Auto Sector Retiree Health Care Trust

asr TRUST
RETIREE HEALTH CARE

Chrysler Retiree Health Care Benefits Plan

As of January 1, 2025

THE AUTO SECTOR RETIREE HEALTH CARE TRUST – BACKGROUND

The Auto Sector Retiree Health Care Trust or "asrTrust" is a new legal entity established to fund and administer retiree health care benefits for a closed group of Chrysler retirees, surviving spouses and active Chrysler employees represented by the CAW (now Unifor) as of May 4, 2009, along with their eligible dependents (the "Covered Group").

The establishment of an independent health care trust was a condition of government financial assistance provided to Chrysler Canada to assist with its restructuring resulting from the crisis in the auto industry in 2008/09, which included a filing for bankruptcy protection by Chrysler's U.S. parent company. As part of this restructuring the CAW agreed to amend its collective agreement with Chrysler and agreed to a framework that would permit Chrysler to transfer responsibility for retiree health care benefits to an independent trust fund.

The agreement between the CAW and Chrysler to establish the asrTrust was the subject of a class action court process in 2010 in which Court approved representatives, who were independent of the CAW and Chrysler, represented the retirees and surviving spouses (the "Retiree Representatives"). The Retiree Representatives retained an independent lawyer and received advice from their own actuary. The parties to the class proceedings, which included the Retiree Representatives, the CAW and Chrysler, reached a settlement dated October 5, 2010 (the "Settlement"), which was approved by order of the Court dated October 4, 2010 (the "Approval Order").

The Settlement and Approval Order terminated Chrysler's obligation to provide health care benefits to the Covered Group and required the establishment of the asrTrust to deliver the retiree health care benefits previously provided by Chrysler under its collective agreements with the CAW (the "Chrysler Health Care Program").

The asrTrust provides health benefits which are supplementary to and not covered by a government health care program. The benefits payable by the asrTrust for former Chrysler employees and their dependents are to be exclusively funded with the assets available to the asrTrust for the Chrysler benefit plan. These assets consist of an initial cash contribution and promissory notes from Chrysler as required by the Settlement and monthly member contributions. The initial cash contribution by Chrysler together with the member contributions will not be sufficient to fund all the benefits provided Chrysler to the Covered Group. The asrTrust is dependent on receiving future payments from Chrysler under the promissory notes, which is dependent on Chrysler's solvency and ability to make the payments when due.

However, contributions received by the asrTrust can only be used to provide health care benefits to the Chrysler Covered Group and will be maintained separate from Chrysler's assets and will not be available to Chrysler or its creditors if Chrysler faces financial difficulties in the future.

The ability of the asrTrust to provide post-retirement health care benefits in the future will depend on a number of factors, including the cost of benefits, the cost of administering the benefit plan and investment returns, among others. Therefore, the Trustees of the asrTrust have the authority to change, reduce, improve, revoke, suspend, or terminate benefits and will do so with the objective that, as much as practicable, current and future members of the asrTrust in the Chrysler Covered Group will receive similar levels of coverage or value of post-retirement health care benefits.

The asrTrust is also subject to compliance with applicable legislation, including the Canada *Income Tax Act*, which was amended to accommodate the asrTrust by creating a new entity defined as an "employee life and health trust" or "ELHT". The ELHT provisions of the *Income Tax Act* specify conditions to be met by the asrTrust, including the persons eligible to participate in the ELHT and the type of benefits it can provide. The Trustees are obligated to ensure that the asrTrust always complies with the ELHT provisions. As such, benefits provided and eligibility to participate in the plan may be modified by the Trustees to comply with the ELHT provisions of the *Income Tax Act* as they may be amended.

ADMINISTRATION OF THE AUTO SECTOR RETIREE HEALTH CARE TRUST

The terms governing the administration of asrTrust are set out in the Declaration of Trust made as of December 07, 2010, the form of which was approved by the Court in the Approval Order (the "Trust Agreement"). Ultimate authority over the asrTrust and the benefit plan rests with the Board of Trustees, which consists of 5 trustees appointed by Unifor and 5 independent trustees who are experts in fields relevant to the administration of a health care benefit plan (the "Trustees").

