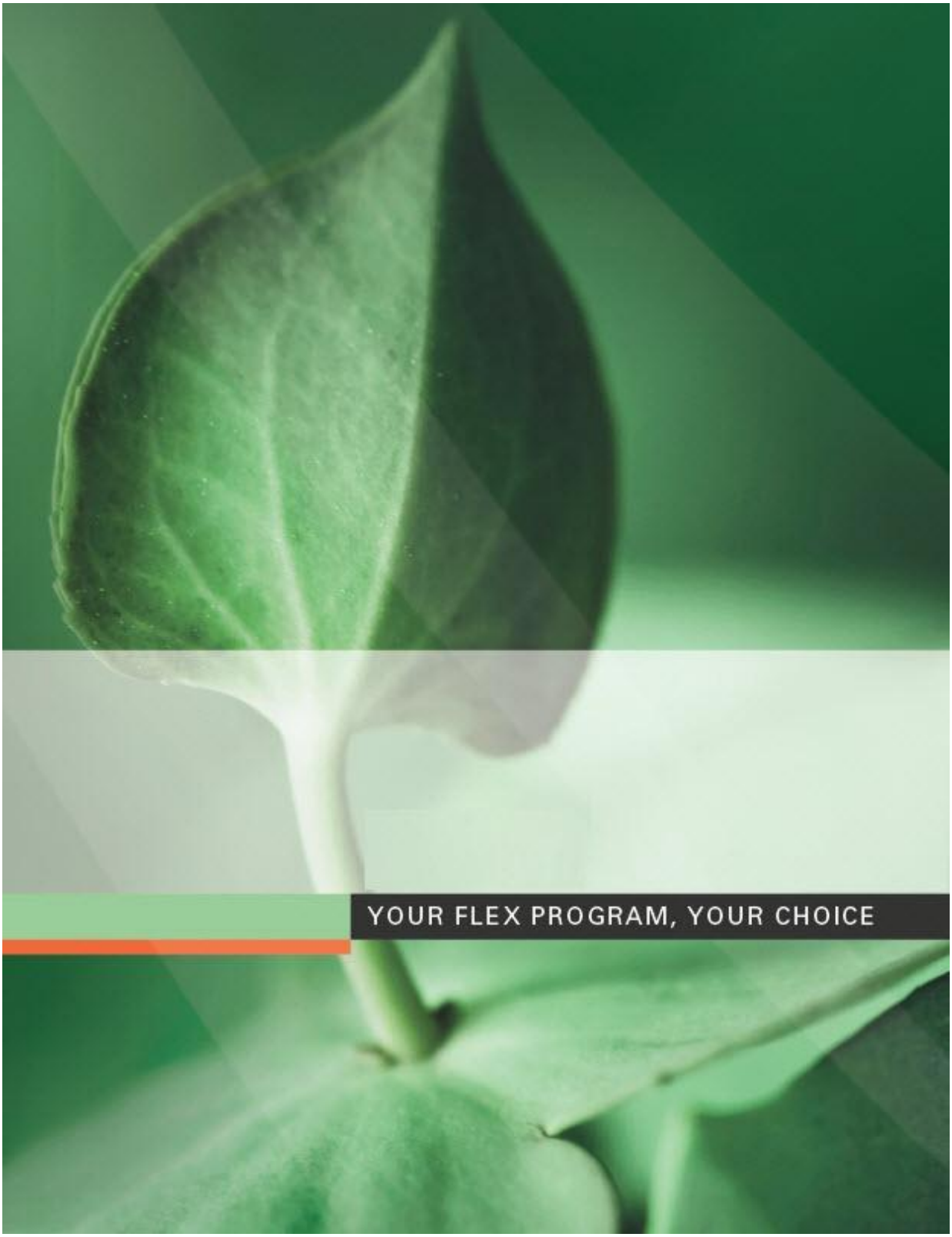
YOUR FLEX PROGRAM, YOUR CHOICE

Contents

How Your Benefits Work

Overview

Under your flexible benefits program, you can choose from a variety of options to create a plan that suits your needs.

The program includes automatic core coverage	• Your employer believes it is important to provide a base level of protection for all employees. • You will automatically receive a set level of core coverage. You receive this coverage regardless of any other choices you make. • A summary of your core coverage is available on the **How Your Benefits Work – Automatic Core Coverage** page.
You can also choose additional coverage from a variety of flexible options	• If you need them, you can choose from a wide range of additional benefits. • A summary of your flexible options is available on the **How Your Benefits Work – Flexible Coverage Options** page. • You choose the coverage that is right for you and your family
You use the online enrollment tool to select the coverage options you want	• You will use the online enrollment tool to make your selections. • Your selections are meant to last for the whole program year. • The standard program year begins January 1 and ends December 31. • You can change your options during the regular re-enrollment periods.
Each flexible coverage option has a price tag (or cost)	• Extensive coverage costs more than basic coverage. • The total cost of your flexible benefits depends on your age (in some cases), family status, and the options you choose.
Your employer gives you flex credits to help pay for your flexible benefits	• Your employer provides you with a pool of funds called flex credits to help you pay for your additional coverage. • A summary of the flex credit formula is available on the **How Your Benefits Work – Paying For Coverage** page. • You can receive additional flex credits by completing the Health Risk Assessment (HRA) questionnaire during the regular re-enrollment periods.

The online enrollment tool will allocate your flex credits for you	• The tool automatically allocates your flex credits so they pay for your flexible coverage in a tax-effective way. • If your flexible coverage costs less than your available flex credits, you can use your unallocated credits to purchase additional coverage, and/or deposit them to your Health Care Spending Account (HCSA), Group RRSP or Personal Spending Account (PSA).
You can allocate some or all of your flex credits to your HCSA	• The online enrollment tool allows you to select how much to deposit to your Health Care Spending Account (HCSA). • Because only employer funds can be used for an HCSA, the maximum you can deposit is the total number of flex credits your employer provides to you.
You may need to pay for some coverage through payroll deductions	• If your selections cost more than the flex credits you have available, you will pay for the difference through regular payroll deductions. • To keep the program tax-effective, flex credits are not used to pay for optional life insurance. You will pay for any optional life insurance you select through regular payroll deductions. • The online enrollment tool will show you what your payroll deductions (if any) will be.

You can change your options during the year only if you experience a life event	• Between regular re-enrollment periods, you can make changes **only** if your family status (single, two-person, family) changes because of:
	  ○ Marriage or reaching a common-law relationship
	  ○ Divorce, legal separation, or the end of a common-law relationship
	  ○ Birth or adoption of a first child
	  ○ Death of a dependent
	  ○ Last dependent child is no longer eligible for coverage
	  ○ Dependent child who returns to full-time studies after age 21 but before age 26.
	• You can also make changes if you:
	  ○ Involuntarily lose or gain access to coverage under your spouse's employer-sponsored group benefits program
	• You will use the online enrollment tool to make your changes.
	• You must make your changes within 31 days of the eligible event.

You will receive default coverage if you do not enroll in the program	• New employees who do not enroll within 31 days of becoming eligible will receive the following default coverage.
	  ○ Automatic core coverage
	  ○ Health care coverage (single coverage only) – level 2 for prescription drug coverage, medical services and supplies, and vision and paramedical services
	  ○ Dental care assistance (single coverage only) – level 2
	  ○ Any remaining flex credits will be allocated to your HCSA.
	• If you have a spouse and/or dependent children, they **will not be covered** if you receive default coverage.

Eligibility

To be covered by the flexible benefits program, you and your dependents must meet the following eligibility requirements.

Full and part-time employees	• Permanent employees who work at least 30 hours per week. • Permanent part-time employees who work at least 24 hours per week. • You become eligible to join the flexible benefits program immediately upon hire. There is no waiting period, except there is a 30-day waiting period for Short Term Disability.
Your spouse	• Your spouse by marriage or under any other formal union recognized by law, or • Your partner of the opposite sex or of the same sex who is publicly represented as your spouse and is an eligible dependent. You can only cover one spouse at a time.

Your dependent children	Your dependent child is eligible for coverage as long as he or she is **unmarried** and: a) Under age 21 and dependent on you; or b) Under age 26 and a full-time student at an accredited educational institute, college, or university; or c) Any age, unmarried and dependent on you because of a mental or physical disability. The disability must have begun while the child was eligible under a) or b) above. The child must be considered as a dependent as defined under the Income Tax Act.

How To Enroll

You will use the online enrollment tool to enroll in the flexible benefits program:

- When you first become eligible to join, and
- During the regular open enrollment periods.

Go to the **How Your Benefits Work – Choosing & Changing Coverage** page if you need to change your options or information at any other time.

Before using the online enrollment tool, make sure you have:

- Reviewed the benefit options available to you.
- Asked yourself the questions that appear in the "Making Your Choices" pages for your flexible coverage options.
- Reviewed your previous-year health care and dental care claims.
- Determined any anticipated health and dental care expenses for the upcoming year.
- Discussed your options with your spouse and/or dependent children.
- Discussed plan coordination with your spouse (if applicable).
- Asked questions if you need additional information.

Automatic Core Coverage

You will automatically receive a set level of core coverage. You receive this coverage regardless of any other choices you make.

Your core coverage includes:

Benefit	Coverage	Paid for by…
Basic employee life insurance	1.5 times your base salary (maximum coverage $1,000,000).	Your employer
Short-term disability insurance	Please refer to your High Liner STD policy for details	Your employer
Long-term disability insurance	70% of your monthly earnings, up to a maximum of $10,000 per month	Your employer

Flexible Coverage Options

You will also be able to choose from a wide range of additional benefits. Your flexible benefits program options include:

- Health care assistance
- Dental care assistance
- Optional life insurance
- Optional accident insurance
- Optional critical illness insurance
- Health Care Spending Account (HCSA)
- Personal Spending Account (PSA)
- Group Registered Retirement Savings Plan (RRSP).

Health & Dental Coverage Categories

When you choose your health and dental care coverage levels, you also choose one of the following coverage categories.

Single (You only)	You can choose to cover only yourself. You can pick this level of coverage even if you have an eligible spouse and/or child.
Two-person (You + one dependent)	You can choose to cover yourself and one other dependent. The dependent can be your eligible spouse or your only child.
Family (You + more than one dependent)	You can choose to cover yourself and two or more dependents. This could be you, your eligible spouse, and one or more dependent children. It could also be just you and two or more dependent children.

You must have the same coverage categories for all three components of the health care plan (prescription drug coverage, medical services and supplies, and vision and paramedical services).

You can have different coverage categories for health care and dental care assistance. Is this still true?

Choosing & Changing Coverage

Anytime changes

Remember: You must add new dependent children within 31 days of birth/adoption.

Life event changes

You can make changes to your coverage options outside of the regular open enrollment periods **only** if:

- Your family status (single, two-person, family) changes because of:
  - Marriage or reaching a common-law relationship status
  - Divorce, legal separation, or the end of a common-law relationship
  - Birth or adoption of a first child
  - Death of a dependent
  - Last dependent child is no longer eligible for coverage
  - Dependent child who returns to full-time studies after age 21 but before age 26.
- You:
  - Involuntarily lose or gain access to coverage under your spouse's employer-sponsored group benefits program

You must make your changes within 31 days of the eligible event.

Paying For Coverage

Your employer contributes to the cost of your employee benefit program by:

- Paying the cost of your automatic core benefits, and
- Providing you with a pool of funds called **flex credits** to help pay for your flexible benefits coverage options.

Determining your flex credits

Your flex credits will be allocated to you when you first enroll in the program and at each regular re-enrollment period based on:

- Your employee status (full time, part time, etc.)
- Your smoking status (smoker, non-smoker)
  - If you are a non-smoker and declare as such in the annual enrolment, you will receive $400 in additional flex credits
- Your health and dental coverage category (single, two-person, family, or opt out).

