

My BENEFIT PLAN

Sysco Canada Inc.

Classification: Regina Union

Billing Division: 25730

Revised Effective Date: August 1, 2019

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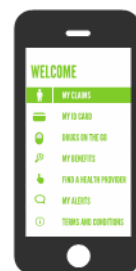
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WELCOME TO YOUR BENEFIT PLAN

This summary contains information about your group benefits with **Sysco Canada Inc.**, your plan sponsor, available through the group contract with Green Shield Canada (GSC), effective July 1, 2018.

HEALTH SUMMARY

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

Benefit Year Deductible: (per person/per family)	No deductible
Maximums Overall Health Maximum:	Unlimited
Your Co-pay:	0%
Your Plan Covers	Maximum Plan Pays
Vision Eyeglasses or contact lenses or medically necessary contact lenses or optometric eye examinations	\$150 every 24 months

ABOUT THIS SUMMARY

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

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

You are covered for only those specific benefits for which you have applied and for which your plan sponsor has certified you are eligible. You must be covered in order for your dependents to be covered. Your coverage will terminate upon the end of the month in which you attain age 70 or the date your plan sponsor advises GSC that you are no longer eligible for coverage. Coverage for your dependents will terminate upon the earlier of termination of your coverage or the date your dependent no longer satisfies the definition of a [dependent](#).

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

PLAN MEMBER ONLINE SERVICES – INFORMATION YOUR WAY

In addition to this summary, and our Customer Service Centre, we also provide you with access to our secure website. Self-service through the GSC website makes things quick, convenient and easy. Register with GSC to:

- View your Benefit Plan Booklet
- Access your personal claims information, including a breakdown of how your claims were processed
- Simulate a claim to instantly find out what portion of a claim will be covered
- Submit certain claims online
- Search for eligible vision care providers in a particular location (within Canada)
- Search for vision and hearing care providers who offer discounts to GSC plan members through our Preferred Provider Network
- Arrange for claim payments to be deposited directly into your bank account
- Print personalized claim forms and replacement Identification Cards
- Print personal Explanation of Benefits statements for when you need to co-ordinate benefits

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

OUR COMMITMENT TO PRIVACY

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

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

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DEFINITIONS

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

Allowed amount means, as determined by GSC, the [reasonable and customary](#) charge for the service or supply but not more than the prevailing charge in the area in which the charge is made for a like service or supply.

Benefit year means the 12 consecutive months commencing on July 1st to June 30th of each year.

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

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

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

Dependent means

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

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

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

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

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

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

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

ELIGIBILITY

For You

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

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

For Your Dependents

To be eligible for coverage you must be:

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

Coverage Effective Date

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

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

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

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

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

Termination

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

- a) the date your employment ends;
- b) the date you are no longer actively working;
- c) the end of the month in which you attain age 70;
- a) the end of the period for which rates have been paid to GSC for your coverage;
- b) the date the group contract terminates.

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

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

Dependent Children Continuation of Coverage

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

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

Survivor Continuation of Coverage

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

- a) 3 months after the date of your death;
- b) the date the covered person would no longer be considered a dependent under the plan if you were still alive; or
- c) the date the benefit under which your dependent is covered terminates.

Losing your Group Benefits?

If your coverage terminates under your Plan Sponsor's benefit plan, you may apply for one of GSC's individual Health and Dental plans. Acceptance for these plans is guaranteed as long as GSC receives your application within 90 days of your employee benefits termination date, provided GSC receives the initial payment. There are no health questions and no medical when you apply. These plans offer coverage for medications that treat pre-existing conditions. Best of all, they provide life-time coverage.

SureHealth™ LINK Plans– Buying directly from GSC

Visit SureHealth.ca where you'll find details about the SureHealth™ LINK plan options available. You can request an information package, you can get quotes online, and you can buy completely online. It is quick and easy. You can give us a call at 1.844.753.SURE (7873) –we can answer any questions you have or we can take your application over the phone.

PRISM CONTINUUM® – Buying from an Advisor

Special Benefits Insurance Services (SBIS) can help. Call 416.601.0429 or 1.800.667.0429 to speak with a specialist about the Prism Continuum program. They can review the options available to you and advise you on the coverage that best suits your needs.

[™]Trademark of Green Shield Canada.

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DESCRIPTION OF BENEFITS

HEALTH BENEFIT PLAN

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

Extended Health Services

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

- a) Prescription eyeglasses or contact lenses;
- b) Optometric eye examinations for visual acuity performed by a licensed optometrist, ophthalmologist or physician. This benefit is available only in those provinces where eye examinations are not covered by the provincial health insurance plan;
- c) 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;
- d) Replacement parts for prescription eyeglasses;
- e) Plano sunglasses prescribed by a legally qualified medical practitioner for the treatment of specific ophthalmic diseases or conditions.

