HEALTH

JULY 2024

# HEALTH BENEFITS INFORMATION

FOR SASKATCHEWAN TEACHERS
AND THEIR FAMILIES

SASKATCHEWAN TEACHERS' FEDERATION

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# INTRODUCTION

The STF Members' Health Plan provides Saskatchewan teachers and their eligible family members with comprehensive coverage for prescription drugs, vision and other health-care expenses, including out-of-country emergency medical expenses.

Members don't pay any premiums to this Plan. As negotiated through the provincial collective bargaining process, funding for the Members' Health Plan is provided by the Saskatchewan government based on a fixed percentage of annual teachers' salaries.

The Saskatchewan Teachers' Federation is responsible for the design, management and administration of the Members' Health Plan. All of the benefits provided by the Plan are self-insured by the Federation and covered by a master plan document issued by Green Shield Canada (GSC).

This booklet contains general information only. The exact terms and conditions of your group health benefits are described in the master plan document, which is considered the final authority in the event of any discrepancy or misunderstanding in interpretation.

This booklet contains important information and should be kept in a safe place.

# YOUR RIGHTS AND RESPONSIBILITIES

## YOUR RIGHTS

### Right to Privacy

At the Saskatchewan Teachers' Federation we are dedicated to protecting your privacy and safeguarding your personal information. The STF Members' Health Plan collects personal information relevant to your insurance coverage, including your name, address, teacher's certificate number, social insurance number, birthdate and dependant information. This information is secured and access is limited to personnel from the Members' Health Plan, GreenShield Canada and/or its claims agents, and any person or organization that has relevant information about you or your dependants that is required in order to process your claims, maintain our databases and provide health care and other related services to you.

We use your personal information to identify you, protect both you and the Plan from error and fraud, comply with legal requirements and administer all of the health and financial services provided to you. This includes many tasks, such as:

- Determining your eligibility for coverage.
- Maintaining your claim file.
- Processing and managing your claims.
- Underwriting activities and financial reporting.
- Conducting internal and external audits.
- Preparing regulatory and statutory reports.

### Right to Access Information

You have certain rights of access and correction with respect to the information in your file. A request for access or correction must be made in writing to the Members' Health Plan.

# YOUR RESPONSIBILITIES

## Complete an Enrolment Form

Each time you sign a new contract of employment, a new Enrolment form must be completed and submitted to the Saskatchewan Teachers' Federation. Your school board must complete their section of the form to verify your employment and you must complete the remainder of the form and submit it to the Federation. The information provided on the Enrolment form will be used to determine if you and your family members are eligible for benefits and the period of eligibility. You will receive notification from the Members' Health Plan confirming your enrolment in the Plan and your eligibility dates.

Enrolment forms are available from your school board and on the STF website at www.stf.sk.ca.

## Registering for GSC everywhere

After you are enrolled in the Plan, GreenShield Canada (GSC), will send you an email containing information on how to register for your *GSC everywhere* account and provide you with your digital GSC card which includes your member ID number. You and your family members will each have your own unique ID number for claiming purposes. You will need to provide your GSC ID number on all correspondence and for identification purposes when speaking with the GSC Customer Service Centre.

Please note that when your coverage terminates, you will no longer be able to use your GSC benefit card.

## Keep Your Health and Dental Records Up to Date

It's critical that you maintain accurate records for you and your family so that your claims can be processed as quickly as possible and you receive updates on benefit and Plan information.

It's your responsibility to inform us of any changes to:

- Your name, mailing address, telephone number or preferred email address.
- Your spouse or eligible dependent children.
- Your contract status (e.g., if you're on a board-approved leave, resign or retire).

You may be asked to provide supporting evidence of a change in your personal information, including, but not limited to, custody agreements and verification of student status, dependant or marital status.

You can update most of your personal information online in the MySTF section of the Federation website. Alternatively, you can complete and submit an STF Change of Information form to the Federation.

Please note, if there’s a change in your contract status (e.g. you resign or retire) you must submit an STF Change of Information form before your contract end date. This form is available on the Federation website or by calling the Members’ Health Plan.

# MEMBER SERVICES

## THE FEDERATION

The Saskatchewan Teachers' Federation administers your health plan and strives to provide teachers and their families with outstanding member service.

### Online Services and Information

The Federation website provides information, forms and tools to help you manage your health benefits when it's convenient for you. Visit www.stf.sk.ca/pension-benefits/health-plan for Plan details, newsletters, Enrolment forms and Change of Information forms. Updates to this booklet can be downloaded from the website as well.

You can also manage your personal information online when you log in to the MySTF section of the website.

Go to My Profile to change your name or contact information.

Go to My Benefits > Health Plan > Manage Family Coverage to:

- Change spouse and dependent children information.
- Upload student verification documents for dependent children aged 21 to 25 who are full-time students.

### If You Have Questions

Our professional staff at the Members' Health Plan provides timely, personalized service to members. If you have any questions about eligibility, commencement and termination of coverage or other general questions about the Plan, contact us at:

**STF Members' Health Plan**
2317 Arlington Avenue
Saskatoon SK S7J 2H8

T: 306-373-1660 or 1-800-667-7762
F: 306-374-1122
E: health@stf.sk.ca
www.stf.sk.ca

# GREENSHIELD CANADA

GreenShield Canada processes all health, prescription drug, vision, dental and out-of-country/province medical expense claims.

## Online and Mobile Services and Information

Register for *GSC everywhere* to:

- Sign up to receive claim payments via direct deposit.
- Submit claims online for fast and easy processing.
- Print Explanation of Benefits statements when you need to co-ordinate benefits.
- Print personalized claim forms.
- Access your claims history, including a breakdown of how your claims were processed.
- Instantly determine what portion of your claim will be covered by checking eligibility and coverage for health services or items.
- Search for a drug to get prescription coverage information.

