MY BENEFIT PLAN BOOKLET

DHL Global Forwarding

Classification: Salaried Employees

Billing Division: 300

Effective Date: January 1, 2013

WELCOME TO YOUR HEALTH AND DENTAL BENEFIT PLAN

ABOUT THIS BOOKLET

This booklet contains important information you will need about your group benefits with **DHL Global Forwarding**, your plan sponsor, available through the group contract with Green Shield. 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-pay 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.

You will receive Identification Card(s) showing your Green Shield Identification Number to be used on all claims and correspondence. Your number will appear on the front of the card and end in -00, while each of your dependents with their numbers will be shown on the back.

PLAN MEMBER ONLINE SERVICES

In addition to this booklet and our Customer Service Centre, we also provide you with access to our secure website. Our website will answer those questions most often asked and give you online access to the following:

- A Benefit Plan Booklet
- Printer friendly personalized claim forms
- Benefit eligibility information, such as the date you are eligible for your next dental recall exam
- Explanation of Benefits information and claim history for you and your dependents
- Claim history for tax purposes or Co-ordination of Benefits
- Request your claim payments to be directly deposited into your bank account*
- And much more

Register online at greenshield.ca and see what our website can do for you!

*Please note that once arrangements have been made for Direct Deposit, claim payments will be deposited directly into the bank account you have chosen. Statements will no longer be mailed to you but will be available for online viewing.

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SCHEDULE OF BENEFITS

This schedule describes the Deductible, Co-pay and Maximums that may be applicable if you are a Salaried employee.

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 based on paid Canadian dollars. **You are covered for only those specific benefits for which you have applied**.

DHL Global Forwarding offers a choice of four Health Options as noted below. Each Option represents a different level of coverage. Please refer to the Eligibility section of this booklet for further information on enrollment and election rules for choosing your Option.

This group benefit plan is intended to supplement your provincial health insurance plan. The benefits shown below will be eligible, if they are reasonable and customary, and are medically necessary for the treatment of an illness or injury.

For the Travel Benefit
Hospital and medical services are eligible only if your provincial health insurance plan provides payment toward the cost of incurred services.

Reimbursement of eligible benefits for emergency services will be made only if the services were required as a result of emergency illness or injury that occurred while you were vacationing or traveling for other than health reasons.

Deductible (Option 2 only):	$25 per covered person, $50 per family, per calendar year (not applicable to Travel, Prescription Drugs or Vision expenses)	**Overall Maximum:**	Unlimited per covered person per calendar year

Your plan covers:	**Option 1**	**Option 2**	**Option 3**	**Option 4**
Travel Benefit	• Your co-pay is 0%	• Your co-pay is 0%	• Your co-pay is 0%	• Your co-pay is 0%
• Maximum Number of Days per Trip	• 60 days	• 60 days	• 60 days	• 60 days
• Emergency Services	• Unlimited maximum	• Unlimited maximum	• Unlimited maximum	• Unlimited maximum
• Referral Services	• $50,000 lifetime maximum	• $50,000 lifetime maximum	• $50,000 lifetime maximum	• $50,000 lifetime maximum
Prescription Drugs – Pay Direct Drug Card (Generic Plan)	Not covered	• Your co-pay is 30% plus any dispensing fee charge in excess of $6 per prescription or refill	• Your co-pay is 20% plus any dispensing fee charge in excess of $6 per prescription or refill	• Your co-pay is any dispensing fee charge in excess of $6 per prescription or refill
• Fertility drugs		• $6,000 lifetime maximum	• $6,000 lifetime maximum	• $6,000 lifetime maximum
• Smoking Cessation drugs		• $125 lifetime maximum	• $125 lifetime maximum	• $125 lifetime maximum
• Erectile Dysfunction drugs		• $1,000 per calendar year maximum	• $1,000 per calendar year maximum	• $1,000 per calendar year maximum

Your plan covers:	Option 1	Option 2	Option 3	Option 4
• All other drugs		• Unlimited maximum	• Unlimited maximum	• Unlimited maximum
Hospital Accommodation • Public general hospital or convalescent or rehabilitation hospital – semi-private room • Public general hospital or convalescent or rehabilitation hospital – private room • Public chronic hospital – semi-private room	Not covered	• Your co-pay is 0% • Reasonable & customary charges Not covered • $3 per day to a maximum of 120 days per calendar year	• Your co-pay is 0% • Reasonable & customary charges Not covered • $3 per day to a maximum of 120 days per calendar year	• Your co-pay is 0% • Reasonable & customary charges • Reasonable & customary charges • $3 per day to a maximum of 120 days per calendar year
Audio • Non-conventional hearing aids • Conventional hearing aids	Not covered	Not covered	• Your co-pay is 0% • $2,400 maximum every 12 months per ear, based on date of first paid claim • Reasonable and customary charges	• Your co-pay is 0% • $2,400 maximum every 12 months per ear, based on date of first paid claim • Reasonable and customary charges
Medical Items and Services **Footwear** • Custom made boots or shoes • Custom made orthotics and stock item orthotics • Optometric eye exams • Diagnostic tests, Laboratory tests and X-rays • Other items and services – see the Description of Benefits section for details	Not covered	• Your co-pay is 30% • $250 per calendar year • $200 combined maximum every 2 calendar years for covered persons aged 18 and over (every calendar year for covered persons aged 17 and under) • Once every 2 years based on date of first paid claim, subject to a maximum of $80 • $500 per calendar year • Reasonable and customary	• Your co-pay is 0% • $250 per calendar year • $200 combined maximum every 2 calendar years for covered persons aged 18 and over (every calendar year for covered persons aged 17 and under) • Once every 2 years based on date of first paid claim, subject to a maximum of $80 • $500 per calendar year • Reasonable and customary	• Your co-pay is 0% • $250 per calendar year • $200 combined maximum every 2 calendar years for covered persons aged 18 and over (every calendar year for covered persons aged 17 and under) • Once every 2 years based on date of first paid claim, subject to a maximum of $80 • $500 per calendar year • Reasonable and customary
Emergency Transportation	Not covered	• Your co-pay is 30% • Reasonable and customary charges	• Your co-pay is 0% • Reasonable and customary charges	• Your co-pay is 0% • Reasonable and customary charges

