



Thompson Rivers University Students' Union

Billing Divisions: 10000 (Academic Students)
20000 (Vocational Students)

Revised Effective Date: September 1, 2026

As a GreenShield plan member, you may have access to services/programs in addition to the coverage provided by this Benefit Plan. Sign into (or return to) your GreenShield+ account at greenshieldplus.ca to see all the services/programs to which you have access.

Such additional services/programs made available through GreenShield+ may be replaced or discontinued by GreenShield or by your Plan Sponsor from time to time. GreenShield reserves the right to add, modify, or end any such services or programs at its discretion and without notice.

WELCOME TO YOUR BENEFIT PLAN

ABOUT THIS BOOKLET

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

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

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

Your Green Shield Canada Insurance (GreenShield) Identification Number is to be used on all claims and correspondence. Your unique GreenShield Identification Number is your student identification number with the prefix “TRU” and ends with -00 – e.g. TRU111222333-00. If you have any eligible dependents, they share the same number as you except their number ends with their own unique dependent code.

GreenShield STUDENT CENTRE

The “Student Centre” is accessed from the GreenShield website at greenshield.ca/student. This website provides quick and easy access to the information you are looking for, such as:

- View information that describes programs, services, or benefits you can access as a GreenShield plan member
- Locating dental providers in your area who are members of the Student Dental Discount Network (if you have GreenShield Dental Benefits)
- Locating discount vision and hearing care providers in your area (regardless of whether you have GreenShield Vision Benefits or not)
- Access to opt-out and opt-in information

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

SCHEDULE OF BENEFITS	1
DEFINITIONS	5
ELIGIBILITY	7
For You.....	7
For your Dependents	7
Coverage Effective Date	7
Termination.....	7
Dependent Children Continuation of Coverage	7
Losing your Group Benefits?.....	8
DESCRIPTION OF BENEFITS	9
HEALTH BENEFIT PLAN	9
Prescription Drugs	9
Extended Health Services.....	10
TRAVEL	15
DENTAL BENEFIT PLAN	23
Basic Services	23
Comprehensive Basic Services	24
Major Services.....	24
CLAIM INFORMATION	28

SCHEDULE OF BENEFITS

HEALTH BENEFIT PLAN

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

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

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

Deductible: No deductible	Overall Maximum: Unlimited
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Your Plan Covers:	Your Co-Pay:	Maximum Plan Pays:
Prescription Drugs – Pay Direct Drug Card	0%	\$3,000 per benefit year Please note: BC residents are required to register for the Fair PharmaCare Program through the BC provincial plan prior to reaching \$500 in drug claim costs. Once you are registered, your pharmacy will submit your eligible prescription drug claims to PharmaCare first and any unpaid portion will then be submitted to GreenShield, payable up to the maximum shown above. For more information call our Customer Service Centre at 1-888-525-7587.
Medical Items and Services	20%	
Gender affirmation* *Diagnosis of gender dysphoria or gender incongruence from a physician (M.D.) or nurse practitioner is required	0%	Reasonable and customary charges, limited to \$10,000 lifetime
- Footwear - custom made boots or shoes, modification/ repair to footwear, footwear as an integral part of a brace, or modification/ repair to custom made foot orthotics		\$150 per benefit year combined
Blood glucose meter		\$150 every 5 benefit years
Wheelchair modification/ repair		\$250 per lifetime
TENS machine		\$700 per lifetime
Insulin pump		1 per lifetime
Bra (mastectomy)		Reasonable and customary charges
Compression Stockings		Reasonable and customary charges

Your Plan Covers:	Your Co-Pay:	Maximum Plan Pays:
Wigs		\$250 per lifetime
Other items and services – See the Description of Benefits section for details		Reasonable and customary charges
Emergency Transportation	20%	\$500 per trip
Professional Services	20%	\$40 per visit up to \$400 per type of practitioner per benefit year including 1 X-ray per benefit year for Chiropractor and Osteopath
Chiropractor		
Registered Massage Therapist (Physician (M.D.) or nurse practitioner recommendation required)		
Naturopath		
Osteopath		
Physiotherapist (Physician (M.D.) or nurse practitioner recommendation required every 12 months)		
Speech Therapist (Physician (M.D.) or nurse practitioner recommendation required every 12 months)		
Psychologist, Social Worker, Clinical Counsellor, Master of Social Work (MSW) or Registered Psychotherapist (Physician (M.D.) or nurse practitioner recommendation required every 12 months)		\$75 per visit up to \$600 per benefit year combined
Holistic Nutritional Consultant		\$75 per visit included in the combined maximum of \$600 per benefit year for Psychologist, Social Worker/Counsellor, Master of Social Work (MSW) and Registered Psychotherapist
Chiropodist or Podiatrist		\$40 per visit up to \$400 per benefit year combined including 1 X-ray per benefit year by a Podiatrist
Accidental Dental	20%	\$1,000 per dental accident
Vision	0%	\$150 every 24 consecutive months based on date of first paid claim
- prescription eye glasses or contact lenses, or medically necessary contact lenses - optometric eye exams		\$100 for one eye exam every 2 benefit years
Tutorial Benefit NOTE: Dependents are not eligible for this benefit	20%	\$15 per hour up to \$2,000 per benefit year for private tutorial service of a qualified teacher. You must be confined to home or hospital for a minimum of 15 consecutive days to qualify (Physician (M.D.) recommendation required)

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

TRAVEL BENEFIT PLAN

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

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

This group benefit plan is intended to **supplement** provincial health insurance plans if you experience a medical emergency while travelling outside your province of residence or Canada. If your provincial health plan includes out-of-Canada benefits, hospital and medical services are eligible only if your provincial 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 illness or injury and reimbursement will be limited to reasonable and customary charges for the area in which they are incurred.

The patient must contact GreenShield Travel Assistance within 48 hours of commencement of treatment. Failure to notify us within 48 hours may result in benefits being limited to only those expenses incurred within the first 48 hours of any and each treatment/incident or the plan maximum, whichever is the lesser of the two.

Deductible: No deductible	Overall Maximum: Does not apply
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Co-pay: Does not apply

Your Plan Covers:	Maximum Plan Pays:
Maximum Number of Days per Trip	90 days
Emergency Services	\$5,000,000 per covered person per benefit year
Referral Services	\$75,000 per covered person per calendar year

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

Looking to travel for more days than this plan covers?
Visit the Student Centre website at greenshield.ca/student-centre for details.