You can download the *GSC everywhere* app from the Apple Store or Google Play.

## Claim and Benefit Inquiries

If you have a question about benefits or a claim that you have submitted, contact the GSC Customer Service Centre at 1-888-711-1119. You'll need to provide your GSC ID number when you call.

# ELIGIBILITY DETAILS

## ELIGIBILITY CRITERIA

You're eligible to participate in the Members' Health Plan if you have completed 20 full or partial days of teaching service (known as the qualification period), and you meet one of the following requirements:

- You're a teacher employed under a continuous, replacement or temporary contract with a board of education or a conseil scolaire pursuant to Section 200 of *The Education Act, 1995*.
- You're a member of the Saskatchewan Teachers' Federation and employed as a teacher in an independent school that receives operating funding from the Saskatchewan Ministry of Education, which is responsible for PreK-12 education, provided that the teachers in the school are not members of any trade union and are not covered by any other collective bargaining agreement.

This Plan only provides coverage if you and your dependants are covered under a provincial health plan and have residence status in your home province.

If you retire, you're not eligible for health plan benefits starting on the date that retirement benefits first become payable under the Saskatchewan Teachers' Retirement Plan or the Saskatchewan Teachers Superannuation Plan (your "retirement date"). If you continue to teach or return to teach under contract after your retirement date, health plan benefits will not recommence until the first school day following your retirement date.

If you're on a school board-approved leave of absence for five consecutive years or less, coverage will continue for the period of your leave.

If you're receiving disability benefits from the Teachers' Long-Term Disability Plan, coverage under the Members' Health Plan will be extended until the end of the month of your 65th birthday.

Substitute teachers are not eligible for coverage under the Plan.

## EFFECTIVE DATE

If you're a new teacher on a contract, you must complete a 20-day qualification period (20 full or partial days of teaching service) before you are enrolled in the Plan. Once the qualification period is complete, coverage will be applied retroactively to the first school day of your contract. For any new teaching contracts thereafter, a qualification period is only required if there has been a break in service of more than 120 days.

## TERMINATION AND REINSTATEMENT OF COVERAGE

### Termination of Coverage

Your coverage under the Members' Health Plan terminates when your employment ends, you're no longer eligible, you're no longer a teacher as defined by *The Education Act, 1995*, or the Plan terminates, whichever is earlier.

Teachers employed on a temporary contract cease to be eligible for benefits on the last school day of the contract.

Retiring teachers are not eligible for benefits starting on the date that retirement benefits first become payable under the Saskatchewan Teachers' Retirement Plan or the Saskatchewan Teachers Superannuation Plan (your "retirement date").

If you're on a school board-approved leave for a period of five consecutive years, coverage will be terminated at the end of the fifth year.

If you're receiving disability benefits from the Teachers Long-Term Disability Plan, health plan benefits terminate at the end of the month of your 65th birthday.

### Reinstatement of Coverage

If you're employed under a continuous or replacement contract that terminates on June 30 (or the last school day of the year), and you enter into a like contract of employment on the next school day, you're entitled to retroactive benefits.

If you're on a temporary contract, benefits will cease on the last school day of the contract. If you enter into another contract, benefits will commence on the **first school day** of the new contract. Please note: If you're on a temporary contract ending June 30 and you sign a new contract of

employment effective July 1, your benefits will be reinstated on the first school day of the new contract. Therefore, you would not have coverage under the Members' Health Plan over the summer months.

If you continue to teach or return to teach under contract after your retirement date, health plan coverage will not be reinstated until the first school day following your retirement date.

A qualification period (completion of 20 full or partial days of teaching service) will be required for each new contract if there has been a break in service of more than 120 days.

### Obtaining Health Insurance After Termination

If your coverage under this Plan terminates for any reason stated in this booklet, you can apply for insurance through GSC or other insurance providers. Please contact them prior to your termination and they can provide you with details on their Plans.

If you retire, you're eligible to apply for group health benefits through the Superannuated Teachers of Saskatchewan within 60 days after retirement without having to provide evidence of insurability. Contact the STS at 306-373-3879 for complete information.

## FAMILY COVERAGE

The Members' Health Plan provides coverage for your eligible spouse (legal or common law) and eligible dependent children as defined below. In order to be eligible, your spouse and/or dependant children must have valid provincial health plan coverage and have residence status in their home province.

Eligible Spouse means:

- Your legal spouse or the person who has been living with you in a spousal relationship for at least 12 consecutive months.

Eligible Dependent Children means unmarried children (natural, adopted or stepchildren) who are:

- Under age 21 and dependent upon you for support. (Children under age 21 are not covered if they're working more than 30 hours per week, unless they're full-time students.)
- Age 21 or older but under age 26, and in full-time attendance at an accredited post-secondary educational institution. (Verification of student status is required for your child to be eligible for coverage.)

- Incapable of supporting themselves because of a physical or mental disability, provided the disabling condition began before they turned age 21 or while they were a full-time student under age 26, and the disabling condition has been continuous since that time. (We require a copy of your child's CRA Disability Tax Credit Notice of Determination when your child turns 21 in order to support eligibility for continued coverage under the Plan.)

If you're the legal guardian of a child who does not meet the definition as stated, please contact the Members' Health Plan. We will request additional information from you to determine if the child may be eligible for benefits.

Your spouse's and/or dependant's coverage terminates when your coverage terminates or when your spouse or dependant no longer qualifies, whichever is earlier.

## Verification of Dependant Eligibility

### Student Status

If your dependent child is age 21 or older but under age 26 and a full-time student at an accredited post-secondary institution, verification of student status is required. Confirmation of continued enrolment must be submitted to the Members' Health Plan each year or semester.