Your plan covers:	Option 1	Option 2	Option 3	Option 4
Private Duty Nursing in the Home	Not covered	• Your co-pay is 20% • $10,000 every 3 calendar years	• Your co-pay is 0% • $10,000 every 3 calendar years	• Your co-pay is 0% • $10,000 every 3 calendar years
Professional Services	Not covered			
• Chiropractor • Registered Massage Therapist • Naturopath • Osteopath • Speech Therapist • Chiropodist/Podiatrist • Acupuncturist • Christian Science Practitioner • Psychologist		• Your co-pay is 20% • $300 per calendar year per practitioner	• Your co-pay is 0% • $300 per calendar year per practitioner	• Your co-pay is 0% • $500 per calendar year per practitioner
• Physiotherapist		• Your co-pay is 20% • Unlimited maximum	• Your co-pay is 0% • Unlimited maximum	• Your co-pay is 0% • Unlimited maximum
• Social Worker/Counselor (Quebec residents only)		• Your co-pay is 50% • $300 per calendar year (combined with the services of a Psychologist)	• Your co-pay is 50% • $300 per calendar year	• Your co-pay is 50% • $300 per calendar year
Accidental Dental	Not covered	• Your co-pay is 20% • $5,000 per accident	• Your co-pay is 0% • $5,000 per accident	• Your co-pay is 0% • $5,000 per accident
Vision • Prescription eye glasses or contact lenses, or medically necessary contact lenses, or laser eye surgery	Not covered	• Your co-pay is 0% • $150 per 24 consecutive months based on date of first paid claim	• Your co-pay is 0% • $200 per 24 consecutive months based on date of first paid claim	• Your co-pay is 0% • $300 per 24 consecutive months based on date of first paid claim

SCHEDULE OF BENEFITS — DENTAL BENEFIT PLAN

This schedule describes the Deductible, Co-pay and Maximums that may be applicable if you are a Salaried employee.

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 based on paid Canadian dollars. **You are covered for only those specific benefits for which you have applied**.

DHL Global Forwarding offers a choice of four Dental Options as noted below. Each Option represents a different level of coverage. Please refer to the Eligibility section of this booklet for further information on enrollment and election rules for choosing your Option.

Deductible:	Nil
Fee Guide:	The current Provincial Dental Association Fee Guide for General Practitioners in the province where services are rendered For Alberta, with no fee guide, reimbursement will be according to a fee schedule established by Green Shield for that province

Your plan covers:	**Option 1**	**Option 2**	**Option 3**	**Option 4**
Basic Services and Comprehensive Basic Services	Not covered	• Your co-pay is 25% • Unlimited maximum per covered person per calendar year	• Your co-pay is 0% • Unlimited maximum per covered person per calendar year	• Your co-pay is 0% • Unlimited maximum per covered person per calendar year
Major Services	Not covered	Not covered	• Your co-pay is 50% • $2,000 per covered person per calendar year (Major Services and Denture Adjustments) combined	• Your co-pay is 50% • Unlimited maximum per covered person per calendar year
Orthodontic Services	Not covered	Not covered	Not covered	• Your co-pay is 50% • $2,500 per covered person per lifetime, for dependent children 20 years of age and under only

Predetermination

It is highly recommended that before your treatment begins:

- for all proposed treatment for crowns, onlays and bridges, an estimate completed by your dental practitioner, **must** be submitted for assessment. Our assessment of the proposed treatment, may result in a lesser benefit being payable or may result in benefits being denied. Failure to submit an estimate prior to beginning your treatment will result in the delay of the assessment.
- if the total cost of any other proposed treatment is expected to exceed $300, it is recommended that you submit an estimate completed by your dental practitioner.

DEFINITIONS

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

Allowed amount means**,** as determined by Green Shield:

a) Drugs – the Green Shield 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 provincial dental association fee guide for general practitioners as specified in the Schedule of Benefits.

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

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

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

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

Custom made boots or shoes means footwear used for 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. (These shoes are 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 calendar 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 any age, if totally disabled by reason of mental or physical disability and remains continuously so disabled and is considered a dependent as defined under the Income Tax Act.

Your child (you 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.

DEFINITIONS

Children who are in full-time attendance at an accredited school do not have to reside with you or attend school in your province. If the school is in another province, you must apply to your provincial health insurance plan for an extension of coverage to ensure your child continues to be covered under a provincial health insurance plan. (Please note that the limitations of the Travel plan still apply).

Emergency means a sudden, unexpected occurrence (disease or injury) that requires immediate medical attention. This includes treatment (non-elective) for immediate relief of severe pain, suffering or disease that cannot be delayed until you or your dependent is medically able to return to your province of residence.

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

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

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

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

Reasonable and customary means in the opinion of Green Shield, 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.

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

Stock item footwear means any mass-produced foot care item that is sold over-the-counter and is readily available without any modifications.

ELIGIBILITY

For you
To be eligible for coverage, you must be:

a) a plan member who is a resident of Canada;
b) covered under your provincial health insurance plan; and
c) actively at work and working a minimum of 25 hours per week on a regular basis.

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.

You will be eligible for coverage on the first day following 3 months of continuous active employment.

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

Enrollment
The enrollment process begins when you receive a letter from Human Resources. You are eligible to elect Option 1, 2, 3 or 4 under the Health*, Vision, Travel* and Dental benefits. Option 1 is mandatory if no other Options are elected.

