My BENEFIT PLAN

Ryerson Students' Union

Billing Division: 70000

Revised Effective Date: September 1, 2016

gsc green shield canada

WELCOME TO YOUR BENEFIT PLAN

ABOUT THIS BOOKLET

This booklet provides a summary of your benefits under your benefit plan. It includes:

- a Table of Contents, to allow easy and quick access to the information you are looking for
- a Schedule of Benefits, listing all the deductibles, co-pays and maximums that may impact the amount paid to you
- a Definitions section, to explain common terms used throughout the booklet
- detailed benefit descriptions for each benefit in your group benefits plan
- information you need to submit a claim

You are encouraged to read this booklet carefully; please keep it in a safe place so that you may refer to it when submitting claims.

YOUR BENEFIT PROVIDERS ARE:

Green Shield Canada (GSC)

- Prescription Drugs, Health and Dental Benefit Plans

Chubb Life Insurance Company of Canada

- Accidental Death and Dismemberment Benefit Plan

RSA Travel Insurance Inc.

- Travel Benefit Plan

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
- 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
- Search for a drug to get information specific to your own coverage (or coverage for your family)
- Search for eligible dental and paramedical 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

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-pays and maximums that may be applicable if you are included in the Billing Division shown on the cover of this booklet.

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

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

Deductible: Nil	**Overall Maximum:** Unlimited

Your Plan Covers:	**Your Co-Pay:**	**Maximum Plan Pays:**
Prescription Drugs – Pay Direct Drug Card ▪ HPV Vaccines ▪ All other covered drugs	35% per prescription or refill 20% per prescription or refill	$5,000 per benefit year for all prescription drugs combined
Medical Items and Services		
• Footwear	20%	
▪ custom made boots or shoes		$750 every 3 benefit years
▪ custom made foot orthotics		$300 every 3 benefit years
• Bra (mastectomy)	0%	2 per benefit year
• Compression Stockings	0%	$50 per benefit year
• Wigs	0%	$500 per lifetime
• Wheelchair/Scooter modifications/ repairs	0%	$250 per lifetime
• Wheelchair Ramp (portable)	0%	$2,000 per lifetime
• Patient Lift	0%	1 every 5 benefit years up to $2,000
• TENS Unit	0%	$700 per lifetime
• Myo-electric arm	0%	$10,000 per prosthesis
• External Breast Prosthesis	0%	1 per benefit year
• Blood Glucose Monitor	0%	$150 every 5 benefit years
• Other items and services – See the Description of Benefits section for details	0%	Reasonable and customary charges
Emergency Transportation	0%	$100 per day
Private Duty Nursing in the Home	0%	$25,000 per benefit year

Your Plan Covers:	Your Co-Pay:	Maximum Plan Pays:
Professional Services	0%	
• Chiropractor		$15 per visit up to 20 visits per benefit year plus 1 X-ray per benefit year
• Chiropodist, Podiatrist, Acupuncturist		$20 per visit up to $300 for all practitioners combined per benefit year plus 1 X-ray by a Podiatrist per benefit year
• Registered Massage Therapist (Physician (M.D.) or nurse practitioner recommendation required)		$25 per visit up to 20 visits per benefit year
• Naturopath		$250 per benefit year
• Osteopath		$20 per visit up to $300 per benefit year plus 1 X-ray per benefit year
• Physiotherapist (Physician (M.D.) or nurse practitioner recommendation required)		$55 per visit up to $240 per benefit year
• Psychologist or Master of Social Work		$500 per benefit year
• Speech Therapist		$250 per benefit year
Accidental Dental	0%	Reasonable and customary charges
Tutorial Benefit Note: Your dependents are not eligible for this benefit	0%	Private tutorial service of a qualified teacher at $15 per hour, up to $1,000 per disability. You must be confined to home or hospital for a minimum of 15 consecutive days to qualify

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

DENTAL BENEFIT PLAN

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

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

Deductible:	Nil

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

Your Plan Covers:	Your Co-Pay:	Maximum Plan Pays:
Basic Services		$750 per covered person per benefit year (Basic, Comprehensive Basic and Major Services combined)
• Diagnostic and preventive	20%	
• Comprehensive oral surgery	90%	
• All other basic services	25%	
Comprehensive Basic Services		
• Endodontics and periodontics (excluding periodontal scaling and root planing)	90%	
• Periodontal scaling and root planing	20%	
Major Services		
• Crowns, bridges and dentures	90%	

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

DEFINITIONS

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

Allowed amount means**,** as determined by GSC:

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

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

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

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

For other Health and Dental Benefits
Co-pay is the eligible allowed amount that must be paid by you or your dependent before reimbursement of an expense will be made.