DENTAL BENEFIT PLAN

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

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

Deductible:	No deductible
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Fee Guide:	The current Provincial Dental Association Fee Guide for General Practitioners in the province where services are rendered For independent Dental Hygienists, the lesser of the current Provincial Dental Hygienists' Association Fee Guide and Provincial Dental Association Fee Guide for General Practitioners in the province where services are rendered
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Your Plan Covers:	Your Co-Pay:	Maximum Plan Pays:
Basic services	20%	\$750 per benefit year (Basic, Comprehensive Basic and Major Services combined)
Comprehensive Basic Services (excluding standard denture services and comprehensive oral surgery)	50%	
Standard denture services	30%	
Comprehensive oral surgery	85%	
Major Services	85%	

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

DEFINITIONS

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

Allowed amount means, as determined by GreenShield:

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

Benefit Year means the 12 consecutive months commencing on the date a plan member's coverage becomes effective.

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

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

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

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

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

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

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

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

Dependent means

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

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

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

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.

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

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

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

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.

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

ELIGIBILITY

For You

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

- a) a resident of Canada;
- b) covered under your provincial health insurance plan;
- c) under age 70 for Travel Benefits; and
- d) a member or staff member of the student association shown on the cover of this booklet.

For your Dependents

To be eligible for coverage you must be:

- a) covered under this plan; and
- b) each dependent must be covered under a provincial health insurance plan.

Coverage Effective Date

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

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

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

Termination

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

- a) the date you are no longer a member or staff member of the student association shown on the cover of this booklet;
- b) the end of the period for which rates have been paid to GreenShield for your coverage; and
- c) the date you attain age 70 for Travel Benefits;
- d) the date the group contract terminates.

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

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

Dependent Children Continuation of Coverage

Any child whose coverage would end because they have reached the specified age limit may qualify for continued coverage, subject to the following conditions:

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

Losing your Group Benefits?

If your 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.

To get important information or discuss your options please contact **Prosum Health Benefits Inc. at 1-855-751-6590.**

Prosum Health Benefits Inc. is a distributor of GreenShield personal health insurance plans.

DESCRIPTION OF BENEFITS

HEALTH BENEFIT PLAN

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

You may have access to additional programs/services not listed within this Benefit Plan Booklet. If applicable, go to the plan member portal to access the Additional Programs and Services brochure.

Prescription Drugs

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

- a) are prescribed by a legally qualified medical practitioner or dental practitioner as permitted by law;
- b) legally require a prescription and has a Drug Identification Number (DIN);
- 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. In addition, this plan includes vaccines for non-travel Hepatitis prevention.

Before your drug claim can be reimbursed, GreenShield may require prior authorization. You can find out if your drug requires prior authorization either by using the online drug search tool available to you through the plan 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 not** eligible benefits.

Quebec residents only: The Student is responsible for complying with RAMQ rules, your student drug plan does not replace the RAMQ (The Regie de l'assurance maladie du Quebec) provincial plan, **you are required to enrol for RAMQ**. The Student Health and Dental plan pays only to the stated maximums noted in this booklet.

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

- a) Drugs for the treatment of erectile dysfunction and infertility;
- b) Vitamins that do not legally require a prescription and oral vitamins;
- c) Fees charged for the administration or injection of serums, drugs, or vaccines, regardless if prescribed;
- d) Smoking cessation drugs and Nicotine replacement products, such as patches, gum, lozenges, and inhalers;
- e) 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";
- f) 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;
- g) Mixtures, compounded by a pharmacist, that do not conform to GreenShield's current Compound Policy.

Extended Health Services

Medical Items and Services: When prescribed by a legally qualified medical practitioner, unless specified otherwise below, reimbursement for reasonable and customary charges, up to the amount, where applicable, as shown in the Schedule of Benefits for:

- a) Aids for daily living: such as hospital style beds, including rails and mattresses; bedpans; standard commodes; decubitus (bedridden) supplies; I.V. stands; portable patient lifts; trapezes/transfer poles; urinals;
- b) Footwear, when prescribed by your attending physician, nurse practitioner, podiatrist or chiroprapist and dispensed by your podiatrist, chiroprapist, chiropractor, orthotist, or pedorthist:
 - i) adjustments to custom made foot orthotics;
 - ii) custom made boots or shoes, adjustments to orthopedic shoes, or footwear as an integral part of a brace, (subject to a medical pre-authorization);
- c) Braces, casts;
- d) Diabetic equipment, such as:
 - i) blood glucose meters;
 - ii) lancets;
 - iii) insulin pumps;
 - iv) insulin pump supplies; and
 - v) glucose monitoring systems (GMS) such as continuous and flash type monitors including sensors and transmitters;
- e) Medical services, such as diagnostic tests, X-rays and laboratory tests;
- f) Incontinence/Ostomy equipment, such as catheter supplies and ostomy supplies;
- g) Mobility aids, such as canes, crutches, walkers and wheelchairs (including wheelchair batteries);
- h) Standard prosthetics, such as an arm, hand, leg, foot, breast, eye and larynx;
- i) Respiratory/Cardiology equipment, such as compressors, inhalant devices, tracheotomy supplies and oxygen;
- j) Compression stockings with a pressure measurement of 15 mmhg or higher;
- k) Wigs, for temporary or permanent hair loss as a result of a medical condition.

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

Limitations

- a) 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;
- b) Durable medical equipment must be appropriate for use in the home, able to withstand repeated use and generally not useful in the absence of illness or injury;
- c) When deluxe medical equipment is a covered benefit, reimbursement will be made only when deluxe features are required in order for the covered person to effectively operate the equipment. Items that are not primarily medical in nature or that are for comfort and convenience are not eligible.

Gender Affirmation: The following services not covered by your provincial/territorial health plan will be considered eligible only when a diagnosis of gender dysphoria or gender incongruence 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 Schedule 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.

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

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

NOTE:

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

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.