* Residents of Quebec must choose Health and Travel Option 2, 3 or 4 if they are under age 65 unless covered by a spousal plan.

If you choose to opt out of coverage for Vision and/or Dental benefits, then elect coverage at a later date, you must elect Option 2. Once you are enrolled for coverage, you may only move up or down one Option per year and you can only opt out by moving down to Option 2 first, and then you are eligible to opt out of coverage.

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

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

Re-enrollment
On January 1 of each year you are eligible to change Options. You may also elect to change Options within 31 days of a change in life event.

ELIGIBILITY

Change in Life Event

A change in Life Event occurs when:

1. you acquire a dependent
2. you have a change in marital status
3. your spouse's coverage ceases involuntarily
4. any dependent ceases to qualify as a dependent, or
5. any dependent dies

Termination

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

a) the date your employment ends;
b) the date you are no longer actively working;
c) the date you attain age 65 for the Travel Benefit and for Private Duty Nursing under the Health Benefit;
d) the end of the period for which rates have been paid to Green Shield for your coverage;
e) 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 first of the month following the date 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.

Survivor Continuation of Coverage
(not applicable to Health Care Spending Account)

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

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

Group Conversion - PRISM CONTINUUM® Program

The PRISM CONTINUUM® Program offers three plans that are focused on providing coverage for you if you are leaving a company group plan.

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

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

DESCRIPTION OF BENEFITS

HEALTH BENEFIT PLAN

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

Prescription Drugs
Prescription drug benefits, up to the amount shown in the Schedule of Benefits, that
a) are prescribed by a legally qualified medical practitioner or dental practitioner as permitted by law;
b) legally requires a prescription; and
c) is paid on a Pay Direct basis.

If approved by Green Shield, this plan includes drugs that do not legally require a prescription, including insulin and all other approved injectibles, as well as related supplies such as diabetic syringes, needles and testing agents.

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

In no event will the amount dispensed exceed a three-month supply (six months if a vacation supply is required) of a prescription at any one time and not more than a 13-month supply in any 12 consecutive months.

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 **is** an eligible benefit.

Quebec residents only: Legislation requires Green Shield to follow the RAMQ (The Regie de l'assurance maladie du Quebec) reimbursement guidelines for all residents of Quebec. If you are younger than age 65, you must enroll for the Green Shield Prescription Drugs benefit plan and Green Shield will be the only payor. If you are age 65 or older, enrollment in RAMQ is automatic, enrollment in the Green Shield Prescription Drugs benefit plan is optional, and RAMQ would be first payor.

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

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

a) 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, excluding smoking cessation products;

b) 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;
c) Mixtures, compounded by a pharmacist, that do not conform to Green Shield's current Compound Policy.

Extended Health Services

1. **Hospital Accommodation:** Reimbursement, as shown in the Schedule of Benefits, of reasonable and customary charges in the area where received, for accommodation in a public general hospital, or a convalescent or rehabilitation hospital or a convalescent or rehabilitation wing in a public general hospital, or a public chronic hospital or chronic care in a public general hospital, provided your provincial health insurance plan has accepted or agreed to pay the ward or standard rate.

2. **Audio:** Reimbursement for hearing aids**,** repairs or replacement parts, if recommended or approved by the attending legally qualified medical practitioner, up to the amount shown in the Schedule of Benefits. No amount will be paid for batteries.

3. **Medical Items and Services:** 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 mattress; bedpan; standard commode; decubitus supplies; I.V. stand; portable patient lift (including batteries); trapeze; urinal;
   b) Footwear:
      i) custom made foot orthotics or stock item orthotics (when prescribed by your attending physician, podiatrist or chiropodist);
      ii) custom made boots or shoes, adjustments to stock item footwear, or footwear as an integral part of a brace, (subject to a medical pre-authorization);
   c) Braces, casts;
   d) Diabetic, such as blood glucose monitors, lancets and insulin pump supplies;
   e) Medical services, such as diagnostic tests, X-rays and laboratory tests;
   f) Incontinence/Ostomy, such as catheter supplies and ostomy supplies;
   g) Mobility aids, such as cane, crutch, walker and wheelchair (including wheelchair batteries);
   h) Prosthetics, such as arm, hand, leg, foot, breast, eye and larynx;
   i) Optometric eye examinations for visual acuity performed by a licensed optometrist, ophthalmologist or physician limited to one eye exam every 2 years (available only in those provinces where eye examinations are not covered by the provincial health insurance plan);
   j) Respiratory/Cardiology, such as compressor, inhalant devices, tracheotomy supplies and oxygen;
   k) Compression stockings.

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

Limitations

a) The rental price of durable medical equipment will not exceed the purchase price. Green Shield's decision to purchase or rent will be based on the physician'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.

4. **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.

5. **Private Duty Nursing in the Home:** Reimbursement for the services of a Registered Nurse (R.N.) or Registered Practical Nurse/Licensed Practical Nurse (R.P.N./L.P.N.) in the home on a full or part shift basis, up to the amount shown in the Schedule of Benefits. No amount will be paid for services which are custodial and/or services which do not require the skill level of a Registered Nurse (R.N.) or Registered Practical Nurse/Licensed Practical Nurse (R.P.N./L.P.N.).

   A Pre-Authorization Form for Private Duty Nursing must be completed by the attending physician and submitted to Green Shield.

6. **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 Green Shield. Please contact the Green Shield Customer Service Centre to confirm practitioner eligibility.

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

7. **Accidental Dental:** Reimbursement for the services of a licensed dental practitioner for dental care 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 Green Shield immediately following the accident and the treatment must commence within 180 days of the accident.

   Green Shield 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 of residence. 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 Green Shield'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.