The document or letter verifying your child's student status must include:

- The student's full name.
- The start and end date of classes.
- Confirmation that the student is in full-time attendance.
- The signature of the registrar of the educational institution.

You can upload the student verification document online in the MySTF section of the Federation website, or send it to the Members' Health Plan by email, fax or mail.

Coverage under the Plan begins on the first day of classes unless your dependent child has been a full-time student during the past academic term and is continuing full-time studies in the fall. Coverage is then extended throughout the summer and into the fall academic term.

Benefits will cease on the last day of the month in which your child completes their education program (i.e., two- or four-year program ends in April, coverage will terminate April 30).

### Physical or Mental Disability

For dependent children who are incapable of supporting themselves because of a physical or mental disability, you're required to provide documentation when the child turns 21 to support eligibility for continued coverage under the Plan. Please contact the Members' Health Plan for details.

## Survivor Benefits

If a member of the Members' Health Plan dies while their spouse and dependent children are insured under this Plan, coverage for the spouse and dependent children will continue to the earlier of:

1. The date they cease to be eligible dependants.
2. Twenty-four months after the member's death.

If a member's child is born after their death, the child is considered to be an insurable dependant.

Survivor benefits are paid to the surviving spouse. If there is no surviving spouse, benefits are paid as follows:

1. For a child who meets the definition of eligibility and who has reached the age of majority, to them.
2. For a minor child who meets the definition of eligibility, to their legal guardian.

# BENEFIT SUMMARY

**The Members' Health Plan covers a wide range of medical expenses to supplement what your provincial health plan provides. The benefits provided by your plan are summarized below. Please see the Benefit Details section of the booklet for more information related to specific benefits.**

Benefit reimbursement levels and benefit maximums apply individually to each eligible family member. There is no overall lifetime health-care maximum.

Reimbursements will be limited to not exceed reasonable and customary charges, 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.

| IN-CANADA PRESCRIPTION DRUGS & DIABETIC DRUG SUPPLIES | REIMBURSEMENT LEVEL (NO DEDUCTIBLE) | BENEFIT MAXIMUM |
|---|---|---|
| Prescription Drugs<br>Saskatchewan Formulary<br>GSC Formulary<br>Preferred Drugs<br>Non-Preferred Drugs<br>High-Cost Specialty Drugs | <br>100%<br><br>100%<br>75%<br>75% | Unlimited |
| Diabetic Drug Supplies | 100% | $2,000 each calendar year |
| Erectile Dysfunction Drugs | 100% | Unlimited |
| Fertility Drugs | 100% | $15,000 lifetime |
| Smoking Cessation Drugs | 100% | $500 lifetime |
| Vaccines | 100% | $300 every 2 calendar years |

| VISION | REIMBURSEMENT LEVEL | BENEFIT MAXIMUM |
|---|---|---|
| Eye Examination<br>• You and your eligible spouse, and dependent children at least age 21 but under age 26<br>• Disabled dependants age 21 or older | 100% | $125 every 24 months |
| Eye Examination<br>• Dependent children under age 21 | 100% | $125 every 12 months |
| Vision Services and Supplies<br>• You and your eligible spouse and dependent children | 100% | $400 every 24 months |

| HEALTH PRACTITIONERS | REIMBURSEMENT LEVEL | BENEFIT MAXIMUM |
|---|---|---|
| Acupuncturist<br>Audiologist<br>Chiropractor<br>Dietitian<br>Massage Therapist<br>Naturopath<br>Occupational Therapist<br>Osteopath<br>Podiatrist/Chiropodist<br>Speech Therapist | 80% | $500 per calendar year for each practitioner listed. |
| Psychologist/Social Worker | 90% | $2,500 per calendar year |
| Physiotherapist/Athletic Therapist | 100% | $1,000 per calendar year |

| MEDICAL SUPPLIES & EQUIPMENT | REIMBURSEMENT LEVEL | BENEFIT MAXIMUM |
|---|---|---|
| Hearing Aids | 80% | $2,500 every 4 years |
| Custom-Made Compression Hose | 80% | $500 each calendar year |
| Custom-Made Foot Orthotics & Orthopedic Shoes | 80% | $500 each calendar year |
| Mechanical or Hydraulic Patient Lifters (excluding stair lifts) | 80% | $2,000 per lifter (electric) once every five years |
| Outdoor Wheelchair Ramps | 80% | $2,000 lifetime |
| Wigs | 80% | $1,000 every 2 calendar years |
| External Breast Prosthesis | 80% | 1 (per side) every 12 months |
| Post-Mastectomy Bra | 80% | 2 every 12 months |
| Blood-Glucose Monitoring Machines | 80% | 1 every 4 years |
| Flash Glucose Monitoring Machines | 80% | No frequency maximum |
| Continuous Glucose Monitoring Machines, Sensors and Transmitters | 80% | $4,000 each calendar year |
| Insulin Infusion Pump | 80% | $6,300 every 4 years |
| Diabetic Supplies | 80% | Unlimited |
| Transcutaneous Nerve Stimulators (TENS) | 80% | $700 lifetime |
| Compression Pumps | 80% | $1,500 lifetime |
| Mobility aids | 80% | See benefit details. |
| Incontinence/Ostomy Supplies | 80% | See benefit details. |
| Respiratory Equipment & Supplies | 80% | See benefit details. |
| Other Medical Supplies, Appliances and Equipment | 80% | See benefit details. |

| AMBULANCE, HOSPITAL & PRIVATE NURSING | REIMBURSEMENT LEVEL | BENEFIT MAXIMUM |
|---|---|---|
| Ambulance | 100% | No maximum |
| Hospital Room | 100% | Semi-private room |
| Chronic Care | 100% | $20 per day to a maximum of 90 days |
| Respite Care | 100% | $20 per day to a maximum of 90 days |
| Private Duty Nursing | 100% | $25,000 every 3 years |

| TRAVEL COVERAGE | REIMBURSEMENT LEVEL | BENEFIT MAXIMUM |
|---|---|---|
| Out-of-Country/Province Emergency Services | 100% | $5,000,000 per incident |
| Travel Assistance | 100% | See benefit details. |

| OTHER COVERAGE | REIMBURSEMENT LEVEL | BENEFIT MAXIMUM |
|---|---|---|
| Medical Travel in Canada | 100% | $2,000 lifetime |