Covered person means the plan member who has been enrolled in the plan or 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 benefit year before reimbursement of an eligible expense will be made.

Dependent means

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

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

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.

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

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

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

ELIGIBILITY

For You
To be eligible for coverage, you must be a plan member who is:
a) a resident of Canada;
b) covered under your provincial health insurance plan;
c) a member or staff member of the student association shown on the cover of this booklet.

For your Dependents
To be eligible for coverage you must be:
a) covered under this plan; and;
b) each dependent must be covered under a provincial health insurance plan.

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

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

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

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

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

Dependent Children Continuation of Coverage
Any child whose coverage would end because they have reached the specified age limit may qualify for continued coverage, subject to the following conditions:
a) your child became dependent upon you by reason of a mental or physical disability prior to reaching this age; and
b) your child has been continuously so disabled since that time.

Group Conversion - PRISM CONTINUUM® Program
The PRISM CONTINUUM® Program offers three plans that are focused on providing coverage for you if you are leaving the GSC plan.

This program may be your solution if you, your spouse or dependent children are losing, or have lost GSC benefits within the last 60 days and are looking for guaranteed coverage.

Call 416.601.0429 in the Toronto area or toll-free at 1.800.667.0429 for an information package or visit our website at greenshield.ca. Coverage is guaranteed if you apply within 60 days of losing your GSC group benefits.

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 has a Drug Identification Number (DIN); and
c) are paid on a Pay Direct basis.

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

Certain drugs may require prior approval. Your Pharmacist is aware of the drugs that fall into this category.

Maintenance drugs required to treat lifelong chronic conditions must be purchased in a 90-day supply of a prescription at any one time. Non-maintenance drugs may be purchased in a supply not exceeding 3-months (90-day) supply of a prescription at any one time. However, for all drugs, 6 months for a vacation supply may be purchased and not more than a 13-month supply in any 12 consecutive months.

Generic drug substitution

Reimbursement will be made for the cost of the lowest priced equivalent drug based on specific provincial regulations, unless your medical or dental practitioner has written that there is to be no substitution of the prescribed drug or medicine.

NOTE:

Drug Benefit over age 65: The Drug Benefit co-pay and the deductible (where applicable) in your province of residence **are** eligible benefits.

Quebec residents only: Your student drug plan does not replace the RAMQ (The Regie de l'assurance maladie du Quebec) provincial plan, you are required to enrol for RAMQ.

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

a) Drugs for the treatment of obesity, erectile dysfunction and infertility;
b) Vitamins that do not legally require a prescription;
c) Smoking cessation drugs and Nicotine replacement products, such as patches, gum, lozenges, and inhalers;
d) 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;
e) 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;
f) Mixtures, compounded by a pharmacist, that do not conform to GSC's current Compound Policy.

Extended Health Services

1. **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, including rails and mattresses; bedpans; standard commodes; decubitus (bedridden) supplies; I.V. stands; portable patient lifts; trapezes; urinals;
   b) Footwear, when prescribed by your attending physician, nurse practitioner, podiatrist or chiropodist and dispensed by your podiatrist, chiropodist, chiropractor, orthotist, or pedorthist);:
      i) custom made foot orthotics or adjustments to custom made foot orthotics
      ii) custom made boots or shoes, adjustments to custom made footwear; or footwear as an integral part of a brace, (subject to a medical pre-authorization);
   c) Braces, casts;
   d) Diabetic equipment, such as blood glucose monitors, lancets and insulin pump supplies;
   e) Medical services, such as diagnostic tests, X-rays and laboratory tests;
   f) Incontinence/Ostomy equipment, such as catheter supplies and ostomy supplies;
   g) Mobility aids, such as canes, crutches, walkers and wheelchairs (including wheelchair batteries);
   h) Standard prosthetics, such as an arm, hand, leg, foot, breast, eye and larynx;
   i) Respiratory/Cardiology equipment, such as compressors, inhalant devices, tracheotomy supplies and oxygen;
   j) Compression stockings;
   k) Wigs, for temporary or permanent hair loss as a result of a chemotherapy or radiation treatment.