The Board of Trustees has the authority and responsibility for all aspects of the management and administration of the asrTrust including the authority to hire its own staff and professional advisors. As well, the Trust Agreement gives the Trustees the authority to establish a benefits plan, including the authority to determine the benefits to be provided, the benefit levels, the eligibility rules and member contribution amounts. These terms and conditions and the legal description of the benefits are set out in the plan document attached as Schedule "A" to the Trust Agreement, as it may be modified from time to time by the Trustees (the "Benefit Plan").

The day-to-day operation of the asrTrust and the Benefit Plan is the responsibility of the Executive Director who is hired and supervised by the Trustees.

BOOKLET CONTENT

This booklet is intended as an easy-to-read outline of the principal features of your health care Benefits Plan that provides coverage for hospital, surgical, medical, hospital care, nursing home, out-of-province, prescription drug, dental, extended health services, vision, hearing aid and health care spending account expense benefits.

The basic hospital, surgical and medical benefits are provided by your provincial health insurance plan. All other covered health expense benefits are administered by Green Shield Canada Insurance (GreenShield). GreenShield administers but does not insure the benefits. The asrTrust is liable for the payment of such non-insured benefits.

This booklet does not grant or create any rights or vested rights nor does it impose any obligations on GreenShield, the asrTrust or the Trustees. Your rights to benefits and the asrTrust's obligations with respect to benefits, if any, are found solely in the Benefit Plan, the Trust Agreement and any underlying insurance policies.

This booklet is designed to give you, in a summary way, information about benefits for which you may be eligible. We have done our best to ensure that this booklet is accurate. However, to the extent that there is any conflict between the terms of this booklet and the Benefit Plan, the Trust Agreement or any underlying insurance policies, the terms of the Benefit Plan, the Trust Agreement or the underlying insurance policies, as applicable, shall apply in place of the terms contained in this booklet.

If any Provincial or Federal legislation is in effect or is enacted or amended to provide hospital, surgical, medical, extended health benefits, semi-private hospital care, prosthetic appliance and durable medical equipment, nursing home, out-of-province, prescription drug, dental, vision, hearing aid or health care spending account expense benefits similar to those described in this booklet, appropriate modifications may be made to your health care coverage under the Benefit Plan.

FURTHER INFORMATION

Detailed information concerning the benefits for which you may be eligible, or regarding your health care claims reimbursement, may be obtained from GreenShield at 1 (877) 266-5494 or (519) 739-1133 Ext.: 6835. Claim submission forms are available online at greenshield.ca and all claims must be submitted within 12 months of the date incurred to be eligible for reimbursement under the Benefit Plan. Please refer to section XII of this booklet for specific GreenShield contact information for inquiries and obtaining any of the forms referred to in this booklet.

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Plan Administration

I. ELIGIBILITY FOR RETIREE HEALTH CARE BENEFITS PLAN COVERAGE

A. WHO IS ELIGIBLE FOR COVERAGE

You and your enrolled dependents are eligible for hospital, surgical, and medical expense benefits, prescription drug, dental, vision, hearing aid expense, extended health services coverage and health care spending account benefits if you are part of the Chrysler Covered Group as defined in the Trust Agreement and you and your dependents satisfy all the conditions to be eligible for coverage under the Benefit Plan (a "Covered Person").

The Chrysler Covered Group includes the following:

- A former employee of Chrysler who, at May 4, 2009, had retired while covered by a Collective Agreement between Chrysler and the CAW without breaking service and who elected to receive an immediate pension under the Chrysler Pension Plan (but not including a former employee entitled to or receiving a deferred pension) (a "Retiree").

- An active employee of Chrysler who, at May 4, 2009, was covered by a Collective Agreement between Chrysler and the CAW (including those on vacation, layoff, medical or other leave of absence who had not broken service), and who do not break seniority between May 4, 2009 and their retirement with an immediate pension under the Chrysler Pension Plan (an "Active Employee").

- A surviving spouse of a deceased former employee as described above who:

  a. Was a Retiree receiving a pension under the Chrysler Pension Plan; or
  b. Was eligible to retire and receive an immediate pension under the Chrysler Pension Plan at the time of death; or
  c. Was an Active Employee who is in receipt of, or eligible to receive, an immediate pension from the Chrysler Pension Plan at the time of death.