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

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) Replacement parts to prescription eyeglasses.

d) Laser eye surgery.

e) Plano 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:

a) Medical or surgical treatment, except for laser eye surgery;

b) Special or unusual procedures such as, but not limited to, orthoptics, vision training, subnormal vision aids and aniseikonic lenses;

c) Follow-up visits associated with the dispensing and fitting of contact lenses;

d) 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) intentionally self-inflicted injury while sane or insane;
   b) an act of war, declared or undeclared;
   c) participation in a riot or civil commotion; or
   d) committing a criminal offence;

2. Services or supplies provided while serving in the armed forces of any country;

3. Failure to keep a scheduled appointment with a legally qualified medical or dental practitioner;

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

5. Any specific treatment or drug which:
   a) does not meet accepted standards of medical, dental or ophthalmic practice, including charges for services or supplies which are experimental in nature, or is not considered to be effective (either medically or from a cost perspective, based on Health Canada's approved indication for use);
   b) is an adjunctive drug prescribed in connection with any treatment or drug that is not an eligible service;
   c) will be administered in a hospital;
   d) is not dispensed by the pharmacist in accordance with the payment method shown under the Prescription Drugs benefit;

e) is not being used and/or administered in accordance with Health Canada's approved indication for use, even though such drug or procedure may customarily be used in the treatment of other illnesses or injuries;

6. Services or supplies that:
   a) are not recommended, provided by or approved by the attending legally qualified (in the opinion of Green Shield) 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 Green Shield, your plan sponsor or you;
   d) are provided by a health practitioner whose license by the relevant provincial regulatory and/or professional association has been suspended or revoked;
   e) are not provided by a designated provider of service in response to a prescription issued by a legally qualified health practitioner;
   f) are used solely for recreational or sporting activities and which are not medically necessary for regular activities;
   g) are primarily for cosmetic or aesthetic purposes, or are to correct congenital malformations;
   h) are provided by an immediate family member related to you by birth, adoption, or by marriage and/or a practitioner who normally resides in your home. An immediate family member includes a parent, spouse, child or sibling;
   i) are provided by your plan sponsor and/or a practitioner employed by your plan sponsor, other than as part of an employee assistance plan;
   j) are a replacement of lost, missing or stolen items, or items that are damaged due to negligence. Replacements are eligible when required due to natural wear, growth or relevant change in your medical condition but only when the equipment/prostheses cannot be adjusted or repaired at a lesser cost and the item is still medically required;
   k) are video instructional kits, informational manuals or pamphlets;
   l) are for medical or surgical audio and visual treatment;
   m) are special or unusual procedures such as, but not limited to, orthoptics, vision training, subnormal vision aids and aniseikonic lenses;
   n) are delivery and transportation charges;
   o) are for Insulin pumps and supplies (unless otherwise covered under the plan);
   p) are for medical examinations, audiometric examinations or hearing aid evaluation tests;
   q) are batteries, unless specifically included as an eligible benefit;
   r) are a duplicate prosthetic device or appliance;
   s) are from any governmental agency which are obtained without cost by compliance with laws or regulations enacted by a federal, provincial, municipal or other governmental body;
   t) would normally be paid through any provincial health insurance plan, Workplace Safety and Insurance Board or tribunal, the Assistive Devices Program or any other government agency, or which would have been payable under such a plan had proper application for coverage been made, or had proper and timely claims submission been made;
   u) were previously provided or paid for by any governmental body or agency, but which have been modified, suspended or discontinued as 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 out of 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

Eligible travel benefits will be reasonable and customary charges in the area where they were received, less the amount payable by your provincial health insurance plan.

All maximums and limitations stated are 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.

Reimbursement of eligible benefits for emergency services will be made only if the services were required as a result of emergency illness or injury that occurred while you were vacationing or travelling for other than health reasons.

Upon notification of the necessity for treatment of an accidental injury or medical emergency, **the patient must contact Green Shield Canada Travel Assistance within 48 hours of commencement of treatment.**

> **Emergency means** a sudden, unexpected occurrence (disease or injury) that requires immediate medical attention. This includes treatment (non-elective) for immediate relief of severe pain, suffering or disease that cannot be delayed until you or your dependent is medically able to return to your province of residence.
>
> Any invasive or investigative procedures must be pre-approved by our Green Shield Canada Assistance Medical Team.

Eligible benefits are limited to a maximum of **60** days per trip commencing with the date of departure from your province of residence. If you are hospitalized on the **60th** day, benefits will be extended until the date of discharge.

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

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

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

4. **Referral services** – (a) hospital services and accommodation, up to a standard ward rate in a public general hospital, and/or (b) medical surgical services rendered by a legally qualified physician or surgeon;

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

5. **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 Green Shield Canada Travel Assistance the original paid receipt from the pharmacist, physician or hospital outside your province of residence showing the name of the prescribing physician, prescription number, name of preparation, date, quantity and total cost;

6. **Cost of returning your personal use motor vehicle** to your residence or nearest appropriate vehicle rental agency when you are unable to due to sickness, physical injury or death. We require original receipts for costs incurred, i.e. gasoline, accommodation and airfares;

7. **Transportation to the bedside** including round trip economy airfare by the most direct route from the province of residence, for any one spouse, parent, child, brother or sister, or a person with whom the covered person normally resides, 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 their province of residence, plus the written verification of the attending physician that the situation was serious enough to have required the visit;

8. **Return of deceased** covers charges incurred for the return of yourself or your covered dependent to the place of former residence in Canada;

9. **Return of covered dependent children** to their residence in Canada in the event you or your spouse are hospitalized and the children are left unattended. The children must be under 16 years of age. Arrangements for an escort to accompany the children will be made if necessary;

10. **Return Trip Delay – Transportation** covers the cost of one way economy class transportation for delay of the return trip of a covered person due to hospitalization of that person or of another covered person with whom that person is travelling;

11. **Return Trip Delay – Accommodation** covers extra costs incurred for commercial accommodation and meals for covered persons while staying with a hospitalized family member when their return trip is delayed due to an illness or accident;

12. **Convalescent Benefit** charges incurred for accommodation for covered persons requiring convalescence following hospitalization.