You can also receive $100 in additional flex credits by completing the voluntary online Heath Risk Assessment (HRA) questionnaire on the Green Shield website during the regular re-enrollment periods.

The online enrollment tool will show you how many credits you have.

Your flex credits will be pro-rated if you join the program for the first time outside of a regular re-enrollment period.

Spending your flex credits

Once you've selected the coverage you want using the online enrollment tool, it will total the cost of your selections and allocate your flex credits in a tax-effective order.

Your flex credits will be used to help pay for your:

- Health and dental options
- Optional accident insurance for you, your spouse, and your children
- Optional critical illness for you, your spouse, and your children.

You can also allocate your flex credits to your:

- Health Care Spending Account (HCSA)
- Group Registered Retirement Savings Plan (RRSP)
- Personal Spending Account (PSA).

If the total cost of all your coverage selections cost more than the flex credits you have available, you will pay for the difference through regular payroll deductions. The online enrollment tool will show you what your payroll deductions will be.

If the total cost of all your coverage selections costs less than the flex credits you have available, you must use your unallocated credits to purchase additional coverage, and/or deposit them to your HCSA, Group RRSP or Personal Spending Account before the online enrollment tool will let you proceed.

You can allocate as many flex credits as you want to your HCSA, PSA or RRSP up to the total amount of flex credits you receive from your employer. The number of flex credits you can allocate depends on the number of credits remaining after you've paid for all of your other coverage selections.

Flex credits and taxes

Optional life insurance:

To keep the program tax-effective, flex credits are not used to pay for optional life insurance.

You will pay for any optional life insurance you select for you, your spouse, and your children through regular payroll deductions.

Health Care Spending Account (HCSA):

If you live outside of Quebec you do not pay income tax on flex credits you deposit to an HCSA.

Group Registered Retirement Savings Plan (RRSP):

Flex credits deposited to your RRSP are earnings to you and will be added to your taxable income for tax purposes. You may claim these as a tax-deductible RRSP contribution on your annual income tax return.

Personal Spending Account (PSA):

Flex credits deposited to your Personal Spending Account are a taxable benefit to you and will be added to your taxable income for federal income tax purposes.

All other benefits:

Flex credits used to pay for any optional accident or critical illness insurance are a taxable benefit to you and will be added to your taxable income for federal income tax purposes. In Quebec, flex credits used for health care, dental care, and your HCSA are considered to be taxable income for provincial income tax purposes.

Default Coverage

New employees who do not enroll within 31 days of becoming eligible will receive the following default coverage:

- Automatic core coverage
- Based on smoker status
- Health care assistance (single coverage only) – level 2 for prescription drug coverage, medical services and supplies, and vision and paramedical services
- Dental care assistance (single coverage only) – level 2.

Any payroll deductions will be automatically deducted from your bi-weekly pay.

What Happens If…

You are receiving short-term disability benefits

Your benefits will continue while you are receiving short-term disability benefits as long as you continue to pay any required costs.

You will not be allowed to change your benefit options while receiving short-term disability benefits. If you miss a re-enrollment period while you are on leave, you will be able to re-enroll at the next scheduled re-enrollment or when you experience an eligible life event.

You are receiving long-term disability benefits

When you are receiving long-term disability benefits, some of your other benefits may continue. Contact Human Resources for more details.

If the insurer agrees to waive the cost of your coverage as a result of you meeting the waiver of premium definitions, your coverage will continue until you are no longer eligible to receive disability benefits or until you turn age 65, whichever happens first.

Your health and dental care coverage will be handled according to the internal High Liner policy. Please contact Human Resources if you have questions.

You will not be allowed to change your benefit coverage while receiving long-term disability benefits. If you miss a re-enrollment period while you are on leave, you will be able to re-enroll at the next scheduled re-enrollment or when you experience an eligible life event.

If you take a maternity/parental leave

Your benefits will be handled in accordance with High Liner Foods' internal policy and applicable provincial legislation. Please contact Human Resources for more information.

If you take a paid leave of absence

Your benefits will be handled in accordance with High Liner Foods' internal policy and applicable provincial legislation. Please contact Human Resources for more information.

If you take an unpaid leave of absence

Your benefits will be handled in accordance with High Liner Foods' internal policy and applicable provincial legislation. Please contact Human Resources for more information.

If you leave your employer

If you leave your employer, all of your benefits coverage will end on your last day of active employment.

If you leave your employer before you reach age 65, you can choose to apply for a conversion of your life insurance if you wish. You may also be eligible to convert some of your benefits to individual plans when you leave, such as accident insurance, critical illness insurance and health and dental care. Note that certain limitations will apply.

For more information on the benefits you can convert when you leave your employer, contact Human Resources.

If you retire

All coverage ends at the date of your retirement.

Your long-term disability coverage ends when you reach age 65 less the LTD waiting period.

Conversion options may apply depending on your age at retirement.

In the event of your death while working for your employer

If you die while working for your employer, your health and dental coverage may continue for your covered spouse and/or dependent children for 12 months after your death.

Tax Implications

If any employer money (including flex credits) is used to help pay for any of the following coverage or fund any applicable accounts, the cost of the coverage is a taxable benefit for you:

- basic employee life insurance
- optional accident insurance for you, your spouse, or your dependent children
- optional critical illness insurance for you, your spouse, and your dependent children
- Personal Spending Account (PSA).

Any amount your employer contributes to the above coverage and accounts will be added to your taxable income for your federal and some provincial jurisdiction taxes. The amount that your employer pays for health care assistance, dental care assistance, and some of your other benefits is generally tax-free.

If you live in Quebec, any amount that your employer pays for the following coverage is also a taxable benefit to you for provincial tax purposes:

- Health care assistance (prescription drug coverage, medical services, and vision and paramedical services)
- Dental care assistance
- Health Care Spending Account.

Residents of Ontario, Quebec and Manitoba are required to pay Provincial Retail Sales Tax (RST) on some or all insurance premiums. Where employer money is used to pay for any portion of the cost of your disability insurance, any benefits you may receive while disabled will be taxable income.

When Coverage Ends

Your flexible benefits program coverage ends at the earlier of the date you:

- Retire
- Terminate your employment
- Die
- No longer meet the eligibility requirements
- Reach the applicable termination age as shown in the following table:

Benefit	Coverage ends…
Basic employee life insurance	Reduces by 50% at age 65 Ends at age 70 or retirement
Optional life insurance for you	Ends at age 70 or retirement
Optional life insurance for your spouse	Optional coverage for your spouse will end when you retire or reach age 70, or when your spouse reaches age 70, whichever is earlier
Optional life insurance for your dependent children	When you reach age 70, retire or when the child no longer meets the definition of an eligible dependent, whichever comes first
Optional accident insurance for you or your spouse	Age 70
Optional accident insurance for your dependent children	When the child no longer meets the definition of an eligible dependent
Long-term disability insurance	Age 65 less the LTD waiting period
Optional critical illness insurance for you or your spouse	Age 70
Optional critical illness insurance for your dependent children	When you reach age 70, or when the child no longer meets the definition of an eligible dependent, whichever comes first
Health care assistance • Prescription drug coverage • Medical services and supplies • Vision and paramedical services	If you no longer work for High Liner Foods, retire, or pass away
Dental care assistance	If you no longer work for High Liner Foods, retire, or pass away
Employee and Family Assistance Program	When you are no longer an eligible member of the flexible benefits program

Coverage for your spouse or dependent children

Coverage for your spouse or your dependent children ends when you are no longer eligible to participate in the flexible benefits program or when they no longer meet the eligibility requirements.

Policy Numbers

Policy Numbers

Benefit	Carrier / Claims adjudicator	Policy number
Health care assistance • Prescription drug coverage • Medical services and supplies • Vision and paramedical services	Green Shield Canada	HLFS
Dental care assistance	Green Shield Canada	HLFS
Health Care Spending Account	Green Shield Canada	HLFS
Personal Spending Account	Green Shield Canada	HLFS
Basic employee life insurance	Sun Life Financial	43438
Optional life insurance	Sun Life Financial	43438
Optional accident insurance	SSQ Financial Group	1GS95
Short-term disability insurance	High Liner Foods	401
Long-term disability insurance	Sun Life Financial	43438
Optional critical illness insurance	SSQ Financial Group	1N400

Claims Information

How To Make Claims

How to make a claim depends on the benefit type. For example, if you are purchasing a prescription drug, simply present your prescription drug card to your pharmacist. For other health and dental claims or HCSA or PSA claims, you will need to submit a claim form or submit online if applicable.

You may also wish to coordinate claims with your spouse's employer's plan to receive up to 100% reimbursement for your health and dental expenses. To set up COB information with Green Shield, please contact Green Shield directly.

For details about claims, refer to the other pages in the **Claims Information** section.

Prescription Drug Card

When you enroll in the program, you will receive a Green Shield plan member ID card that you can use when you purchase prescriptions drugs at the pharmacy. When your pharmacist uses the card you will be advised:

- Which drugs are covered by your plan,
- What portion of the expense will be reimbursed by the plan, and
- What portion of the expense you must pay for.

If, for any reason, you are unable to use your drug card you must pay for the prescription and submit a claim form for reimbursement.

Health & Dental Claims

For detailed claims submission instructions, visit the "How to submit a claim" section of the Green Shield Canada website.

You will find PDFs of all applicable claim forms on Green Shield Canada's "Forms" page.

If you register for Green Shield Canada's Plan Member Online Services, you can print personalized claim forms that will already include much of your personal and plan information.

Direct payment to the provider of service (not applicable to Health Care Spending Account)

Present your Green Shield Identification Card to your provider and, after you pay any applicable copayment, your provider may bill Green Shield directly. In many cases, payment will be made directly to your provider of service. Most providers will also have a supply of claim forms.

Emergency Out-Of-Province Claims

If you have a medical emergency while travelling outside of your home province, you must contact Green Shield Canada by phone within 48 hours of commencement of treatment. If you have opted out of health care coverage, you will still receive single Out of Country coverage.

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 4930** 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.

You can also visit the "Travel Coverage" section of the Green Shield website for more information.

HCSA Claims

The Health Care Spending Account (HCSA) pays out claims after all other applicable insurance plans have paid their portions.

You should submit your claims to all other sources before using your HCSA.

Your Health Care Spending Account (HCSA) does not have automatic coordination with your health and dental benefits. If you would like to enable this functionality, you may do so through Plan Member Online Services (the Green Shield Customer Service Centre is unable to arrange set up of this function).

If you have opted out of health and dental and wish to claim under your HCSA for your dependents you must notify Green Shield of your dependent information otherwise your claim may not be processed.

Auto-Coordination with HCSA

Once you have accessed Plan Member Online Services and have set up your HCSA auto-coordination, your health and dental claims will automatically be coordinated with your HCSA. You must pay the provider of service the HCSA portion of the claim and you will be automatically

reimbursed from your HCSA without having to submit a paper claim. The claim **will not** be re-directed to a secondary plan (COB) before paying out of the HCSA.

Manual Coordination with HCSA

If you choose **not** to have all your traditional health and dental claims automatically coordinated with your HCSA, you must pay the provider of service the HCSA portion of the claim, then complete a HCSA Claim Submission Form and attach proof of payment. You can indicate on 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.

Personal Spending Account Claims

To make a Personal Spending Account claim, visit the Green Shield Canada website to download and print a claim form.

Make sure all information on the form is complete and clearly legible. Incomplete or missing information will delay the processing of your claim.

- Sign and date the form.
- Attach all receipts to the form. Claims cannot be considered or paid without supporting receipts. Keep copies of your receipts and form for income tax and other purposes.
- Mail the completed form to the address listed on the form.

The administrator will mail the cheque for your eligible expenses directly to your home, or you can arrange with the administrator to deposit your reimbursement directly into your bank account.

To see the balance of your Personal Spending Account, or if you have questions concerning the status of your claims, contact Green Shield Canada directly.