  (a "Surviving Spouse")

- A person who on or after the date of the Court Approval Order is the surviving dependent of two deceased persons who were, while living, a Chrysler Retiree (including an Active Employee when they retire) and/or a Surviving Spouse as described above (an "Orphan Dependent").

B. WHEN COVERAGE COMMENCES

Covered Persons become eligible for hospital, surgical and medical expense benefits, prescription drug, dental, vision, hearing aid expense, extended health services and health care spending account benefits coverage on the following dates:

- For Retirees, Surviving Spouses, their eligible dependents and Orphan Dependents, on the effective date of the Benefit Plan – December 31, 2010.

- For Active Employees and their eligible dependents, the first day of the calendar month following the month in which he or she retires with an immediate pension under the Chrysler Pension Plan.

- For a Surviving Spouse or Orphan Dependent(s) of a Covered Person who dies after December 31, 2010, on the first day of the calendar month following the month in which the deceased's coverage under the Benefit Plan was terminated.

C. ELIGIBLE DEPENDENTS

If you are an eligible Retiree as defined under A. above your eligible dependents include:

1. Your **spouse**. Your spouse includes the person to whom you are legally married, or if you are not legally married, a person who:

    a. Resides with you, and
    b. You have an established relationship of cohabitation for a continuous period of at least one year, and
    c. You publicly represent as your spouse.

2. Your **unmarried children,** provided they meet the criteria set forth below, until the end of the calendar year in which they attain 25 years of age, or at any age if they are totally and permanently disabled by a medically determinable physical or mental condition which prevents the child from engaging in substantially gainful activity and which can be expected to be long-continued or of indefinite duration or to result in death.

    a. Each child who has reached the end of the calendar year in which he/she attains 21 years of age must legally reside with or be a member of your household and must be registered as a full-time student in a school or university.

    b. Eligible children include:

        (1) Your children by birth, legal adoption or by Court Order while they are in your full custody and legally reside with and are dependent upon you;
        (2) Children of your spouse while they are in the custody of and dependent upon your spouse and reside in and are members of your household;
        (3) Children, as defined above, who do not reside with you but are your legal responsibility for the provision of health care; and
        (4) For Health Care Spending Account, in addition to your dependents above (spouse and children), your relative who is a Canadian resident and dependent on you for support and for whom you are claiming a tax deduction on your federal tax return, as outlined in the rules and regulations of the Canadian Income Tax Act.

If you are a Surviving Spouse, your eligible dependents include your unmarried children as defined in C.2. who are enrolled or were eligible to be enrolled for coverage at the time of your spouse's death.

Eligible children also include orphan dependents provided they were enrolled at the time of the Covered Person's death and for as long as they otherwise continue to meet the above criteria or until they become the dependent of someone else.

You may be requested to provide proof of eligibility for all dependents covered under the Benefit Plan. This may include a request annually to attest to the eligibility status of dependent children age 21-25. Failure to comply with such requests may result in removing the dependent(s) from group coverage. If you subsequently substantiate eligibility of the dependent(s), coverage will be reinstated retroactively up to 6 months.

D. COVERAGE FOR SPONSORED DEPENDENTS

Hospital, surgical, medical, prescription drug, vision, hearing aid expense, extended health services and health care spending account benefits coverage is available for sponsored dependents provided:

- The dependent either is related to you by blood or marriage and resides with you as a member of your household; and
- The person qualifies in the current year for dependency tax status or was reported as a dependent on your most recent Income Tax Return.

Surviving Spouses may only continue coverage for sponsored dependents enrolled at the time of their spouse's death.

The Covered Person must pay the full cost of such coverage for sponsored dependents as determined from time to time by GreenShield and adopted by the Trustees.

Sponsored dependents are not eligible for dental expense coverage. Sponsored Dependents are not eligible for long term care benefits (unless they are currently residing in a long term care facility prior to January 1, 2016).

E. WHEN DEPENDENT ELIGIBILITY CEASES

Your dependent's eligibility ceases at the time of any of the following occurrences:

- **Legally Married Spouse**
  - The effective date of your Divorce Judgement.

