



Agnico Eagle Mines Limited

Classification: All Employees enrolled in the Flex Plan

Billing Divisions: 101, 111, 116, 122, 131, 132, 135, 151,
160, 161, 162, 165, 201, 205, 211, 231,
901

Effective Date: November 1, 2025

WELCOME TO YOUR BENEFIT PLAN

This summary contains information about your group benefits with Agnico Eagle Mines Limited, your plan sponsor, available through the group contract with Green Shield Canada Insurance (GreenShield), effective November 1, 2025.

HEALTH SUMMARY

The [health benefits](#) are intended to supplement your provincial/territorial 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.

	Gold	Gold Plus
Benefit Year Deductible: (per person/per family)	No deductible	No deductible
Maximums		
Overall Health Maximum:	Unlimited	Unlimited
Smoking cessation program:	One course of treatment in any 12-month period	One course of treatment in any 12-month period
Your Coinsurance		
Prescription Drugs:	100%	100%
Pharmacogenetic testing:	100%	100%
Hospital:	100%	100%
Vision:	100%	100%
All Other Health Benefits:	80%	100%
Prescription Drug dispensing fee cap		
• Quebec:	None	None
• All other provinces:	\$12 per prescription or refill	None
	Gold	Gold Plus
Your Plan Covers	Maximum Plan Pays	Maximum Plan Pays
Prescription Drugs (Mandatory Generic)	Unlimited, except as stated above	Unlimited, except as stated above
Hospital Accommodation	Semi-private room	Semi-private or private room
Hearing Care	\$2,500 every 60 months	\$5,000 every 60 months
Orthotics/Orthopedic Footwear		
Custom-made boots or shoes, orthopedic shoes, or stock orthotics:	\$400 every 12 months combined	\$600 every 12 months combined
Custom-made orthotics:	\$400 every 12 months	One pair every 12 months
Gender Affirmation *		
* Diagnosis of gender dysphoria from a physician (M.D.) or nurse practitioner is required	\$25,000 per lifetime	\$25,000 per lifetime

MY BENEFIT PLAN SUMMARY

<u>Paramedical Practitioners</u> Chiropractor, Chiropract/Podiatrist, Osteopath, Registered Massage Therapist, Naturopath, Speech Therapist, Audiologist, Occupational Therapist, Acupuncturist, Dietitian, Orthotherapist	\$1,000 every benefit year combined for all types of practitioners	\$1,500 every benefit year combined for all types of practitioners
Physiotherapist, Athletic Therapists, Kinesiologist, Physical Rehabilitation Therapist	\$1,200 every benefit year combined for all types of practitioners	\$2,000 every benefit year combined for all types of practitioners
Psychologist, Clinical Counsellor, Social Worker, Master of Social Work (MSW), Psychoanalyst, Psychotherapist, Psychoeducator, Certified Behavioural Therapist (only for the treatment of Autism)	\$1,000 every benefit year combined for all types of practitioners	\$1,500 every benefit year combined for all types of practitioners
<u>Vision</u>		
Eyeglasses or contact lenses or medically necessary contact lenses	\$350 every 24 months	\$500 every 24 months
Laser eye surgery	\$500 per lifetime	\$1,000 per lifetime
Eye examinations	Once every 12 months	Once every 12 months

TRAVEL SUMMARY

The [travel benefits](#) are intended to **supplement** provincial/territorial health insurance plans if you experience a medical emergency while travelling outside of your province/territory of residence or Canada. If your provincial/territorial health insurance plan includes out-of-Canada benefits, hospital and medical services are eligible only if your provincial/territorial health insurance plan provides payment toward the cost of incurred services. The benefits shown below will be eligible if they are medically necessary for the emergency treatment of a sudden and unforeseen illness or injury and reimbursement will be limited to [reasonable and customary](#) charges for the area in which they are incurred.

	Gold	Gold Plus
Benefit Year <u>Deductible</u>: (per person/per family)	No deductible	No deductible
Your <u>Coinsurance</u>	100%	100%
Maximum Number of Days per Trip:	180 days	180 days
Your Plan Covers	Maximum Plan Pays	Maximum Plan Pays
Emergency Services	\$5,000,000 per lifetime	\$5,000,000 per lifetime
Referral Services	\$75,000 per calendar year	\$75,000 per calendar year

Before you travel, visit [greenshield.ca](https://www.greenshield.ca) for important information you will need to know if you experience a medical emergency while you are travelling.

DENTAL SUMMARY

The [dental benefits](#) shown below will be eligible if they are necessary for the prevention of dental disease or treatment of dental disease or injury and reimbursement will be limited to the amount stated in the Provincial/Territorial Dental Association Fee Guide indicated below.

	Gold	Gold Plus
Benefit Year Deductible: (per person/per family)	\$50/\$100 (effective January 1, 2026)	\$25/\$50 (effective January 1, 2026)
Dental Fee Guide: (General Practitioners)	Current province of treatment	Current province of treatment
Your Coinsurance Basic Services: Basic Oral Surgery, General anaesthesia, deep sedation, and intravenous sedation in conjunction with eligible oral surgery:	80%	100%
All other Basic Services:	100%	100%
Comprehensive Basic Services :	80%	100%
Major Services :	50%	60%
Orthodontics :	50%	50%
Your Plan Covers	Gold	Gold Plus
Basic Services	\$2,000 per benefit year combined for all Basic, Comprehensive Basic and Major Services	\$3,000 per benefit year combined for all Basic, Comprehensive Basic and Major Services
Comprehensive Basic Services		
Major Services		
Orthodontics	\$2,500 per lifetime for dependent children 19 years of age and under	\$4,000 per lifetime
Late Entrants	For Basic, Comprehensive Basic and Major Services - \$250 per covered person for the first 12 months of coverage if the covered person becomes insured more than 31 days following the eligibility date For Orthodontic Services - \$250 per covered person for the first 36 months of coverage	For Basic, Comprehensive Basic and Major Services - \$250 per covered person for the first 12 months of coverage if the covered person becomes insured more than 31 days following the eligibility date For Orthodontic Services - \$250 per covered person for the first 36 months of coverage
Summary of Covered Benefits		
Basic Services include recall visits once every 6 months, fillings and extractions		
Comprehensive Basic Services include root canal therapy, periodontal scaling/root planing and denture relining/rebasing, repairs, or adjustments		
Major Services include crowns, dentures and/or bridgework (replacements of each limited to once every 5 years), and inlay restorations		
Orthodontics includes treatment to straighten teeth/correct the bite.		