GREEN SHIELD CANADA TRAVEL ASSISTANCE SERVICE

The following services are available 24 hours per day, 7 days per week through Green Shield Canada'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
- Our Assistance Medical Team’s consultative and advisory services, including second opinion and review of appropriateness and analysis of the quality of medical care
- Assistance in establishing contact with family, personal physician and employer as appropriate
- Monitoring of progress during treatment and recovery
- Emergency message transmittal services

- Translation services and referrals to local interpreters as necessary
- 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
- Special assistance in replacing lost or stolen travel documents including passports
- Courtesy assistance in securing incidental aid and other travel related services
- Emergency and payment assistance for major health expenses, which would result in payments in excess of $200

How Travel Assistance Service Works

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

Quote the Green Shield Canada travel assist group number and your Green Shield Canada Identification Number, found on your Green Shield Canada Identification card, and explain your medical emergency. **You must always be able to provide your Green Shield Canada Identification Number and your provincial 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 both provincial health insurance plan coverage and Green Shield Canada travel benefits as detailed above.

The provider may then bill Green Shield Canada Travel Assistance directly for these approved services for amounts in excess of $200.

Our Assistance Medical Team will follow your progress to ensure that you are receiving the best available medical treatment. These physicians also keep 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 Green Shield Canada Travel Assistance and submit them for reimbursement upon your return to Canada.

Travel Limitations

1. Benefits will be eligible only if existing or pre-diagnosed conditions are completely stable (in the opinion of Green Shield Canada Assistance Medical Team) at the time of departure from your province of residence. Green Shield Canada reserves the right to review your medical information at the time of claim;

2. The eligible benefits must be required for the immediate relief of acute pain or suffering as recommended by a legally qualified physician or surgeon. Eligible benefits will not be reimbursed for treatment or surgery that could reasonably be delayed until you return to your province of residence;

3. Reimbursement for eligible benefits will be made only if your provincial health insurance plan covers and provides payment toward the cost of the services received;

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

5. Upon notification of the necessity for treatment of an accidental injury or medical emergency, Green Shield Canada's Assistance Medical Team reserves the right to determine whether repatriation is appropriate if the patient's medical condition will require immediate or scheduled care. Such repatriation is mandatory, where the Assistance Medical Team determines that the patient is medically fit to travel and appropriate arrangements have been made to admit the patient into the provincial government health care system of their province of residence. Repatriation will ensure continued coverage under the plan. Should the patient opt not to be repatriated or elects to have such treatment or surgery outside their province of residence, the expense of such continuing treatment will not be an eligible benefit;

   The patient must contact Green Shield Canada 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;

6. Air ambulance services will only be eligible if:
   - they are pre-approved by Green Shield Canada 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, and
   - you or your dependent are admitted directly to a hospital in your province of residence, and
   - medical reports or certificates from the dispatching and receiving legally qualified physicians are submitted to Green Shield Canada Travel Assistance, and
   - proof of payment (including air ticket vouchers or air carrier invoices) is submitted to Green Shield Canada Travel Assistance;

7. If planning to travel in areas of political or civil unrest, contact Green Shield Canada Travel Assistance for pre-travel advice, as we may be unable to guarantee assistance services;

8. Green Shield Canada reserves the right, without notice, to suspend, curtail or limit its services in any area in the event of political or civil unrest, including rebellion, riot, military uprising, labour disturbance or strike, act of God, or refusal of authorities in a foreign country to permit Green Shield Canada to provide service;

9. No services will be provided during any trip undertaken for the purpose of seeking medical treatment or advice unless pre-authorized as outlined in referral services.

Travel Exclusions
Eligible Benefits do not include and reimbursement will not be made for:

1. Treatment or services required for ongoing care, rest cures, health spas, elective surgery, check-ups or travel for health purposes, even if the trip is on the recommendation of a physician;

2. Treatment or service that you elect to have performed outside Canada when the medical condition would not prevent your return to Canada for such treatment;

3. Amounts paid or payable under any Workplace Safety and Insurance Board or similar plan;

4. Hospital and medical care for childbirth occurring within 8 weeks of the expected delivery date from the date of departure, or deliberate termination of pregnancy;

5. Treatment or service provided in a chronic care or psychiatric hospital, chronic unit of a general hospital, Long Term Care (LTC) facility, health spa, or nursing home;

6. Services received from a chiropractor, chiropodist, podiatrist, or for osteopathic manipulation;

7. Cataract surgery or the purchase of eyeglasses or hearing aids;

8. Green Shield Canada 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 Green Shield Canada Travel Assistance;

9. Services or supplies received as a result of disease, illness or injury due to:
   a) intentionally self-inflicted injury while sane or insane;
   b) an act of war, declared or undeclared;
   c) participation in a riot or civil commotion; or
   d) committing a criminal offence.

DESCRIPTION OF BENEFITS

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.

Predetermination
Before your treatment begins:
- for all proposed treatment for crowns, onlays and bridges, an estimate completed by your dental practitioner, **must** be submitted for assessment. Our assessment of the proposed treatment, may result in a lesser benefit being payable or may result in benefits being denied. Failure to submit an estimate prior to beginning your treatment will result in the delay of the assessment.
- if the total cost of any other proposed treatment is expected to exceed $300, it is recommended that you submit an estimate completed by your dental practitioner.