Coordinating Claims With Another Plan

Coordination of Benefits (COB) is a process that allows you to submit health and dental claims to more than one plan. By doing so, you can maximize the reimbursement you receive and limit your out-of-pocket expenses.

You can coordinate benefits for:

- Yourself
- Your spouse
- Your dependent children.

To coordinate benefits, you must enroll your spouse and/or child(ren) as dependents in your flexible benefits program. Your spouse must also enroll you and/or your child(ren) in his or her plan.

When you submit a claim, if the first plan does not cover your full expense, you can submit the remaining amount to the second plan and be reimbursed up to 100% of the cost.

If you and your spouse both have prescription drug cards, be sure to provide your Coordination of Benefits (COB) information to the pharmacy on your first visit. Once they have this information on file, your pharmacist can also coordinate coverage for your prescription drugs.

When you coordinate benefits, there is an order in which you must submit your claims:

Claims for you

Submit the claim and receipts to your flexible benefits program first	• Keep copies of your receipts to submit to your spouse's plan later. • The insurer will send you an "explanation of benefits" statement once it processes the claim. • This statement will show the reimbursed amount of your claim and any portion of your expense that your flexible benefits program does not reimburse.
Submit the remaining portion of the claim to your spouse's benefits plan	• Attach the explanation of benefits statement from your insurance company to the claim form. • Attach copies of your receipt(s) to the claim form.

Claims for your spouse

Submit the claim and receipts to your spouse's plan first	• Keep copies of your spouse's receipts to submit to your flexible benefits program later. • The insurer will send you an "explanation of benefits" statement once it processes the claim. • This statement will show the reimbursed amount of your spouse's claim and any portion of the expense that your spouse's plan does not reimburse.
Submit the remaining portion of the claim to your flexible benefits program	• Attach the explanation of benefits statement from your spouse's insurance company to the claim form. • Attach copies of your spouse's receipt(s) to the claim form.

Claims for your child(ren)

Submit the claim and receipts first to the plan of the parent whose month and day of birth is earliest in the year	• Submit claims for your child's expenses to the plan of the parent whose birthday comes first in the calendar year. For example, if you were born in February and your spouse was born in June, your child's expenses should go to your plan first. • If you share the same birthday as your spouse, submit the claim to the plan of the parent whose first name comes first alphabetically. For example, **J**oan comes before **S**am, so Joan's plan is the first payer. • Keep copies of your receipts to submit to the second plan later. • The insurer will send you an "explanation of benefits" statement once it processes the claim. • This statement will show the reimbursed amount of your child's claim and any portion of the expense that the first plan does not reimburse.
Submit the remaining portion of the claim to the other parent's plan	• Attach the explanation of benefits statement from the first insurance company to the claim form. • Attach copies of your child's receipt(s) to the claim form.

Important to know…

If you are divorced, legally separated, or have remarried or entered into a common-law relationship with another individual, the process for submitting claims for your children will depend on your custody arrangement (see chart below).

In all cases, to coordinate benefits, you and your ex-spouse must both enroll your child(ren) as a dependent in your respective benefit plans.

	Submit first	**Submit second**
If you have custody and have not remarried or entered into a common-law relationship	Your flexible benefits program	Your ex-spouse's plan
If you have custody and have remarried or entered into a common-law relationship	Your flexible benefits program	Your new spouse's plan*
If your ex-spouse has custody and he or she has not remarried or entered into a common-law relationship	Your ex-spouse's plan	Your flexible benefits program
If your ex-spouse has custody and he or she has remarried or entered into a common-law relationship	Your ex-spouse's plan	Your ex-spouse's new spouse's plan**

	Submit first	Submit second
If your share custody with your ex-spouse	The plan of the parent whose birth month and day is earliest in the year	The other parent's plan
If your custody situation is **unresolved**	The plan of the parent who has covered the child the longest	The other parent's plan

*Your new spouse must enroll your child(ren) as a dependent in his or her plan. If there is still an unpaid portion of an expense remaining after it is submitted to your flexible benefits program, the claim should then be submitted to your new spouse's plan (provided he or she has enrolled your child as a dependent).

**Your ex-spouse's new spouse must enroll your child(ren) as a dependent in his or her plan. If there is still an unpaid portion of an expense remaining after it is submitted to your ex-spouse's plan, the claim should then be submitted to your ex-spouse's new spouse's plan (provided he or she has enrolled your child as a dependent).

Life, Accident, Critical Illness & Disability Claims

To make a life, accident, critical illness or disability insurance claim, you (or your beneficiary) should contact Human Resources for instructions.

Green Shield Canada Plan Member Online Services

Green Shield Canada Plan Member Online Services provides you with instant access to important benefit plan information. This service makes it easier for you to:

- Access your benefit eligibility
- Determine when you are eligible for your next pair of glasses
- Get detailed information about your claims payments
- Get answers to those important questions that you ask most often.

The Plan Member Online Services website will also answer frequently asked questions 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.

It's easy!

Provided you are a Green Shield Canada plan member (ID card number ends with -00), all you have to do is register online with your unique Green Shield Canada ID number and an e-mail address.

Health Care

Health Care Options

Your health care coverage consists of three separate plans:

- Prescription drug coverage
- Medical services and supplies
- Vision and paramedical services

You can choose a different level of coverage (Level 1, Level 2 or Level 3) for each plan. However you must elect the same tier, i.e., Employee, Employee Plus 1 or Family for all three plans.

For example, you could choose:

- Prescription drug coverage – level 2
- Medical services and supplies – level 1
- Vision and paramedical services – level 3

For each plan, you can change your level at each re-enrollment period. At re-enrollment you can:

- Move up as many levels as you wish (from level 1 to level 3, for example)
- Move down only one level at a time (from level 3 to level 2, for example).

This rule does not apply if you change your coverage because of an eligible life event.

Opting out

If you have health care coverage elsewhere (such as through a spouse's plan), you can choose to opt out and not have health care coverage under your employer's flexible benefits program. However, you will be asked to provide proof of alternate coverage during online enrollment on each of the health and dental coverage.

Important: Keep in mind that if you opt out of health care coverage, you are covered for single out-of-province coverage. If you travel out-of-province, you may wish to verify that you have out-of-province coverage elsewhere, such as through your spouse's benefits plan.

Prescription Drugs

The reimbursement you receive for your prescription drug expenses depends on the prescription drug option you select.

Prescription drug coverage options

All maximums and limits are per covered person per program year.

	Level 1	Level 2	Level 3
Low, average, or high benefits user	Low	Low to average	Average to high
Reimbursement (less the applicable deductible)	75%	85%	95%
Deductible	$12 per prescription	$10 per prescription	$8 per prescription
Smoking cessation products lifetime maximum	$800	$800	$800
Fertility drug lifetime maximum	Not applicable	$1,500	$2,500
100% "safety net" coverage begins after you pay this amount out of your own pocket	Not applicable	Not applicable	$750

What is "safety net" coverage?

Level 3 includes a "safety net" protection feature. Safety net coverage begins once you pay a certain amount of your own money toward eligible prescription drug costs for a covered person during the program year.

Once safety net coverage begins, the plan covers 100% of eligible prescription drug expenses for the covered person for the remainder of the program year.

The out-of-pocket amount must be above any amount covered by your provincial health insurance plan, your flexible benefits program (including your Health Care Spending Account), your spouse's benefits program, and any other insurance plan.

You will need to keep your receipts to show that you have spent more than the specified amount out of your own pocket.

What's covered

To be eligible for coverage, your drugs must be:

- Prescribed by a legally qualified medical practitioner or dental practitioner as permitted by law
- Legally require a prescription and has a DIN.

If approved by Green Shield Canada, your plan includes:

- Drugs that do not legally require a prescription, including insulin and other approved injectables
- Related supplies such as diabetic syringes, needles, and testing agents.
- Vaccines, oral contracptives, Mirena & Depo-Provera
- Has an NPN number for potassium replacement agents and limited access drugs and iron supplements only.

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

The maximum amount you can have filled at one time for one prescription is a three-month supply (six months if a vacation supply is required) and not more than a 13-month supply in any 12 consecutive months. For maintenance medications, Green Shield will establish a 100-day supply rule for ongoing medications that fall in this category.

Mandatory generic

All levels under the prescription drugs plan are subject to the mandatory generic substitution price.

This means that if there is a lower-cost generic alternative (LCGA) product on the market, as defined by Green Shield Canada, the plan will reimburse you up to the cost of the LCGA – even if you are prescribed and purchase a more expensive product and even if your doctor writes “no substitution” on the prescription.

Here is an example of how the LCGA price works. This is simply an example and may not reflect the actual reimbursement offered by your program.

	Level 1 ($20 deductible)	Level 2 (80% reimbursement)	Level 3 (90% reimbursement)
Your prescription cost	$80	$80	$80
Generic alternative cost	$50	$50	$50
Your employer pays	$30	$40	$45
You pay*	$50	$40	$35

*The amount **you pay** includes your deductible or co-insurance plus the amount over and above the lower-cost generic alternative price.

Generic drugs, like all prescribed drugs in Canada, are manufactured to standards set by Health Canada. By law, they must contain the same amount of active drug and have the same therapeutic effect as their more expensive equivalents. It is possible, however, that a generic drug may not be the appropriate drug in all instances.

Many drugs do not have a lower-cost generic alternative. If your prescription does not have an LCGA, you will be reimbursed on the price of the prescribed drug.

A lower-cost generic alternative price policy makes it possible for your employer to maintain a cost-effective drug plan while still maintaining quality prescription drug coverage.

Pay direct drug card

Your Green Shield Canada card is your pay direct drug card. This card allows you to pay only the prescription deductible or co-payment when you fill your prescription.

You will receive your Green Shield Canada card once you enroll in the flexible benefits program.

If you are covered under your spouse's plan, you may be able to submit the cost of the deductible or co-payment to that plan for reimbursement.

See the **Claims Information** page for more information about your prescription drug claims and coordinating your claims with another employer's plan.

If you live in Quebec

Legislation requires Green Shield Canada to follow the RAMQ (The Régie de l'assurance maladie du Quebec) reimbursement guidelines for all residents of Quebec.

If you are younger than age 65, you must enroll for prescription drug coverage (unless you are covered by another employer's plan) and Green Shield Canada will be the only payor.

If you are age 65 or older, enrollment in RAMQ is automatic, enrollment in the prescription drug coverage 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.

Please refer to your Green Shield "My Benefit Plan" booklet for full plan details. The booklet can be found on the enrolment portal under the "Plan Details" tab.

Medical Services & Supplies

The reimbursement you receive for eligible medical supplies and services depends on the medical services and supplies option you select.

Medical services and supplies options

All maximums and limits are per covered person per program year.

	Level 1	Level 2	Level 3
Low, average, or high benefits user	Low	Low to average	Average to high
Reimbursement	100%	100%	100%
Out-of-province emergency medical coverage	$5 million per incident Coverage is in effect for a maximum of 180 days per trip	$5 million per incident Coverage is in effect for a maximum of 180 days per trip	$5 million per incident Coverage is in effect for a maximum of 180 days per trip
Hospital	Semi-private	Semi-private	Semi-private
Convalescent care	$20 per day for a maximum of 180 days	$20 per day for a maximum of 180 days	$30 per day for a maximum of 180 days
In-home nursing care	$5,000 per 12 months	$7,500 per 12 months	$10,000 every 3 years
Hearing aids	$500 every 5 years	$700 every 5 years	$700 every 4 years
Orthopedic shoes and orthotics combined	$200 per 12 month period	$300 per 12 month period	$400 per 12 month period
Miscellaneous supplies and services	Covered at the reimbursement level	Covered at the reimbursement level	Covered at the reimbursement level

Accidental dental

You are covered for the repair, extraction, and/or replacement of natural teeth if they are damaged because of an accident. When natural teeth have been damaged, eligible services are limited to one set of artificial teeth. You must notify the insurer and obtain treatment within 180 days of the accident.