HEALTH CARE SPENDING ACCOUNT SUMMARY

This [Health Care Spending Account \(HCSA\)](#) is funded by your plan sponsor and administered by GreenShield. It can be used to pay for health and dental expenses that are not covered by your group benefit plan or your provincial/territorial health plan.

	Gold	Gold Plus
Lump sum per plan member per benefit year	As determined by your plan sponsor	As determined by your plan sponsor

PERSONAL SPENDING ACCOUNT

This [Personal Spending Account \(PSA\)](#) is a spending account funded by your plan sponsor that you can use to pay for a range of personal wellness related expenses not covered by your group benefit plan or provincial/territorial health plan. Expenses claimed are subject to income tax as outlined by the Canada Revenue Agency

	Gold	Gold Plus
Lump sum per plan member per benefit year	As determined by your plan sponsor	As determined by your plan sponsor

ABOUT THIS SUMMARY

This information is intended to provide an overview of the coverage available. Detailed benefit information about your coverage, including limitations and exclusions applicable to the benefits appearing in this summary, which will form part of your Benefit Plan Booklet, will be available online at greenshield.ca.

This summary describes the [deductibles](#), [coinsurance](#) and maximums that may be applicable to your coverage if you are included in the Billing Division shown on the cover of this summary. All dollar maximums stated in this summary are expressed in Canadian dollars.

You are covered for only those specific benefits for which you have applied and for which your plan sponsor has certified you are eligible. You must be covered in order for your dependents to be covered. Your coverage will terminate upon the earliest of the dates appearing in the Termination section or the date your plan sponsor advises GreenShield that you are no longer eligible for coverage. Coverage for your dependents will terminate upon the earlier of termination of your coverage or the date your dependent no longer satisfies the definition of a [dependent](#).

You will receive Identification Cards showing your GreenShield Identification Number to be used on all claims and correspondence, and for identification purposes when speaking with our Customer Service Centre. Your number will appear on the front of the card and end in -00, while each of your dependents with their numbers will be shown on the back.

OUR COMMITMENT TO PRIVACY

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

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

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DEFINITIONS

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

Allowed amount means, as determined by GreenShield:

- Drugs – the GreenShield National Pricing Policy and/or the [reasonable and customary](#) charge;
- 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;
- Dental – the [fee guide](#) as specified in the Summary of Benefits.

Benefit year means the 12 consecutive months commencing on the first day of July to the last day of June of each year.

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

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

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

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

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

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

Dependent means

- your spouse, if you are legally married or if not legally married, you have lived in a common-law relationship for more than 12 continuous months. Only one spouse will be considered at any time as being covered under the group contract;
- your unmarried child who:
 - is under age 21;
 - is under age 26 and is enrolled and in full-time attendance at an accredited college, university or educational institute;
 - regardless of age became totally disabled while eligible and enrolled in this plan, and who has been continuously so disabled since that time and is considered a dependent as defined under the Canada Revenue Agency's Disability Tax Credit also qualifies as a dependent; and
- for Health Care Spending Account, in addition to your dependents above, your relative who is a Canadian resident and dependent on you for support and for whom you are claiming a tax deduction on your federal tax return, as outlined in the rules and regulations of the Canadian Income Tax Act.

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

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

Children who are in full-time attendance at an accredited school do not have to reside with you or attend school in your province. If the school is in another province or country, you must apply to your provincial/territorial 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/territory of residence if any dental service is provided outside Canada) and in effect at the time the service is provided.

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

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

Pharmacogenetic testing means a type of genetic testing that determines whether the covered person has genetic mutations known to influence the way the covered person responds to certain drugs. Based on that information, their health care provider could choose medications better suited to them.

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

Private room for hospital accommodation means a room having only one treatment bed.

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

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

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

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

ELIGIBILITY

For You

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

- a resident of Canada;
- covered under your provincial health insurance plan; or
- actively at work and working a minimum of 20 hours per week on a regular basis.

NOTE: in order to participate in the Phased Retirement plan, you must be:

- actively at work;
- aged 55 years or older; and
- have worked for Agnico for at least 5 years prior to starting the phased retirement.

Please contact your plan sponsor for further information.

For Your Dependents

To be eligible for coverage:

- you must be covered under this plan;
- each dependent must satisfy the definition of Dependent, and
- each dependent must be covered under a provincial health insurance plan.

Coverage Effective Date

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

You will be eligible for coverage on the first day of active employment.

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

Enrollment

To enrol, you must request coverage in writing by supplying the appropriate enrolment information to your plan sponsor within 31 days of your employment. You are eligible to elect from the following options of coverage (i.e. you may elect Gold Health and Gold Plus Dental):

- Gold Health or Gold Plus Health
- Gold Dental or Gold Plus Dental

You are eligible for the Travel Benefit, Health Care Spending Account and Personal Spending Account regardless of which Health and Dental options you have chosen.

Participation in this plan is compulsory. If you do not choose a coverage Plan within 31 days of your employment, you will be enrolled in the following options, and will not be permitted to change the selection before the next re-enrollment unless you experience a Life Event.

- Gold Health
- Gold Travel
- Gold Dental
- Personal Spending Account (PSA)*
- Health Care Spending Account (HCSA)*

*Leftover credits will be divided equally between PSA and HCSA

Locked-in Coverage

Once you have selected your coverage from those shown in the Summary of Benefits, your coverage will be locked-in until the next re-enrollment date, unless you experience a life event. If you experience a life event, you will be permitted to increase or decrease your coverage, as long as this occurs within the period specified in the Life Events section below.