Basic Services
1. Basic Diagnostic and Preventive Services:
    - complete oral examinations, once every 2 years
    - emergency and specific oral examinations
    - full series X-rays and panoramic X-rays, once every 2 years
    - bitewing X-rays:
        - once every 6 months for Option 3 and Option 4
        - once every 9 months for Option 2
    - recall examinations:
        - once every 6 months for Option 3 and Option 4
        - once every 9 months for Option 2
    - cleaning of teeth (up to 1 time unit of polishing plus up to 1 time unit of scaling) once per recall examination period
    - topical application of fluoride once per recall examination period
    - oral hygiene instruction once per recall examination period
    - denture cleaning once per recall examination period
    - pit and fissure sealants on permanent molars only, for dependent children 14 years of age and under
    - space maintainers
    - mouth guards once every 12 months

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

3. Basic oral surgery:
    - extractions of teeth and/or residual roots

4. Anaesthesia and intravenous sedation in conjunction with eligible oral surgery only

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

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

Comprehensive Basic Services

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

2. Periodontal treatment of diseased bone and gums including:
   - periodontal scaling and/or root planing 11 time units per calendar year
   - occlusal equilibration - selective grinding of tooth surfaces to adjust a bite 2 time units per calendar 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 12 months

Major Services

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

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

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

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

Orthodontic Services

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

When a lump sum fee has been paid toward orthodontic treatment, the total amount of the claim will be split into equal portions to include the initial fee and a monthly fee and will be reimbursed over the duration of the treatment.

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

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

Limitations
1. Laboratory charges must be completed in conjunction with other services and will be limited to the co-pay of such services. Laboratory charges that are in excess of 40% of the dentist's fee in the current General Practitioners Fee Guide 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. When more than one surgical procedure is performed during the same appointment in the same area of the mouth, only the most comprehensive procedure will be eligible for reimbursement;

4. 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 General Practitioners Fee Guide;

5. Reimbursement for root canal therapy will be limited to payment once only per tooth. The total fee for root canal includes all pulpotomies and pulpectomies performed on the same tooth;

6. 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;

7. The benefits payable for multiple restorative services in the same quadrant performed at one appointment may be reduced by 20% for all but the most costly service in the quadrant;

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

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

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

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

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

2. Services or supplies provided while serving in the armed forces of any country;

3. Failure to keep a scheduled appointment with a legally qualified dental practitioner;

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

5. Any dental service that is not contained in the procedure codes developed and maintained by the Canadian Dental Association, adopted by the provincial or territorial dental association of the province or territory in which the service is provided (or your province of residence if any dental service is provided outside Canada) and in effect at the time the service is provided;

6. Implants;

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

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

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

10. Service and charges for sleep dentistry;

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

12. Any specific treatment or drug which:
    a) does not meet accepted standards of medical, dental or ophthalmic practice, including charges for services or supplies which are experimental in nature, or is not considered to be effective (either medically or from a cost perspective, based on Health Canada's approved indication for use);
    b) is an adjunctive drug prescribed in connection with any treatment or drug that is not an eligible service;
    c) will be administered in a hospital;
    d) is not dispensed by the pharmacist in accordance with the payment method shown under the Health Benefit Plan Prescription Drugs benefit;
    e) is not being used and/or administered in accordance with Health Canada's approved indication for use, even though such drug or procedure may customarily be used in the treatment of other illnesses or injuries;

13. Services or supplies that:
    a) are not recommended, provided by or approved by the attending legally qualified (in the opinion of Green Shield) 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 Green Shield, 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 out of a motor vehicle accident;
       Note: Payment of benefits for claims relating to automobile accidents for which coverage is available under a motor vehicle liability policy providing no-fault benefits will be considered only if–
       i) the service or supplies being claimed is not eligible; or
       ii) the financial commitment is complete;
       A letter from your automobile insurance carrier will be required;
    q) are cognitive or administrative services or other fees charged by a provider of service for services other than those directly relating to the delivery of the service or supply.

HEALTH CARE SPENDING ACCOUNT (HCSA)

Your Health Care Spending Account is provided by your plan sponsor and administered by Green Shield.

It pays for expenses that qualify as a Medical Expense Tax Credit under the Income Tax Act of Canada.

You can claim for reimbursement of eligible expenses. An eligible expense would be –

a) a deductible expense on your income tax return, as outlined in the Income Tax Act regulations and Canada Revenue Agency (CRA) interpretation bulletins; and
b) an item for which you are not receiving benefits coverage under a provincial health insurance plan or under your group benefit plan or your spouse's group benefit plan.
(This means you can be reimbursed for the amount of the deductible, the percentage not covered by the group benefit plan, or the amount in excess of group benefit plan maximums.)

Dependent means your eligible dependent as defined under Definitions in this booklet. In addition, your eligible dependent is a relative who is a Canadian resident and dependent on you for support and for whom you are claiming a tax deduction on your federal tax return. The definition of an eligible dependent is governed at all times by the rules and regulations of the Canadian Income Tax Act.

Your HCSA is an account, established by your plan sponsor, under which a predetermined lump sum amount will be allocated to your account at the beginning of each benefit year. Your benefit year runs from January 01 to December 31.

A predetermined lump sum amount as determined by your plan sponsor will be allocated to your account to cover the reimbursement of your eligible expenses incurred during that benefit year. When you submit a claim, you will be reimbursed for eligible expenses up to the balance in your account.

Any balance remaining in your account on the last day of the benefit year will be forfeited at the expiration of the benefit year in which it was allocated. However, any expense incurred during the benefit year and not reimbursed as a result of insufficient credits at the end of the benefit year, may be resubmitted to be reimbursed from credits received in the following benefit year.