   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.

2. **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.

3. **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.

4. **Professional Services:** Reimbursement for the services of the practitioners included, up to the amount shown in the Schedule of Benefits, when the practitioner rendering the service is licensed by their provincial regulatory agency or a registered member of a professional association and that association is recognized by GSC. Please contact the GSC Customer Service Centre to confirm practitioner eligibility.

   NOTE:
   - Podiatry services are not eligible until your provincial health insurance plan annual maximums have been exhausted

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 and the treatment must commence within 180 days of the accident.

   GSC will not be liable for any services performed after the earlier of a) 365 days following the accident, or b) the date you or your dependent cease to be covered under this plan.

   No amount will be paid for periodontia or orthodontia treatments or the repair or replacement of artificial teeth.

   Charges will be based on the current Provincial Dental Association Fee Guide for General Practitioners in the province where services are rendered. Approval will be based on the current status and/or benefit level of the covered person at the time that we are notified of the accident. Any change in coverage will alter GSC's liability.

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

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) committing a criminal offence;

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. The completion of any claim forms and/or insurance reports;

5. 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, or is not considered to be effective (either medically or from a cost perspective, based on Health Canada's approved indication for use);
   b) is an adjunctive drug prescribed in connection with any treatment or drug that is not an eligible service;
   c) is administered in a hospital or is required to be administered in a hospital in accordance with Health Canada's approved indication for use;
   d) is not dispensed by the pharmacist in accordance with the payment method shown under the Prescription Drugs benefit;
   e) 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;

6. 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 3 years
   - emergency and specific oral examinations
   - full series X-rays and panoramic X-rays once every 3 years
   - bitewing X-rays once per benefit year
   - recall examinations once per benefit year
   - cleaning of teeth (up to 1 unit of polishing plus up to 1 unit of scaling) once per recall period
   - topical application of fluoride twice per benefit year for covered persons 19 years of age and under
   - oral hygiene instruction once per lifetime
   - denture cleaning once per recall period
   - pit and fissure sealants on molars only
   - space maintainers
   - mouth guards once every 12 months

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

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

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

6. Comprehensive oral surgery:
   - surgical exposure, repositioning, transplantation or enucleation of teeth
   - remodeling and recontouring - shaping or restructuring of bone or gum
   - excision - removal of cysts and tumors
   - incision - drainage and/or exploration of soft or hard tissue
   - fractures including the treatment of the dislocation and/or fracture of the lower or upper jaw and repair of soft tissue lacerations
   - maxilofacial deformities - frenectomy - surgery on the fold of the tissue connecting the lip to the gum or the tongue to the floor of the mouth

Comprehensive Basic Services

1. 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

2. Periodontal treatment of diseased bone and gums including:
   - periodontal scaling and/or root planing 1 time unit per benefit year
   - occlusal equilibration - selective grinding of tooth surfaces to adjust a bite 4 time units per benefit year

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

   - bruxism appliance once every 2 benefit years

Major Services

1. Standard onlays or crown restorations to restore diseased or accidentally injured natural teeth, once every 5 benefit years

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

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

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

Alternate Treatment

The group benefit plan will reimburse the amount shown in the Fee Guide for the least expensive service or supply, provided that both courses of treatment are a benefit under the plan.

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-pay of such services. Laboratory services that are in excess of 40% of the dentist's fee in the applicable Fee Guide shown in the Schedule of Benefits will be reduced accordingly; co-pay is then applied;

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

3. Reimbursement will be pro-rated and reduced accordingly, when time spent by the dentist is less than the average time assigned to a dental service procedure code in the applicable Fee Guide shown in the Schedule of Benefits;

4. Reimbursement for root canal therapy will be limited to payment once only per tooth. Extra charges for difficult access, exceptional anatomy, calcified and retreatments are not included. The total fee for root canal includes all pulpotomies and pulpectomies performed on the same tooth;

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

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

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

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

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

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

Dental Exclusions

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

1. Services or supplies received as a result of disease, illness or injury due to:
   a) an act of war, declared or undeclared;
   b) participation in a riot or civil commotion; or
   c) committing a criminal offence;

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. The completion of any claim forms and/or insurance reports;

5. 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;

6. Implants;

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

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

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

10. Service and charges for sleep dentistry;

11. Diagnostic and/or intraoral repositioning appliances including maintenance, adjustments, repairs and relines related to treatment of temporomandibular joint dysfunction;