Life Events

If you experience one of the following life events, your coverage will be unlocked for 31 days in order to allow you to change your coverage and/or change the status of coverage. You must notify the plan sponsor of the change(s) within 31 days of the life event; otherwise you will be required to wait until the next re-enrollment period. Life events are as follows:

- the birth or adoption of a child;
- a change in dependent child eligibility;
- the death of a spouse or dependent child;
- a change in your marital status, or
- the loss of coverage under your spouse's plan.

Re-enrollment

Re-enrollment occurs every 2 years and the coverage option you select at re-enrollment will be effective on the following July 1st. During the re-enrollment period, you are permitted to change your coverage and/or change the status of your coverage without experiencing a life event. If you do not change your selection, your existing coverage will be locked-in again until the next re-enrollment period.

Once the re-enrollment period closes, your coverage selections will be locked-in until the next re-enrollment period, unless you experience a life event.

Termination

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

- the date your employment ends;
- the date you are no longer actively working;
- the end of the period for which rates have been paid to GreenShield for your coverage;
- the date the group contract terminates.

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

- the date your coverage terminates;
- the date your dependent is no longer an eligible dependent;
- the date on which your dependent child attains the age limit specified in the definition of Dependent;
- the end of the period for which rates have been paid for dependent coverage;
- the date the group contract terminates.

Continuation of Coverage for Disabled Dependent Children

While you are covered under this plan, any child whose coverage would end because they have reached the specified age limit may qualify for continued coverage, subject to the following conditions:

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

Continuation of Coverage for Surviving Dependents

(not applicable to Health Care Spending Account and Personal Spending Account)

In the event of your death while covered by this plan, coverage will continue for your eligible covered dependents until the earliest of the following dates:

- 24 months after the date of your death;
- the date the covered person would no longer be considered a dependent under the plan if you were still alive, or
- the date the benefit under which your dependent is covered terminates.

Losing your Group Benefits?

If your employee group benefits end (for any reason), you are eligible to apply for one of GreenShield's personal health insurance plans. They help to protect you and your family from day-to-day and unforeseen medical and dental expenses, including emergency medical travel protection. There's a wide selection of plans and benefit options from which to choose.

LINK plans may be an ideal solution for you. All LINK plans provide coverage for pre-existing conditions and offer guaranteed acceptance – there are no medical questions or exams when you apply. Your LINK application will be approved as long as GreenShield receives your application within 90 days of your group benefit end date, along with your initial payment.

ZONE plans may be alternative options for you to consider. Some offer guaranteed acceptance while others require medical underwriting and completion of a health questionnaire.

All GreenShield personal health plans provide benefits for life. Once approved, your coverage will continue, regardless of age or any future changes in health, whether you're self-employed, working on contract or retired (as long as premiums are paid).

To be eligible to apply for GreenShield personal health insurance plans, individuals must be under 80 years of age.

Visit www.greenshield.ca/personal where you'll find plan details. You can request an information package, get quotes, and buy completely online. It is quick and easy.

Or give us a call at 1-833-478-7873. Our licensed representatives are ready to support you. They'll be happy to answer questions and help you choose the plan and level of coverage that is right for you.

DESCRIPTION OF BENEFITS

HEALTH BENEFIT PLAN

The benefits described in this section will be eligible, up to the amount shown in the Summary of Benefits, if they are medically necessary for the treatment of an illness or injury. Reimbursement will be limited to [reasonable and customary](#) charges in addition to any specific limitations and maximums stated in the Summary of Benefits and as stated in this Description of Benefits.

Prescription Drugs

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

- a) are prescribed by a legally qualified medical practitioner or dental practitioner as permitted by law, and
- b) legally require a prescription and have a Drug Identification Number (DIN) or have a Natural Product Number (NPN) for iron supplements or potassium replacement agents; and
- c) are approved under GreenShield's drug review process, and
- d) are submitted on a Pay Direct basis.

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

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

Before your drug claim can be reimbursed, GreenShield may require prior authorization. You can find out if your drug requires prior authorization by using the online drug search tool available to you through the member portal or by contacting GreenShield's Customer Service Centre. Further, reimbursement of reference drugs (including biologics) that have an approved biosimilar may not be reimbursed or may be limited to the lower cost drug unless medical evidence is provided.

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

Mandatory generic drug substitution

Reimbursement will be made for the cost of generic drugs, however if a medical practitioner indicates a brand name drug is medically required due to a serious medical reaction to at least two generic drugs, GreenShield must be provided with a copy of the "Health Canada Vigilance Adverse Reaction Reporting Form" (that 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.

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

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

Prescription Drug Exclusions

The following are excluded and no amount will be paid for:

- drugs for the treatment of erectile dysfunction;
- vitamins that do not legally require a prescription;
- nicotine replacement products, such as patches, gum, lozenges, and inhalers;
- 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;
- mixtures, compounded by a pharmacist, that do not conform to GreenShield's current Compound Policy.

Extended Health Services

Hospital Accommodation: Provided your provincial health insurance plan has accepted or agreed to pay the ward or standard rate, reimbursement for hospital accommodation will be limited to 180 days per benefit year combined (excluding a public general hospital), for accommodation in a:

- semi-private or private room in a public general hospital (including program treatment accommodation), or a convalescent or rehabilitation hospital or a convalescent or rehabilitation wing in a public general hospital or a public chronic hospital or chronic care in a public general hospital, under the Gold Plus option;
- semi-private room in a public general hospital (including program treatment accommodation), or a convalescent or rehabilitation hospital or a convalescent or rehabilitation wing in a public general hospital or a public chronic hospital or chronic care in a public general hospital, under the Gold option.

Hearing Care: Reimbursement for hearing aids, initial battery, repairs or replacement parts, if recommended or approved by the attending legally qualified medical practitioner, up to the amount shown in the Summary of Benefits. No amount will be paid for replacement batteries.