# BENEFIT DETAILS

**The Members' Health Plan covers the following services and supplies, provided they are not covered under your provincial government plan and provincial law permits coverage. All expenses will be reimbursed at the level and up to the maximums shown in the Benefit Summary section of the booklet.**

Covered expenses and limitations apply to each eligible family member. Benefits will be eligible if they are medically necessary for the treatment of an illness or injury.

## PRESCRIPTION DRUGS AND DIABETIC DRUG SUPPLIES

The Members' Health Plan provides coverage for eligible prescription drugs and diabetic drug supplies provided in Canada.

### Covered Expenses

The Plan provides coverage for the list of medications and diabetic drug supplies indicated under the following formularies, as well as certain other eligible drugs.

#### Saskatchewan Drug Formulary

The Saskatchewan Formulary is a listing of high-quality, therapeutically effective drugs that have been approved for coverage under the Saskatchewan Drug Plan.

#### GSC Drug Formulary

- Preferred Drugs: Eligible brand and generic drugs that are less expensive than other drugs within the same therapeutic class. These drugs are defined on the basis of need, safety, efficacy and cost.
- Non-preferred Drugs: Eligible brand and generic drugs that usually have less costly alternatives within the same therapeutic class. These drugs are defined on the basis of need, safety, efficacy, and cost.
- High-Cost Specialty Drugs: Specialty drugs generally prescribed for complex or ongoing medical conditions. Typically, these are high-cost medications that are often injected or infused (although some are taken by mouth), or require complicated treatment regimens, unique storage requirements, additional patient support or educational requirements. They are not typically stocked by most retail pharmacies and are typically prescribed by specialists. These drugs are subject to prior authorization from GSC.

### Diabetic Drug Supplies

The following diabetic drug supplies covered under this section are:

- Minimed syringes
- Syringes
- Test strips
- Lancets
- Disposable needles for use with non-disposable insulin injection devices
- Sensors for flash glucose monitoring machines (i.e. Freestyle Libre sensors)

(See Medical Supplies and Equipment on page 24 for other diabetic supplies and equipment covered under the Plan.)

### Other Eligible Drugs

- Eligible vaccines
- Fertility drugs
- Drugs used to treat erectile dysfunction
- Smoking cessation drugs requiring a prescription

## 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. If a medical practitioner indicates a brand name drug is medically required due to a serious medical reaction to at least two generic equivalent drugs, GSC must be provided with a copy of the “Health Canada Vigilance Adverse Reaction Reporting Form” (which can be obtained from the Health Canada website) completed by the medical practitioner, to determine eligibility for payment of the cost of the prescribed drug.

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 biosimiliar drug.

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

In no event will the amount dispensed exceed a three-month supply (six 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.

## Prescription Drug Exclusions

The following are excluded drugs. No amount will be paid for:

- drugs for the treatment of obesity;
- reference biologic drugs that have an approved biosimilar;
- vitamins that do not legally require a prescription;
- products which may lawfully be sold or offered for sale other than through retail pharmacies, and which are not normally considered by practitioners as medicines for which a prescription is necessary or required, unless specifically identified and included as eligible in "Prescription Drugs;"
- 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.

## Saskatchewan Special Support Program

If you're a Saskatchewan resident, you may be eligible to have a portion of your prescription drug expenses paid for by the provincial government through the Saskatchewan Special Support Program.

If you receive a letter from GSC advising you to apply for SSP, follow the instructions in the letter and apply for SSP as soon as possible. If you don't apply, your drug card will be suspended until GSC receives your information.

Individuals or families who are covered under federal government programs, such as the federal Non-Insured Health Benefits Program or Veterans Affairs, are not eligible for the SSP. If this applies to you, please advise GSC accordingly.

## Seniors' Drug Plan

If you're a Saskatchewan resident 65 years of age or older, you may be eligible to have a portion of your prescription drug expenses paid for by the provincial government through the Saskatchewan Seniors' Drug Plan.

# VISION

Covered vision expenses and limitations apply to each individual eligible family member. Benefit periods (i.e., 12- or 24-month periods) apply from the date of purchase of the service or supply, not your effective date of coverage. **The date of purchase is the date the service or supply was paid for in full.**

To confirm the date you'll be eligible for an eye exam or vision supplies, or to confirm the amount of coverage still available in the current benefit period, contact GSC at 1-888-711-1119 or access *GSC everywhere* to check your vision balances and next eligible service date.

## Eye Exams

Eye exams must be performed by a licensed optometrist or ophthalmologist.

## Vision Services and Supplies

Vision services and supplies must be prescribed and/or provided by a licensed optometrist or ophthalmologist and provided by a qualified optician.

## Covered Expenses

- Prescription glasses (frames and/or lenses)
- Contact lenses and contact lens service
- Sunglasses with prescription lenses
- Safety glasses with prescription lenses
- Laser eye surgery
- Visual training and therapy preformed in the office of a licensed optometrist or ophthalmologist

# HEALTH PRACTITIONERS

The Members' Health Plan covers out-of-hospital services by the health practitioners listed below. Reimbursement levels for these services are shown in the Benefit Summary, and will be paid only when the practitioner providing the service is licensed by their provincial regulatory agency or is a registered member of a professional association recognized by GSC. Please contact the GSC Customer Service Centre to confirm whether a given practitioner is covered.

