MY BENEFIT PLAN BOOKLET

Lakehead University

Classification: Contract Lecturers

Billing Division: 11

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WELCOME TO YOUR HEALTH CARE SPENDING ACCOUNT BENEFIT PLAN

ABOUT THIS BOOKLET

This booklet contains important information you will need about your group benefits with **Lakehead University**, your plan sponsor, available through the group contract with Green Shield. It includes:

- a Table of Contents, to allow easy and quick access to the information you are looking for
- a Definitions section, to explain common terms used throughout the booklet
- detailed benefit description
- information you need to submit a claim

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

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

PLAN MEMBER ONLINE SERVICES

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

- A Benefit Plan Booklet
- Printer friendly personalized claim forms
- Benefit eligibility information
- Explanation of Benefits information and claim history for you and your dependents
- 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.

TABLE OF CONTENTS

DEFINITIONS

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

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

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

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

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

Dependent means

a) your spouse, if you are legally married or if not legally married, you have lived in a common-law relationship for more than 1 year. Only one spouse will be considered at any time as being covered under the group contract;
b) your unmarried child under age 21;
c) your unmarried child under age 25, if enrolled and in full-time attendance at an accredited college, university or educational institute;
d) your unmarried child any age, if totally disabled by reason of mental or physical disability and remains continuously so disabled and is considered a dependent as defined under the Income Tax Act.

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

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.

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

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

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

ELIGIBILITY

For You
To be eligible for coverage, you must be:
a) a plan member who is a resident of Canada;
b) covered under your provincial health insurance plan; and
c) actively at work and working a minimum of 35 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 of active employment.

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

If you do not apply for coverage within 31 days of becoming eligible, you must submit medical evidence to Green Shield for coverage, and you will be eligible for coverage on the date the medical evidence is approved.

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 Green Shield 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 period for which rates have been paid to Green Shield for your coverage;
d) the date the group contract terminates.

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

Dependent Children Continuation of Coverage
Any child whose coverage would end because they have reached the specified age limit may qualify for continued coverage, subject to the following conditions:
a) your child became dependent upon you by reason of a mental or physical disability prior to reaching this age; and
b) your child has been continuously so disabled since that time.

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

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

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

DESCRIPTION OF BENEFITS

HEALTH CARE SPENDING ACCOUNT (HCSA)

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

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

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

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

Dependent means your eligible dependent as defined under Definitions in this booklet.

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

A predetermined lump sum amount of $625 will be allocated to your account annually to cover the reimbursement of your eligible expenses incurred during that benefit year. When you submit a claim, you will be reimbursed for eligible expenses up to the balance in your account.

Any balance remaining in your account on the last day of the benefit year will be carried forward to, but not beyond the end of, the next benefit year. This balance will be added to your new credits, and claims for the new benefit year may be applied to the combined amount, using the previous benefit year credits first. At the end of the new benefit year, any remaining previous benefit year credits will be forfeited.

ELIGIBLE EXPENSES

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

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

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

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

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

Exclusions

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

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

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

Maternity, Adoption or Parental Leave

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

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

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

CLAIM INFORMATION

Inquiries

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

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

Pre-authorization

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

Submitting Claims

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

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

- Covered person's name, address and Green Shield Identification Number
- Provider's name and address
- Date of service (this is the date of pick up)
- Charges for each service or supply
- A detailed description of the service or supply
- Medical referral/physician prescription when required

You must pay the provider of service for the claim and you will be reimbursed from your HCSA. The claim **will not** be re-directed to a secondary plan (COB) before paying out of the HCSA.

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

Submit the HCSA Claim Form to:
Green Shield Canada

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

Reimbursement

Reimbursement will be made by one of the following methods:

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

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

Subrogation

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

PREFERRED PROVIDER VISION NETWORK ARRANGEMENT

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

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

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

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

3. Trustworthy retail chains with convenient locations;

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

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

6. Professional opticians to assist in selecting products;

7. For some vendors, this offer applies to non-disposable contact lenses only (excludes disposable contact lenses.

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

How to Submit Your Vision Claim

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

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

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

OUR COMMITMENT TO PRIVACY

The Green Shield Canada Privacy Code balances the privacy rights of our group and benefit plan members and their dependents, and our employees, with the legitimate information requirements to provide customer service. It consists of the following key principles:

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

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

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

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

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

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

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