Medical Items and Services: Unless otherwise specified, the following must be prescribed by a legally qualified medical practitioner. Reimbursement is limited to the [reasonable and customary](#) charges, up to the amount stated in the Summary of Benefits, where applicable.

- Aids for daily living such as:
 - hospital style beds including rails and mattresses;
 - bedpans, standard commodes, and urinals;

- decubitus (bedridden) supplies, portable patient lifts (including batteries), trapezes/transfer poles, and I.V. stands;
- Footwear, when prescribed by your attending physician, nurse practitioner, podiatrist, or chiropractist, and dispensed by your podiatrist, chiropractist, chiropractor, orthotist, or pedorthist:
 - Custom-made foot orthotics or stock item foot orthotics or repairs to custom-made foot orthotics;
Custom-made foot orthotics means devices made from a 3-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, orthopedic shoes and modifications and repairs to orthopedic shoes, 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.
Orthopedic shoes means off-the-shelf, ready-made footwear prescribed for covered persons diagnosed with a specific medical condition that affects their feet and who require specialized footwear to treat their condition and assist with mobility. The footwear may be modified or adjusted to fit the covered person's feet.
- Diabetic equipment and supplies, such as:
 - blood glucose meters, limited to once every 4 years;
 - insulin infusion pump and insulin infusion pump supplies;
 - glucose monitoring systems (GMS) such as continuous and flash type monitors including sensors and transmitters, limited to \$4,000 every benefit year;
- Medical services, such as:
 - diagnostic and laboratory tests, limited to:
 - \$1,500 every 12 months for the Gold Plus option;
 - \$1,000 every 12 months for the Gold option;
 - x-rays;
 - magnetic resonance imaging (MRI) and electrocardiogram (ECG), included in Quebec only;
 - [pharmacogenetic testing](#) only through GenXys Health Care Systems, subject to prior approval, and limited to once per lifetime;
- Medical items such as:
 - braces and casts;
 - transcutaneous electrical nerve stimulators (TENS machine), limited to one every 60 months;
 - intrauterine devices, limited to 1 every 24 months;
 - viscosupplementation therapy, limited to once every 6 months;
- Incontinence/Ostomy equipment, such as catheters and ostomy supplies;
- Mobility aids, such as:
 - canes, crutches, and walkers;
 - wheelchairs and scooters (including batteries);
- Prosthetics, such as:
 - myo-electric arm;
 - arm, hand, leg, foot, eye, larynx;
 - external breast prosthesis;
 - post-mastectomy bra, limited to 2 every 12 months;

- Respiratory/Cardiology equipment, such as:
 - compressors and inhalant devices;
 - oxygen and equipment for its administration;
 - tracheotomy supplies;
- Compression stockings with a pressure measurement of 15 mmhg or higher, limited to 2 pairs every 12 months;
- Wigs for temporary or permanent hair loss as a result of a medical condition limited to \$200 per lifetime.

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

Limitations

- The rental price of durable medical equipment will not exceed the purchase price. GreenShield'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;
- 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;
- When deluxe medical equipment is a covered benefit, reimbursement will be made only when deluxe features are required in order for the covered person to effectively operate the equipment. Items that are not primarily medical in nature or that are for comfort and convenience are not eligible.

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

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

Family-building Benefit: Reimbursement up to \$15,000 per lifetime, for you, your eligible spouse as described in the definition of Dependent or your surrogate named in the surrogacy agreement when services are performed in a fertility clinic in Canada.

- **Fertility medical services** such as, but not limited to:
 - Physician services' fees,
 - Diagnostic testing, medical imaging, laboratory and genetic testing,
 - Cryopreservation and services related to sperm retrieval, selection, testing, washing, and preparation,
 - Artificial insemination (AI), Intrauterine insemination (IU), In-vitro fertilization (IVF), Assisted Hatching, Intra-cytoplasmic sperm injection (ICSI), In-vitro maturation.

Note: Eligible prescription fertility drugs are subject to the maximums and limitations applicable to the Prescription Drugs benefit.

- **Surrogacy medical services**, such as, but not limited to:
 - Physician services' fees,
 - Diagnostic testing, medical imaging, laboratory and genetic testing,
 - Cryopreservation and services related to sperm retrieval, selection, testing, washing, and preparation,
 - Artificial insemination (AI), Intrauterine insemination (IU), In-vitro fertilization (IVF), Assisted Hatching, Intra-cytoplasmic sperm injection (ICSI), In-vitro maturation,
 - Eligible prescription drugs for your surrogate must be listed on the receipt from the fertility clinic and are subject to the Family-building Benefit maximum.

Important: Your first claim **must** be submitted with a copy of the legal surrogacy agreement that identifies by name the surrogate who has incurred the expenses in order for any of the incurred expenses to be considered. Your first claim must identify the name of the plan member, as well as the name of the surrogate. Eligible claims incurred on behalf of your surrogate will be reimbursed to the plan member.

This benefit does **not** pay for any fees charged by a surrogacy agency, or any non-medical expenses incurred by the surrogate such as, but not limited to, maternity clothing, nutritional supplements, transportation costs to medical appointments.

Emergency Transportation: 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.

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 \$10,000 every 12 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 GreenShield.

Paramedical Practitioners: Reimbursement for the services of the practitioners included, up to the amount shown in the Summary 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 GreenShield. Please contact the GreenShield Customer Service Centre to confirm practitioner eligibility.

Note: Podiatry services are eligible in coordination with your provincial health insurance plan.

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 GreenShield immediately following the accident and the treatment must commence within 180 days of the accident, and be completed within 365 days of the date of the accident.

GreenShield will not be liable for any services performed after 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 GreenShield's liability.