Emergency transportation services

You are covered to be reimbursed 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.

Hearing aids

You are covered for hearing aids (including repairs and replacement parts) prescribed by a licensed health care professional. The maximum reimbursement you may receive each year depends on the medical services level you select. No amount will be paid for batteries.

Hospital

Provided your provincial health insurance plan has accepted or agreed to pay the ward or standard rate, you are covered for reasonable and customary charges for semi-private hospital accommodation in a:

- Public general hospital
- Convalescent or rehabilitation hospital or a convalescent or rehabilitation wing in a public general hospital
- Public chronic hospital or chronic care in a public general hospital.

In-home nursing care

You are covered for nursing services provided in your home on written order of a physician and pre-approved by the insurer. Services must be provided by a:

- Registered nurse (R.N.)
- Registered practical nurse (R.P.N.)
- Licensed practical nurse (L.P.N.)

The person providing the nursing services cannot be a relative or someone who ordinarily lives in your home.

The maximum reimbursement you may receive each year for in-home nursing care depends on the medical services level you select.

The attending physician must complete a Pre-Authorization Form for Private Duty Nursing and submit the form to the insurer.

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 (R.P.N.) / Licensed Practical Nurse (L.P.N.).

Miscellaneous supplies 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 mattresses; trapezes;
b. Footwear (when prescribed by your attending physician, podiatrist or chiropodist):

    i. custom made foot orthotics;
    ii. custom made boots or shoes, adjustments to stock item orthopedic footwear (subject to a medical pre-authorization); or footwear as an integral part of a brace.
c. Braces, casts;
d. Blood glucose monitors; diabetic supplies
e. Medical services, such as diagnostic tests, X-rays and laboratory tests;
f. Incontinence/Ostomy, such as ostomy supplies;
g. Mobility aids, such as canes, crutches, walkers and wheelchairs); and portable wheelchair ramps
h. Prosthetics, such as arm, hand, leg, foot, breast, eye and larynx;
i. Respiratory/Cardiology equipment, such as compressors, inhalant devices, tracheotomy supplies and oxygen.
j. Optometric exams for visual acuity
k. Compression stockings
l. Wigs for temporary or permanent hair loss as a result of a medical condition

Items are subject to reasonable and customary maximums or maximums indicated per the individual benefit, and some may require pre-authorization. To confirm eligibility prior to purchasing or renting equipment, submit a pre-authorization form to Green Shield.

There are some limitations on these miscellaneous supplies and services:

1. The rental price of durable medical equipment will not be greater than the purchase price. The insurer's decision to purchase or rent will be based on the physician's estimate of the duration of a 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.
2. 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.
3. 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.

Orthopedic shoes

You are covered for 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**.

The maximum reimbursement you may receive each calendar year for orthopedic shoes depends on the medical services level you select. Please refer to the Plan Member Update – Claim Requirements for Custom Orthotics, Orthopedic Shoes, and Custom Shoes on the enrolment portal under the "Plan Details" tab.

Orthotics

You are covered for custom-made foot orthotics. Your orthotics must be prescribed by a physician, podiatrist, or chiropodist. Please refer to the Plan Member Update – Claim Requirements for Custom Orthotics, Orthopedic Shoes, and Custom Shoes on the enrolment portal under the "Plan Details" tab.

Out-of-province emergency medical coverage

Out-of-province emergency medical insurance provides protection to you and your family when you travel outside your home province (including outside of Canada).

Details of your coverage are available in the Green Shield Canada "Travel Benefits" page.

Please refer to your Green Shield "My Benefit Plan" booklet for full plan details. The booklet can be found on the enrolment portal under the "Plan Details" tab.

Vision & Paramedical Services

The reimbursement you receive for eligible vision care and paramedical services expenses depends on the vision and paramedical services option you select.

Vision and paramedical services options

All maximums and limits are per covered person per program year.

	Level 1	Level 2	Level 3
Low, average, or high benefits user	Low	Low to average	Average to high
Vision care assistance			
Eye exams	$75 every 2 years for adults, 12 months for children under age 19	$75 every 2 years for adults, 12 months for children under age 19	$75 every 2 years for adults, 12 months for children under age 19
Glasses, contact lenses	No coverage for prescription glasses and contact lenses	$175 per 24 months for adults, 12 months for children under age 19	$200 per 24 months for adults, 12 months for children under age 19
Laser eye surgery reimbursement and lifetime maximum	50%, up to a maximum of $500 per person	50%, up to a maximum of $500 per person	50%, up to a maximum of $700 per person

Basic paramedical services

Dietician **Psychologist/Social worker** **Speech therapist**	$500 per calendar year for all practitioners combined	$600 per calendar year for all practitioners combined	$700 per calendar year per practitioner

Additional paramedical services

Acupuncturist **Audiologist**	$400 per calendar year for all	$500 per calendar year for all	$600 per calendar year per practitioner
	Level 1	**Level 2**	**Level 3**
Naturopath **Occupational therapist** **Osteopath** **Podiatrist/Chiropodist**	practitioners combined	practitioners combined	

Comprehensive paramedical services

Chiropractor **Massage therapist** **Physiotherapist**	$300 per calendar year for all practitioners combined	$400 per calendar year for all practitioners combined	$500 per calendar year per practitioner

Vision care services (Level 2, 3)

Eligible vision care expenses include reimbursement for the services performed by a licensed Optometrist, Optician or Ophthalmologist up to the amount shown in the schedule of benefits for:

- Prescription eyeglasses or contact lenses.
- Medically necessary contact lenses when visual acuity cannot otherwise be corrected to at least 20/40 in the better eye or when medically necessary due to keratoconus, irregular astigmatism, irregular corneal curvature or physical deformity resulting in an inability to wear normal frames.
- Replacement parts for prescription eyeglasses.
- Laser eye surgery.
- Prescription industrial safety eyeglasses

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

- Medical or surgical treatment, except for laser eye surgery.
- Special or unusual procedures such as, but not limited to, orthoptics, subnormal vision aids and aniseikonic lenses.
- Follow-up visits associated with the dispensing and fitting of contact lenses.
- Charges for eyeglass cases.

Paramedical practitioners

Eligible paramedical practitioners include:

- Acupuncturist
- Audiologist
- Chiropractor
- Dietician
- Massage therapist
- Naturopath
- Occupational therapist
- Osteopath
- Physiotherapist
- Podiatrist/Chiropodist
- Psychologist
- Social worker
- Speech therapist.

Eligible paramedical practitioners must be licensed by their provincial regulatory agency or a registered member of a professional association and Green Shield must recognize that association.

Contact the Green Shield Customer Service Centre to confirm practitioner eligibility.

Please refer to your Green Shield “My Benefit Plan” booklet for full plan details. The booklet can be found on the enrolment portal under the “Plan Details” tab.

What’s Not Covered

Prescription drugs

You will not be reimbursed for the following ineligible expenses:

- Drugs for the treatment of obesity and erectile dysfunction.
- Products which may lawfully be 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.
- Ingredients or products which have not been approved by Health Canada for the treatment of a medical condition or disease and are deemed to be experimental in nature and/or may be in the testing stage.

Mixtures, compounded by a pharmacist, that do not conform to Green Shield Canada's current Compound Policy.

Health care

Under the health care assistance plans (prescription drugs, medical services, vision and paramedical services), 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 the insurer) 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 the insurer, 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 video instructional kits, informational manuals or pamphlets;
k. 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;
l. Are video instructional kits, informational manuals or pamphlets;
m. Are for medical or surgical audio and visual treatment;
n. Are special or unusual procedures such as, but not limited to, orthoptics, vision training, subnormal vision aids and aniseikonic lenses;
o. Are delivery and transportation charges;
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 properly 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 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 charge by a provider of service for services other than those directly relating to the delivery of the service or supply.

Making Health Care Choices

Thinking about the kind and the cost of the health care expenses you and your family typically have will help you determine the options that are best for you. When making your decisions, ask yourself the following questions:

General health care

How many and what kind of health care expenses do my family and I typically have?
If you and your family have only a few health care expenses, you may find that lower coverage and lower cost options will suit your needs. Rather than purchasing higher-cost options, you may want to fund a Health Care Spending Account (HCSA) with your flex credits instead to help pay for any out-of-pocket expenses you may have.

Out-of-pocket expenses are those not covered by:

- Your provincial health insurance plan
- This flexible benefits program
- Your spouse's benefits plan
- Any other insurance plan you may have.

On the other hand, if you and your family have a wide variety of expensive medical needs, you may find that higher coverage options will suit you best – even though you may have to pay more for this coverage.

Does my family have health care coverage under another employer's health care plan?
If the answer is no, you must enroll in an option for each health care coverage plan:

- Prescription drug coverage
- Medical services and supplies
- Vision and paramedical services.

If the answer is yes, there are a number of ways you can use the program:

a. You can opt out of all three health care plans and be covered only as a dependent under your spouse's plan.

This may be an option for you if:

- Your spouse's plan has similar or better coverage and you don't need to coordinate your benefits.
- You don't want to be required to always submit your claims to your employer's plan first.
- You have few health care needs that can easily be covered by your spouse's plan alone.

Note: If you opt out of health care coverage you can still allocate flex credits to your HCSA to help pay for eligible expenses not covered by your spouse's plan.

Important: If you opt out of health care coverage, you will receive single coverage for out-of-province travel. You may wish to verify that you have out-of-province coverage elsewhere (such as through a spouse's plan) before your trip.

b. You can choose health care coverage under the flexible benefits program and coordinate with your spouse's coverage so you can take advantage of both plans.

This may be an option for you if:

- You want to be able to coordinate your claims under both plans so you can be covered for up to 100% of your eligible expenses. If your selected options cover less than 100% of the cost or have annual or lifetime maximums, you may be able to be reimbursed for the balance from your spouse's plan.

Note: If you choose this option, you may be able to select lower coverage levels for your prescription drug, medical care, and vision and paramedical services because you can coordinate with your spouse's plan.

c. You can consider enrolling for single coverage under your employer's health care coverage.

- Single coverage will cost less than two-party or family coverage and you may be able to use your flex credits to help fund your HCSA.
- If you are covered as a dependent under your spouse's plan, you could still coordinate your claims with that plan.
- **Remember,** if you enroll for single coverage, your spouse and/or dependent children will not be covered under your program.

Note: Take a look at who pays for what under both your and your spouse's programs to help determine your best use of costs and benefits when considering coordination between two plans

Will my family be coordinating health care claims with another plan?

If you and your family are covered under another health care plan you can coordinate your claims to reduce your out-of-pocket expenses. This means you can submit claims to both plans for reimbursement. If the first plan does not cover the entire cost, you may be able to receive

some (or all) of the outstanding balance from the other plan.

If you will be coordinating your coverage with another plan:

- Choose the lowest level of coverage you feel will comfortably suit your needs. Coordinate with the other plan to be reimbursed for any eligible out-of-pocket costs.
- To coordinate claims for your spouse and/or children, you must enroll them as dependents in your flexible benefits program. Your spouse must also enroll you and your children in his or her plan.
- If you have any out-of-pocket costs after you have been reimbursed by both plans, you can also use any flex credits you have allocated to your HCSA to help cover the difference.

Prescription drug coverage

How many prescriptions do my family and I typically have filled in a year?
The prescription drug coverage levels are designed with low, average, and high prescription drug needs in mind.

- Level 1 is designed for low users (few prescriptions per year and/or low-cost prescriptions).
- Level 2 is designed for low to average users (an average number of prescriptions per year and/or average cost prescriptions).
- Level 3 is designed for average to high users (many prescriptions per year and/or high cost prescriptions).

Estimate how many prescriptions you and your family will have in the coming year. Then assess how much the total deductible (if any) and your portion of the drug costs will be.