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

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

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

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

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

- Medical or surgical treatment, unless specifically identified and included as eligible in "Vision" above;
- Special or unusual procedures such as, but not limited to, orthoptics, vision training (unless specifically identified and included as eligible in "Vision"), 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);
 - g) is invoiced as a fee for the administration or injection of serums, drugs, or vaccines, regardless if prescribed;
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 audio and visual treatment unless specifically identified and included as eligible under the plan;
- m) are special or unusual procedures such as, but not limited to, orthoptics, vision training unless specifically identified and included as eligible under the plan, 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 medical examinations, audiometric examinations or hearing aid evaluation tests unless specifically identified and included as eligible under the plan;
- 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;

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

- 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.

The 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/chiropractist, 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 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.

Quote your GreenShield Identification Number 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, we 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 Schedule of Benefits.

Basic Services

Basic Diagnostic and Preventive Services:

- complete oral examinations once every 3 years based on date of first paid claim
- emergency and specific oral examinations
- full series X-rays once every 5 benefit years for covered persons 12 years of age and over
- panoramic X-rays once every 5 benefit years
- bitewing X-rays once every 9 months
- recall examinations once every 9 months
- cleaning of teeth up to 1 unit of polishing once per recall period plus 1 unit of scaling twice per recall period
- topical application of fluoride once per recall period
- denture cleaning once per recall period
- pit and fissure sealants on molars only
- space maintainers, for covered persons 14 years of age and under
- protective mouth guards once every 12 months based on date of first paid claim

Basic Restorative Services:

- amalgam, tooth coloured filling restorations (paid to full metal on molars), and temporary sedative fillings
- inlay restorations – these are considered basic restorations and will be paid to the equivalent non-bonded amalgam
- pre-fabricated full coverage restorations once per tooth per benefit year

Basic oral surgery:

- extractions of teeth and/or residual roots limited to 2 wisdom teeth extractions per benefit year

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

Comprehensive Basic Services

Standard denture services:

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

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 including:

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

Periodontal treatment of diseased bone and gums including:

- periodontal scaling and/or root planing 3 time units per benefit year
- occlusal equilibration - selective grinding of tooth surfaces to adjust a bite 4 time units per benefit year

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

- bruxism appliance once every 5 benefit years
- maintenance and relining of bruxism appliance once per benefit year

Major Services

- Standard onlays or crown restorations (paid to full metal on molar) to restore diseased or accidentally injured natural teeth, once every 5 years based on date of first paid claim
- Standard bridges, including pontics, abutment retainers/crowns (paid to full metal on molar) on natural teeth, once every 5 benefit years
- Standard repair or recementing of crowns, onlays and bridge work on natural teeth

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 must be completed in conjunction with other services and will be limited to the co-pay of such services. Laboratory services that are in excess of 40% of the dentist's fee in the applicable Fee Guide shown in the Schedule of Benefits will be reduced accordingly; co-pay is then applied;
2. Reimbursement will be made according to standard and/or basic services, supplies or treatment. Related expenses beyond the standard and/or basic services, supplies or treatment will remain your responsibility;
3. Reimbursement will be pro-rated and reduced accordingly, when time spent by the dentist is less than the average time assigned to a dental service procedure code in the applicable Fee Guide shown in the Schedule of Benefits;
4. Reimbursement for root canal therapy will be limited to payment once only per tooth. Extra charges for difficult access, exceptional anatomy, calcified canals and retreatments are not included. The total fee for root canal includes all pulpotomies and pulpectomies performed on the same tooth;
5. Common surfaces on the same tooth/same day will be assessed as one surface. If individual surfaces are restored on the same tooth/same day, payment will be assessed according to the procedure code representing the combined surface. Payment will be limited to a maximum of 5 surfaces in any 36-month period;
6. When more than one surgical procedure, including multiple periodontal surgical procedures, is performed during the same appointment in the same area of the mouth, only the most comprehensive procedure will be eligible for reimbursement, as the fee for each procedure is based on complete, comprehensive treatment, and is deemed part of the multiple services factor;
7. The multiple services factor occurs when a minimum of 6 or more restorations (fillings) or multiple periodontal services are performed at the same appointment and the full fee guide price is charged for each restoration or periodontal service, the first service will be paid in full and all remaining services will be reduced by 20%;
8. Root planing is not eligible if done at the same time as gingival curettage;
9. In the event of a dental accident, claims should be submitted under the health benefits plan before submitting them under the dental plan.

Dental Exclusions

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

1. Services or supplies received as a result of disease, illness or injury due to:
 - a) an act of war, declared or undeclared;
 - b) participation in a riot or civil commotion; or
 - c) 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 dental service that is not contained in the procedure codes developed and maintained by the Canadian Dental Association, adopted by the provincial or territorial dental association of the province or territory in which the service is provided (or your province of residence if any dental service is provided outside Canada) and in effect at the time the service is provided;
7. Implants;
8. Restorations necessary for wear, acid erosion, vertical dimension and/or restoring occlusion;
9. Appliances related to treatment of myofascial pain syndrome including all diagnostic models, gnathological determinants, maintenance, adjustments, repairs and relines;
10. Posterior cantilever pontics/teeth and extra pontics/teeth to fill in diastemas/spaces;
11. Service and charges for sleep dentistry;
12. Diagnostic and/or intraoral repositioning appliances including maintenance, adjustments, repairs and relines related to treatment of temporomandibular joint dysfunction;
13. Any specific treatment or drug which:
 - a) does not meet accepted standards of medical, dental or ophthalmic practice, including charges for services or supplies which are experimental in nature;
 - b) is not considered to be effective (either medically or from a cost perspective) as determined by 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);
 - g) is invoiced as a fee for the administration or injection of serums, drugs, or vaccines, regardless if prescribed;

14. 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:

- ♦ 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

Pre-authorization

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

Submitting Claims

All claims submitted to GreenShield require your GreenShield Identification number. Your GreenShield Identification Number is your student number with the prefix "TRU" – e.g. **TRU111222333**.

Original itemized paid receipts are required for claims reimbursement (**cash receipts or credit card receipts alone are not acceptable as proof of payment**).

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 **0.519.742.3556** when traveling outside Canada and the United States.

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.

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

Reimbursement

Reimbursement will be made by one of the following methods:

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

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

Direct Payment to the Provider of Service (where applicable)

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

Subrogation

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.

DENTAL DISCOUNT NETWORK ARRANGEMENT

GreenShield provides access to a Student Dental Discount Network. The intent of this network is to provide our student plan members access to high quality dental services at an affordable cost.

