based on date of first paid claim, subject to a maximum of $75 per claim
Prescription Drugs – Pay Direct Drug Card	80%, plus any allowed dispensing fee charge up to $7 per prescription or refill. Once $500 in out-of-pocket maximum has been reached in each calendar year, plan pays 100% (subject to $7 per prescription or refill maximum)	$70,000 lifetime maximum Each January 1, up to $2,500 will be reinstated towards the lifetime maximum
• Therapeutic substitution for some blood pressure medications, specifically ACE Inhibitors and ACE II Receptor Blockers and Proton Pump Inhibitors	100% for preferred drug; 40% if non-preferred drug selected	
• Ontario Drug Benefit co-pay and deductible for covered persons over age 65		$100 deductible per calendar year and up to $6.11 per prescription or refill for co-pay
• Limits on the frequency of prescription refills for maintenance medications (i.e. medications for chronic medical conditions)		Up to 5 prescription refills allowed per calendar year for maintenance medications, unless the covered person is in a Long Term Care home, or meets GSC criteria for compliance packaging

The Plan Covers:	The Plan Pays:	Maximum the Plan Pays:
• Limits on drug price markups by pharmacist		Maximum 10% markup allowed for brand name drugs, 8% for generic drugs
• Migraine therapy (excluding Quebec)		$1,500 every 12 months based on date of first paid claim
• All other covered drugs		Subject to maximum shown above
Hearing Care (see page 10 under Extended Health Care for details)	80%	$1,000 per ear every 5 years based on date of first paid claim
Medical Items and Services		
• Footwear	80%	
▪ custom made boots or shoes		1 pair per calendar year to a maximum of $300
▪ custom made foot orthotics		$300 every 36 months based on date of first paid claim
• Bra (mastectomy)	80%	3 per calendar year
• TENS unit (rental, purchase and supplies)	80%	$500 every 5 years based on date of first paid claim
• Stump socks	80%	4 pairs per calendar year
• Compression stockings	80%	3 pairs per calendar year
• Respiratory / Cardiology	80%	
▪ C.P.A.P. Machine		$1,500 per claim, once every 5 years (in accordance with ADP guidelines) based on date of first paid claim
▪ All other eligible respiratory / cardiology equipment and supplies		Reasonable and customary charges
• Wigs	80%	$200 per lifetime
• Delivery charges for medical items	100%	$25 per claim
• Other eligible medical items and services	80%	Reasonable and customary charges

The Plan Covers:	The Plan Pays:	Maximum the Plan Pays:
Emergency Transportation	80%	Reasonable and customary charges
Private Duty Nursing in the Home	80%	$10,000 per calendar year, subject to a $50,000 lifetime maximum
Professional Services		
• Chiropractor, Physiotherapist, Psychologist, Social Worker/Counsellor, or Master of Social Work, Psychotherapist	80%	$300 per calendar year, combined for all types of practitioners
Accidental Dental	80%	$1,000 per incident

DENTAL BENEFIT PLAN

This schedule describes the deductibles, co-insurance and maximums that may be applicable if you are included in one of the Billing Divisions 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 two years Provincial Dental Association Fee Guide for General Practitioners in the province where services are rendered For independent Dental Hygienists, the current minus two years Provincial Dental Hygienists' Association Fee Guide in the province where services are rendered For Alberta, with no fee guide, reimbursement will be according to a fee schedule established by GSC for that province

The Plan Covers:	**The Plan Pays:**	**Maximum the Plan Pays:**
Basic Services and Comprehensive Basic Services	80%	$2,000 per covered person per calendar year (Basic, Comprehensive Basic and Major combined)
Major Services	75%	

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.

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-insurance is the percentage of the eligible allowed amount that you or your dependent are entitled to receive for reimbursement of an eligible expense, after the deductible is satisfied.

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

Custom made boots or shoes means footwear used by an individual whose condition cannot be accommodated by existing footwear products. The fabrication of the footwear involves making a unique cast of the covered person's feet and the use of 100% raw materials. (This footwear is used to accommodate the bony and structural abnormalities of the feet and lower legs resulting from trauma, disease or congenital deformities.)