### Covered Expenses

Services of the following health practitioners are eligible for coverage:

- Acupuncturist
- Audiologist
- Chiropractor
- Dietitian
- Massage therapist
- Naturopath
- Occupational therapist
- Osteopath
- Physiotherapist/athletic therapist
- Podiatrist/chiropodist
- Psychologist/social worker
- Speech therapist

## MEDICAL SUPPLIES AND EQUIPMENT

All expenses in this category must be prescribed by a legally qualified medical practitioner. Some items may require pre-authorization. To confirm eligibility prior to purchasing or renting equipment, contact the GSC Customer Service Centre.

For claiming purposes, expenses are considered to be incurred the date the supply is received and paid for in full.

Other medical supplies and equipment not listed below may be eligible for coverage. Please contact the GSC Customer Service Centre for further details.

### Covered Expenses

**Aids for daily living such as:**

- Manual hospital style beds
- Decubitus (bedridden) supplies, portable patient lifts (including batteries) limited to 1 every 60 months up to $2,000 per claim, trapezes/transfer poles and IV stands.
- Bath rails, shower chair

**Footwear, when prescribed by your attending physician, podiatrist, or chiropodist, and dispensed by your podiatrist, chiropodist, chiropractor, orthotist or pedorthist, such as:**

- Custom-made foot orthotics or repairs to custom-made foot orthotics. Custom-made foot orthotics means devices made from a three-dimensional model of an individual's foot and made from raw materials. These devices are used to relieve foot pain related to biomechanical misalignment to the feet and lower limbs;
- Custom-made boots or shoes and modifications and repairs or footwear as an integral part of a brace, (subject to a medical pre-authorization). 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.

**Medical services, such as:**

- Diagnostic and laboratory tests
- X-rays

**Medical items such as:**

- Braces and casts
- Transcutaneous electrical nerve stimulators (TENS machine)
- Incontinence/ostomy equipment, such as catheters and ostomy supplies

**Mobility aids, such as:**

- Canes, crutches and walkers
- Wheelchairs (including batteries)
- Wheelchair ramp

**Standard Prosthetics, such as:**

- Arm, hand, leg, foot, eye, larynx
- External breast prosthesis limited to one left and one right every 12 months
- Post-mastectomy bra, limited to two every 12 months

**Respiratory/Cardiology equipment, such as:**

- Compressors and inhalant devices
- Oxygen and equipment for its administration
- Tracheotomy supplies

- CPAP, APAP, BIAP, including supplies

Please note: The Saskatchewan Aids to Independent Living (SAIL) Respiratory Equipment Program offers the loan of a selection of respiratory equipment, including (CPAP/APAP/BIAP) flow generators to Saskatchewan residents who meet certain criteria. Eligible clients have access to a machine for a program fee of $275. Members must access all government programs available. Should you not meet their eligibility criteria, contact GSC for details on coverage under this Plan. This Plan covers the cost of the program fee at 80% along with additional supplies.

**Diabetic Supplies and equipment, such as:**

- The following diabetic supplies: novolin-pens or similar insulin injection devices using a needle, bloodletting devices including platforms (not including lancets), insulin infusion sets (not including infusion pumps), and insulin infusion pump supplies such as insulin pods, Omnipods, etc. (additional diabetic drug supplies are covered under Prescription Drugs and Diabetic Drug Supplies, page 19)
- Blood-glucose monitoring machines
- Insulin infusion pumps
- Continuous glucose monitoring machines, sensors and transmitters
- Flash glucose monitoring machines

**Hearing Aids:**

- Reimbursement for hearing aids, initial battery or repairs, if recommended or approved by the attending legally qualified medical practitioner. No amount will be paid for replacement batteries.

**Other items, such as:**

- Compression stockings with a pressure measurement of 15 mmhg or higher
- Compression pumps
- Wigs for temporary or permanent hair loss as a result of a medical condition

## AMBULANCE AND HOSPITAL

### Covered Expenses

- Reimbursement for reasonable and customary charges 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.
- Coverage for semi-private room in a public general hospital

## CHRONIC CARE, RESPITE CARE AND PRIVATE NURSING

To establish the amount of coverage available for chronic care, respite care and services provided by a private duty nurse, you must contact GSC for prior approval.

### Covered Expenses

- 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 $25,000 every 36 months. No amount will be paid for services which are custodial and/or services that 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.
- Respite Care/Short Stay, limited to $20 per day up to 90 days per disability
- Long-Term Care Facility, limited to $20 per day up to 90 days per disability

## TRAVEL COVERAGE

### OUT-OF-COUNTRY/PROVINCE EMERGENCY BENEFITS

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

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

Travel Assistance on the covered person's behalf within 48 hours. If GSC Travel Assistance is not notified within the first 48 hours, reimbursement of incurred expenses may be limited to the lesser of the amount of only those expenses incurred within the first 48 hours of any and each treatment/incident or the Plan maximum. This means the covered person will be responsible for all expenses thereafter.

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

**Emergency** excludes treatment of a pre-existing condition that was not completely stable for the 90-day period immediately preceding the covered person's departure.

**Pre-existing condition** means any medical condition that exists prior to the date of the covered person's departure.

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

A medical condition is considered stable when all of the following statements are true during the 90-day period immediately preceding the date of the covered person's departure.

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

b) The Medical Condition has not become worse.

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

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

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

f) There is no planned or pending treatment.

g) There has not been any change to an existing prescribed drug (including an increase, decrease, or stoppage to prescribed dosage), or any recommendation or starting of a new prescription drug. The following are not considered changes to existing prescribed drug treatment:

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

ii. A change from a brand name to a generic equivalent product as long as the dosage is the same – including a transition from a biologic to a biosimilar product

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

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

**Travelling Companion** means any person who has prepaid accommodation and/or transportation with the Covered Person for the same covered trip.