Features of this great value-added service and how it works:

1. This program includes more than 800 dental provider locations from coast to coast.
2. Once a dental provider elects to participate in the network, they are added to a list of GreenShield's participating dental providers. This list is available at greenshield.ca/student
3. You may visit a dentist from the list of participating dental providers, or you may ask your existing dentist to join this network; the advantage to your dentist of joining the network is the potential of an increase in business. Your dentist can call our Customer Service Centre at 1.888.525.7587 for more information.
4. The discount offer applies to most dental procedures and *may* be up to 30%.
5. Our system will automatically calculate the applicable discount when you visit a dental provider in this network. The applicable discount is dependent on your particular college or university's plan design, and will be subtracted from your co-pay, or share of the cost.
6. Eligible dental claims must be processed electronically; therefore, **you must first be enrolled on GreenShield's system in order to be eligible for the discount.** GreenShield will pay your dentist directly; you only have to pay the dentist your share of the cost (if any) for services provided.
7. You will receive professional dental services while incurring lower out-of-pocket expenses and maintain ongoing oral health.

Visit greenshield.ca/student or call the Customer Service Centre at 1.888.525.7587 for more information.

Co-ordination of Benefits (COB)

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

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

GreenShield Plan Member

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

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

Spouse

If your spouse is a plan member under another benefit plan, this 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.

Travel Benefits

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

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.

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.

STUDENT GROUP ACCIDENT INSURANCE BENEFIT AD&D

The Student Group Accident Insurance benefits are provided by The Wawanesa Life Insurance Company (Wawanesa Life).

STUDENT GROUP ACCIDENT INSURANCE AD&D

Policy GRE1001 - \$7,500

Insurer - The Wawanesa Life Insurance Company (Wawanesa Life)

When are you Covered?

The Student Accident Insurance plan covers you 24 hours a day, anywhere in the world, for specified losses. If you suffer any of the eligible losses listed in the policy or the loss occurs within 365 days of a date of and Accident, the benefits indicated in the policy will be paid.

“Accident” means a single sudden and unexpected event, which:

- a) occurs at an identifiable time and place;
- b) causes unexpected bodily Injury at the time it occurs; and
- c) arises from an external source to the Insured Person.

Aircraft Coverage

Insurance includes Injury sustained by you while and in consequence of:

- a) riding as a passenger, in or on any aircraft operated on a regular, special or chartered flight by a domestic or international scheduled air carrier, licensed by the Department of Transport of Canada or the governmental authority having jurisdiction over such air carrier in the country of its registry; or
- b) riding as a passenger, in or on any aircraft operated by the Canadian Armed Forces or by a similar military service of any duly constituted governmental authority of any other recognized country; or
- c) boarding or alighting from or being struck by any aircraft.

Notwithstanding (a) and (b) above, this policy excludes Injury sustained while and in consequence of:

- a) riding as a pilot, operator or member of the crew in or on any aircraft; or
- b) riding as a passenger, in or on any aircraft owned, operated, or leased by or on behalf of the Policyholder.

Exposure and Disappearance

If, by reason of an Accident, you are unavoidably exposed to the elements and as the result of such exposure, suffer a loss which indemnity is otherwise payable under this policy, such Loss will be covered under the terms of the policy.

If your body is not found within one year after the date of the disappearance and the disappearance is a result of the sinking or wrecking of the conveyance in which you were riding at the time of the Accident, and under such circumstances as would otherwise be covered under this policy, it will be presumed you suffered a Loss of Life resulting from injury caused by an Accident at the time of such sinking or wrecking.

Who is Covered?

All active full-time & part-time students, under the age of 70, whose names are on file with the Health Plan Administrator provided the student is actively carrying out their curriculum.

If a student is not actively carrying out their curriculum on the date they become eligible coverage will be delayed until they begin their studies. Coverage also terminates when a student ceases to carry out their curriculum on account of leave of absence, disability, abandoned course of study or is expelled.

Plan A - all active domestic and international students of the Policyholder, under Age 70

Plan B - Class I: all active international students of the Policyholder, under Age 70

SCHEDULE OF BENEFITS

Benefit amount for each eligible student \$7,500 or as shown below. The amount specified shall apply to each student, subject to all terms of the policy.

Accidental Death or Dismemberment Indemnity	\$ 7,500
Accident Reimbursement Expense.....	\$ 10,000
Accidental Dental Expense	\$ 1,000
Bereavement Expense	\$ 5,000
Brain Death Indemnity	\$ 7,500
Cosmetic Disfigurement Indemnity	\$ 7,500
Day-Care Indemnity	\$ 5,000
Education Indemnity	\$ 5,000
Family Transportation Expense	\$ 15,000
Funeral Expense	\$ 2,500
Home Alteration and/or Vehicle Modification Expense.....	\$ 10,000
Hospital Indemnity	\$ 2,500
Identification Expense	\$ 15,000
Occupational Training Expense	\$ 15,000
Rehabilitation Expense	\$ 15,000
Repatriation Expense	\$ 15,000 (class A), \$ 25,000 (class B)
Seat-Belt Indemnity.....	\$ 2,250
Suicide Death Indemnity (Class I only)	\$ 7,500

Non-Evidence Benefit Maximums - \$50,000

Aggregate Limit of Indemnity - \$1,000,000

Grace Period for Premium Payment – 60 days

General Policy Definitions

“Accident” means a single sudden and unexpected event, which:

- (a) occurs at an identifiable time and place;
- (b) causes unexpected Injury at the time it occurs; and
- (c) arises from an external source to the Insured Person.

“Actively at Work” means a Class II Member capable of working and present at his or her place of work to carry out normal duties in accordance with the Member’s regular work schedule, on vacation, or on a leave approved by their employer.

“Administrator” means Green Shield Canada and J&D Benefits

“Age” means the attained Age of an Insured Person (last birthday).

“Benefit Amount” means the insurance benefits provided in the policy and is the amount of insurance issued as shown on the Schedule.

“Certificate” means the Certificate of Insurance issued to clients by the Policy Administrator which outlines the Benefit Amount applicable to the identified client.

“Disease” means any unhealthy condition of part or all of the body.

“Evidence” means evidence deemed satisfactory by the Insurer to confirm a state or condition.