12. 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, or is not considered to be effective (either medically or from a cost perspective, based on Health Canada's approved indication for use);
    b) is an adjunctive drug prescribed in connection with any treatment or drug that is not an eligible service;
    c) will be administered in a hospital or is required to be administered in a hospital in accordance with Health Canada's approved indication for use;
    d) is not dispensed by the pharmacist in accordance with the payment method shown under the Health Benefit Plan Prescription Drugs benefit;
    e) 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;

13. 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 your Benefits Administrator or contact us:

- 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

Pre-authorization

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

Submitting Claims

All claims submitted to GSC require your GSC Identification number. Your GSC Identification Number is your student number with the prefix "**RSU**" – e.g. **RSU 111222333**.

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 certain claims, we may require additional confirmation of payment so we recommend you keep a copy of some other identifiable confirmation of payment, such as a cancelled cheque (copy is acceptable if both sides of the cheque are provided), an authorized electronic credit card receipt and/or statement, direct payment /debit receipt or bank statements.

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:

GSC

Attn: Drug Department	PO Box 1652	Windsor, ON	N9A 7G5
Attn: Medical Items	PO Box 1623	Windsor, ON	N9A 7B3
Attn: Professional Services	PO Box 1699	Windsor, ON	N9A 7G6
Attn: Dental Department	PO 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 funds for both providers and plan members.

Direct Payment to the Provider of Service (where applicable)

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

Subrogation

GSC retains the right of subrogation 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 payor first. Any unpaid balances should then be submitted to the secondary plan(s). Use the following guidelines to identify the primary and secondary plans:

GSC Plan Member

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

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

Spouse

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

Children

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

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

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

DISCLAIMER

The Travel benefits are provided by RSA Travel Insurance Inc.

The Accidental Death & Dismemberment Insurance benefits are provided by Chubb Life Insurance Company of Canada.

Viator™ Group Out-of-Province/Canada
Travel Medical Emergency Insurance

National Student Health Network

Policy #: 1167965
Administrator: ..... RSA Travel Insurance Inc.
Underwriter: ..... Royal & Sun Alliance Insurance Company of Canada

A summary of your benefits can be found at the following link:

https://mystudentplan.ca/rsu/en/travel-insurance

For assistance with a claim, or for coverage inquiries, please contact Global Excel Management Inc., company appointed by the Insurer to provide medical assistance and claims services under the policy, directly at toll free 1.866.870.1898 or 819.566.1898.

To extend your coverage beyond the coverage period shown below, please contact RSA Travel Insurance Inc. at toll free 1.877.562.5412 or 819.562.5412.

While travelling, please ensure to carry the Medical Assistance card provided to you on the RSA Travel Insurance Inc.'s website.

Basic Accidental Death & Dismemberment Insurance

For the Students of:
Ryerson Students' Union

CHUBB®

Policy Number:
SG10476301

Underwritten by:
Chubb Life Insurance Company of Canada

Effective Date:
October 01, 2016

This brochure has been prepared in connection with a group plan underwritten by Chubb Life Insurance Company of Canada ("Chubb Life"). For ease of reference it contains a brief description only and does not mention every provision of the contract issued. Please remember that rights and obligations are determined in accordance with the contract and not this brochure. For the exact provisions applicable, please consult your Plan Administrator.

COVERAGE

The plan offers you full 24-hour protection against accidents, on or off the job, on business, on vacation, at home, regardless of your health history.

ELIGIBILITY

All active, students enrolled under the health plan of the policyholder, under age 70.

BENEFIT AMOUNT

Flat $5,000

In the event of your death, the benefit amount is payable to the beneficiary you have named under your Group Life Insurance Plan or in the absence of such designation, to your Estate.

SCHEDULE OF LOSSES

Accidental Death & Dismemberment

If such injuries shall result in any one of the following specific losses within one year from the date of the accident, Chubb Life Insurance Company of Canada ("Chubb Life") will pay the percentage of the benefit amount, based on the amount stated under the benefit amount section, however, that not more than one (the largest) of such benefits shall be paid with respect to injuries resulting from one accident.