**Treat, Treated, Treatment** means a procedure prescribed, performed, or recommended by a Physician for a Medical Condition. This includes but is not limited to prescribed medication, investigative testing, and surgery.

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

## Eligible travel expenses include the following:

**Hospital services and accommodation**

- Up to a standard ward rate in a public general hospital
- Up to $350 for out-of-pocket expenses such as telephone, television rental and parking

**Medical/surgical services rendered by a legally qualified physician or surgeon to relieve the symptoms of, or to cure an unforeseen illness or injury**

**Emergency Transportation**

- Land ambulance to the nearest qualified medical facility
- Air ambulance - the cost of air evacuation (including a medical attendant when necessary) between hospitals and for hospital admission into Canada when approved in advance by your provincial/territorial health insurance plan or to the nearest qualified medical facility

**Referral services**

Reasonable and customary hospital, medical, surgical and transportation expenses in excess of those expenses covered by your provincial/territorial health insurance plan for you and an approved escort.

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

**Private nursing**

Services of a registered private nurse up to a maximum of $10,000 per calendar year, at the reasonable and customary rate charged by a qualified nurse registered and licensed in the jurisdiction in which treatment is provided. You must contact GSC Travel Assistance for pre-approval.

**Diagnostic laboratory tests and X-rays when prescribed by the attending physician.**

Except in emergency situations, GSC Travel Assistance must pre-approve these services (i.e. cardiac catheterization or angiogram, angioplasty and bypass surgery).

**Prescription drugs**

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

**Medical appliances**

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

**Treatment by a dentist only when required on an emergency basis for:**

- Services and treatment of a direct accidental blow to the mouth up to a maximum of $2,500. Treatments (prior to and after return) must be provided within 90 days of the accident. Details of the accident must be provided to GSC Travel Assistance along with dental X-rays.
- Treatment to relieve dental pain up to a maximum of $500 per trip.

**Coming Home When your emergency illness or injury is such that:**

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

This benefit assumes that you are not holding a valid open-return air ticket. Charges for upgrading, departure taxes and cancellation penalties are not included.

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

Cost of returning your personal use motor vehicle to your residence or nearest appropriate vehicle rental agency when you are unable to due to sickness, physical injury or death, up to a maximum of $10,000 per trip. GSC Travel Assistance requires original receipts for costs incurred, i.e. gasoline, accommodation and airfares.

Meals and accommodation up to a maximum of $250 per day to a maximum of $5,000 per trip will be reimbursed for the extra costs of commercial hotel accommodation and meals incurred by you or a covered dependent when the trip is delayed or interrupted due to an illness, accidental injury to or

death of a Travelling Companion and the covered person remains until they or their Travelling Companion is fit to travel. This must be verified in writing by the attending legally qualified physician or surgeon and supported with original receipts from commercial organization.

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

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

Return airfare if the personal use motor vehicle of you or your covered dependent is stolen or rendered inoperable due to an accident, reimbursement will be made for the cost of a one-way economy airfare to return you and your covered dependents travelling with you, or a Travelling Companion by the most direct route to the major airport nearest your departure point in your province/territory of residence. An official report of the loss or accident is required.

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

Paramedical Practitioners up to a maximum of $500 per practitioner per Emergency (including x-rays) for the services of a licensed chiropractor, physiotherapist, podiatrist/chiropodist or osteopath in conjunction with treatment for an Emergency.

Child Care when pre-approved by GSC Travel Assistance, up to $5,000 for one of the following benefits for dependent children under the age of 16 in the event of an Emergency involving you or your spouse while travelling:

- Additional cost of one-way economy airfare for the return home of accompanying dependent children when you or your spouse are hospitalized, plus the cost of an escort if required

- The cost of services of a caregiver (who is not a relative) in the location where you or your spouse is hospitalized
- The cost of services of a caregiver (who is not a relative) in your home province when the children are left unattended due to the delayed return of you or your spouse

Pet Return up to a maximum of $500 for the return to your accompanying pet(s) in the event you are hospitalized or repatriated during an Emergency.

## GSC TRAVEL ASSISTANCE SERVICE

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

### These services include:

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

- Special assistance in making arrangements for interrupted and disrupted travel plans resulting from emergency situations to include:
  - The return of unaccompanied travel companions
  - Travel to the bedside of a stranded person
  - Rearrangement of ticketing due to accident or illness and other travel related emergencies
  - The return of a stranded personal use motor vehicle and related personal items
- Knowledgeable legal referral assistance
- Co-ordination of securing bail bonds and other legal instruments
- Guidance in replacing lost or stolen travel documents including passports
- Courtesy assistance in securing incidental aid and other travel related services

## How Travel Assistance Service Works

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

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

A multilingual assistance specialist will provide direction to the best available medical facility or legally qualified physician able to provide the appropriate care.

Upon admission to a hospital or when consulting a legally qualified physician or surgeon for major emergency treatment, GSC Travel Assistance will guarantee the provider (hospital, clinic or physician) that you have the required provincial/territorial health insurance plan coverage and GSC travel benefits as detailed above.

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

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

## Travel Limitations

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

2. GSC Travel Assistance must be notified before obtaining Emergency Treatment in order for GSC Travel Assistance to:

    - Confirm coverage; and
    - Provide pre-approval of treatment.

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

    If GSC Travel Assistance is not notified before the Emergency Treatment was received, benefits will be limited to the lesser of the amount of only those expenses incurred within the first 48 hours of any and each treatment/incident or the plan maximum. This mean you will be responsible for all expenses thereafter.