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

Deductible is the amount that must be paid by or on behalf of you and your dependent in any calendar 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 1 year. Only one spouse will be considered at any time as being covered under the group contract;
b) your unmarried child under age 19;
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 spouse (or surviving spouse) and dependents must have been enrolled in the prior USSC plan on July 1 2017 in order to be eligible under the Trust.

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

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

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

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

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

Off-label drug 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.

Orthopedic shoes means off-the-shelf, ready-made footwear prescribed for covered persons diagnosed with a specific medical condition that affects their feet and who require specialized footwear to treat their condition and assist with mobility. The footwear may be modified or adjusted to fit the covered person's feet.

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.

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.

ELIGIBILITY

For You

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

a) is a resident of Canada;
b) is covered under your provincial health insurance plan;
c) retired prior to July 1, 2017 and is included on a closed list of eligible retired employees as provided by Stelco Inc. through the court-supervised CCAA process;
d) is a non-represented employee who retires on or after July 1, 2017 and is identified as eligible under the 2017 CCAA Court proceedings.

For Your Dependents

To be eligible for coverage:

a) you must be covered under this plan;
b) your dependents must be enrolled and covered under the prior plan as of July 1, 2017; and
c) 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.

You will be eligible for coverage upon your retirement. Stelco is responsible for notifying the Trust and GSC of your eligibility under this plan once you retire.

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 end of the period for which rates have been paid to GSC for your coverage;
b) the date the Trust funds are exhausted;
c) the date the group contract terminates; or
d) the date of your death if no eligible dependents are covered under this plan.

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

a) the date your coverage terminates;
b) the date your Trust funds are exhausted;
c) the date your dependent is no longer an eligible dependent;
d) the end of the calendar year in which your dependent child attains the specified age limit;
e) the date of your dependents death;
f) the end of the period for which rates have been paid for dependent coverage; or
g) 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.

Survivor Continuation of Coverage

In the event of your death while covered by this plan, coverage will continue for your spouse or an eligible dependent listed at the time of your retirement as follows:

1. subject to the specified plan co-insurance and maximums; or
2. subject to 100% co-insurance and the specified plan maximums, if you pass away on or after September 1, 2017, and your retiree life insurance coverage was cancelled under the US Steel life insurance policy as a result of the CCAA process;

   Until the earliest of:
   a) the date the Trust funds are exhausted; or
   b) the date your surviving spouse remarries or enters into a common law relationship; or
   c) the date the covered person would no longer be considered a dependent under the plan if you were still alive; or
   d) the date the benefit under which your dependent is covered, terminates.

Losing your Group Benefits?

If your coverage terminates under your Plan Sponsor's benefit plan, you may apply for one of GSC's individual Health and Dental plans. Acceptance for these plans is guaranteed as long as GSC receives your application within 90 days of your employee benefits termination date, provided GSC receives the initial payment. There are no health questions and no medical when you apply. These plans offer coverage for medications that treat pre-existing conditions. Best of all, they provide life-time coverage.

SureHealth™ LINK Plans– Buying directly from GSC

Visit SureHealth.ca where you'll find details about the SureHealth™ LINK plan options available. You can request an information package, you can get quotes online, and you can buy completely online. It is quick and easy. You can give us a call at 1.844.753.SURE (7873) –we can answer any questions you have or we can take your application over the phone.

PRISM CONTINUUM® – Buying from an Advisor

Special Benefits Insurance Services (SBIS) can help. Call 416.601.0429 or 1.800.667.0429 to speak with a specialist about the Prism Continuum program. They can review the options available to you and advise you on the coverage that best suits your needs.

DESCRIPTION OF BENEFITS

HEALTH BENEFIT PLAN

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

Prescription Drugs

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

a) are prescribed by a legally qualified medical practitioner or dental practitioner as permitted by law; and
b) legally require a prescription and 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, but not limited to nitroglycerin, insulin and all other approved injectables, as well as related supplies such as diabetic syringes, needles and testing agents.