You should also estimate the total prescription drug cost each family member may have in a year.

To maximize your flex credits, choose the lowest level of coverage that will comfortably meet your family's needs. Remember if you allocate flex credits to your HCSA you can use it to help pay for your portion of any eligible prescription drug costs.

Does anyone in my family use brand-name prescription drugs when a generic version is available?
Generic drugs are copies of brand-name drugs. Like all prescribed drugs in Canada, Generics are manufactured to standards set by Health Canada. By law, they must contain the same amount of active drug and have the same therapeutic effect as their brand-name equivalents.

Generic drugs are generally less expensive than their brand-name equivalents because their manufacturers do not need to spend the same amount of money on research, development, and marketing.

To help control plan costs all prescriptions are subject to the lowest cost drug price. This means that if there is a Lower Cost Alternative product on the market, as defined by the insurer, the plan will reimburse you up to the cost of the LCA – even if you are prescribed and purchase a more expensive product.

If you or anyone in your family regularly takes a brand-name drug when a generic version is available you should be aware that your reimbursement for that brand-name drug will be lower.

Many drugs do not have a lower cost alternative. If your prescription does not have a LCA, you will be reimbursed on the price of the prescribed drug.

Does anyone in my family need hearing aids, orthotics, or orthopedic shoes?
If you and your family have specific medical needs, such as hearing aids, look at the level of reimbursement and overall maximums under each option. Compare the price tag for that option against the value of the benefit (total reimbursement) you may receive.

Vision and paramedical services

Does anyone in my family need glasses or contact lenses?
Determine how many pairs of glasses or contact lenses you and your family will need over the next 24 months. Also determine how much you expect to spend on these glasses or contacts.

- **If your family needs several pairs of glasses or contacts** then the vision care coverage offered under the applicable options may be useful to you.
- **If you need only one pair of glasses or contact lenses** you may want to consider a lower coverage option. Rather than paying more for a higher-coverage option, you may get better value by choosing a lower-coverage option and putting some flex credits into your HCSA to help pay for your glasses.

How much will my family and I spend on paramedical practitioners in the coming year?
To help determine what option may be right for you:

- Estimate how much you and your family will spend on each type of paramedical practitioner.
- Compare this to the reimbursement levels and maximums for each option.
- Calculate what your out-of-pocket costs would be under each option.
- Compare the price tag for each option against the value of the benefit (total reimbursement) you may receive.
- Choose the lowest coverage level that meets your family's needs.

Your provincial health plan may also cover the cost of some practitioners, up to a maximum amount per visit per year. Your practitioner can tell you what the government coverage may be.

Dental Care

Dental Care Options

You can choose from three levels of dental care assistance.

You can change your level at each re-enrolment period. At re-enrollment you can:

- Move up as many levels as you wish (from level 1 to level 3, for example)
- Move down only one level at a time (from level 3 to level 2, for example).

This rule does not apply if you change your coverage because of an eligible life event.

Opting out

If you have dental care coverage elsewhere (such as through a spouse's plan), you can choose to opt out and not have dental care assistance under your employer's flexible benefits program.

You can choose to opt out of any health benefits, dental care assistance, or all as long as you have coverage under another plan.

Dental care assistance options

Your dental care assistance is designed to help you and your family maintain healthy teeth and gums. The reimbursement you receive for your dental care expenses depends on the dental care option you select.

For detailed instructions about making dental care claims, see the **Claims Information** section.

Your three dental care assistance levels are:

	Level 1	Level 2	Level 3
Low, average, or high benefits user	Low	Low to average	Average to high
Each level covers the following percentage of your eligible dental expenses:			
Basic Services • Preventative & Basic Services	80%	80%	70%
• Periodontal Services	70%	70%	70%

	Level 1	Level 2	Level 3
Major services	50%	50%	60%
Orthodontic services (for children under 19)	Not covered	50%	60%
The maximum reimbursement you can receive per person:			
Per calendar year for basic & major services combined	$1,500	$1,500	$2,000
Per calendar year for dental implants	None	None	$500
In the covered person's lifetime for orthodontics	None	$1,500	$2,000
Covered persons are eligible for a recall exam (check-up) every…			
If they are adults	12 months	9 months	6 months
If they are children	6 months	6 months	6 months

Basic Dental Services

Basic dental services are designed to help you maintain healthy teeth and gums. These types of services include:

- Exams
- X-rays
- Polishing and scaling
- Fillings (also known as restorations)
- Extractions
- Oral surgery
- Endodontics (such as root canals)
- Periodontics (such as scaling)
- Denture repairs and rebasing.

You will find a detailed listing of covered basic services, and any restrictions or conditions related to them, below.

Diagnostic services

Exams

- Complete oral exams once every 2 years
- Recall examinations – the frequency depends on the dental option you select
- Emergency exams
- Specific oral exams

Preventive services

- Polishing – up to one time unit once per recall period. One time unit equals 15 minutes.
- Scaling – up to one time unit once per recall period. One time unit equals 15 minutes.
- Fluoride treatment – once per recall period
- Oral hygiene instruction – once per recall period
- Denture cleaning – once per recall period
- Space maintainers
- Pit and fissure sealants on permanent molars only
- Full service x-rays and panoramic x-rays are once every 2 years
- Bitewing x-rays

Restorative services

- Restorations (amalgam, tooth coloured filling restorations, and temporary sedative fillings)
- Inlay restorations – these are considered basic restorations and will be paid to the equivalent non-bonded amalgam

Basic Oral surgery

- Extraction of teeth and/or residual roots

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

Endodontics

- 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
- Hemisection
- Bleaching of non-vital tooth/teeth
- Emergency procedures including opening or draining of the gum/tooth

Periodontics

- Scaling and/or root planing
- Occlusal equilibration – selective grinding of tooth surfaces to adjust a bite 2 time units per participant per calendar year. One time unit equals 15 minutes.
- Bruxism appliance

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.

Denture services

- Denture repairs and/or tooth/teeth additions
- Standard relining and rebasing of dentures
- 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

Adjunctive services

- Anesthesia and intravenous sedation in conjunction with eligible oral surgery only

Major Dental Services

Major dental services include dentures, crowns, and bridges. You will find a detailed listing of covered major services, and any restrictions or conditions related to them, below:

- Standard onlays or crown restorations (paid to full metal on molar) to restore diseased or accidentally injured natural teeth, once every 5 years
- Standard bridges, including pontics, abutment retainers/crowns (paid to full metal on molar) on natural teeth, once every 5 years
- Standard dentures, including complete, immediate, transitional, and partial dentures, once every 5 years
- Standard repair or recementing of crowns, onlays and bridge work on natural teeth.

Orthodontic Services

Covered orthodontic services are designed to help position teeth and bite in a normal and harmonious relationship and 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.

Dental Fee Guide

The dental association of each province (except Alberta) publishes a dental fee guide every year. The published fee guide lists suggested charges for each dental procedure.

- Dentists may charge more or less than the suggested fees.
- Your flexible benefits program covers costs up to the suggested amount in the fee guide for the current year.
- For Alberta, the insurer sets its own fee guide which reflects the fees currently charged by most dental offices (most of the time) across Alberta.
- If the dentist charges more than what is published in the fee guide, your flexible benefits program does not cover the higher amount.

Remember: Your flexible benefits program **will not pay** for charges exceeding the fee guide. It's a good idea to bring this to your dentist's attention and discuss the fees with your dentist before you undergo a particular procedure.

Alternate Treatment

The flexible benefits program 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 program.

Pre-Determination of Benefits

If you aren't sure whether the dental care plan covers a specific procedure, or if you expect major or unusual expenses, call Green Shield Canada before you begin treatment to find out if you are covered.

For all proposed treatment for crowns, onlays and bridges, your dentist **must** complete and submit an estimate to Green Shield for assessment. Green Shield's 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.

Except in the case of an emergency, if your dentist expects all other treatments to cost more than $300, you should have your dentist send the proposed treatment plan to Green Shield before beginning treatment. Dental pre-determinations can be submitted electronically by the Dentist's office.

Limitations

- 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 current General Practitioners Fee Guide will be reduced accordingly; co-pay is then applied.
- Reimbursement will be made according to standard and/or basic services, supplies or treatment. Related expenses beyond the standards and/or basic services, supplies or treatment will remain your responsibility.
- When more than one surgical procedure including multiple periodontal services is performed during the same appointment in the same area of the mouth, only the most comprehensive procedure will be eligible for reimbursement.
- 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.
- 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.
- 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.
- 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.
- 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.
- Root planing is not eligible if done at the same time as gingival curettage.
- In the event of a dental accident, claims should be submitted under the health benefits plan before submitting them under the dental plan.

What's Not Covered

Under the dental care assistance plan, 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 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 for levels 1 & 2.
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, gnathaological 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 the insurer) 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 the insurer, 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, 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 properly 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 charge by a provider of service for services other than those directly relating to the delivery of the service or supply.

Making Dental Care Choices

Thinking about the kind and the cost of dental care expenses you and your family typically have will help you determine the option that is best for you. When making your decision, ask yourself the following questions:

Are basic dental services all my family and I need?
Basic dental services include:

- Preventive services - regular check-up exams and x-rays
- Restorative services - fillings, extractions and other surgery
- Periodontic services - treatment of tissues and bones supporting teeth
- Endodontic services - treatment of the diseases of the dental pulp, including root canal therapy.

If you and your family need only these kinds of services a lower coverage option may be enough to meet your needs.

Note: It may make sense for you to choose a lower coverage option and put some of your flex credits into your Health Care Spending Account (HCSA) to pay for any additional out-of-pocket costs you may have.

How frequently do my family and I need to have cleanings and check-ups?
Your flexible benefits program covers dental check-ups and cleanings. The frequency of **covered** check-ups depends on the dental care option you choose.

When selecting your option, keep in mind:

- If you want to have check-ups more frequently than what is covered under your selected option, you can use flex credits in your HCSA to help pay for them.
- The plan will cover additional units of scaling (having your teeth cleaned) outside of your regular covered check-ups if you want to have your teeth cleaned more frequently.

Before deciding which option may be best for you, ask your dentist how much it will cost for a dental exam. It may make sense for you to allocate flex credits to your HCSA to pay for these exams instead of choosing a higher level of coverage simply to have more frequent examinations.

Does anyone in my family need major dental work such as a crown or dentures?
If you know you and your family will need coverage for major dental services such as crowns or dentures, you may want to choose an option that provides a higher level of coverage or overall maximum for these services.

Before making your option choice, you should:

- Find out from your dentist how much the major services will cost.
- Compare the cost of the services with the overall annual maximum for those services under each option.
- Determine what your out-of-pocket cost will be under each option.

Can I spread my dental work over two benefit program years?
If you expect your claims to be greater than the annual maximum for one option, consider planning treatments that require multiple visits near the end of the benefit program year.

This way you can use the following year's maximum as well.

Does anyone in my family need braces?
If anyone in your family needs braces, consider the reimbursement level and lifetime maximum for orthodontics under each option.

How much does my family expect to spend on dental services?
Before making your option choice, you should:

- Estimate how much you expect to spend on dental services over the next year. You may want to look at how much your dental expenses were last year and this year to help estimate your expenses for next year.
- Compare how much you expect to spend on dental care for each person in your family against the maximums for basic and major services under each option.
- Estimate what your out-of-pocket costs will be under each option. This is how much you will have to pay out of your own pocket. If you have coverage under another plan, you can claim this amount from the other plan.

Once you have looked at your needs, your out-of-pocket costs, and the cost for each option, choose the option that most closely fits your needs for the most reasonable cost.

Note: Sometimes the most comprehensive (and most expensive) coverage may be more than you actually need. For instance, if you have very basic dental care needs, you can choose a lower coverage option and put flex credits into your HCSA to help pay for your out-of-pocket costs.