“Hospital” means an institution licensed as a Hospital, which is always open for the care and treatment of sick and injured persons, has a staff of one or more Physicians always available and which continuously provides 24-hour nursing service by graduate registered Nurses. It provides organized facilities for diagnostics and Surgery, is an active treatment Hospital and not primarily a clinic, rest home, nursing home, convalescent Hospital or similar establishment. For the purposes of this definition, Hospital includes a facility or part of a facility used for rehabilitative care. For the purposes of this definition, Physicians and Nurses will not exclude an Immediate Family Member.

“Immediate Family Member” means a person at least 18 years of Age, who is the son, daughter, father, mother, brother, sister, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, sister-in-law, (all of which include natural, adopted or step relationships), Spouse, grandson, granddaughter, grandfather or grandmother of an Insured Person.

“Injury” means bodily Injury caused solely by an Accident that occurs while this policy is in force. The Injury must be the basis of a claim and result directly and independently of all other losses covered by this policy, 24 hours a day, anywhere in the world. With the exception of sections A5.12 Family Transportation Expense (applicable to Plan B, option 4) and A5.20 Repatriation Expense (applicable to Plan B, option 4) Injury does not mean Sickness or Disease unless caused by an Accident.

“Insured Person” means an Insured Member eligible for insurance under a provision of this policy, unless otherwise stated in this policy.

“Member” means an active student or student union office employee of a Post-Secondary Educational Institution who is enrolled under the Policyholder's Health and Dental program, as operated by the Policy Administrator.

“Nurse” means a graduate registered Nurse (R.N.), or a Nurse who is licensed to practice nursing services by a governmental agency that has jurisdiction over such licensing. A Nurse cannot be the Insured Person nor an Immediate Family Member.

“Participating Member Client” means student union clients who are participating in this benefit program administered by the Policy Administrator.

“Physician” means a doctor of medicine (other than an Insured Person or an Immediate Family Member) who is licensed to practice medicine by:

(a) a recognized medical licensing organization in the locale where the treatment is rendered, on condition that he or she is a member in good standing of such licensing body; or

(b) a governmental agency that has jurisdiction over such licensing in the locale where the treatment is rendered.

“Policy Administrator” means Prosum Health Benefits Inc.

“Regular Care and Attendance” means observation and treatment to the extent necessary under existing standards of medical practice for the condition to require such treatment or disability, or that causes Hospital confinement.

“Residence” means both the primary dwelling in Canada of which an Insured Person is an occupant and the premises on which it is situated.

“Sickness” means an impairment of normal physiological function and includes illness and infections.

“Spouse” means a person of the same or opposite sex who is under the Age of 70, resides in Canada, is

covered by a Provincial Health insurance plan and:

(a) to whom the Insured Member is legally married; or

(b) with whom the Insured Member has continuously cohabited in a conjugal relationship for a minimum of one year immediately before a loss is incurred under the policy.

Only one individual will qualify as a Spouse. If the Insured Member is legally married but is also cohabiting with an individual as described under item (b), the Insured Member may elect in writing which one of the individuals will qualify as a Spouse under the policy. This election must be filed with the Policyholder. The Insurer will not be bound by an election not filed before the event insured against. If an election is not filed, the Spouse will be the individual to whom the Insured Member is legally married.

“Suicide” means an Insured Person intentionally causing their own death.

SCHEDULE OF LOSSES

Accidental Death and Dismemberment

If you suffer an injury that results in one of the following losses, within one year from the date of the accident, Wawanesa Life will pay a percentage as shown below of the Accidental Death and Dismemberment Benefit Amount indicated in the **Schedule of Benefits**, however, not more than one (the largest) shall be paid with respect to all injuries resulting from one accident.

For Loss of:

% of Benefit Amount

Life	100%
Entire Sight of Both Eyes	300%
Speech and Hearing in Both Ears	300%
One Hand and the Entire Sight of One Eye	300%
One Foot and the Entire Sight of One Eye	300%
Entire Sight of One Eye	210%
Speech	150%
Hearing in Both Ears	300%
Hearing in One Ear	150%
All Toes on Same Foot	25%

One Finger	10%
Four Fingers on Same Hand	33.33%

For Loss or Loss of Use of:

% of Benefit Amount

Both Hands	300%
Both Feet	300%
Both Arms	300%
Both Legs	300%
One Hand and One Foot	300%
One Arm	225%
One Leg	225%
One Hand	210%
One Foot	210%
Thumb and Index Finger on Same Hand	50%

For Paralysis of:

% of Benefit Amount

Both Upper and Lower Limbs (Quadriplegia)	300%
Both Lower Limbs (Paraplegia)	300%
Upper and Lower Limbs of One Side of Body (Hemiplegia)	300%

Accident Reimbursement Expense

If, by reason of Injury, you require and receive medical treatment and incur expenses for any of the following services or supplies while under the Regular Care and Attendance of a Physician, the Insurer will pay the reasonable and customary expenses actually incurred by you within 52 weeks after the date of the Accident. Payment by the Insurer for the total of all expenses incurred by you will not exceed the Benefit Amount stated in the Schedule as the result of any one Accident.

- (a) Expenses for the services of a Nurse ordered or prescribed by a Physician, on condition such Nurse does not ordinarily reside in your Residence and is not an Immediate Family Member, subject to the Benefit Maximum stated in the Schedule.
- (b) Hospital charges for the difference between the public ward allowance under your Provincial Hospital plan and the semi-private accommodation charge (private accommodation charge if recommended by a Physician);
- (c) Expenses for transportation by a licensed ambulance service or, when recommended by a Physician, by any other conveyance licensed to carry passengers for hire to or from the nearest Hospital that is equipped to provide the required treatment.
- (d) Prosthetic Appliance, subject to a maximum of \$1,000.

Accidental Dental Expense

If an Injury to whole and sound teeth is caused by a force or blow external to the mouth, and the Injury requires treatment, replacement, or x-rays by a legally qualified dentist or oral surgeon, then the Insurer will pay the reasonable and necessary expenses actually incurred by you, that are in excess of the deductible, within 52 weeks after the date of the Accident. Payment by the Insurer for the total of all expenses incurred by you will not exceed the Benefit Amount stated in the Schedule.

The expense cannot duplicate the cost of any such services covered under the terms of any existing plan of dental insurance services.