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

Vision: Reimbursement for the services performed by a licensed Optometrist, Optician or Ophthalmologist, up to the amounts shown in the Summary of Benefits, for:

- Prescription eyeglasses or contact lenses;
- Medically necessary contact lenses when visual acuity cannot otherwise be corrected to at least 20/40 in the better eye or when medically necessary due to keratoconus, irregular astigmatism, irregular corneal curvature or physical deformity resulting in an inability to wear normal frames;
- Optometric eye examinations for visual acuity performed by a licensed optometrist, ophthalmologist or physician. This benefit is available only in those provinces where eye examinations are not covered by the provincial health insurance plan;
- Replacement parts for prescription eyeglasses;
- Laser eye surgery;
- Non-prescription sunglasses prescribed by a legally qualified medical practitioner for the treatment of specific ophthalmic diseases or conditions;
- Prescription industrial safety glasses.

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

- Non-prescription industrial safety eyeglasses;
- Medical or surgical treatment, unless specifically identified and included as eligible in "Vision" above;
- Special or unusual procedures such as, but not limited to, visual training (unless specifically identified and included as eligible in "Vision"), orthoptics, subnormal vision aids and aniseikonic lenses;
- Follow-up visits associated with the dispensing and fitting of contact lenses;
- Charges for eyeglass cases.

Health Exclusions

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

1. Services or supplies received as a result of disease, illness or injury due to:
 - a) an act of war, declared or undeclared;
 - b) participation in a riot or civil commotion; or
 - c) attempting to commit or committing a criminal offence or illegal act;
2. Services or supplies provided while serving in the armed forces of any country;
3. Failure to keep a scheduled appointment with a legally qualified medical or dental practitioner;
4. Any treatment, drug, service, or supply received outside of Canada on a non-emergency basis;
5. Charges for the translation or completion of any claim forms and/or insurance reports;
6. Any form of medical cannabis for the treatment of any medical condition, regardless of whether it is authorized by way of a medical document or prescription from a legally-authorized medical practitioner and obtained from a Health Canada-licensed producer pursuant to any federal or provincial legislation or regulation regarding access to and/or distribution of medical cannabis;

7. Any specific treatment or drug which:
- a) does not meet accepted standards of medical, dental or ophthalmic practice, including charges for services or supplies which are experimental in nature;
 - b) is not considered to be effective (either medically or from a cost perspective) as determined by GreenShield's drug review process regardless if Health Canada has approved the drug;
 - c) is an adjunctive drug prescribed in connection with any treatment or drug that is not an eligible service;
 - d) is administered in a hospital or is required to be administered in a hospital in accordance with Health Canada's approved indication for use;
 - e) is not dispensed by the pharmacist in accordance with the payment method shown under the Prescription Drugs benefit;
 - f) is not being used and/or administered in accordance with Health Canada's approved indication for use, even though such drug or procedure may customarily be used in the treatment of other illnesses or injuries (i.e. [off-label use](#)).
8. Services or supplies that:
- a) are not recommended, provided by or approved by the attending legally qualified (in the opinion of GreenShield) 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 GreenShield, 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 visual treatment (unless specifically identified and included as eligible under the plan) or medical or surgical audio treatment;
 - m) 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;
 - n) are delivery and transportation charges;
 - o) are for Insulin pumps and supplies (unless specifically identified and included as eligible under the plan);
 - p) are for audiometric examinations or hearing aid evaluation tests (unless specifically identified and included as eligible under the plan), or medical examinations;
 - 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.

TRAVEL

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 GreenShield 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 their home province/territory – whether pre-planned or not.
- GreenShield reserves the right to review your medical information at the time of claim. Any invasive or investigative procedures must be pre-approved by GreenShield 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 GreenShield Travel Assistance on the covered person’s behalf within 48 hours. If GreenShield 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 GreenShield Travel Assistance indicates that no further Treatment is required at your destination, or you are able to return to your province/territory of residence for further Treatment. If GreenShield 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), and
- b) The Medical Condition has not become worse, and
- c) There has not been any new, more frequent, or more severe symptoms, and
- d) There has been no hospitalization or referral to a specialist, and
- e) There have not been any tests, investigation or Treatment recommended, but not yet complete, nor any outstanding test results, and
- f) There is no planned or pending treatment, and
- 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 GreenShield **must be obtained**. Your provincial/territorial health insurance plan may cover this referral benefit entirely. You must provide GreenShield 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.**

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 GreenShield Travel Assistance for pre-approval;

Diagnostic laboratory tests and X-rays when prescribed by the attending physician. Except in emergency situations, GreenShield Travel Assistance must pre-approve these services (i.e. cardiac catheterization or angiogram, angioplasty and bypass surgery);

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 GreenShield 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 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 GreenShield 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:

- GreenShield 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.
- GreenShield 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; and

- the cost incurred for a one-way economy airfare for a Travelling Companion.

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

Cost of returning your personal use motor vehicle to your residence or nearest appropriate vehicle rental agency when you are unable to do so due to sickness, physical injury or death, up to a maximum of \$10,000 per trip. GreenShield 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 family 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 5 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 7 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/chiropract, or osteopath in conjunction with treatment for an Emergency;

Child Care when pre-approved by GreenShield 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/territory 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 of your accompanying pet(s) in the event you are hospitalized or repatriated during an Emergency.

GREENSHIELD TRAVEL ASSISTANCE SERVICE

The following services are available 24 hours per day, 7 days per week through GreenShield'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 **519.742.3556** when traveling outside Canada and the United States. These numbers appear on your GreenShield Identification Card.

Quote your GreenShield Identification Number, found on your GreenShield Identification Card, and explain your medical emergency. **You must always be able to provide your GreenShield Identification 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, GreenShield Travel Assistance will guarantee the provider (hospital, clinic or physician), that you have the required provincial/territorial health insurance plan coverage and GreenShield travel benefits as detailed above.

GreenShield Travel Assistance will follow your progress to ensure that you are receiving the best available medical treatment. GreenShield 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 GreenShield Travel Assistance and submit them for reimbursement upon your return to Canada.