If you expect your claims to be greater than the annual maximum of one option, consider planning treatments that require multiple visits near the end of the year so you can use the following year's maximum as well. This may be more cost-effective than choosing a level with a higher maximum.

Does my family have dental care coverage under another plan?
If the answer is no, you must enroll in an option for dental care coverage.

If the answer is yes, there are a number of ways you can use the program:

a. **You can opt out of the dental care plan and be covered only as a dependent under your spouse's plan.**

This may be an option for you if:

- Your spouse's plan has similar or better coverage and you don't need to coordinate your benefits.

- You don't want to be required to always submit your claims to your employer's plan first.
- You have few dental care needs that can easily be covered by your spouse's plan alone.

Note: If you opt out of dental care coverage you can still allocate flex credits to your HCSA to help pay for eligible expenses not covered by your spouse's plan.

b. You can choose dental care coverage under the flexible benefits program and coordinate with your spouse's coverage so you can take advantage of both plans.

This may be an option for you if:

- You want to be able to coordinate your claims under both plans so you can be covered for up to 100% of your eligible expenses. If your selected option covers less than 100% of the cost or has annual or lifetime maximums, you may be able to be reimbursed for the balance from your spouse's plan.

Note: If you choose this option, you may be able to select a lower coverage option because you can coordinate with your spouse's plan.

c. You can consider enrolling for single coverage under your employer's dental care coverage.

- Single coverage will cost less than two-party or family coverage and you may be able to use your flex credits to help fund your HCSA.
- If you are covered as a dependent under your spouse's plan, you could still coordinate your claims with that plan.
- **Remember,** if you enroll for single coverage, your spouse and/or dependent children will not be covered under your program.

Note: Take a look at who pays for what under both your and your spouse's programs to help determine your best use of costs and benefits when considering coordination between two plans.

Will my family be coordinating dental care claims with another plan?

If you and your family are covered under another dental care plan you can coordinate your claims to reduce your out-of-pocket expenses. This means you can submit claims to both plans for reimbursement. If the first plan does not cover the entire cost, you may be able to receive some (or all) of the outstanding balance from the other plan.

If you will be coordinating your coverage with another plan:

- Choose the lowest level of coverage you feel will comfortably suit your needs. Coordinate with the other plan to be reimbursed for any eligible out-of-pocket costs.
- To coordinate claims for your spouse and/or children, you must enroll them as dependents in your flexible benefits program. Your spouse must also enroll you and your children in his or her plan.
- If you have any out-of-pocket costs after you have been reimbursed by both plans, you can also use any flex credits you have allocated to your HCSA to help cover the difference.

Please refer to your Green Shield "My Benefit Plan" booklet for full plan details. The booklet can be found on the enrolment portal under the "Plan Details" tab.

Health Care Spending Account

What Is The HCSA?

You can use your Health Care Spending Account (HCSA) to help pay for eligible medical and dental expenses not covered by:

- Your provincial health plan
- Your employer's flexible benefits plan, including deductibles and co-insurance
- Your spouse's plan (if applicable).

You may choose to allocate some or all of your flex credits to a Health Care Spending Account (HCSA).

If you live outside of Quebec, the flex credits you allocate to your Health Care Spending Account are not taxed. This means you can use the full amount for your eligible expenses.

If you live in Quebec, any HCSA flex credits you use during the year are a taxable benefit to you for provincial income tax purposes.

How The HCSA Works

You deposit flex credits into your HCSA	• Only flex credits are allowed. • You cannot use payroll deductions. • Flex credits deposited into your HCSA are not taxable (except in Quebec).

You submit claims to the account	• You can claim a broad range of eligible medical and dental expenses.
	• The amount of the claim is subtracted from your account balance.
	• You can claim only the portion of expenses **not covered** by:
	  ○ The health and dental options you choose, including deductibles and co-insurance
	  ○ Your spouse's health and dental plans
	  ○ Your provincial health care plan.
	• You can claim only expenses paid for in the current program year.
	• You can claim only up to the maximum amount in the account.
	• You must submit all claims within 90 days of the end of each program year.

If you use all the flex credits in your HCSA in one year	• In this case, you must wait until the next program year to deposit more flex credits to your account.
If you have flex credits left over in your HCSA at the end of the program year	• In this case, you can carry unused flex credits over into the next program year. • Claims are first paid from any amounts you have carried forward in your HCSA from the previous year.
If you still have unused flex credits remaining after two years, you lose them	• If you do not use the amount you carried forward in the second program year, you forfeit it (i.e., if you don't use it, you lose it). • You **cannot** receive unused flex credits as cash. • You **cannot** transfer unused flex credits into any other vehicle (such as a Group RRSP or Personal Spending Account). • To qualify as a private health services plan, there must be an element of risk – you risk losing your unused flex credits. If this was not part of the plan design, you would be taxed on the money you receive for your HCSA because it would not qualify as a private health services plan.

Let's look at an example:

In this example, the employee forfeits $25 in Year 3 because $100 was carried forward from Year 2, but only $75 was claimed from it. The $200 deposited in Year 3, however, carries forward into Year 4.

	Plan year 1	Plan year 2	Plan year 3
Prior year flex credits carried forward	0	→ 100	→ 100
Flex credits deposited	+200	+200	+200
Total flex credits available	200	300	300
Claims reimbursed from your HCSA	-100	- 200	- 75
Eligible flex credits remaining in your HCSA	100	100	200
Forfeited flex credits	0	0	25

Eligible HCSA Claims

The Federal Government determines the expenses that are eligible for reimbursement from your Health Care Spending Account (HCSA).

You can use your HCSA to help pay for the same expenses you can claim for the Medical Expense Tax Credit. These expenses are defined in the Income Tax Act. The entire list of eligible expenses for the HCSA is available on Canada Revenue Agency's (CRA) website.

You should contact Green Shield Canada before making your purchase to make sure your expense can be reimbursed from your HCSA. Your employer will not reimburse you for any ineligible expenses that you may incur.

The types of expenses you can submit to your HCSA include:

- Health and dental premiums you pay through payroll deductions.
- Prescription drug dispensing fees.
- Your co-payment for all eligible health and dental expenses (i.e., the percentage not covered by your flexible benefits program).
- All fees above the plan maximums – including vision care and laser eye surgery, paramedical, and dental fees.
- Expenses not covered under certain options, such as vision care and orthodontic dental services.
- Cosmetic surgery that is medically necessary.
- Cosmetic dentistry that is medically necessary.
- Dental implants.
- Private hospital accommodation.
- Practitioners such as dieticians.
- Medical devices and supplies such as crutches.

Eligible HCSA Dependents

You can submit claims to your Health Care Spending Account (HCSA) for a broad range of dependents. These include:

- You
- Your eligible spouse
- Your eligible dependent children
- The grandchildren of you or your spouse
- The parent, grandparent, brother, sister, uncle, aunt, niece, or nephew of you or your spouse.

To be eligible, these dependents **must**:

- Be dependent on you for support as per Canada Revenue Agency guidelines, and
- Reside in Canada.

For more information about eligible dependents, see the Medical Expense and Disability Tax Credits and Attendant Care Expense Deduction bulletin on the CRA website. You can also contact the Canada Revenue Agency National Call Centre at 1-800-959-8281.

Note: You may submit HCSA claims for all of your dependents who meet these eligibility requirements regardless of the health care and dental care coverage you have under the flexible benefits program. For example, if you choose employee-only coverage under the health care and dental care assistance plans, you may still submit your family's claims to your HCSA. However, you must notify Green Shield of these dependents directly prior to the first claim.

Making HCSA Choices

How you plan to use your Health Care Spending Account (HCSA) will play a critical role in the health and dental care decisions you make.

When deciding how many flex credits to deposit to your HCSA, ask yourself the following questions:

Based on my health and dental care selections, how much do my family and I expect to spend out of our own pocket for health and dental care services?
As you consider your options, keep track of how much you expect to spend out of your own pocket. Do you want to allocate flex credits to your HCSA to help pay for these expenses tax- effectively?

Do I plan on using my HCSA instead of relying on the health or dental care plans?
If you choose to opt out of the health and/or dental care plans, you should:

- Estimate how much you expect your health or dental expenses to be, and
- Allocate a sufficient number of flex credits to your HCSA.

Don't worry if you allocate more credits to your HCSA than you use in the year. You can carry forward unused credits for use in the following year.

Will my family and I have medical or dental care needs that are not covered by the health and dental care plans?
For a complete list of eligible HCSA expenses, visit the Canada Revenue Agency (CRA) website. To access the CRA website:

- Go to www.cra-arc.gc.ca
- From the left menu, click **"Forms and publications"**.
- Click on the link **"Topic"**.
- Scroll down to the letter **"M"** and click **"Medical expenses"**.
- Click the link under **"Other Publications"**.

Do I have a parent, grandparent, sibling, etc., who is dependent on me for support (according to Canada Revenue Agency rules)?
Extended family members are not eligible for coverage through your flexible benefits program.

However, you may be able to use your HCSA to help pay for your extended family's eligible medical and dental expenses if they are dependent on you for support.

Do I have unused flex credits remaining after I have made all my benefit selections?
If you still have unused flex credits after you make all of your benefit selections, the HCSA is one of the most tax-effective ways to use them.

You are not taxed on any flex credits you deposit to your HCSA (unless you live in Quebec), so it is one of the best values in the flexible benefits program.

Will I be able to spend the flex credits I allocate to the HCSA within two years?
If you are not able to use the flex credits you allocate to your HCSA within two program years, you will lose them.

Keep this in mind when determining how many credits to allocate to your HCSA. Only allocate as many credits to your account as you think you can reasonably use within two years.

Please refer to your Green Shield "My Benefit Plan" booklet for full plan details. The booklet can be found on the enrolment portal under the "Plan Details" tab.

Health Risk Assessment (HRA)

What is the Health Risk Assessment (HRA)?

Your flexible benefits program provides you with a full range of benefit options to help you manage your day-to-day health expenses. The voluntary Health Risk Assessment (HRA) questionnaire takes it one step further by focusing on prevention and managing potential health risks.

Benefits of a Health Risk Assessment

The voluntary online HRA questionnaire will ask you questions about your current health, lifestyle habits, family history, and interest in health promotion programs. You can complete it at any time.

Once you complete the HRA questionnaire, you'll receive a personalized data that shows you:

- If you're at risk for any medical conditions and how high that risk is
- A personalized action plan to help you address your risks
- Information, resources, and tools to support healthy habits and behaviours.

Get additional flex credits!

You can voluntarily complete the HRA questionnaire at any time throughout the year. However, you'll receive an additional $100 in flex credits if you complete the HRA during the regular re-enrollment periods.

During the regular re-enrollment periods, the online enrollment tool will ask if you have completed the HRA questionnaire. If your answer is "Yes", the system will automatically add $100 to your flex credit balance. You must complete the HRA at each re-enrollment period to continue to receive the additional flex credits.

HRA Frequently Asked Questions

What is the Health Risk Assessment (HRA) questionnaire?
The Health Risk Assessment (HRA) questionnaire is a confidential, online questionnaire that assesses your lifestyle and overall health condition. It's an opportunity for you to determine if you are at risk for any health-related issues so that you can strive towards a healthier lifestyle as well as a lower risk of chronic disease.

You can complete the questionnaire online at any time through the flexible benefits website. However, if you complete the questionnaire during the enrollment period, you will also receive additional flex credits to spend on your flexible benefit options.

What will I be asked in the HRA questionnaire?
The HRA is a confidential questionnaire about your current health. You'll be asked to provide information with respect to your:

- Physical measurements
- Biometrics (blood pressure, Body Mass Index (BMI), blood glucose levels, etc.)
- Lifestyle habits
- Emotional health
- Work life balance.

Completing the HRA is voluntary; however, we encourage everyone to complete the questionnaire so you can take charge of managing and preventing potential health risks.