ELIGIBLE EXPENSES

Eligible expenses are those that would qualify as a medical expense tax credit under the Income Tax Act of Canada and outlined in the Income Tax Act regulations and CRA Interpretation Bulletins. This would not include an expense for which you or your dependent is eligible for reimbursement under a group benefit plan or provincial health insurance plan.

Following is an overview of many of the items included in CRA Interpretation Bulletin IT-519R2 "Medical Expense and Disability Tax Credits and Attendant Care Expenses Deduction" of the Income Tax Act, and is subject to change.

- Out-of-pocket expenses not reimbursed through your group benefit plan. This would be any applicable deductible, benefit percentage or amounts exceeding any applicable benefit plan maximums
- Fees for Professional Services, such as -
acupuncturist (qualified medical practitioner), chiropodist (podiatrist), chiropractor, Christian Science practitioner, dentist, naturopath, nurse, optometrist, physician, physiotherapist, psychologist (when licensed by the province to provide therapy or rehabilitation), speech therapist (for pathological or audiological impediments), therapeutist (therapist). (Medical practitioners must be registered in the jurisdiction in which the services are rendered.)
- Fees for Dental Care services, such as - diagnostic, preventive, endodontics, periodontics, restorative and orthodontics

HEALTH CARE SPENDING ACCOUNT

- Drugs and medicines (preparations or substances) prescribed by medical practitioner, including over-the-counter drugs
- Eyeglasses and contact lenses or other devices for the treatment or correction of a vision defect, as prescribed by a licensed medical practitioner or optometrist
- Fees paid to a public or licensed private hospital (as defined in the Income Tax Act)
- Fees paid for facilities and services, such as -
  - care in a nursing home; a self-contained domestic establishment; or a special school, institution or other place required by reason of a mental or physical handicap
  - care of a person who has been certified to be mentally incompetent; or a blind person
  - full-time attendants or care in a nursing home (for those confined to a bed or wheelchair)
- Ambulance fees for transportation to or from hospitals
- Fees paid for Medical Equipment and Devices, which are prescribed by a medical practitioner, such as -
  - Artificial eye; limb; artificial kidney machine (including reasonable installation, home alteration and operating costs)
  - Blood sugar level measuring devices for diabetes
  - Brace for a limb
  - Colostomy and ileostomy pads
  - Crutches
  - Diapers, disposable briefs, catheters, catheter trays, tubing or other products required by persons who are incontinent on account of illness, injury or affliction
  - Heart monitoring or pacing devices
  - Hospital bed (when required at home)
  - Needles and syringes
  - Wheelchair
  - Wigs made to order and required as a result of abnormal hair loss due to disease, accident or medical treatment
  - Power-operated lift designed exclusively for use by disabled individuals (to allow access to different levels of a building, to assist in gaining access to a vehicle, or to place wheelchairs in or on a vehicle)
  - Device designed to assist a person in entering or leaving a bathtub or shower, or getting on or off the toilet
  - Devices designed exclusively to enable an individual with a mobility impairment to operate a vehicle
  - Device to aid the hearing of a deaf person
  - Electronic speech synthesizers that enable mute individuals to communicate using a portable keyboard
  - Synthetic speech systems, Braille printers and large print-on-screen devices that enable blind persons to utilize computers
  - Monitors which can be attached to babies identified as being prone to sudden infant death syndrome and which sound an alarm when the baby stops breathing
  - Hearing aids
- Other Eligible Expenses include –
  - Premiums paid to a private insurer for medical or hospital coverage
  - Costs of acquisition, care and maintenance (including food and veterinarian care) of a dog specially trained to assist a person who is blind, deaf, or severely impaired in the use of arms or legs
  - Costs of arranging and having a bone marrow or organ transplant, including legal fees, insurance premiums, travel, meal and accommodation expenses
  - Reasonable home renovations for persons who lack normal physical development or who have severe and prolonged mobility impairment, to enable them to be mobile and functional within the dwelling

HEALTH CARE SPENDING ACCOUNT

A complete listing of eligible expenses can be found in the CRA Interpretation Bulletin IT-519R2, "Medical Expense and Disability Tax Credits and Attendant Care Expense Deduction" as amended from time to time. This is available on the Internet site at www.cra-arc.gc.ca/E/pub/tp/it519r2-consolid/README.html. For additional information, you can consult a CRA office or call the Green Shield Customer Service Centre at 1.888.711.1119.

Exclusions

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

a) premiums paid to provincial medical or hospitalization plans; and
b) medical costs for which the person is reimbursed or is entitled to be reimbursed.

The HCSA is at all times governed by the non-eligible expenses, restrictions and limitations set forth in the Income Tax Act.

Maternity, Adoption or Parental Leave

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

Only expenses incurred prior to the date of termination of employment, retirement, death, or leave of absence greater than 30 days (other than a Maternity, Adoption or Parental Leave) will be eligible for reimbursement.

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

CLAIM INFORMATION

Inquiries

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

- Call our Customer Service Centre at 1.888.711.1119 to determine eligibility for a specific item or service and Green Shield'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

When submitting a claim to Green Shield, you must show the Green Shield Identification Number for the person who has received the benefit. You can find the applicable Green Shield Identification Number for yourself and each of your dependents listed on your Green Shield Identification Card. Original itemized paid receipts are required for claims reimbursement (cash receipts or credit card receipts alone are not acceptable as proof of payment).

For **claims reimbursement** forward an original itemized paid receipt **(cash receipts or credit card receipts alone are not acceptable)** including:

- Covered person's name, address and Green Shield Identification Number
- Provider's name and address
- Date of service (this is the date of pick up)
- Charges for each service or supply
- A detailed description of the service or supply
- Medical referral/physician prescription when required
- For Audio, a copy of audiogram and details of provincial funding, if applicable
- For Hospital, admission and discharge dates; daily accommodation charges; number of days in preferred accommodation

For dental claims, forward a dental claim form, completed by both the plan member and the dentist. If your claim is the result of an accident, a Dental Accident Report Form and your dental X-rays must be submitted to Green Shield for prior approval. Failure to comply may result in non-payment.