	Percentage of Benefit Amount
Loss of Life	100%
Loss of Both Hands or Both Feet	300%
Loss of Entire Sight of Both Eyes	300%
Loss of One Hand and One Foot	300%
Loss of One Hand and Entire Sight of One Eye	300%
Loss of One Foot and Entire Sight of One Eye	300%
Loss of Speech and Hearing in Both Ears	300%
Brain Death	100%
Loss of Use of Both Arms, Both Hands, Both Legs or Both Feet or combination of Hand and Foot or Arm and Leg	300%
Quadriplegia	300%
Paraplegia	300%
Hemiplegia	300%
Loss of One Arm or One Leg	225%
Loss of Use of One Arm or One Leg	225%
Loss of One Hand or One Foot	210%
Loss of Entire Sight of One Eye	210%
Loss of Use of One Hand or One Foot	210%
Loss of Speech or Hearing in One Ear	150%
Loss of Thumb and Index Finger of Same Hand	50%
Loss of Use of Thumb and Index Finger of Same Hand	50%
Loss of Four Fingers of Same Hand	33 1/3%
Loss of Hearing in One Ear	150%
Loss of All Toes of Same Foot	25%
Loss of One Finger	10%

"Loss" shall mean with respect to hand or foot, the actual severance through or above the wrist or ankle joint; with respect to arm or leg, the actual severance through or above the elbow or knee joint; with respect to eye, the total and irrecoverable loss of sight; with respect to speech, the total and irrecoverable loss of speech which does not allow audible communication in any degree; with respect to hearing, the total and irrecoverable loss of hearing which cannot be corrected by any hearing aid or device; with respect to thumb and index finger, the actual severance through or above the first phalange; with respect to fingers, the actual severance through or above the first phalange of all four fingers of the same hand; with regard to toes, the actual severance of both phalanges of all toes of the same foot If an Insured Person suffers complete severance of a hand, foot, arm or leg as described above, then Chubb Life will pay the amount specified in the Schedule of Losses even if the severed limb is surgically reattached, whether successful or not.

"Loss" as used with reference to quadriplegia (paralysis of both upper and lower limbs), paraplegia (paralysis of both lower limbs), and hemiplegia (total paralysis of upper and lower limbs of one side of the body), means the complete and irrecoverable paralysis of such limbs.

"Loss of Use" shall mean the total and irrecoverable loss of function of an arm, hand, foot, or leg provided such loss of function is continuous for twelve consecutive months and such loss of function is thereafter determined on evidence satisfactory to Chubb Life to be permanent.

"Brain Death" means irreversible unconsciousness with total loss of brain function; and complete absence of electrical activity of the brain, even though the heart is still beating.

Repatriation Benefit

When injuries covered by this plan result in a loss of life outside fifty (50) kilometers from your city of permanent residence or outside Canada and the loss of life occurs within 365 days from the date of the accident, Chubb Life will pay the actual expense incurred for preparing the deceased for burial and shipment of the body to the city of residence of the deceased, but not to exceed $15,000.

Rehabilitation Benefit

When injuries result in a payment being made by Chubb Life under any benefit excluding the Loss of Life Benefit, Chubb Life will also pay the reasonable and necessary expenses actually incurred up to a limit of $15,000 for special training provided:

a. such training is required because of such injuries and in order for you to become qualified to engage in an occupation in which you would not have been engaged except for such injuries;
b. expenses are to be incurred within two years from the date of the accident;
c. no payment will be made for ordinary living, travelling, or clothing expenses.

Family Transportation Benefit

When injuries result in your confinement as an in-patient in a hospital outside one hundred and fifty (150) kilometers from your city of permanent residence or outside Canada and requires personal attendance of a member of your immediate family as recommended by the attending physician, in writing, Chubb Life will pay for the expense incurred by your family member, for the transportation by the most direct route by a licensed common carrier to you, while confined, but not to exceed an amount of $15,000.

"Member of your immediate family" means your spouse, (legal or common-law), parents, grandparents, children over age 18, brother, or sister.

Spousal Occupational Training Benefit

When injuries to you result in a payment being made by Chubb Life under the Loss of Life Benefit, Chubb Life will pay in addition, the expenses actually incurred, within 365 days from the date of the accident, by your spouse for a formal occupation training program for the purpose of specifically qualifying your spouse to gain active employment in an occupation for which your spouse would otherwise not have sufficient qualifications. The maximum payable hereunder is $15,000.