Benefits as the result of any one Accident are subject to a deductible of \$100 per injury.

For the purpose of this policy, capped or crowned teeth will be considered whole and sound except where they have undergone endodontic treatment. If an Injury to a capped or crowned tooth causes damage to the remaining tooth structure requiring the preparation of a new cap or crown, the policy will cover the cost of treatment necessitated thereby. If a cap or crown is damaged or dislodged without Injury to the remaining tooth structure, the policy will not cover the cost of treatment necessitated thereby.

The legally qualified dentist or oral surgeon must not ordinarily reside in your Residence and cannot be an Immediate Family Member.

You must consult with the dentist or oral surgeon within 30 days from the date of Accident.

Any payments made under this section will be in accordance with the current Fee Guide for General Practitioners published by the Dental Association in the province or territory of your Residence.

Bereavement Expense

If you suffer Loss of Life as the result of an Accident, and a Physician recommends that your Spouse and Dependent Children undergo bereavement counselling by a licensed Psychologist, then the Insurer will pay the cost of such counselling, not to exceed the Benefit Amount as stated in the Schedule. The Loss of Life must occur within 365 days of the Accident to be eligible for this benefit.

Brain Death Indemnity

If you suffer Brain Death as the result of an Accident then the Insurer will pay the Benefit Amount in one sum, less any amount paid or payable under Specific Loss Accident Indemnity. The Loss of Life must occur within 365 days of the Accident to be eligible for this benefit.

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

Cosmetic Disfigurement Indemnity If, as a direct result of suffering a loss under the circumstances described in sections A1 - Description of Coverage and A2 - Aircraft Coverage, an Insured Member suffers cosmetic disfigurement due to a burn, the Insurer will pay the Cosmetic Disfigurement Indemnity, on condition that such burn is classified as a third-degree burn.

The amount of benefit payable under this section is based on the percentage of the Benefit Amount, as shown in the following Cosmetic Burn Schedule, which is determined by the Area Classification Factor times the percentage of body surface actually burned.

The Maximum Allowable Percentage for Body Surface Burned, as shown in the following Cosmetic Burn Schedule, is based on 100% of the specific body part that was burned. The attending Physician will determine the actual percentage applicable to each burn.

If an Insured Member suffers burns to more than one body part as a result of any one Accident, benefits payable for all such burns will not exceed 100% of the Benefit Amount.

Area Classification Factor

Cosmetic Burn Schedule

Body Part	
Face, Neck, Head	11
Hand & Forearm (Right)	5
Hand & Forearm (Left)	5
Upper Arm (Right)	3
Upper Arm (Left)	3
Torso (Front)	2
Torso (Back)	2
Thigh (Right)	1
Thigh (Left)	1
Lower Leg - below knee (Right)	3
Lower Leg - below knee (Left)	3

Body Part	Maximum Allowable % for Body Surface Burned
Face, Neck, Head	9.0%
Hand & Forearm (Right)	4.5%
Hand & Forearm (Left)	4.5%
Upper Arm (Right)	4.5%
Upper Arm (Left)	4.5%
Torso (Front)	18.0%
Torso (Back)	18.0%
Thigh (Right)	9.0%
Thigh (Left)	9.0%
Lower Leg - below knee (Right)	9.0%
Lower Leg - below knee (Left)	9.0%

Body Part	Maximum % of Benefit Amount Payable
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Face, Neck, Head	99.9%
Hand & Forearm (Right)	22.5%
Hand & Forearm (Left)	22.5%
Upper Arm (Right)	13.5%
Upper Arm (Left)	13.5%
Torso (Front)	36.0%
Torso (Back)	36.0%
Thigh (Right)	9.0%
Thigh (Left)	9.0%
Lower Leg - below knee (Right)	27.0%
Lower Leg - below knee (Left)	27.0%

If benefits are payable under this section and Specific Loss Accident Indemnity or Brain Death Indemnity, the total benefits payable will not exceed 100% of the Benefit Amount.

Day Care Indemnity

If a Loss of Life results from an Injury sustained by you, and indemnity for such Loss becomes payable in accordance with the terms of this policy, the Insurer will pay the lesser of the following amounts for any Dependent Child who, on the date of or within 365 days of your death, is enrolled in a legally licensed Day-Care Centre:

- (a) 5% of the Benefit Amount; or
- (b) \$5,000 for each year (up to four consecutive years) your child remains enrolled in a legally licensed Day-Care Centre.

The total maximum payable under this benefit in combination with the Day-Care Indemnity maximum provided under any other policy issued by the Insurer will not exceed the Benefit Amount as stated in the Schedule.

The benefit will be paid each year immediately upon receipt of satisfactory proof that the child is enrolled in a legally licensed Day-Care Centre.

Education Indemnity

If a Loss of Life results from an Injury sustained by you, and indemnity for such Loss becomes payable in accordance with the terms of this policy, the Insurer will pay the lesser of the following amounts for any Dependent Child who, on the date of or within 365 days from the Insured Person's death, is enrolled as a full-time student in any Institution for Higher Learning:

- (a) 5% of the Specific Loss Accident Indemnity Benefit Amount; or
- (b) the Education Benefit Amount stated in the Schedule each year (up to four consecutive years) such child remains enrolled as a full-time student in an Institution for Higher Learning.

The total maximum payable under this section, in combination with the Education Benefit maximum provided under any other policy issued by the Insurer, will not exceed the Education Benefit Amount per year as stated in the Schedule.

The benefit will be paid each year immediately upon receipt of satisfactory proof that the Dependent Child is enrolled as a full-time student in an Institution for Higher Learning.

If a Dependent Child satisfies these requirements, such child will be deemed the Beneficiary with respect to the benefits payable under this provision.

Family Transportation Expense (Plan A & B)

If, by reason of Injury, you sustain a Loss payable under the Specific Loss Accident Indemnity of this policy and is confined as an inpatient in a hospital located more than 150 kilometres from your normal place of residence, the Insurer will pay the reasonable expenses actually incurred by any Immediate Family Members or a family representative for Accommodation and transportation by the most direct route to and from the confined Insured Person, subject to the following:

- (a) the Insured Person must be under the Regular Care and Attendance of a Physician; and
- (b) the Immediate Family Members or family representative must originate from and return to their normal place of residence.