- **Common-law Spouse and His/Her Children**
  - The date you no longer reside together in an established relationship of cohabitation.

- **Children Before the End of the Calendar Year in which they turn Age 21**
  - The date your child marries or commences to reside in an established common-law relationship, or
  - The date your child commences working full-time (does not include temporary full-time summer employment).

- **Children Age 21 (End of the Calendar Year) or Over**
  - The date your child marries or commences to reside in an established common-law relationship, or
  - The date your child commences working full-time (does not include temporary full-time summer employment), or
  - The date your child graduates or no longer attends a school or university on a full-time basis.

- **Sponsored Dependent**
  - The date your dependent no longer qualifies for dependency tax status.

F. REPORTING CHANGES IN ELIGIBILITY STATUS

Please notify GreenShield immediately of any event affecting your eligibility or the eligibility of your dependents.

You are liable for any and all expenses incurred and charged to the asrTrust under the Benefit Plan by persons who are no longer eligible dependents.

G. PLAN LIMITS

Where any benefit payable under the Benefit Plan is subject to a maximum limit payable for a period of time (plan year, calendar year, 5 years, lifetime, etc,) the specified period will include the period of time during which you and your eligible dependent(s) were covered by and received the same or similar benefits under the Chrysler Health Care Program.

Where the amount of benefit payable is subject to a lifetime, annual, treatment or other maximum limit, the calculation of the maximum benefit payable for you or your eligible dependent(s), will include the amount paid for the same of similar benefits under the Chrysler Health Care Program.

II. HOSPITAL, SURGICAL, AND MEDICAL (HSM) EXPENSE BENEFITS

A. PROVINCIAL HEALTH INSURANCE PLAN

The hospital, surgical, medical expense benefits provided under public health plans for Covered Persons residing in Canada are as follows:

(a) For Covered Persons residing in Ontario, the benefits shall be those provided under The Ontario Health Insurance Plan (OHIP),
(b) For Covered Persons in other provinces or territories in Canada, the benefits shall be those provided by the applicable provincial, territorial, or federal health plans, supplemented as necessary by the asrTrust so that the Covered Person receives benefits that are substantially equal to the level of benefits available to Covered Persons in Ontario.

The provincial health insurance plan provides a wide range of basic benefits for physicians' services and hospital care in standard ward accommodations. Benefits under a provincial plan are available only to individuals who are residents of the province. Information concerning such benefits is provided in separate booklets published by the provincial health insurance plan. Information on OHIP for Ontario residents may be obtained through the Ministry of Health and Long Term Care's INFOline at 1-800-268-1154.

Residents of all provinces are responsible for registering themselves and their dependents for coverage under their provincial health insurance plan and notifying GreenShield of any changes affecting their registration (e.g. marriage, divorce, change of address).

B. SEMI-PRIVATE HOSPITAL ACCOMMODATION EXPENSE BENEFITS

Covered Benefits

The Semi-private Hospital Accommodation Expense Benefit provides for **limited coverage** as follows:

a. Reimbursement for the difference in cost between standard ward charges and the cost of semi-private accommodation up to a maximum of $200 per day, in a convalescent or rehabilitation hospital or a convalescent or rehabilitation wing in a public general hospital when the standard ward charges are paid by any provincial government health insurance plan of the province in which the Covered Person is a resident and when the Covered Person is occupying or has occupied a convalescent or rehabilitation bed.

b. Reimbursement of up to $30 per day for the difference between the charges for a standard ward and the cost of semi-private accommodation in a public chronic hospital or chronic wing facilities of a public general hospital, or in a bed designated as an alternate level of care (ALC) bed by the attending physician when the Covered Person has occupied semi-private accommodation.

c. Reimbursement of the current Ontario Ministry of Health rate up to a maximum of $60 per day toward the chronic care co-payment charge following the expiration of the co-pay benefit period paid by the provincial government health plan for a standard ward in a public chronic hospital or chronic wing facilities of a public general hospital, or in a bed designated as an alternate level of care (ALC) bed by the attending physician.