Travel Limitations

1. Coverage becomes effective at the time you or your dependent 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. GreenShield Travel Assistance must be notified **before** obtaining [Emergency Treatment](#) in order for GreenShield 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, GreenShield Travel Assistance requires either the covered person or someone on behalf of the covered person to call GreenShield Travel assistance within 48 hours of commencement of treatment.

If GreenShield 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, GreenShield 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, MRI.
4. Repatriation is mandatory when GreenShield 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 GreenShield Travel Assistance;
 - there is a medical need for you or your dependent to be confined to a stretcher or for a medical attendant to accompany you during the journey;
 - you or your dependent are admitted directly to a hospital in your province/territory of residence, and;
 - medical reports or certificates from the dispatching and receiving legally qualified physicians are submitted to GreenShield Travel Assistance;
 - proof of payment (including air ticket vouchers or air carrier invoices) is submitted to GreenShield 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 GreenShield Travel Assistance for pre-travel advice, as we may be unable to guarantee assistance services.
 7. GreenShield 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; or
 - refusal of authorities in a foreign country to permit GreenShield 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 GreenShield Travel Assistance Team;
 - b) where medical evidence suggested a reasonable expectation that treatment or hospitalization could be required while traveling; or
 - c) a physician advised the covered person not to travel.

GreenShield 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 GreenShield 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; or
 - e) are for a recurrence or complication directly or indirectly related to the emergency that GreenShield Travel Assistance determined 3.a), b), c), or d) above.
4. Any expenses incurred for services received after GreenShield 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; or
 - d) the services are for a recurrence or complication directly or indirectly related to the emergency that GreenShield Travel Assistance determined 4.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; or
 - 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 8-week period before and after the expected date of delivery.
8. Any expenses incurred for a child born during the trip within the 8-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.

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

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 Summary of Benefits.

Basic Services

Basic Diagnostic and Preventive Services:

- complete oral examinations once every 6 months;
- emergency and specific oral examinations;
- complete series of X-rays or a panoramic X-ray once every 2 years;
- bitewing X-rays once per recall period;
- recall examinations once every 6 months;
- cleaning of teeth, up to 1 unit of polishing plus up to 1 unit of scaling once per recall period;
- topical application of fluoride once per recall period for covered persons 17 years of age and under;
- oral hygiene instruction once per lifetime;
- denture cleaning once per recall period;
- pit and fissure sealants for covered persons under age 16, on molars only.

Basic Restorative Services:

- amalgam, tooth coloured filling restorations and temporary sedative fillings.

Basic Oral Surgery:

- extractions of teeth and/or residual roots.

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

Comprehensive Basic Services

Standard Denture Services:

- denture adjustments and remount and equilibration procedures, only after 3 months have elapsed from the installation of a denture;
- denture repairs and/or tooth/teeth additions;
- standard relining and rebasing of dentures once every 2 years, only after 6 months have elapsed from the installation of a denture;
- soft tissue conditioning linings for the gums to promote healing;
- remake of a partial denture using existing framework, once every 5 years.

Comprehensive Oral Surgery:

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

Endodontic Treatment

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

Periodontal Treatment

- treatment of diseased bone and gums;
- periodontal scaling and/or root planing 8 time units every 12 months;
- occlusal equilibration – selective grinding of tooth surfaces to adjust a bite 2 time units every 12 months.

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, limited to one every 24 months

Major Services

- Standard onlays or crown restorations to restore diseased or accidentally injured natural teeth, once every 5 years;
- Standard bridges, including pontics, abutment retainers/crowns when required to replace natural teeth once every 5 years;
- Standard dentures, including complete, immediate, transitional, and partial dentures when required to replace natural teeth once every 5 years;
- Standard repair or recementing of crowns, onlays and bridge work on natural teeth;
- Standard inlay restorations.

Note: Dental implants are not covered under this plan.

Orthodontic Services

- Reimbursement for orthodontic treatment to straighten teeth and/or correct the bite;
- Space maintainers for covered persons 17 years of age and under.

Receipts for payment must be received by GreenShield no later than 12 months from the date the service is incurred while treatment is in progress, not at the end of the treatment.

If orthodontic treatment is terminated for any reason before completion, the obligation to pay benefits will cease with payment to the date of termination. If such services are resumed, benefit for the remaining services, will be resumed. The benefit payment for orthodontic services will be only for the months that coverage is in force.

Alternate Benefit Clause

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

Predetermination

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

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

Limitations

1. Laboratory services that are in excess of 40% of the dentist's fee in the applicable Fee Guide shown in the Summary of Benefits will be reduced accordingly. Laboratory services must be completed in conjunction with other services and reimbursement is limited to the same percentage as the service for which the laboratory service was received.
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 Summary of Benefits.
4. If this plan includes endodontic services, reimbursement for root canal therapy will be limited to payment once only per tooth. Extra charges for difficult access, exceptional anatomy, calcified canals, and retreatments are not included. The total fee for root canal therapy 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 if this plan covers periodontics, 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, if this plan covers periodontics, 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. If this plan includes coverage for major services (crowns), 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. If this plan includes periodontics, root planing is not eligible if done at the same time as gingival curettage.
10. In the event of a dental accident, claims should be submitted under the health benefit plan before submitting them under the dental plan.

Dental Exclusions

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

1. Services or supplies received as a result of disease, illness or injury due to:
 - a) an act of war, declared or undeclared;
 - b) participation in a riot or civil commotion; or
 - c) attempting to commit or committing a criminal offence or illegal act.
2. Services or supplies provided while serving in the armed forces of any country;
3. Failure to keep a scheduled appointment with a legally qualified dental practitioner;
4. Any treatment, drug, service, or supply received outside of Canada on a non-emergency basis;
5. Charges for the translation or completion of any claim forms and/or insurance reports;
6. Any dental service that is not contained in the procedure codes developed and maintained by the Canadian Dental Association, adopted by the provincial or territorial dental association of the province or territory in which the service is provided (or your province of residence if any dental service is provided outside Canada) and in effect at the time the service is provided;
7. 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;
 - b) is not considered to be effective (either medically or from a cost perspective) as determined by GreenShield's drug review process regardless if Health Canada has approved the drug;
 - c) is an adjunctive drug prescribed in connection with any treatment or drug that is not an eligible service;
 - d) is administered in a hospital or is required to be administered in a hospital in accordance with Health Canada's approved indication for use;
 - e) is not dispensed by the pharmacist in accordance with the payment method shown under the Health Benefit Plan Prescription Drugs benefit;
 - f) is not being used and/or administered in accordance with Health Canada's approved indication for use, even though such drug or procedure may customarily be used in the treatment of other illnesses or injuries (i.e. [off-label use](#)).

