GreenShield™ Insurance

Hamilton Health Sciences

Classification:	ONA Local 70
Billing Division:	27610
Revised Effective Date:	September 3, 2025

WELCOME TO YOUR BENEFIT PLAN

This summary contains information about your group benefits with Hamilton Health Sciences, your plan sponsor, available through the group contract with Green Shield Canada Insurance (GreenShield), effective October 1, 2020.

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.

Calendar Year Deductible (per person/per family):	$22.50/$35 including a 3-month Carry-over (excluding Hospital Accommodation)
Maximums Overall Health Maximum: Smoking Cessation Program: Fertility Drugs:	 Unlimited One course of treatment in any 12-month period 12 cycles per lifetime
Your Co-pay	0%
Your Plan Covers	**Maximum Plan Pays**
Prescription Drugs	Unlimited, except as stated above
Hospital Accommodation	Semi-private or private room
Hearing Care	$700 every 36 months
Orthotics/Orthopedic Footwear Custom-made boots or shoes: Custom-made orthotics:	 Reasonable and customary charges 2 pairs every calendar year, limited to $475 per pair
Paramedical Practitioners Chiropractor, Registered Massage Therapist* Physiotherapist/Athletic Therapist Speech Therapist* Psychologist, Master of Social Work (MSW), Registered Psychotherapist * physician (M.D.) or nurse practitioner recommendation required	 $450 per calendar year per type of practitioner Reasonable and customary charges $200 per calendar year Reasonable and customary charges
Vision Eyeglasses or contact lenses or medically necessary contact lenses or laser eye surgery Eye examinations	 $450 every 24 months (12 months for dependent children age 17 and under) Once every 24 months (12 months for dependent children age 17 and under)
Emergency Out-of-Province/Out-of-Canada* **(Limited Coverage Only)**	Reasonable and customary charges in the area in which the services are received. Only expenses incurred in the first 6 weeks of the period you are out-of-province/out-of-Canada are eligible.

*Your Travel Plan provides limited coverage on a reimbursement basis. You will be expected to pay for services rendered and submit the paid receipts upon return to your province of residence. Your plan sponsor strongly encourages you to buy a travel plan before leaving your province of residence.

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.

Calendar Year Deductible (per person/per family):	No deductible
Dental Fee Guide (General Practitioners)	Current province of Ontario
Your Co-pay Basic Services: Space Maintainers All Other Basic Services	 50% 0%
Comprehensive Basic Services:	0%
Major Services:	50%
Orthodontics:	50%
Your Plan Covers	
Basic Services Comprehensive Basic Services	Unlimited
Major Services	$1,000 per calendar year for Dentures $2,500 per calendar year for Crowns, Bridges, Bridge Repairs and Implants
Orthodontics	$2,500 per lifetime
Late Entrants	$150 per covered person for first 12 months of coverage, based on covered person's status effective date

Summary of Covered Benefits

Basic Services include recall visits once every 9 months (6 months for dependent children age 17 and under), 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)
Orthodontics includes treatment to straighten teeth/correct the bite.

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, co-pays 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.

TABLE OF CONTENTS

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.

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.

Carry-over means claims incurred during the last 3 months of the calendar year may be used to satisfy the deductible for the following year.

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

Covered person means the plan member who has been enrolled in the plan or 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 1 year. Only one spouse will be considered at any time as being covered under the group contract;
- your unmarried child who:
  - is under age 21;
  - 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.

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.

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

Active Plan Members

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

- a resident of Canada;
- covered under your provincial health insurance plan;
- under age 70, and
- actively at work and working a minimum of 37.5 hours per week on a regular basis.

Retired Plan Members

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

- a resident of Canada;
- covered under your provincial health insurance plan; and
- under age of 65.

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 the month following 90 days of continuous active employment.

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

If you have waived eligibility due to having coverage through your spouse's benefit plan, you must request coverage from your plan sponsor within 31 days after termination of the coverage under your spouse's plan.

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

Termination

Active Plan Members

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 date you attain age 70;
- the end of the period for which rates have been paid to GreenShield for your coverage;
- the date the group contract terminates.

Retired Plan Members

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

- the end of the month in which you attain age 65;
- the date of your death;
- 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.

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), and
c) are approved under GreenShield's drug review process, and
d) are paid 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, limited access drugs and some over-the-counter drugs. In addition, this plan includes vaccines.

Before your drug claim can be reimbursed, GreenShield may require prior authorization or GreenShield may require the drug to be purchased from an approved pharmacy that is a member of GreenShield's Specialty Care Program. You can find out if your drug requires prior authorization or is covered under GreenShield's Specialty Care Program either 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.

Generic drug substitution

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

NOTE:

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

Quebec residents only: Legislation requires GreenShield to follow the RAMQ (The Regie de l'assurance maladie du Quebec) reimbursement guidelines for all residents of Quebec. If you are younger than age 65, you must enroll for the 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, and RAMQ would be first payer.