For Health Care Spending Account (HCSA), forward a HCSA claim form and indicate on the claim form if you want your eligible expenses paid from your Green Shield health and/or dental plan first, and any unpaid portion of your eligible expenses paid from your HCSA. These claims must first be submitted to any provincial health insurance, or any private health care plan you may have (including another Green Shield plan, spousal plan, etc.).

When Green Shield is identified as a secondary carrier, submit the original Explanation of Benefits statement from the primary carrier and a copy of the claim form in order to receive any balances owing.

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

All HCSA claims must be received by Green Shield no later than 365 days after the end of the benefit year or immediately after your termination date, your retirement date, your date of death, or the date of your leave of absence greater than 30 days (other than a Maternity, Adoption or Parental Leave).

CLAIM INFORMATION

SUBMIT ALL CLAIM FORMS TO:
GREEN SHIELD CANADA

Attn: Drug Department	PO Box 1652	Windsor, ON	N9A 7G5
Attn: Medical Items	PO Box 1623	Windsor, ON	N9A 7B3
Attn: Professional Services	PO Box 1699	Windsor, ON	N9A 7G6
Attn: Hospital/Vision Department	PO Box 1615	Windsor, ON	N9A 7J3
Attn: Out-of-Country Department	PO Box 1606	Windsor, ON	N9A 6W1
Attn: Dental Department	PO Box 1608	Windsor, ON	N9A 7G1

Reimbursement
Reimbursement will be made by one of the following methods:

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

All 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.

Direct Payment to the Provider of Service (where applicable)
(not applicable to Health Care Spending Account)
Present your Green Shield Identification Card to your provider and, after you pay any applicable co-payment, they may bill Green Shield 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.

Emergency Travel
Green Shield Travel Assistance must be contacted by phone within 48 hours of commencement of treatment.

Call our Customer Service Centre at 1.888.711.1119 for detailed claims submission instructions.

If you have incurred out of pocket expenses, claims must be submitted together with supporting original receipts to Green Shield Travel Assistance who will then co-ordinate with the provincial health insurance plan reimbursement of those approved, eligible expenses.

To make a claim, submit the patient name, provincial health insurance plan number, address and Green Shield Identification Number with a detailed statement showing the services rendered and the fees charged for each service.

Subrogation
Green Shield retains the right of subrogation if benefits paid on behalf of you or your dependent are or should have been paid or provided by a third party liability. This means that Green Shield has the right to recover payment for reimbursement where you or your dependent receives reimbursement, in whole or in part, in respect of benefits or payments made or provided by Green Shield, from a third party or other coverage(s). In cases of third party liability, you must advise your lawyer of our subrogation rights.

CLAIM 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:

Green Shield Plan Member

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

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

Spouse

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

Children

When dependent children are covered under both your Green Shield 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 Green Shield 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.

PREFERRED PROVIDER VISION NETWORK ARRANGEMENT

As a Green Shield plan member, you have access to our national preferred provider vision network arrangement where all Green Shield plan members are eligible to receive a discount on eyewear and laser eye surgery.

Features of this great value-added service for either eyewear or laser eye surgery include:

1. Offer applies to any Green Shield plan member, regardless of whether you have Green Shield vision benefits or not;

2. The vision provider may bill Green Shield directly; the plan member just pays any portion of the expense not covered under their vision benefit;

3. Trustworthy retail chains with convenient locations;

4. The discount offer applies to everything such as all extra coatings, upgrades and accessories;

5. Hundreds of the latest frame styles to choose from plus the latest lens and coating technology;

6. Professional opticians to assist in selecting products;

7. Offer applies to non-disposable contact lenses (excludes disposable contact lenses).

Visit our website at greenshield.ca or call our Customer Service Centre at 1.888.711.1119 for information on the vision providers.

How to Submit Your Vision Claim

1. Present your Green Shield Identification Card as proof of being a Green Shield plan member.

2. The vision provider will apply the appropriate discount(s) to your claim and may submit the claim directly to Green Shield for payment. You pay your vision provider any balance not covered under your vision benefit.

3. If no vision benefit exists, you pay your provider the full balance owing after the applicable discounts have been applied.

OUR COMMITMENT TO PRIVACY

The Green Shield Canada 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. It consists of the following key principles:

1. **We ask for your personal information for the following purposes:**
   - To establish your identification
   - To provide you and/or your dependents with the applicable benefit coverage
   - To protect you and us from error and fraud
   - To provide ongoing access to other services at Green Shield

2. **Consent**
   When you enrolled in your group benefit plan as a plan member, your personal information was obtained and used only with your consent. We obtained your consent before we:
   - Provided benefit coverage
   - Offered you other Green Shield services
   - Obtained, used or disclosed to other persons, information about you unless we were obliged to do so by law or to protect our interests
   - Used your personal information in any way we did not tell you about previously

   Your consent can be either express or implied. Express consent can be verbal or written.

   Consent can be implied or inferred from certain actions. For our existing group and benefit plan members and their dependents, we will continue to use and disclose your personal information previously collected in accordance with our current privacy code, unless you inform us otherwise and will infer that consent has been obtained by your continued use.

3. **Withdrawal of Consent**
   You can withdraw your consent any time after you've given it to us, provided there are no legal or regulatory requirements to prevent this.

   If you don't consent to certain uses of personal information, or if you withdraw your consent, we will no longer be able to administer your benefit coverage. If so, we will explain the situation to you to help you with your decision.

   For further information on our privacy policies and procedures, please refer to the Green Shield website at greenshield.ca.