Home Alteration and Vehicle Modification Benefit

In the event you sustain an injury which results in a payment being made under the Schedule of Losses, excluding the Loss of Life Benefit, and such injury subsequently requires the use of a wheelchair to be ambulatory, Chubb Life will pay the reasonable and necessary expenses actually incurred within 3 years from the date of the accident for:

1. the one-time cost of alterations to your principal residence to make it wheelchair accessible and habitable; and
2. the one-time cost of modifications necessary to a motor vehicle utilized by you to make the vehicle accessible or operable for you.

Benefit payments herein will not be paid unless:

i. home alterations are made by a person or persons experienced in such alterations and recommended by a recognized organization, providing support and assistance to wheelchair users; and
ii. vehicle modifications are carried out by a person or persons with experience in such matters and modifications are approved by the Provincial vehicle licensing authorities.

The maximum amount payable under both items 1 and 2 will not exceed $10,000.

Special Education Benefit

If you suffer a loss of life in a covered accident while the policy is in force, Chubb Life will pay, in addition to all other benefits payable under this policy, a “Special Education Benefit” up to 5% of your benefit amount, (subject to a maximum of $5,000 per year), on behalf of any dependent child who, on the date of the accident, is enrolled as a full-time student in any post-secondary institution beyond the 12th grade level, or was at the 12th grade level and subsequently enrolls as a full-time student in an institution of higher learning within 365 days following the date of the accident.

The “Special Education Benefit” is payable annually for a maximum of four consecutive annual payments but only if the dependent child continues his/her education as a full-time student in an institution of higher learning.

Day Care Benefit

If you suffer a loss of life in a covered accident while the policy is in force, Chubb Life will pay, in addition to all other benefits payable under the policy a "Day Care Benefit" equal to the reasonable and necessary expenses actually incurred, subject to the lesser of 5% of your benefit amount or a maximum of $5,000 per year, on behalf of your dependent child who is enrolled in a legally licensed day care centre on the date of the accident or who enrolls in a legally licensed day care centre within 365 days following the date of the accident. The "Day Care Benefit" will be paid each year for 4 consecutive years, but only upon receipt of satisfactory proof that your child is enrolled in a legally licensed day care centre.

“Dependent Child” means either a legitimate or illegitimate child, adopted child, step-child or any child who is in a parent-child relationship with you and who is twelve (12) years of age and under and dependent upon you for maintenance and support.

Seat Belt Benefit

In the event you sustain an injury which results in a payment being made under the Schedule of Losses, your benefit amount will be increased by 10%, if, at the time of the accident, you were driving or riding in a vehicle and wearing a properly fastened seat belt. Due proof of seat belt use must be provided as part of the written proof of loss.

“Vehicle” means a private passenger car, station wagon, van, or jeep-type automobile. **“Seat Belt”** means those belts that form a restraint system.

Continuance of Coverage

If you are temporarily absent from the curriculum due to short-term disability, coverage shall be extended for 12 months, subject to the payment of premiums.

Conversion Privilege

On the date of termination of enrollment as a student or during the 60 day period following termination of enrollment as a student, you may convert your insurance to an individual insurance policy of Chubb Life. The individual policy will be effective either as of the date that the application is received by Chubb Life or on the date that coverage under the group policy ceases, whichever occurs later. The premium will be the same, as a person would ordinarily pay when applying for an individual policy at that time. The amount of insurance benefit converted will not exceed that amount prior to the termination of coverage.

In-Hospital Confinement Monthly Income

In the event you sustain an injury which results in a payment being made under the Schedule of Losses excluding the Loss of Life Benefit and you are hospital confined as an in-patient and are under the care of a legally qualified and registered physician or surgeon other than himself, Chubb Life will pay for each full month, one percent (1%) of your Principal Sum, subject to a maximum benefit of $2,500, or one-thirtieth of such monthly benefit for each day of partial month, retroactive to the 1st full day of such confinement but not to exceed 365 days in the aggregate for each period of hospital confinement.

"Hospital" as used herein means a legally constituted establishment which meets all of the following requirements: (1) operates primarily for the reception, care and treatment of sick, ailing or injured persons as in-patients; (2) provides 24 hour a day nursing service by registered or graduate nurses; (3) has a staff of one or more licensed physicians available at all times; (4) provides organized facilities for diagnosis and surgical facilities; and (5) is not primarily a clinic, nursing home or convalescent home or similar establishment nor, other than incidentally, a place for alcoholics or drug addicts.