Payment by the Insurer for the total of all expenses incurred by any Insured Person will not exceed the Benefit Amount as stated in the Schedule.

Payment will not be made for board or other ordinary living, travelling or clothing expenses. If transportation occurs in a vehicle or device other than one operated under a license for the conveyance of passengers for hire, then reimbursement of transportation expenses will be limited to a maximum of \$0.35 per kilometre travelled.

Funeral Expense

If you suffer Loss of Life as the result of an Accident that is payable under Specific Loss Accident Indemnity of this policy, then the Insurer will pay the actual expense incurred for Customary Funeral Expenses, not to exceed the Benefit Amount as stated in the Schedule.

‘Customary Funeral Expenses’ *means* the services and material provided by an undertaker, mortician, crematorium, or funeral home relative to the burial of the deceased Insured Person, as well as the costs incurred for the purchase of a cemetery plot, tomb, or a mausoleum for the burial or interment of the deceased. Eligible expenses include a plaque, tombstone, or monument.

Home Alteration and/or Vehicle Medication Expense

If, by reason of Injury, you sustain:

- (a) the Loss of Both Feet or Legs; or
- (b) the Loss of Use of Both Feet or Legs; or
- (c) becomes Quadriplegic, Paraplegic or Hemiplegic; and

for which indemnity is payable in accordance with the terms of this Employee Accidental Death or Dismemberment Insurance, and you subsequently require the use of a wheelchair to be ambulatory, the Insurer will pay the reasonable and necessary expenses actually incurred within three years of the date of Loss for:

- (a) the one-time cost of alterations to your principal Residence for the purpose of making it accessible. Home alterations must be made by persons experienced in such alterations, and must be recommended by a recognized organization that provides support and assistance to wheelchair users; and
- (a) the one-time cost of modifications to one motor vehicle utilized by the Insured Person. Such modifications must be carried out by persons with experience in such matters and must be approved by licensing authorities (where required) for the purpose of adapting it to the needs of the Insured Person.

Payment by the Insurer for the total of all expenses incurred by or for any Insured Person will not exceed the maximum as stated in the Schedule as the result of any one Accident. The amount payable under this section will be coordinated with any amount paid or payable under any other insurance plan providing the same or similar benefit.

Hospital Indemnity

A Daily Benefit will be payable to you when you are in a hospital and under the Regular Care and Attendance of a Physician, but only if such Period of Hospitalization is necessary for the treatment of an Injury that results in a Loss payable under Specific Loss Accident Indemnity of this policy. Such Daily Benefit will be paid from the first Day of Hospitalization, but for no more than 365 days per Accident.

Subject to anything contrary in this policy, a Period of Hospitalization that becomes necessary for the treatment of an Injury, other than for a specific Loss, will be covered in accordance with the terms of this section, on condition that such Period of Hospitalization commences:

- (a) within 365 days of the date of the Accident that causes the Injury; and
- (b) while insurance under this policy is in force for the Insured Person.

Such Daily Benefit will be paid from the fifth Day of Hospitalization.

Only one Period of Hospitalization will be payable for all Injuries sustained by the Insured Person as the result of the same Accident.

Identification Expense

If a Loss of Life results from an Injury sustained by yourself, and the police or similar governmental authority require identification of your body, the Insurer will reimburse one Immediate Family Member's or a family representative's expenses incurred for transportation to the location of your body and return to their normal place of Residence by the most direct route and for lodging and board, subject to the Benefit Maximum as stated in the Schedule. If transportation is by any motor vehicle not for hire, then the reimbursement of transportation expenses will be limited to a maximum of \$0.35 per kilometre travelled. Your body must be located more than 150 kilometres from the Immediate Family Member's Residence.

Occupational Training Expense

If a Loss of Life results from an Injury sustained by an Insured Person, and indemnity for such Loss becomes payable in accordance with the terms of this policy, the Insurer will pay the reasonable and necessary expenses actually incurred, within 365 days from the date of such Loss, by the Spouse of the Insured Person who engages in a formal occupational training program in order to become specifically qualified for active employment in an occupation for which he or she would not otherwise have sufficient qualifications, not to exceed the Benefit Amount as stated in the Schedule for all such expenses. Payment will not be made for room, board or other ordinary living, travelling, or clothing expenses.

If the Insured Person's Spouse satisfies these requirements, such Spouse will be deemed the Beneficiary with respect to the benefits payable under this provision.

Rehabilitation Expense

If an Insured Person sustains a loss under section A5.1 Specific Loss Accident Indemnity due to an Injury, which then requires the Insured Person to participate in a rehabilitation program in order to be qualified to engage in an occupation in which he or she would not have otherwise engaged, then the Insurer will pay the reasonable and necessary expenses actually incurred within three years from the date of Loss.

Payment will not be made for room, board, or other ordinary living, travelling, or clothing expenses. Payment by the Insurer for the total of all expenses incurred by any Insured Person will not exceed the Benefit Amount as stated in the Schedule as the result of any one Accident.

Repatriation Expense (Plan A and Plan B)

If a Loss of Life results from an Injury sustained by an Insured Person more than 50 kilometres from his or her normal place of Residence, or outside Canada, and indemnity for such Loss becomes payable in accordance with the terms of this policy, then the Insurer will pay the reasonable and customary expenses actually incurred for the transportation of the body of the deceased Insured Person to the first resting place (including but not limited to a funeral home or the place of interment) in proximity to the normal place of Residence of the deceased, including charges for the preparation of the body for such transportation. Payment by the Insurer will not exceed Benefit Maximum as stated in the Schedule.

Seat Belt Indemnity

If you sustain an Injury that results in a Loss payable under Specific Loss Accident Indemnity of this policy, then the Insurer will pay an additional sum equal to 10% of the applicable amount payable under Specific Loss Accident Indemnity, if at the time of the Accident the Insured Person was driving or riding in a Motorized Vehicle and wearing a properly fastened Seat Belt. Payment by the Insurer for the total of all expenses incurred by any Insured Person will not exceed the Benefit Maximum as stated in the Schedule.

The driver of the Motorized Vehicle must hold a current and valid driver's license of a rating authorizing him or her to operate such Motorized Vehicle and cannot be intoxicated nor under the influence of drugs, unless such drugs are taken as prescribed by a Physician, at the time of the Accident. "Intoxicated" and "under the influence of drugs" are as defined by the local jurisdiction where the Accident occurs.