Why should I complete the HRA questionnaire?
In addition to helping you assess your health and lifestyle, and any potential health issues you may be at risk for, you will receive $100 of **additional flex credits** for completing the HRA questionnaire ***before*** enrolling in the flexible benefits program.

You can use these additional flex credits to put toward your flexible benefit coverage options.

Can I complete the HRA questionnaire only prior to enrolling or re-enrolling in the program?
No, you're not limited to completing the HRA questionnaire only prior to enrolling or re-enrolling. You can complete the HRA questionnaire at any time – 24/7! In fact, if you're experiencing a health issue, we strongly recommend that you complete the questionnaire throughout the year to help you monitor and assess your health status.

Personal Spending Account

How The Personal Spending Account Works

Your employer is dedicated to promoting wellness for employees. Wellness activities promote healthy bodies and minds for employees and improve their quality of life at home and at work.

Because there are many ways for you to improve your health and well-being, the Personal Spending Account (PSA) allows you to select the option that contributes best to your wellness solution. You can use your PSA to help pay for eligible physical activity, healthy living, and personal development expenses.

You may allocate flex credits and/or payroll deductions to your PSA. You may do this when you first enroll in the flexible benefits program and during the regular re-enrolment periods.

Any flex credits allocated to your PSA are a taxable benefit to you and will be included in your taxable income.

You can use your PSA throughout the year to help pay for eligible physical activity, healthy living, and personal development expenses.

As long as you have sufficient credits in your account, you can submit claims to your PSA and be reimbursed for your eligible expenses. The amount of your claims will be deducted from the balance of your account.

Once you have used all of your account balance, you must wait until the next program year before you can have more credits allocated to your account and submit any more claims. You can never receive a reimbursement for more than the number of credits available in your PSA.

If you still have a balance left in your account at the end of the benefit program year, the remaining amount will be carried forward to the next program year. If you do not use the amount you carried forward in the second program year, you forfeit it (i.e., if you don't use it, you lose it).

For detailed instructions about making PSA claims, see the **Claims Information** page.

Please refer to your Green Shield "My Benefit Plan" booklet for full plan details. The booklet can be found on the enrolment portal under the "Plan Details" tab.

Eligible PSA Expenses

Eligible Personal Spending Account expenses include the following:

Fitness/sports fees

- Recreational program, classes, team registration fees
- Personal training, consultation
- Club, resort, park annual memberships
- Recreational, individual event pass, registration or fee
- Gym, fitness centre, pool, annual memberships

Fitness equipment

- Fitness equipment
- Sports equipment
- Bicycle (manual)
- Heart rate monitor
- Athletic sportswear and accessories
- Wii Fit or Xbox Kinect, PlayStation Fitness (entertainment system not included)
- Fishing equipment

Family care

- Child care

- Elder care
- Homecare assistance services and products (lifts, supportive aids)
- Caregiver support programs and services

Educational and personal development

- Hobby and general interest classes
- Education fees, tuition, books
- Training, classes, tutoring, language, First Aid, CPR
- Professional designation and membership fees and/or dues
- Personal computer and accessories
- Music equipment

Wellness services

- Smoking cessation programs
- Safety equipment
- Health assessments
- Weight loss programs, counseling (excluding food)
- Nutritional counseling
- Vitamins, supplements, natural products
- Maternity services (pre-natal classes and mid-wife services)
- Stress management programs
- Medical tests
- Alternative health practitioners (reflexologist, iridologist, herbalist, homeopath, chinese medicine, shiatsu therapist, acupuncturist)
- Holistic health services

Non-health professional services

- Legal services
- Financial services

Making PSA Choices

In addition to selecting your other coverage, you will need to decide whether you want to allocate flex credits to your Personal Spending Account (PSA).

When deciding how many flex credits to deposit to your PSA, ask yourself the following questions:

Do I have flex credits available after I've made my selections?
The online enrollment tool automatically allocates your flex credits in the most tax-effective way.

That means it will use flex credits to pay for non-taxable benefits first, such as your health care, dental care, and Health Care Spending Account (HCSA).

If you still have credits remaining after you have selected your other coverage, you can choose to deposit them to your PSA.

Do I want to allocate additional funds to my PSA?
You may use your flex credits to fund a PSA. You can choose to:

- allocate unused flex credits to your PSA – these will be a taxable benefit to you

Remember that once you deposit funds to your PSA, you MUST use them for wellness-related expenses. You can carry any unused funds forward for as long as you want, but you cannot withdraw them as cash.

Note: Since there is no tax advantage to making contributions to the PSA through payroll deductions, you should estimate your wellness expenses and only deposit as much as you think you can reasonably use within two years. Keep in mind that similar to your HCSA, if you still have a balance left in your account at the end of the benefit program year, the remaining amount will be carried forward to the next program year. If you do not use the amount you carried forward in the second program year, you forfeit it (i.e., if you don't use it, you lose it).

Where would be the most valuable place to deposit my leftover flex credits?
Consider the types of expenses you and your family incur most:

- If they are health or dental care expenses you may wish to deposit your flex credits to your HCSA. If you live outside of Quebec the credits you deposit to your HCSA are not a taxable benefit.
- If you participate in a lot of fitness activities the PSA is a great place to deposit flex credits and/or payroll deductions. Remember, though, these credits will be a taxable benefit to you.

Please refer to your Green Shield "My Benefit Plan" booklet for full plan details. The booklet can be found on the enrolment portal under the "Plan Details" tab.

Life Insurance

Life Insurance Options

Life insurance is designed to protect you and your family from financial problems that might arise if you have a death in the family. If the insured person dies, a lump sum, tax-free benefit is paid to the beneficiary.

You automatically receive a core level of life insurance. You can see your coverage amount on your **Personal profile** page and in the online enrollment tool when you enroll or re-enroll in the program.

If you choose to, you can buy optional life insurance for:

- Yourself
- Your spouse
- Your dependent children.

To keep the program tax-effective, flex credits are not used to pay for optional life insurance. You will pay for any optional life insurance you select for you, your spouse, and your children through regular payroll deductions.

Your coverage options for optional life insurance are:

	Optional life insurance for you	Optional life insurance for your spouse	Optional life insurance for your dependent children*
Coverage	Units of $10,000	Units of $10,000	Units of $5,000
Maximum	$500,000	$250,000	$25,000
Cost	Based on the coverage amount and your age, gender, and smoking status at the beginning of the program year	Based on the coverage amount and your spouse's age, gender, and smoking status at the beginning of the program year	Based on the coverage amount
Proof of good health	Required above $50,000	Required for all amounts of coverage	Not required

***** If you purchase optional life insurance for your dependent children, each child is covered for the amount of insurance you purchase.

Applying for coverage

Your basic employee life insurance coverage will begin automatically. Basic life non-evidence maximum is $1,000,000.

If you wish to buy optional life insurance (or increase your existing coverage) for yourself or your spouse, you must indicate the amount using the online enrollment tool.

You and/or your spouse must also complete a proof of good health form if applicable (which the online enrollment tool will provide to you) and be approved for coverage.

Premium rates & taxes

The cost of your basic employee life insurance depends on the amount of coverage you have. Any employer money used to pay for your basic employee life insurance is a taxable benefit to you.

The cost of any optional life insurance you purchase for yourself and/or your spouse depends on:

- The amount of coverage
- You or your spouse's age, gender, and smoking status.

The cost of any optional life insurance you purchase for your dependent children depends on the amount of coverage you select.

Changing your smoking status

To be considered a non-smoker, you (and/or your spouse) must not have smoked for at least 12 consecutive months.

If you and/or your spouse start to smoke, you must declare your smoking status:

- You must tell the insurer immediately by completing the applicable declaration form. If you don't, your coverage and/or your spouse's optional life insurance coverage may become invalid.

If you and/or your spouse stop smoking for at least 12 consecutive months, you may change your smoking status to non-smoker.

To change smoking status:

- You may change your (and/or your spouse's) smoking status at any time using the online enrollment tool.

What's not covered

If you (or your spouse) die by suicide, while sane or insane, no payment will be made for any amount of optional life insurance that has been in force for less than two years.

Life Insurance Beneficiaries

Your named beneficiary receives any life insurance benefits payable under your flexible benefits program if you die.

You can name any person and/or organization as your beneficiary. You can also name more than one beneficiary.

If you name only one primary beneficiary for your benefit, consider naming a contingent beneficiary as well. A contingent beneficiary is the person to whom you assign your life insurance benefits in the event your primary beneficiary dies. You can assign a contingent beneficiary after you print off the beneficiary form from the online enrollment tool.

If a beneficiary is under your provincial age of majority (usually 18 or 19), you should also designate a trustee for that beneficiary.

If you do not name a beneficiary, any benefits payable will go to your estate.

You are automatically the beneficiary of any spousal and/or dependent child life insurance you buy.

You can designate or change your beneficiary at any time using the online enrollment tool.

For more information about naming your beneficiary, you may wish to speak with a lawyer.

If you live in Quebec:

- If you name your spouse as your beneficiary, the designation is "irrevocable" unless you declare otherwise.
- An irrevocable designation means you cannot change your beneficiary unless your spouse agrees in writing.
- If you declare the designation is "revocable" when you first make it, you can change it without your spouse's consent.
- Outside Quebec, all designations are revocable unless you specify otherwise.

Life Insurance Conversion

If life insurance coverage for you and/or your spouse ends or reduces, you may apply to the insurer to convert* the group life insurance coverage to an individual life insurance policy without providing proof of good health.

***Note:** If your life insurance coverage ends because you stop paying the required premiums or you reach age 70, you will not be eligible to convert your coverage.

You must make your request to convert your coverage within 31 days of the reduction or end of the life insurance coverage.

There are a number of rules and conditions in the group contract that apply to converting this coverage. In all cases, the amount of the individual life insurance policy cannot exceed $200,000.

For more information on the conversion privilege, contact your life insurance carrier.

Making Life Insurance Choices

Life insurance is designed to protect you and your family from financial problems that might arise if you have a death in the family.

Ask yourself the following questions to help you decide what life insurance options may be best for you. Use the online enrollment tool to see how much additional coverage will cost.

Coverage for yourself

Do I already have life insurance as part of my financial plan?
Life insurance is an important part of your overall financial plan. You may want to work with a financial advisor to determine how much life insurance you need.

If you have already consulted a financial advisor and have already purchased an individual policy, you may not need any additional optional life insurance through your flexible benefits program.

Is my basic employee life insurance sufficient for my needs?
If you are single and have virtually no debts, basic life insurance coverage may be all you need.

If you have dependents or significant debts such as a mortgage, and your basic employee life insurance is not enough for your needs, you may want to purchase optional life insurance protection.

The optional life insurance coverage available under the flexible benefits program can be used to cover unexpected and short-term needs such as:

- Mortgage insurance protection
- Education funding
- Tax liabilities
- Estate funding if you die unexpectedly while employed.

Note: Your group life insurance coverage ends when you no longer work for your employer. Because of this, you should make sure you have enough personal life insurance outside the flexible benefits program to cover you and your family's long-term needs.

Am I in good health now?
If you are in good health now, you may want to take advantage of the optional life insurance available under the program.

Once you are approved for optional life insurance coverage, you can keep it for as long as you work for your employer. If you are eligible for the flexible benefits program and you pay the premiums, your life insurance will never be cancelled even if your health changes.

How old am I? Can I purchase personal life insurance at a better rate?
You may want to compare the cost of optional life insurance under the flexible benefits program with the cost of equivalent coverage under a personal life insurance policy. Depending on your age and circumstances, you may find that personal insurance is more or less expensive.

If you are young and relatively healthy you may be able to get a better rate through individual insurance. When you compare costs, make sure you compare similar products.

Remember that any optional life insurance you purchase under the flexible benefits program will end when you leave your employer (this does not happen with a personal policy). If you leave your employer, you can move or "convert" your group life insurance over to a personal plan. This means you can buy a personal policy from the insurance company without having to give proof of good health.