"In-Patient" means a person admitted to a hospital as a resident or bed-patient and who is provided at least one day's room and board by the hospital.

Accidental Dental Expense Benefit

When injury to whole and sound teeth shall, within thirty (30) days from the date of the accident, require treatment, replacement or x-rays by a legally qualified dentist or dental surgeon, Chubb Life will pay the necessary expense actually incurred therefore by or behalf of you within fifty-two (52) weeks after the date of the accident, not to exceed in the aggregate the amount of $1,000 and does not duplicate the cost of any such services covered under the terms of any existing plan of dental insurance services - Benefits as the result of any one accident subject to a deduction of $100.

Teeth which have been capped or crowned shall, for purposes of this policy, be considered whole and sound except where they have undergone endodontic treatment. If an injury to a capped or crowned tooth causes damage to the remaining tooth structure requiring the preparation of a new cap or crown, the policy shall cover the cost of treatment necessitated thereby. If a cap or crown is damaged or dislodged without injury to the remaining tooth structure, the policy shall not cover the cost of treatment necessitated thereby.

Any payments made under this section shall be in accordance with the schedule of fees published by the Dental Association in the Province or territory of the Insured Person's residence.

Accidental Medical Reimbursement Expense Benefit

If on account of such injuries the Insured Person shall require treatment by a legally qualified physician or surgeon, confinement in a legally constituted hospital, employment of a trained nurse, x-ray examination, the use of an ambulance or prescribed prosthetic appliance up to $1,000, Chubb Life, subject to the maximum amount of $10,000, will pay the actual expense incurred therefore within 52 weeks from the date of accident to the extent that such expense (1) exceeds the deductible amount (if any) and (2) exceeds and does not duplicate the cost of any such services covered under the terms of any existing plan of health insurance services.

Cosmetic Disfigurement Benefit

If, an Insured Person suffers a third degree burn due to a non-occupational accident, Chubb Life will pay a percentage of the Principal Sum depending on the area of the body which was burned according to the following table:

Body Part	(A) Area Classification	(B) Maximum allowable % for Area Burned	(C) Maximum % of Principal Sum Payable
Face, Neck, Head	11	9%	99%
Hand & Forearm	5	4.5%	22.5%
Either Upper Arm	3	4.5%	13.5%
Torso (Front or Back)	2	18%	36%
Either Thigh	1	9%	9%
Either Lower Leg (below knee)	3	9%	27%

The maximum percent of Principal Sum Payable (C) is determined by multiplying the Area Classification (A) by the Maximum Allowable percent for Area Burned (B). In the event of a 50% surface burn, the Maximum Allowable percent for Area Burned (B) is reduced by 50%. This table only represents the maximum percent of the Principal Sum payable for any one accident. If the Insured suffers burns in more than one area as a result of any one accident, benefits will not exceed a maximum of $25,000.

Identification Benefit

In the event accidental Loss of Life is sustained by you not less than one hundred and fifty (150) kilometers from your normal place of residence and identification of the body by a member of the immediate family has been requested by the police or a similar governmental authority, Chubb Life will reimburse the reasonable expenses actually incurred by such member for:

a. transportation by the most direct route to the city or town where the body is located; and
b. hotel accommodation in such city or town, subject to a maximum duration of three (3) days.

The reimbursement of such expenses incurred is subject to the accidental loss of life indemnity being subsequently payable in accordance with the terms of this policy following the identification of the body as the Insured Person. The maximum amount payable will not exceed $15,000 for all such expenses.

Payment will not be made for board or other ordinary living, travelling or clothing expenses, and transportation must occur in a vehicle or device operated under a license for the conveyance of passengers for hire.

Benefits payable under this section will be limited to only one (1) policy in the event this benefit is contained in two (2) or more policies issued to the Policyholder by Chubb Life.

Bereavement Benefit

When injuries covered by this policy result in loss of life of an Insured Person within 365 days from the date of the accident, Chubb Life will pay the reasonable and necessary expenses actually incurred by the Spouse and Dependent Children of the Insured Person for up to six (6) sessions of grief counseling, by a Professional Counsellor, subject to a maximum of $500.

"Professional Counsellor" means a therapist or counsellor who is licensed, registered, or certified to provide such treatment.

Funeral Expense

When injuries covered by this policy result in loss of life of an Insured Person within 365 days from the date of the accident, Chubb Life will pay the actual expense incurred for customary funeral expenses but shall not exceed the maximum amount of $2,500.