Due proof of Seat Belt use must be provided as part of the written Proof of Loss.

"Motorized Vehicle" means a passenger car, station wagon, van, jeep-type automobile, truck, ambulance or any type of motorized vehicle used by municipal, provincial or federal police forces.

"Seat Belt" means those belts that form a restraint system and includes infant and child restraint systems when properly used with a Seat Belt, and the restraining belts which are part of a stretcher used in the transportation of sick or injured persons by ambulance.

Suicide Death Indemnity

If the Suicide Death Indemnity is elected for coverage by the Policyholder and the Insured Person suffered a Loss of Life resulting from suicide, the Insurer will pay the Benefit Amount as specified in the Schedule. Payment will not be made for International Students who suffered a loss of life resulting from suicide outside of Canada. This benefit is not applicable to Plan A Class II Insured Persons.

Aggregate Limit of Indemnity

The Insurer's aggregate limit of indemnity for all Losses arising out of any one Accident, for which coverage is provided under this policy, is as stated in the Schedule. If said limit of indemnity for any one Accident is insufficient to pay the full amount of indemnity for each Insured Person, then the amount payable for each Insured Person will be in the proportion that the limit of indemnity for any one Accident bears to the total amount of insurance that would have been payable, except for such limit of indemnity

This section only applies to losses payable under Specific Loss Accident Indemnity and Brain Death Indemnity.

When Will Benefits Not Be Paid?

This policy does not cover any Loss, fatal or non-fatal, caused or contributed to by:

- a) war or civil war, whether declared or undeclared
- b) active full-time, part-time or temporary service in the armed forces of any country;
- c) riding as a passenger or otherwise in any vehicle or device for aerial navigation, other than as provided in Aircraft Coverage;

This policy does not cover any of the following supplies or services or costs thereof:

- (a) expenses paid or payable under any government/group hospital, medical, dental or health care plan, or expenses for which insurance is prohibited by law;
- (b) expenses incurred outside of Canada if you are an international student, unless it is an Injury that occurs while on a trip to the United States of America, to a maximum duration of 3 weeks per trip.

Beneficiary Designation

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

- a) On your Effective Date under this plan your beneficiary is the executors or administrators of your estate or your heirs, unless you forward a written declaration to the Administrator designating a beneficiary. Any designation or change in beneficiary shall be effective on the date your written declaration is received at the office of the Administrator.
- b) you will be considered the beneficiary for all other indemnities payable.
- c) If, at your death, there is no designated beneficiary, benefit payments shall be made to the executors or administrators of your estate, or your heirs.
- d) If more than one (1) beneficiary is designated with no indication of their respective interests, they shall share equally in the benefit payments.
- e) The rights of a beneficiary who predeceases you shall revert to yourself

Reserving Rights

As a condition precedent to recovery of insurance money under this contract the Insurer reserves the right to:

- a) examine the full details regarding the claim;
- b) require the Insured Person to undergo a medical examination at the Insurer's expense;
- c) examine the Insured Person when and so often as it reasonably required while the claim hereunder is pending;
- d) require an autopsy to be performed on the Insured Person in the event of death, unless prohibited by law or religious belief;
- e) disallow the claim based on information developed from the attending Physician's report, medical examination, payroll records, or other sources of pertinent data.

Fraudulent Claims

Any claim for benefits under the policy which is based on false or incorrect information on an application, claim form or other documents required to verify benefits will result in the benefits being denied or the liability assumed by the Beneficiary if the benefit has already been provided or performed.

Limitation of Action

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the *Insurance Act* (Alberta and B.C.).

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in *The Insurance Act* (Manitoba).

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the *Limitations Act, 2002* (Ontario).

Otherwise, in Quebec every action must be brought within three (3) years after the date evidence is furnished, and in all other provinces within one (1) year from the date of loss or such longer period as may be required under the law applicable in such province.

Subrogation

The Insurer is subrogated in all the rights of Insured Persons against the third party liable for the damage that has given rise to an entitlement to payment of benefits under this policy up to the limitation of amounts paid by the Insurer.

The Insurer may, in the exercise of its right of subrogation and if it deems that a third party is liable, require that the Insured Person sign, if applicable, an act of subrogation in its favor at the time of paying any benefits.

Insured Right of Access

As required by your provincial legislation, the Insured Person and any claimant may request a copy of the Insured Person's application, any written evidence of insurability and the Group Policy (other than confidential commercial information or other information exempted from disclosure by applicable law).

For further plan information please contact your plan administrator.

Member Mandatory Accidental Death or Dismemberment Insurance Exclusions

This policy does not cover any Loss, fatal or non-fatal, caused or contributed to by:

- (a) suicide or intentionally self-inflicted Injury while sane or insane other than as provided in section -Suicide Death Indemnity;
- (b) war or civil war, whether declared or undeclared;
- (c) active full-time, part-time, or temporary service in the armed forces of any country;
- (d) riding as a passenger or otherwise in any vehicle or device for aerial navigation, other than as provided in section - Aircraft Coverage;
- (e) medical treatment or Surgery, except as needed due to an Accident.

This policy does not cover any of the following supplies or services or costs thereof:

- (a) expenses paid or payable under any government/group hospital, medical, dental or health care plan, or expenses for which insurance is prohibited by law;
- (b) expenses incurred outside of Canada with respect to Insured Persons who are international students except for expenses incurred for an Injury that occurs while on a trip to the United States of America for which coverage applies under Section – Description of Coverage.

HOW TO CLAIM

In the event of a claim, contact your Health Plan Administrator at your Student Union Office to have a Notice of Claim form completed. The Notice of Claim form must be forwarded to Green Shield Canada for confirmation of coverage prior to submission to the carrier.

Notice of claim must be given to the Insurer within 30 days from the date of the occurrence, and subsequent proof of claim must be submitted to the insurer within 90 days from the date of the accident.

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

This summary of coverage has been prepared in connection with a group plan administrator.. For ease of reference, it contains only a brief description and does not mention every provision of the contract issued. Please remember that rights and obligations are determined in accordance with the contract and not this summary of information. For the exact provisions applicable, please consult your Health Plan Administrator at your Student Union Office.