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

4. Repatriation is mandatory when GSC Travel Assistance determines that the covered person should transfer to another facility or return to the home province/territory of residence for treatment, or at the end of the emergency. If you choose not to return:

    - No benefits will be paid for any further medical treatment;
    - No benefits will be paid for any recurrence or complications related directly or indirectly to the Medical Condition that caused the emergency; and
    - For the remainder of the trip, coverage will be limited to Medical Conditions completely unrelated to the Medical Condition that caused the emergency.

5. Air ambulance services will only be eligible if:

- They are pre-approved by GSC Travel Assistance
- There is a medical need for you or your dependant to be confined to a stretcher or for a medical attendant to accompany you during the journey
- You or your dependant are admitted directly to a hospital in your province/territory of residence
- Medical reports or certificates from the dispatching and receiving legally qualified physicians are submitted to GSC Travel Assistance
- Proof of payment (including air ticket vouchers or air carrier invoices) is submitted to GSC Travel Assistance

6. If planning to travel in areas of political or civil unrest, or in areas where the Canadian government has issued a formal travel warning regarding non-essential travel, contact GSC Travel Assistance for pre-travel advice, as we may be unable to guarantee assistance services.
7. GSC Travel Assistance reserves the right, without notice, to suspend, curtail or limit its services in any area if any of the following occur:
   - Political or civil unrest, rebellion, riot or military uprising
   - Labour disturbance or strike
   - Act of God
   - Refusal of authorities in a foreign country to permit GSC Travel Assistance to provide service

   This includes travel if when you booked your trip (including delay of travel), or before your departure date, the Canadian government issued a formal travel warning advising Canadians to avoid either all travel or all non-essential travel regarding the country, region, city or other key components of your travel arrangements (e.g., cruise ship) due to a likely or actual epidemic or pandemic.

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

## Travel Exclusions

In addition to the health exclusions, travel claims will not be paid for the following:

1. Any expenses incurred for the treatment related directly or indirectly to a pre-existing medical condition that, at the time of your departure from your province/territory of residence and the 90-day period immediately preceding your departure from your province/territory of residence:

   a. Was not completely stable in the professional opinion of GSC Travel Assistance Team

   b. Where medical evidence suggested a reasonable expectation that treatment or hospitalization could be required while traveling

   c. A physician advised the covered person not to travel

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

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

3. Any expenses incurred for any services received that:

   a. Were not required to treat an emergency

   b. Were not recommended by a legally qualified physician or surgeon

   c. Are not covered under your provincial/territorial health insurance plan

   d. Are normally covered under the out-of-Canada benefits of your provincial/territorial health insurance plan's out-of-Canada coverage (where applicable), when the provincial/territorial plan has declined payment

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

   a. The covered person was to return to the province/territory of residence for treatment, but the covered person chose not to return to the province/territory of residence

   b. The services could be reasonably delayed until the covered person returned to the province/territory of residence

   c. The emergency had ended

   d. The services are for a recurrence or complication directly or indirectly related to the emergency that GSC Travel Assistance determined 3.a), b) or c) above

5. Any expenses incurred for services to treat a medical condition or complications of a medical condition directly or indirectly related to an epidemic or pandemic if, when the trip was booked, or before the departure date:
   - An official travel advisory was issued by the Canadian government advising Canadians to avoid either all travel or all non-essential travel regarding any country, region, city or other key components of your travel arrangements (e.g., cruise ship)
   - To view the travel advisories, visit the Government of Canada Travel site
6. Any expenses incurred for services to treat:
   a. Any medical condition, including symptoms of withdrawal, arising from or in any way related to the chronic use of alcohol, drugs or other intoxicants whether prior or during the trip
   b. Any medical condition arising during the trip resulting from, or in any way related to, the abuse of alcohol that results in a blood alcohol level of more than 80 milligrams in 100 millilitres of blood, drugs or other intoxicants
   c. Any medical condition resulting from not following Treatment as prescribed, including prescribed or over-the-counter medication
7. Any expenses related to pregnancy, delivery, or complications of either, arising during the eight-week period before and after the expected date of delivery.
8. Any expenses incurred for a child born during the trip within the eight-week period before and after the expected date of delivery.
9. Any expenses incurred during any trip made for the purpose of obtaining a diagnosis, treatment, surgery, palliative care or any alternative therapy, as well as any directly or indirectly related complication.

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

## MEDICAL TRAVEL IN CANADA

If your doctor refers you or your eligible family members for treatment by another physician within your own province, or elsewhere in Canada and the round-trip distance is 1,000 kilometres or more, the Members' Health Plan will pay for the following expenses:

- Travelling expenses for the person requiring the treatment and one companion, if recommended by the attending doctor. Benefits are limited to either round-trip economy class travel or automobile fuel expenses. Taxi, car rental charges and automobile repair charges are not covered.
- Lodging expenses for the person requiring the treatment and one companion. Benefits are limited to moderate quality accommodation for the area in which the expense is incurred. Telephone and meal expenses are not covered.
- Transportation and lodging expenses associated with in-Canada medical travel are limited to a maximum of $2,000 in a person's lifetime. All claims must be supported by documentation and receipts.

# SUBMITTING A CLAIM

You have 15 months from the date an eligible expense is incurred to submit a claim to GSC unless the expense was incurred outside of Canada. Claim periods for out-of-country claims depend on the province in which you live (See Out-of-Country/Province Claims).

## HOW TO SUBMIT YOUR PRESCRIPTION DRUG, VISION AND HEALTH CLAIMS

You can present your GSC benefit card to providers such as pharmacists, medical practitioners and vision providers. Your claim will be submitted and processed electronically at the point of service.

Submit your claim online through *GSC everywhere*. When you submit your claim, you will be provided with information regarding claim requirements or if prior authorization is required.