The term 'customary funeral expenses" as used in this policy means the services and materials provided by an undertaker, crematorium or funeral home relative to the burial of the deceased Insured Person and the costs incurred for the purchase of a cemetery plot, tomb or a mausoleum for the burial or internment of the deceased including a plaque, tombstone or monument.

Psychological Therapy Benefit

When injuries covered by this policy result in loss of life of an Insured Person within 365 days from the date of the accident, Chubb Life will pay the reasonable and necessary expenses actually incurred by the spouse and dependent children of the Insured Person for up to three (3) sessions of grief counseling, by a Professional Counsellor, subject to a maximum of $5,000.

"Professional Counsellor" means a therapist or Counsellor who is licensed, registered, or certified to provide such treatment.

Exposure and Disappearance

Loss resulting from unavoidable exposure to the elements shall be covered to the extent of the benefits afforded you. If your body has not been found within one year of disappearance, stranding, sinking or wrecking of the conveyance in which you were riding at the time of the accident, it shall be presumed, subject to all other conditions of this policy, that you suffered a loss of life resulting from bodily injuries sustained in an accident covered under this policy.

Waiver of Premium

If you are under age 65 and become totally disabled* while you are insured under this plan and satisfactory evidence of your total disability is provided to Chubb Life on an annual basis, payment of premium will be waived until the earlier of the following occurs:

a. you return to school;
b. you attain age 65;
c. the master policy underwritten by Chubb Life is terminated.

Once you return to school, your coverage will continue only upon the commencement of premium payments.

*You will be considered totally disabled if your disability prevents school attendance and has existed continuously for a period of at least 12 months or is in accordance with the waiver of premium requirements under the Policyholder's Group Life Insurance Policy.

EXCLUSIONS

The plan does not cover any loss, which is the result of:

1. intentionally self-inflicted injuries, suicide or any attempt thereat, while sane or insane;
2. war or any act thereof;
3. flying in an aircraft owned or leased by your employer, yourself or a member of your household, or aircraft being used for any test or experimental purpose, firefighting, power line inspection, pipeline inspection, aerial photography or exploration;
4. full-time, active duty in the armed forces.
5. flying as pilot or crew member in any aircraft or device for aerial navigation.

HOW TO CLAIM

In the event of a claim, claim forms can be obtained from the Plan Administrator.
Notice of claim must be given to Chubb Life within 30 days from the date of the accident, the beginning of the disability or after the survival period, and subsequent proof of claim must be submitted to Chubb Life within 90 days from the date of the accident or after survival period.

Failure to give notice of claim or furnish proof of claim within the time prescribed in the policy condition will not invalidate the claim if the notice or proof is given or furnished as soon as reasonably possible and if it is shown that it was not reasonably possible to give notice or furnish proof within the time so prescribed. In no event, will Chubb Life accept notice of claim beyond one (1) year.

GENERAL PROVISIONS

Beneficiary

A student or any spouse has the right to name a beneficiary when he applies for insurance.

Failing such designation, all benefits will be paid to the estate of the insured person.

All other indemnities of the policy will be payable to the insured person.
An insured person can change his beneficiary at any time, where permitted by law. The Company assumes no responsibility for the validity of such designation or change of beneficiary.

The beneficiary designation made by the insured person (if any) under the replaced policy has been retained. The insured person should review the existing designation to ensure it reflects his/her current intention.

The policy contains a provision removing or restricting the right of the insured person to designate persons to whom or for whose benefit insurance money is to be payable.

Legal Actions

No action at law or in equity shall be brought to recover on the policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with requirements of the policy. For residents of Alberta and British Columbia: Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the Insurance Act. For residents of Manitoba: Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in The Insurance Act. For residents of Ontario: Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the Limitations Act, 2002. Otherwise, every action must be brought within one year from the date of loss or such longer period as may be required under the law applicable in the insured person's province of residence.

Change of Insurer

An insured person under a former policy may not be excluded from the new policy or be denied benefits solely because of a pre-existing condition limitation that was not applicable or that did not exist in the former policy, or because the person is not at work on the date of coming into force of the new policy.
The insured person and any claimant under the policy has the right, as determined by law applicable in the insured person's province of residence, to obtain a copy of his/her application, any written evidence of insurability (as applicable) and the Policy, on request, subject to certain access limitations.

1216