Certain drugs require prior approval from GSC before your drug claim can be reimbursed. Further, certain drugs defined by GSC as specialty, high cost drugs may be required to be purchased from an approved pharmacy that is a member of GSC's Specialty Drug Preferred Provider Network (PPN) before your claim can be reimbursed. You can find out if your drug requires prior approval or is included in the PPN either by using the online drug search tool available to you through GSC's Plan Member Online Services, or by contacting GSC's Customer Service Centre.

Quebec Retired Employees

In no event will the amount dispensed exceed a 3-month supply (6 months if a vacation supply is required) of a prescription at any one time and not more than a 13-month supply in any 12 consecutive months.

All other Retired Employees

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.

Conditional Drug Formulary™ - Effective January 1, 2018

New drugs introduced to the Canadian marketplace and approved by Health Canada after **January 1, 2018** (conditional/controlled date) will be subject to an evaluation process by GSC to determine the Need, Safety, Effectiveness and Cost.

Upon filling a prescription, your Pharmacist will know whether the drug is covered, covered with conditions or not covered. If the drug is covered with conditions, you must contact our Customer Service Centre to obtain a Special Authorization Form and a Criteria Sheet for your physician to complete. Once these forms are completed, they must be returned to GSC for review. We will advise you if the drug is covered or not covered. Once the drug has been approved for your use, all future claims can be submitted electronically.

Mandatory generic drug substitution
Based on specific provincial health insurance plan regulations, where a generic equivalent drug exists, reimbursement will only be made up to the cost of the lowest priced equivalent drug.

NOTE:

Drug Benefit over age 65: The Ontario Drug Benefit co-pay and the deductible **are** eligible benefits.

Quebec residents only: Legislation requires GSC to follow the RAMQ (The Regie de l'assurance maladie du Quebec) reimbursement guidelines for all residents of Quebec. If you are younger than age 65, you must enroll for the GSC Prescription Drugs benefit plan and GSC will be the only payer. If you are age 65 or older, enrolment in RAMQ is automatic, enrolment in the GSC Prescription Drugs benefit plan is optional, and RAMQ would be first payer.

If any provisions of this plan do not meet the minimum requirements of the RAMQ plan, adjustments are automatically made to meet RAMQ requirements.

Eligible benefits do not include and no amount will be paid for:
a) Drugs for the treatment of erectile dysfunction and infertility;
b) Reference biologic drugs that have an approved biosimilar;
c) Vitamins that do not legally require a prescription;
d) Vaccines;
e) Smoking cessation oral drugs;
f) 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;
g) 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;
h) Mixtures, compounded by a pharmacist, that do not conform to GSC's current Compound Policy.

Extended Health Services

1. **Hearing Care:** Reimbursement for hearing aids, batteries, repairs or replacement parts, if recommended or approved by the attending legally qualified medical practitioner, up to the amount shown in the Schedule of Benefits.

2. **Medical Items and Services:** When prescribed by a legally qualified medical practitioner unless specified otherwise below, 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 (excluding electric), including rails and mattresses; decubitus (bedridden) supplies; trapezes; urinals;

b) Footwear, when prescribed by your attending physician, nurse practitioner, podiatrist or chiropodist:
   i) custom-made foot orthotics or adjustments to custom made foot orthotics;
   ii) custom-made boots or shoes, adjustments to orthopedic shoes, or footwear as an integral part of a brace, (subject to a medical pre-authorization);
c) Braces, casts;
d) Diabetic equipment and supplies, such as:
   i) blood glucose meters, lancets, insulin pumps when prescribed by an endocrinologist (upon completion of a 3 month trial), and insulin pump supplies;
   ii) glucose monitoring systems (GMS) such as continuous and flash type monitors subject to medical pre-authorization and reimbursed to the cost of a blood glucose meter. Disposable GMS supplies (used with the monitor), such as, but not limited to sensors and transmitters, are included and subject to any overall annual maximum applicable to diabetic testing and monitoring equipment and supplies;
e) Medical services, such as diagnostic tests, X-rays and laboratory tests;
f) Incontinence/Ostomy, such as catheter supplies, ostomy supplies and diapers;
g) Mobility aids, such as canes, crutches, walkers, manual wheelchairs, and, electric wheelchairs for quadriplegics only;
h) Standard prosthetics, such as arm, hand, leg, foot, breast, eye and larynx;
i) Respiratory/Cardiology equipment, such as compressors, inhalant devices and oxygen;
j) Compression stockings (15 mmhg or higher);
k) Wigs for temporary or permanent hair loss due to chemotherapy or radiation.