You can also complete a General Claim Submission form found on *GSC everywhere*. Please note, if your contract has terminated, you will need to complete a General Claim Submission form and mail it to the address on the form. The form must include the original itemized paid in full receipts (cash receipts or credit card receipts are not acceptable).

### GSC Claim Audits

GSC may audit your claim, so you must retain all original claim receipts and supporting documentation for at least 13 months. In the event GSC audits your claim, you must provide the requested documentation to them within the time frame specified.

### Processing and Payment

You can arrange for your claim payment to be deposited directly into your bank account by registering for *GSC everywhere*. Your payments will be directly deposited whether you submit a claim online or use a General Claims Submission form. If you don’t register for direct deposit, a claim cheque will be mailed to you directly from GSC.

If you submit your claim online, you will be able to view your claim payment details. An Explanation of Benefits statement will be available should you need to co-ordinate your claims.

# OUT-OF-COUNTRY/PROVINCE EMERGENCY CLAIMS

## Submitting Your Claim

Out-of-country/province emergency expenses must be submitted within a certain time period, which varies by province of residence and is subject to change. Please be aware of these time limits and submit your claim as soon as possible after the date of service.

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

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

If you have incurred out of pocket expenses, make sure you tell GSC Travel Assistance about all the travel coverage you have when submitting claims. Claims must be submitted together with supporting original receipts to GSC Travel Assistance who will then co-ordinate reimbursement of those approved, eligible expenses from all sources (e.g., provincial plans that provide out-of-Canada coverage, a spousal plan, travel coverage provided through your credit card, etc.).

When submitting your Emergency Medical claim, please include:

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

# CO-ORDINATION OF BENEFITS

Your health plan benefits may be co-ordinated with the benefits provided by any other plan to increase your coverage for eligible expenses. The total amount received from all sources cannot exceed the amount of the actual expenses incurred.

Benefits will automatically be co-ordinated or reduced by any amount payable under a government plan. The reduced amount is then considered to be the covered expense under all other co-ordination provisions. It is subject to any applicable deductibles, reimbursement levels and maximums under this Plan.

## Co-ordinating Your Claim

You and your spouse must first submit your own claims to your own group plans, regardless of whether or not you have reached the benefit maximum. If you and your spouse are both covered under the Members' Health Plan, you can co-ordinate benefits so that eligible expenses are calculated first as a member and secondly as a dependent spouse at the same time. You can use your GSC ID numbers at the pharmacy or other health-care providers so they can electronically co-ordinate benefits for you.

If you're submitting the balance of a claim to another plan, you must include the explanation of benefit (itemization of expenses) that you receive from GSC. This allows the other insurer to reimburse you properly for the claims incurred.

Remember to include copies of receipts and bills when submitting claims for co-ordination of benefits, as well as retaining the same for your own files.

Claims for dependent children must be submitted to the plan of the parent who has the earlier birth date in the calendar year (the year of birth is not considered). This applies whether the parents are spouses, or in the event of a separation or divorce, when there is joint custody.

If you're separated or divorced and one parent has full custody of a dependent child, claims should be submitted in the following order:

- To the plan of the parent with custody of the child.
- To the plan of the spouse of the parent with custody of the child.
- To the plan of the parent without custody of the child.
- To the plan of the spouse of the parent without custody of the child.

Any amount that is not paid by the first plan, may be submitted to the plan of the other spouse. Each person will receive payment for the portion of the eligible claim submitted to their plan, regardless of who incurred the total

cost. The Members' Health Plan cannot pay benefits to any individual or organization other than the covered member under whose plan the claim is being submitted.

Please ensure you advise the Members' Health Plan if you separate or divorce so that the correct order for payment of benefits can be determined. If the Plan is not advised, it is assumed that the first payor is the plan of the parent who has the earlier birthday in the calendar year.

# HEALTH BENEFIT 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
    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 any federal or provincial legislation or regulation regarding access to and/or distribution of medical cannabis.
7. Any specific treatment or drug which:
    - Does not meet accepted standards of medical, dental or ophthalmic practice, including charges for services or supplies which are experimental in nature
    - 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
    - Is an adjunctive drug prescribed in connection with any treatment or drug that is not an eligible service
    - Is administered in a hospital or is required to be administered in a hospital in accordance with Health Canada’s approved indication for use
    - Is not dispensed by the pharmacist in accordance with the payment method shown under the Prescription Drugs benefit

- 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:
    - 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
    - Are legally prohibited by the government from coverage
    - 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
    - Are provided by a health practitioner whose license by the relevant provincial regulatory and/or professional association has been suspended or revoked
    - Are not provided by a designated provider of service in response to a prescription issued by a legally qualified health practitioner
    - Are used solely for recreational or sporting activities and which are not medically necessary for regular activities
    - Are primarily for cosmetic or aesthetic purposes, or are to correct congenital malformations
    - 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.
    - Are provided by your plan sponsor and/or a practitioner employed by your plan sponsor, other than as part of an employee assistance plan
    - 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.
    - Are video instructional kits, informational manuals or pamphlets
    - Are for medical or surgical visual treatment (unless specifically identified and included as eligible under the plan) or medical or surgical audio treatment

- Are special or unusual procedures such as, but not limited to, visual training unless specifically identified and included as eligible under the plan), orthoptics, subnormal vision aids and aniseikonic lenses
- Are delivery and transportation charges
- Are for insulin pumps and supplies (unless specifically identified and included as eligible under the Plan)
- Are for audiometric examinations or hearing aid evaluation tests (unless specifically identified and included as eligible under the plan), or medical examinations
- Are batteries, unless specifically included as an eligible benefit
- Are a duplicate prosthetic device or appliance
- 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
- 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

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