13. Services or supplies that:

- a) are not recommended, provided by or approved by the attending legally qualified (in the opinion of GreenShield) 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 GreenShield, 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.

HEALTH CARE SPENDING ACCOUNT (HCSA)

Your HCSA is governed at all times by the rules and regulations of the Income Tax Act. In the event of a dispute the Income Tax Act shall prevail. The liability for the HCSA lies solely with your plan sponsor.

Your HCSA is provided by your plan sponsor and administered by GreenShield.

Your HCSA is a spending account funded by your plan sponsor that you can use to pay for health and dental expenses that are not covered by your group benefit plan or your provincial health plan.

At the beginning of each benefit year, a predetermined lump sum amount as shown in the Summary of Benefits will be allocated to your account annually to cover the reimbursement of your eligible expenses incurred during that benefit year. When you submit a claim, you will be reimbursed for eligible expenses up to the balance in your account.

Any balance remaining in your account on the last day of the benefit year will be carried forward to, but not beyond the end of, the next benefit year. This balance will be added to your new allocation, and claims for the new benefit year will be applied to the combined amount, using the previous benefit year's allocation first. At the end of the new benefit year, any remaining previous benefit year's allocation will be forfeited.

ELIGIBLE EXPENSES

Eligible expenses include but are not limited to those that qualify for medical expense tax credits under the Canada Revenue Agency (CRA) Income Tax guidelines. It also includes the amount of the deductible and the percentage not covered by the group benefit plan or the amount in excess of group benefit plan maximums.

For a list of eligible medical expenses, visit our website greenshield.ca, or for more information about eligible expenses you can consult a CRA office or visit the CRA website.

Exclusions

Expenses not eligible for reimbursement are at all times governed by the non-eligible expenses, restrictions and limitations outlined in the Canadian Income Tax Act. An example of expenses would be:

- premiums paid to provincial medical or hospitalization plans, and
- medical costs for which you or your dependent are reimbursed or entitled to be reimbursed under a provincial health insurance plan, your group benefit plan or your spouse's group benefit plan

Maternity, Adoption or Parental Leave

If you elect to continue benefits under your group plan, you may continue to submit claims for expenses incurred prior to, or during, the period of your leave.

PERSONAL SPENDING ACCOUNT (PSA)

Your PSA is provided by your plan sponsor and administered by GreenShield. Your plan sponsor reserves the right to cancel, alter or amend the terms and provisions of the PSA to ensure the program is reaching the desired goal of increased health and wellness.

Your PSA is a spending account funded by your plan sponsor that you can use to pay for a range of personal wellness related expenses not covered by your group benefit plan or provincial health plan. Expenses claimed are subject to income tax as outlined by the Canada Revenue Agency.

At the beginning of each benefit year, a predetermined lump sum amount as shown in the Summary of Benefits will be allocated to your account annually to cover the reimbursement of your eligible expenses incurred during that benefit year. When you submit a claim, you will be reimbursed for eligible benefits up to the balance in your account.

Any balance remaining in your account on the last day of the benefit year will be carried forward for up to 12 months until the end of the next benefit year. This balance will be added to your new allocation, and claims for the new benefit year will be applied to the combined amount, using the previous benefit year's allocation first. At the end of the new benefit year, any remaining previous benefit year's allocation will be forfeited.

ELIGIBLE EXPENSES

The following items are covered under the Personal Spending Account. These items are a taxable benefit so all expenses submitted for payment will be shown on your T4A slip received from your plan sponsor. Any item not included in this list should be discussed with your Human Resources before purchasing to determine if it will be eligible for payment.

Fitness/Sports Fees

Recreational Program, Classes, Team Registration Fees
Personal Training, Consultation
Club, Resort, Park, Annual Memberships
Recreational, Individual Event Pass, Registration or Fee
Gym, Fitness Centre, Pool, Annual Memberships

Fitness Equipment

Fitness Equipment
Sports Equipment
Bicycle (Manual)
Heart Rate Monitor
Athletic Sportswear and Accessories
Wii Fit or Xbox Kinect, PlayStation Fitness (entertainment system not included)
Fishing Equipment

Family Care

Child Care
Elder care
Homecare Assistance Services and Products (lifts, supportive aids)
Caregiver Support Programs and Services

Educational and Personal Development

Hobby and General Interest Classes
Education Fees, Tuition, Books
Training, Classes, Tutoring, Language, First Aid, CPR
Professional Designation and Membership Fees and/or dues
Personal Computer and Accessories
Music Equipment

Wellness Services

Smoking Cessation Programs
Safety Equipment
Health Assessments
Weight Loss Programs, Counselling (excluding food)
Nutritional Counselling
Vitamins, Supplements, Natural Products
Maternity Services (Pre-Natal Classes and Mid-Wife Services)
Stress Management Programs
Medical Tests
Alternative Health Practitioners (Examples: Reflexologist, Iridologist, Herbalist, Homeopath, Chinese medicine, Shiatsu therapist, Acupuncturist)
Holistic Health Services

Non-Health Professional Services

Legal Services
Financial Services

Insurance Premiums

Individual Health and Dental Plan
Individual Life and Disability Plan
Individual Travel Insurance Plan
Individual Critical Illness Plan
Individual Long Term Care Plan

CLAIM INFORMATION

Inquiries

For detailed inquiries, contact your Benefits Administrator or contact us:

- Call our Customer Service Centre at 1-833-880-0087 to determine eligibility for a specific item or service and GreenShield's pre-authorization requirements, or
- Visit our website at greenshield.ca to e-mail your question.