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

Limitations

a) The rental price of durable medical equipment will not exceed the purchase price. GSC's decision to purchase or rent will be based on the legally qualified medical practitioner's estimate of the duration of need as established by the original prescription. Rental authorization may be granted for the prescribed duration. Equipment that has been refurbished by the supplier for resale is not an eligible benefit;

b) Durable medical equipment must be appropriate for use in the home, able to withstand repeated use and generally not useful in the absence of illness or injury;

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

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

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

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

5. **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.

   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.

6. **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) Replacement parts for prescription eyeglasses.
   d) Laser eye surgery.
   e) 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).

   Eligible benefits do not include and no amount will be paid for:
   a) Medical or surgical treatment, except for laser eye surgery;
   b) Special or unusual procedures such as, but not limited to, orthoptics, vision training, subnormal vision aids and aniseikonic lenses;
   c) Follow-up visits associated with the dispensing and fitting of contact lenses;
   d) Charges for eyeglass cases.

Health Exclusions

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

1. Services or supplies received as a result of disease, illness or injury due to:
   a) an act of war, declared or undeclared;
   b) participation in a riot or civil commotion; or
   c) 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 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's 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);
   g) are Nicotine replacement products such as patches, gum, lozenges, buccal and inhalers;

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;
   m) are special or unusual procedures such as, but not limited to, orthoptics, vision training, subnormal vision aids and aniseikonic lenses;
   n) are delivery and transportation charges;
   o) are for Insulin pumps and supplies (unless otherwise covered under the plan);
   p) are for medical examinations, audiometric examinations or hearing aid evaluation tests;

q) are batteries, unless specifically included as an eligible benefit;
r) are a duplicate prosthetic device or appliance;
s) are from any governmental agency which are obtained without cost by compliance with laws or regulations enacted by a federal, provincial, municipal or other governmental body;
t) would normally be paid through any provincial health insurance plan, Workplace Safety and Insurance Board or tribunal, the Assistive Devices Program or any other government agency, or which would have been payable under such a plan had proper application for coverage been made, or had proper and timely claims submission been made;
u) were previously provided or paid for by any governmental body or agency, but which have been modified, suspended or discontinued as a result of changes in provincial health plan legislation or de-listing of any provincial health plan services or supplies;
v) may include but are not limited to, drugs, laboratory services, diagnostic testing or any other service which is provided by and/or administered in any public or private health care clinic or like facility, medical practitioner's office or residence, where the treatment or drug does not meet the accepted standards or is not considered to be effective (either medically or from a cost perspective, based on Health Canada's approved indication for use);
w) are provided by a medical practitioner who has opted out of any provincial health insurance plan and the provincial health insurance plan would have otherwise paid for such eligible service;
x) relates to treatment of injuries arising from a motor vehicle accident;
   Note: Payment of benefits for claims relating to automobile accidents for which coverage is available under a motor vehicle liability policy providing no-fault benefits will be considered only if–
   i) the service or supplies being claimed is not eligible; or
   ii) the financial commitment is complete;
   A letter from your automobile insurance carrier will be required;
y) are cognitive or administrative services or other fees charged by a provider of service for services other than those directly relating to the delivery of the service or supply.