Note: If you convert your group life insurance to a personal policy there will be a maximum amount of life insurance you can buy. There will also be conditions that you will have to meet in order to convert this coverage and the cost will be based on your age, gender and smoking status. This is a good option if you leave your employer and you are older or in poor health. If you are in good health, you may be able to find more cost-effective alternatives. Keep this in mind if you are getting close to retirement.

How much money will my survivors need to meet their financial obligations?
When thinking about your survivors' needs, consider expenses such as:

- Funeral costs
- Outstanding debts

- Mortgage payments
- Childcare, education, and housekeeping expenses.

Will your family have other sources of income if you die? Will they have access to:

- Personal savings?
- Other life insurance policies?
- Canada/Quebec Pension Plan benefits?

Many life insurance companies provide calculators on their websites. You can use these to help figure out how much life insurance you and your family will need. These calculators take into account your:

- Income
- Debts
- Dependents' ages and future requirements (like savings for higher education expenses).

Do I have a mortgage or other significant debts?
Even if you have no dependents, you may want to apply for additional life insurance to pay off debts in the event of your death.

If you have mortgage insurance right now, take a look at the cost of your coverage. It may be less expensive for you to replace your mortgage insurance with optional life insurance.

Keep in mind that your optional life insurance coverage **does not** decrease as you pay down your mortgage, like your mortgage insurance does.

Do I want to leave money to my favorite charity?
You can name your favorite charity as the beneficiary of your basic and/or optional life insurance policy. If you die, the charity will receive a tax-free, lump-sum payment.

You can also name a charity as one of several beneficiaries and indicate what percentage of the benefit you want it to receive.

For example: You can ask to have 80% of the benefit paid to your spouse and the other 20% paid to the charity. You may find that this is a cost-effective way for you to make your donation to support a cause you believe is important.

Coverage for your spouse

What expenses will I have if my spouse dies?
Will these expenses be a burden on your personal finances?

Do I depend on my spouse for part of our household income?
If so, what portion of your household income will you need to replace if your spouse dies? Will the loss of your spouse's income cause financial hardship?

Are others dependent upon me for financial support?
If so, will you need to pay more for childcare or household maintenance if your spouse died?

Does my spouse have other life insurance coverage?
Your spouse may have coverage through his or her personal or employer plan. If so, how does the cost of your spouse's existing coverage compare with the cost of coverage under the flexible benefits program?

Coverage for your dependent children

Do I have eligible dependent children?
To be covered for optional life insurance, your children must meet the eligibility requirements for the flexible benefits program.

Do I wish to insure my child's life?
You can use the payment you receive from dependent life insurance for any purpose. However, the coverage is intended to help pay funeral expenses in the unlikely event of your child's death.

For some people, life insurance for their dependents helps to give them peace of mind. Others may feel that this kind of life insurance is unnecessary. The choice is yours.

Are my children covered under another life insurance plan?
Your children may already be covered under another life insurance plan. This could be one you bought when they were born or one provided by your spouse's employer.

You should review all the life insurance you may currently have and decide whether you need the higher level of coverage.

Accident Insurance

Accident Insurance Options

Accident insurance (also known as accidental death & dismemberment or AD&D insurance) pays a benefit if you are hurt or die because of an accident. This benefit is paid in addition to any life insurance coverage you may have.

If you choose to, you can buy optional accident insurance for:

- Yourself
- Your spouse
- Your dependent children.

Proof of good health is **not** required for any accident insurance.

The cost of optional accident insurance for you, your spouse, and your dependent children can be paid with flex credits or through regular payroll deductions.

Your coverage options are:

	Optional accident insurance for you	Optional accident insurance for your spouse	Optional accident insurance for your dependent children*
Coverage	Units of $10,000	Units of $10,000	Units of $5,000
Maximum	$350,000	$350,000	$50,000
Cost	Based on the coverage amount	Based on the coverage amount	Based on the coverage amount

***** If you purchase optional accident insurance for your dependent children, each child is covered for the amount of insurance you purchase.

Premium rates & taxes

The cost of any optional accident insurance you purchase for yourself and/or your spouse and children depends on the amount of coverage.

Any employer money (flex credits) used to pay for any optional accident insurance is a taxable benefit to you.

Accident Insurance Coverage

Your accident insurance covers you, (and your spouse and dependent children, if applicable) 24 hours a day.

The amount of coverage you buy is called the **principal amount**.

If you die, your beneficiary receives the principal amount. If you're injured, you receive a percentage of the principal amount. The percentage you receive depends on the kind of injury, as shown in the table below.

Please refer to the Voluntary Accidental Death and Dismemberment Insurance Booklet – Policy No. 1GS95 for full plan details. The booklet can be found on the enrolment portal under the "Plan Details" tab.

Critical Illness Insurance

Critical Illness Insurance Options

Critical illness insurance provides you with a lump sum, tax-free benefit in the event you suffer from an eligible illness or condition covered by this benefit.

If you choose to, you can buy optional critical illness insurance for:

- Yourself
- Your spouse
- Your dependent children.

The cost of optional critical illness insurance for you, your spouse, and your dependent children can be paid with flex credits and/or through regular payroll deductions depending upon whether or not you have remaining flex credits.

Your coverage options for optional critical illness insurance are:

	For you	For your spouse	For your dependent children*
Coverage	Units of $10,000	Units of $10,000	Unit of $5,000
Maximum	$150,000	$150,000	$25,000
Cost	Based on the amount you purchase, age at the beginning of the program year, gender, and smoking status	Based on the amount you purchase, age at the beginning of the program year, gender, and smoking status	Set rate
Proof of good health	Required above $10,000	Required above $10,000	Not required

***** If you purchase optional critical illness insurance for your dependent children, each child is covered for the amount of insurance you purchase.

Applying for coverage

If you wish to buy optional critical illness insurance (or increase your existing coverage) for yourself, your spouse or your dependent children, you must indicate the amount using the online enrollment tool.
You and/or your spouse must also complete a proof of good health form (which the online enrollment tool will provide to you) and be approved for coverage above the guaranteed issue amount.

Premium rates & taxes

The cost of any optional critical illness insurance you purchase for yourself and/or your spouse depends on:

- The amount of coverage
- You or your spouse's age, gender, and smoking status.

The cost of any optional critical illness insurance you purchase for your dependent children depends on the amount of coverage you select.

Any employer money (flex credits) used to pay for optional critical illness insurance is a taxable benefit to you.

Pre-existing conditions

No critical illness benefit will be paid for any pre-existing conditions.

Remember critical illness insurance under your flexible benefits program ends when you no longer work for your employer. You may be able to convert your coverage to an individual policy when you leave the company, but the amount you can convert may be limited.

If critical illness coverage is a particularly important part of your financial plan you may want to consider purchasing an individual policy that will remain in effect even if you leave your employer.

Please refer to the Critical Illness Insurance Booklet – Policy No. 1N400 for full plan details.
The booklet can be found on the enrolment portal under the "Plan Details" tab.

Short-Term Disability Coverage

Short-Term Disability Coverage

How the STD plan works

If you are unable to work due to non-occupational injury or illness, the short-term disability (STD) benefit will replace a percentage of your income while you are away from work in accordance with High Liner's internal policy regarding short-term disability. There is a 30-day waiting period. Please contact Human Resources for further details.

Long-Term Disability Coverage

How the LTD plan works

For the first 180 uninterrupted workdays you are away from work because of illness or injury, you may receive benefits under the short-term disability plan.

If you are absent from work because of illness or injury for longer than 180 uninterrupted workdays, you may qualify for long-term disability (LTD) benefits.

Your LTD benefit will be equal to 70% of your monthly basic earnings (pre-disability), to a maximum benefit payment of $10,000 per month.

Because your employer pays for this coverage, any benefits you may receive from the LTD plan while ill or injured will be taxable income to you, as dictated by the Income Tax Act.

LTD benefit payments start 181 workdays from the date of your illness or injury. They continue until the earlier of the date you recover, last day of the month in which you retire, last day of the month you reach age 65, or die.

Definition of disability

For the purposes of the long-term disability plan, disability means a medical condition that causes you to be:

- **For the first 24 months** – continuously unable due to an illness to do the essential duties of your own occupation.
- **After 24 months** – continuously unable due to an illness to do any occupation for which you are or may become reasonable qualified by education, training or experience.
- If you have worked 35 or more years of employment with High Liner Foods – you will be

considered totally disabled while you are prevented by illness from performing the essential duties of your own occupation.

If you are disabled for a period of time and then begin participating in an employment rehabilitation program, your LTD benefits may be adjusted if you earn income because of that employment.

Pre-existing conditions

You will not receive benefits if your disability results directly or indirectly from a condition which existed on or before the date your coverage began. However, this limitation will not apply to you if:

- you have been covered for LTD with your employer for at least 13 weeks during which you have been actively working continuously (up to 3 days of absence does not count) and you have not been treated by a doctor, or any medical personnel under the direction of a doctor, for the condition, or
- you became totally disabled more than 12 months after your coverage began.

Continuation of other benefits

When you are receiving long-term disability benefits, some of your other benefits may continue. For more information, contact Human Resources.

When LTD benefits end

Your LTD payments end on the earlier of the following dates:

- The date you are no longer totally disabled.
- The last day of the month in which you reach age 65. If your disability extends beyond age 65, your LTD benefit will continue until you have received a minimum of 12 months of benefits.
- The last day of the month in which you retire with a pension or are eligible to retire with a full pension or full pension equivalent.
- The last day of the month in which you die.

What's not covered

You will not receive LTD benefits for any period:

- you are not receiving appropriate treatment.
- that you do any work for wage or profit except as approved by Sun Life.
- you are not participating in an approved partial disability or rehabilitation program, if required by Sun Life.

- you are on a leave of absence, strike or lay-off except as stated under maternity / parental leave of absence or except where specifically agreed to by Sun Life.
- you are absent from Canada longer than 4 months due to any reason, unless Sun Life agrees in writing in advance to pay benefits during the period.
- you are serving a prison sentence or are confined in a similar institution.

LTD Claims

To make a claim, complete the Notice of Claim for Group Long-Term Disability Benefits that is available from your employer.

Sun Life must receive notice of claim on the earlier of the following dates:

- 60 days after the total disability begins.
- within 30 days of the termination of your long term disability benefit.

Part of the application process will include filling out claim forms that gives Sun Life as many details about the claim as possible. You, the attending doctor and your employer will all have to complete claim forms.

In order to receive benefits, Sun Life must receive these forms no later than 6 months after the end of the elimination period.

Sun Life will assess the claim and send you or your employer a letter outlining our decision.

From time to time, Sun Life can require that you provide them with proof of your total disability. If you do not provide this information within 90 days of this request, you will not be entitled to benefits.

Coordination With Other Sources Of Income

If you are disabled and receiving LTD benefits, your monthly benefit will be reduced (if necessary) by any other disability benefits or income you receive from the following sources:

- Any government-sponsored plan, excluding dependent benefits, employment insurance benefits and automatic cost of living increases under any government sponsored plan that occur after benefits begin
- Workers' Compensation benefits
- A motor vehicle insurance plan which provides disability benefits, to the extent the law does not prohibit such a deduction
- Other group or employer-sponsored disability benefits
- A retirement or pension plan funded in whole or in part by your employer
- The Quebec Parental Insurance Plan

- Any Criminal Injuries Compensation Act or similar law, where allowed by law.

The value of your LTD benefit, plus the value of any disability benefits you may be entitled to receive from the above sources, will equal no more than 85% of your pre-disability basic earnings.

HIGH LINER FOODS

The fine print …

The information provided in this booklet is for general information purposes only. It is not a contract, and it is not legal or professional advice. If the information in this booklet is different than what is in the official plan text, the plan text and any applicable legislation will govern in all cases.

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