Limitations

- Where the Covered Person had occupied a chronic bed in a semi-private room either in, or outside, of the province of residence, a maximum of $30 difference per day shall be allowed;
- To be eligible for reimbursement for occupancy of a chronic bed, accommodation must be in a public chronic hospital or a chronic wing facility of a public general hospital; or in a bed designed as an alternative level of care bed by the attending physician;
- No benefit shall apply to semi-private accommodation in a nursing home, T.B. Sanatorium or mental hospital;
- Payment of benefits is contingent upon the provincial health insurance plan in the province in which the Covered Person resides accepting or agreeing to pay the ward or standard rate;
- Reimbursement will not be made in respect to any eligible expense unless a claim is filed as required by GreenShield. In most cases the hospital will bill GreenShield directly.

Exclusions

Covered semi-private hospital accommodation expense does not include and no benefit is payable for:

- Semi-private hospital accommodation for acute care;
- Semi-private hospital accommodation where the Covered Person is occupying an active treatment bed in a public general hospital;
- Semi-private hospital accommodation where the Covered Person is not occupying a rehabilitation or convalescent bed, or a chronic care bed;
- Occupation of a bed not requested by the Covered Person;
- Charges for completion of any forms;
- Charges for semi-private hospital accommodations where such benefits are provided to the Covered Person without cost by compliance with laws or regulations enacted by any federal, provincial, municipal, or other governmental body.

How to Claim Hospital Accommodation Benefits

In most cases, claims for semi-private accommodation are submitted directly by the hospital. If you or your dependent has paid the hospital directly, you must submit the original paid receipt along with a completed **General Submission Claim Form** available from GreenShield. Submitted claim information must include the admitting and discharge dates, the number of days billed, and the daily semi-private rate. Claims for chronic care/ALC must be submitted with a fully completed **Chronic Care/Alternate Level of Care Claim Form** available from GreenShield. Claims for covered expenses must be submitted within 12 months of the date incurred to be considered for reimbursement.

C. LONG TERM CARE FACILITY EXPENSE BENEFITS

1. Benefits for Residents of Ontario

The Long Term Care Facility Expense Benefit provides for the payment toward the patient co-payment expense that is charged to a Covered Person (other than a Sponsored Dependent) who resides in a Long Term Care Facility as an approved resident as determined by the Placement Coordination Office under the *Long Term Care Homes Act, 2007* as it may be amended.

For Covered Persons resident in a Long Term Care Facility prior to January 1, 2006, the benefit payment toward the patient co-payment expense in any such approved Long Term Care Facility shall be the difference between the daily allowance paid to the Long Term Care Facility by the Province of Ontario in a standard ward and the Long Term Care Facility's daily charge up to the semi-private rate, if a semi-private or private accommodation is occupied, as approved by the Province of Ontario.

For Covered Persons who commence residence in a Long Term Care Facility on or after January 1, 2006 but prior to January 1, 2009, the benefit payment toward the patient co-payment expense will be limited to $2,000 monthly, regardless of the type of accommodation occupied.

For Covered Persons who commence residence in a Long Term Care Facility on or after January 1, 2009 but prior to January 1, 2011, the benefit payment toward the patient co-payment expense will be limited to $2,000 monthly, regardless of the type of accommodation occupied.

For Covered Persons who commence residence in a Long Term Care Facility on or after January 1, 2011, the benefit payment toward the patient co-payment expense will be limited to $2,000 monthly, regardless of the type of accommodation occupied.

Benefits will be payable only on submission of proof satisfactory to GreenShield that an eligible Covered Person has been approved and a payment of an allowance for such care was made to that Long Term Care Facility on behalf of such Covered Person by the Province of Ontario for each day benefits are claimed.

How to Claim Long Term Care Facility Benefits in Ontario

The following information must be supplied to GreenShield with the initial claim:

(i) A copy of '**Authorization for Admission to a Long-Term Care Facility**' form as completed by the Community Care Access Centre (CCAC) naming the facility and confirming that the Covered Person is a resident there;

(ii) A copy of the Ministry of Health '**Application for Reduction in Long-Term Care Facility Accommodation Fees**' as completed by the facility for those in a ward or standard accommodation.