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

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

Health Exclusions

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

1. Services or supplies received as a result of disease, illness or injury due to:
 - a) an act of war, declared or undeclared;
 - b) participation in a riot or civil commotion; or
 - c) 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. Services or supplies that:
 - a) are not recommended, provided by or approved by the attending legally qualified (in the opinion of GSC) 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 GSC, your plan sponsor or you;

- d) are provided by a health practitioner whose license by the relevant provincial regulatory and/or professional association has been suspended or revoked;
- e) are not provided by a designated provider of service in response to a prescription issued by a legally qualified health practitioner;
- f) are used solely for recreational or sporting activities and which are not medically necessary for regular activities;
- g) are primarily for cosmetic or aesthetic purposes, or are to correct congenital malformations;
- h) are provided by an immediate family member related to you by birth, adoption, or by marriage and/or a practitioner who normally resides in your home. An immediate family member includes a parent, spouse, child or sibling;
- i) are provided by your plan sponsor and/or a practitioner employed by your plan sponsor, other than as part of an employee assistance plan;
- j) are a replacement of lost, missing or stolen items, or items that are damaged due to negligence. Replacements are eligible when required due to natural wear, growth or relevant change in your medical condition but only when the equipment/prostheses cannot be adjusted or repaired at a lesser cost and the item is still medically required;
- k) are video instructional kits, informational manuals or pamphlets;
- l) are for medical or surgical audio and visual treatment;
- m) are special or unusual procedures such as, but not limited to, orthoptics, visual training, subnormal vision aids and aniseikonic lenses;
- n) are delivery and transportation charges;
- o) are for Insulin pumps and supplies (unless otherwise covered under the plan);
- p) are for medical examinations, audiometric examinations or hearing aid evaluation tests;
- q) are batteries, unless specifically included as an eligible benefit;
- r) are a duplicate prosthetic device or appliance;
- s) are from any governmental agency which are obtained without cost by compliance with laws or regulations enacted by a federal, provincial, municipal or other governmental body;
- t) would normally be paid through any provincial health insurance plan, Workplace Safety and Insurance Board or tribunal, the Assistive Devices Program or any other government agency, or which would have been payable under such a plan had proper application for coverage been made, or had proper and timely claims submission been made;
- u) were previously provided or paid for by any governmental body or agency, but which have been modified, suspended or discontinued as a result of changes in provincial health plan legislation or de-listing of any provincial health plan services or supplies;
- v) may include but are not limited to, drugs, laboratory services, diagnostic testing or any other service which is provided by and/or administered in any public or private health care clinic or like facility, medical practitioner's office or residence, where the treatment or drug does not meet the accepted standards or is not considered to be effective (either medically or from a cost perspective, based on Health Canada's approved indication for use);
- w) are provided by a medical practitioner who has opted out of any provincial health insurance plan and the provincial health insurance plan would have otherwise paid for such eligible service;
- x) relates to treatment of injuries arising from a motor vehicle accident;
Note: Payment of benefits for claims relating to automobile accidents for which coverage is available under a motor vehicle liability policy providing no-fault benefits will be considered only if–
 - i) the service or supplies being claimed is not eligible; or
 - ii) the financial commitment is complete;A letter from your automobile insurance carrier will be required;
- y) are cognitive or administrative services or other fees charged by a provider of service for services other than those directly relating to the delivery of the service or supply.

CLAIM INFORMATION

Inquiries

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

- ♦ Call our Customer Service Centre at 1.888.711.1119 to determine eligibility for a specific item or service and GSC's pre-authorization requirements, or
- ♦ Visit our website at greenshield.ca to e-mail your question.

Submitting Claims

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

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

GSC reserves the right to request supplementary claims information, failure to respond to such requests may result in the denial of the claim.

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

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

Reimbursement

Reimbursement will be made by one of the following methods:

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

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

Overpayments

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

Limitation on Legal Action

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

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

Subrogation

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

Co-ordination of Benefits (COB)

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

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

GSC Plan Member

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

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

Spouse

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

Children

When dependent children are covered under both your GSC plan and your spouse's benefit plan, use the following order to determine where to submit the claims:

- The plan of the parent whose birth date (month and day) occurs earliest in the calendar year
- The plan of the parent whose first name begins with the earlier letter of the alphabet, if the parents have the same birth date
- In cases of separation or divorce with multiple benefit plans for the children, the following order applies:
 - The benefit plan of the parent who has custody of the dependent child
 - The plan of the spouse of the parent who has custody of the dependent child
 - The plan of the parent who does not have custody of the dependent child
 - The plan of the spouse of the parent who does not have custody of the dependent child

If the parents have joint custody and both have the children listed as dependents under their plans, claims should first be submitted to the plan of the parent whose birth date (month and day) occurs earliest in the calendar year. Balances can then be submitted to the other parent's plan.

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

Access to Information

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

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

GSC may charge you to provide any additional copies.