Submitting Claims

Claim forms, including Pre-Authorization forms, and valuable claims submission information, is available at greenshield.ca.

Please note that in addition to a completed claim form, claims reimbursement requires the original itemized paid receipt (**cash receipts or credit card receipts alone are not acceptable**).

GreenShield reserves the right to request supplementary claims information. Failure to respond to such requests may result in the denial of the claim.

The intentional omission, misrepresentation or falsification of information relating to any claim constitutes fraud. Submission of a fraudulent claim is a criminal offence and will be reported to the applicable law enforcement and/or regulatory agencies and your plan sponsor. This could result in termination of your coverage under this benefit plan.

Emergency Travel

GreenShield 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 **519.742.3556** when traveling outside Canada and the United States. These numbers appear on your GreenShield Identification Card.

If you have incurred out of pocket expenses, make sure you tell GreenShield Travel Assistance about all the travel coverage you have when submitting claims. Claims must be submitted together with supporting original receipts to GreenShield 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 GreenShield Travel Assistance when notice of claim has been given, which you must complete and sign for the purpose of allowing GreenShield 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 GreenShield Travel Assistance.

Health Care Spending Account

Your HCSA does not have automatic coordination with your health and dental benefits. If you would like to enable this functionality, you may do so through the member portal (the GreenShield Customer Service Centre is unable to arrange set up of this function).

Auto–Coordination with HCSA

Once you have accessed the member portal and have set up your HCSA Auto–Coordination, your health and dental claims will automatically be coordinated with your HCSA. You must pay the provider of service the HCSA portion of the claim and you will be automatically reimbursed from your HCSA without having to submit a paper claim. The unpaid balance of your health and dental claims **will not** be re-directed to a secondary plan (COB) before paying out of the HCSA.

Manual Coordination with HCSA

If you choose **not** to have all your traditional health and dental claims automatically coordinated with your HCSA, you must pay the provider of service the HCSA portion of the claim, then complete a HCSA Claim Submission Form and attach proof of payment. You can indicate on this claim form if you want your eligible expenses paid from your GreenShield health and/or dental plan first, and any unpaid portion of your eligible expenses paid from your HCSA.

PSA Expenses

For PSA, forward a PSA claim form to GreenShield to have your eligible expenses paid from your PSA account.

Claims Submission Period

All Health, Travel and Dental claims must be received by GreenShield no later than 12 months from the date the eligible benefit was incurred.

All HCSA claims must be received by GreenShield no later than 90 days after the end of the benefit year in which the expense was incurred, or, no later than 90 days after your termination date, your retirement date, your date of death or your leave of absence date (other than a Maternity, Adoption or Parental Leave).

All PSA claims must be received by GreenShield no later than 90 days after the end of the benefit year in which the expense was incurred, or, no later than 12 months from the date the eligible benefit was incurred after your termination date.

Reimbursement

Reimbursement will be made by one of the following methods:

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

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

Overpayments

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

Limitation on Legal Action

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

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

Subrogation

GreenShield retains the right of subrogation of benefits. This means if GreenShield paid benefits on behalf of you or your dependent, but the benefits either should have been paid or are subsequently paid or provided, in whole or in part, by a third party liability or other coverage(s), GreenShield has the right to recover such payment or reimbursement. In cases of third party liability, you must advise your lawyer of our subrogation rights.

Co-ordination of Benefits (COB)

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

Claims must be submitted to the primary payer first. Any unpaid balances should then be submitted to the secondary plan(s). When GreenShield 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.

Use the following guidelines to identify the primary and secondary plans:

GreenShield Plan Member

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

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

Spouse

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

Children

When dependent children are covered under both your GreenShield 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.

Travel Benefits

In the event of a travel claim, all plans equally share the cost of the claim.

Access to Information

If you live in a province where the law permits you to request copies of your records, GreenShield will provide one copy of the following at no charge:

- a) any enrollment form you completed for coverage under this plan that was submitted to GreenShield;
- b) any written statements or other record about your health that you submitted to GreenShield during the course of applying for coverage under this plan;
- c) one copy of the group contract.

GreenShield may charge you to provide any additional copies.

As a GreenShield plan member, the following services/programs are available to you. Sign into your GreenShield+ account at greenshieldplus.ca to access all your services.

GREENSHIELD HEALTH SERVICES

Employee Assistance Program

Your Employee Assistance Program (EAP) provides you with **confidential help** for any work, health or life concern. Your EAP coverage provides you and your eligible dependents with up to 7 hours of individual counselling and up to 7 hours of couples counselling. You also have access to work, life and health services including legal, financial, career, health and life transitions.

Our therapist matching questionnaire offers personalized options to find your ideal match within our extensive network of multi-disciplinary therapists. To ensure the fit is just right, your first 15 minutes of counselling do not apply to your 7 covered hours.

ADDITIONAL SERVICES

The following services are included in your benefit plan but are not provided by GreenShield. GreenShield has arranged for this coverage and provides only administration on behalf of your plan sponsor.

Pharmacogenetic Testing

If specific criteria are met, you and your eligible dependents will be able to access pharmacogenetic testing provided through GenXys Health Care Systems. Their TreatGx^{Plus} all-in-one product includes the myPGx pharmacogenetic test and a subscription to TreatGx, a medication decision-support software that provides personalized and optimized medication options based on your pharmacogenetic insights, current drug regimen, and other health information.

Telemedicine

You and your eligible dependents have access to virtual care through Telemedicine – connecting you with a Canadian-licensed general practitioner within minutes. Telemedicine provides instant access to general practitioners from your phone, tablet, or computer, available to you through your benefits plan with no out-of-pocket cost.

GreenShield Telemedicine is provided through the Maple platform that is owned and operated by Maple Corporation.