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

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 room accommodation shown in the Summary of Benefits will be limited to:

- reasonable and customary charges in the area where services are received, for accommodation in a public general hospital;
- reasonable and customary charges in the area where received for accommodation in a convalescent or rehabilitation hospital or a convalescent or rehabilitation wing in a public general hospital;
- $3 per day for 120 days every 12 months for accommodation in a public chronic hospital or chronic care in a public general hospital.
- licensed private hospital, not provincially funded, limited to $10 per day and 120 days per lifetime

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 mattresses;
  - decubitus (bedridden) supplies.

- Footwear, when prescribed by your attending physician, nurse practitioner, podiatrist, or chiropodist, and dispensed by your podiatrist, chiropodist, chiropractor, orthotist, or pedorthist:
  - Custom-made 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;
  - insulin infusion pump supplies limited to $2,000 every 3 months;
  - glucose monitoring systems (GMS) limited to $4,000 every 12 months, such as continuous and flash type monitors including sensors and transmitters;
- Medical services, such as:
  - diagnostic and laboratory tests;
  - X-rays;
- Medical items such as:
  - braces and casts;
- Ostomy equipment, such as catheters and ostomy supplies;
- Mobility aids, such as:
  - canes, crutches, and walkers;
  - wheelchairs and scooters;
- Standard Prosthetics, such as:
  - arm, hand, leg, foot, eye, larynx;
  - external breast prosthesis;
  - post-mastectomy bra, limited to 6 every calendar year;
- 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 6 pairs every calendar year;
- Wigs for temporary or permanent hair loss as a result of chemotherapy or radiation treatment of cancer.

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.

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. 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.

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 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.

For an accident involving a dependent child under age 18, when permanent treatment must be delayed due to the age of the child, treatment must be completed by age 19.

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.

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

- 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.

Emergency Out-of-Province/Out-of-Canada (Limited Coverage Only)

This group benefits plan does not include comprehensive travel coverage. You must pay the full cost of the services at the time they are incurred, and submit the claim upon the return to your province of residence. It is recommended that you confirm if you have travel coverage through your travel agent, credit card company, or another benefit plan. If you do not have travel coverage, your plan sponsor strongly encourages you to buy a travel plan before leaving your province of residence.

Expenses arising as a result of a sudden and unforeseen medical emergency while you or an eligible dependent are temporarily outside of your regular province of residence for vacation, business, or education will be considered eligible under this benefit.

Emergency means a sudden, unexpected injury, illness or acute episode of disease that requires immediate medical attention **and could not have been reasonably anticipated based upon the patient’s prior medical condition**. This includes treatment (non-elective) for immediate relief of severe pain, suffering or disease that cannot be delayed until you or your dependent is medically able to return to your province of residence.

To qualify for benefits, the claimants must be covered by their respective provincial government health plan or equivalent at the time the expenses are incurred. Claims must be submitted to your provincial government health plan offering out of province or out of Canada coverage first. To claim the eligible remaining portion after payment has been made by your provincial government health plan, submit the completed claim submission form to GreenShield along with the statement from your (if applicable) and/or paid receipts.

Eligible 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 health insurance plan.

Only expenses incurred in the first 6 weeks of the period you are out-of-province/out-of-Canada are eligible.

All dollar maximums and limitations are stated in Canadian currency. 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.

Hospital services and accommodation up to a standard ward rate in a public general hospital.

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 includes:

- **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 health insurance plan, or to the nearest qualified medical facility.

  Notes: Air ambulance services will eligible only if:
  - 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, and
  - you or your dependent are admitted directly to a hospital in your province of residence, and
  - medical reports or certificates from the dispatching and receiving legally qualified physicians are submitted to GreenShield and
  - proof of payment (including air ticket vouchers or air carrier invoices) is submitted to GreenShield.

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.

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 and panoramic X-rays once every 2 years;
- bitewing X-rays once per recall period;
- recall examinations once every 9 months (every 6 months for dependent children age 17 and under);
- 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;
- oral hygiene instruction once per recall period;
- denture cleaning once per recall period;
- space maintainers;

Basic Restorative Services:

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

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 8 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, one every 24 months, including maintenance once per appliance

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;
- Implants for covered persons aged 16 and over, limited to once per tooth per lifetime; however, implants are not eligible to replace missing or extracted wisdom teeth.

Orthodontic Services

Reimbursement for orthodontic treatment to straighten teeth and/or correct the bite.

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.

CLAIM INFORMATION

Inquiries

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

- Call our Customer Service Centre at 1-888-525-7587 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.

Claims Submission Period

All Health and Dental claims must be received by GreenShield no later than 12 months from the date the eligible benefit was incurred or upon termination 90 days for eligible expenses incurred prior to termination.

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 their 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.

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.