DENTAL BENEFIT PLAN

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

Basic Services

1. Basic Diagnostic and Preventive Services:
   - complete oral examinations once every 6 months
   - specific oral examinations once every 6 months
   - emergency oral examinations
   - full series X-rays once every 3 years
   - panoramic X-rays
   - bitewing X-rays once every 9 months
   - recall examinations once every 9 months
   - cleaning of teeth (up to 1 unit of polishing, plus up to 1 unit of scaling combined with periodontal scaling and/or root planing) once per recall period
   - topical application of fluoride once per calendar year for covered persons 18 years of age and under
   - oral hygiene instruction once per lifetime
   - denture cleaning once per recall period
   - pit and fissure sealants
   - space maintainers

2. Basic Restorative Services:
   - amalgam, tooth coloured filling restorations (paid to full metal on molar), and temporary sedative fillings
   - inlay restorations – these are considered basic restorations and will be paid to the equivalent non-bonded amalgam

3. Basic oral surgery:
   - extractions of teeth and/or residual roots

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

Comprehensive Basic Services

1. Standard denture services:
   - denture repairs and/or tooth/teeth additions
   - denture adjustments and remount and equilibration procedures, only after 6 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

2. Comprehensive oral surgery:
   - surgical exposure, repositioning, transplantation or enucleation of teeth
   - remodeling and recontouring - shaping or restructuring of bone or gum
   - excision - removal of cysts and tumors
   - incision - drainage and/or exploration of soft or hard tissue
   - fractures including the treatment of the dislocation and/or fracture of the lower or upper jaw and repair of soft tissue lacerations

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

3. Endodontic treatment including:
   - root canal therapy
   - pulpotomy (removal of the pulp from the crown portion of the tooth)
   - pulpectomy (removal of the pulp from the crown and root portion of the tooth)
   - apexification (assistance of root tip closure)
   - apical curettage, root resections and retrograde fillings (cleaning and removing diseased tissue of the root tip)
   - root amputation and hemisection
   - bleaching of non-vital tooth/teeth
   - emergency procedures including opening or draining of the gum/tooth

4. Periodontal treatment of diseased bone and gums including:
   - periodontal scaling and/or root planing 9 time units (combined with preventive scaling), per calendar year
   - occlusal equilibration - selective grinding of tooth surfaces to adjust a bite

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

   - bruxism appliance once every 12 months

Major Services

1. Standard onlays or crown restorations (paid to full metal on molar) to restore diseased or accidentally injured natural teeth, once every 5 years

2. Standard bridges, including pontics, abutment retainers/crowns on natural teeth, once every 5 years

3. Standard dentures including complete, immediate, transitional, and partial dentures, once every 5 years

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

5. Standard relining and rebasing of dentures once every 2 years, only after 6 months have elapsed from the installation of a denture

Alternate Treatment

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:

- for all proposed treatment for crowns, onlays and bridges, an estimate completed by your dental practitioner, **must** be submitted for assessment. Our assessment of the proposed treatment, may result in a lesser benefit being payable or may result in benefits being denied. Failure to submit an estimate prior to beginning your treatment will result in the delay of the assessment.
- if the total cost of any other proposed treatment is expected to exceed $300, it is recommended that you submit an estimate completed by your dental practitioner.

Limitations

1. Laboratory services must be completed in conjunction with other services and will be limited to the co-insurance 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-insurance 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 benefit 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 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 and implant related services;

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's 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, contact GSC:

- Call our Customer Service Centre at 1.888.711.1119 to determine eligibility for a specific item or service and GSC's pre-authorization requirements, or
- Visit our website at greenshield.ca to e-mail your question, or
- Contact the plan administrator at stelcobenefitstrust@gmail.com

Pre-authorization

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

Submitting Claims

When submitting a claim to GSC, you must show the GSC Identification Number for the person who has received the benefit. You can find the applicable GSC Identification Number for yourself and each of your dependents listed on your GSC Identification Card. Original itemized paid receipts are required for claims reimbursement (cash receipts or credit card receipts alone are not acceptable as proof of payment).

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

- Covered person's name, address and GSC Identification Number
- Provider's name and address
- Date of service
- Charges for each service or supply
- A detailed description of the service or supply
- Medical referral/ physician prescription when required
- For Hearing Care, a copy of audiogram and details of provincial funding, if applicable

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

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

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

Submit all claim forms to:
Green Shield Canada

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

Reimbursement

Reimbursement will be made by one of the following methods:

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

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

Direct Payment to the Provider of Service (where applicable)

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

Subrogation

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

Co-ordination of Benefits (COB)

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

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

GSC Plan Member

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

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

Spouse

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

Children

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

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

Children (cont'd)

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.