In many cases the Long Term Care Facility will bill GreenShield directly on a monthly basis. In the event the Long Term Care Facility in which the covered person resides does not directly bill GreenShield, a **Long-Term Care Facility Claim Form** must be obtained from GreenShield. The form must be completed in full and submitted directly to GreenShield, ensuring all applicable areas are signed. Long Term Care Facility Benefit Claims must be submitted within 12 months of the date incurred to be considered for reimbursement.

2. Benefits for Residents Other than Ontario

The Long Term Care Facility expense benefit provides for the payment of the co-payment expense that is charged to the Covered Person (other than a Sponsored Dependent) who is certified by GreenShield as meeting the same requirements necessary to receive benefits under the Ontario *Long Term Care Homes Act, 2007* as it may be amended for each day such Covered Person resides in and receives daily care in an approved Long Term Care Facility which is licensed or registered under the laws of the province in which it is located.

The payment for the patient co-payment expense in a Long Term Care Facility will be the lesser of the usual charge payable by the Covered Person; or the co-payment amount up to the maximum level, which would have been payable by GreenShield had such Covered Person been in a licensed Long Term Care Facility in the province of Ontario.

In provinces other than the province of Alberta, the provincial health insurance plans do not provide a Long Term Care Facility benefit comparable to the coverage provided by the province of Ontario. In these provinces the HSM Benefit provides a supplemental Long Term Care Facility benefit. The benefit payment, under this supplemental coverage, would equal the lesser of:

a. The actual charge for such covered services, or
b. The reasonable and customary charge for such covered services, but in no case will the benefit payment exceed the amount provided for such services by the province of Ontario taking into account any deductible or patient co-payment amount provided thereunder, less any reimbursement for which the Covered Person may be eligible under provincial health insurance plans.

How to Claim Long Term Care Facility Benefits Outside of Ontario

Benefits shall be provided upon submission of proof satisfactory to GreenShield that the same requirements are met to receive extended care benefits under the *Health Insurance Act of Ontario*. The Covered Person must reside in and receive daily care in an approved Long Term Care Facility which is licensed or registered under the laws of the province in which it is located.

The following information will be required by GreenShield:

- The name of the facility with confirmation that the Covered Person is a resident;
- Proof of facility requirements based on type of facility and type of care provided;
- Authorization of admission from applicable provincial placement service;
- Any income assessments as required.

Once the above requirements are met, the Long Term Care Facility may choose to bill GreenShield directly on a monthly basis. In the event the Long Term Care Facility in which the Covered Person resides does not directly bill GreenShield, a **Long-Term Care Facility Claim Form** must be obtained from GreenShield. The form must be completed in full and submitted directly to GreenShield, ensuring all applicable areas are signed. Long Term Care Facility Benefit claims must be submitted within 12 months of the date incurred to be considered for reimbursement.

Exclusions

- Benefits will not be provided to Covered Persons eligible for or receiving the same or similar benefits from any branch of any federal, provincial or municipal government or any other third party, regardless of whether the Covered Person has or has not contributed toward providing such benefit for themself or a covered dependent.
- For conditions arising from war, riot, or insurrection or from service in the armed forces.
- Daily benefits will not be paid under this program if the Covered Person is absent from the Long Term Care Facility. However, a Covered Person who has been approved may continue to receive benefits for up to two (2) calendar days following admission to a public general hospital.

D. OUT-OF-PROVINCE HOSPITAL, SURGICAL, AND MEDICAL EXPENSE BENEFITS

1. This supplementary benefit reimburses you for:

    a. Covered hospital, surgical, medical or emergency air ambulance expenses incurred by you or your eligible dependents as a result of accidental injury or emergency medical services while vacationing, travelling or temporarily residing outside of your province of residence (either in another province or another country);
    b. Covered hospital, surgical or medical expenses incurred by you or your eligible dependents as a result of a referral by the Covered Person's attending physician in the Covered Person's province of residence to a treating physician or hospital outside of your province of residence provided prior approval has been obtained from the provincial Ministry of Health; and
    c. Return of deceased up to a maximum of $15,000 toward the cost of preparation and transportation in an appropriate container of yourself or your covered dependent when death is caused by illness or accident. The body will be returned to the major airport nearest the point of departure in your province/territory of residence. In the case of cremation and/or burial at the place of death, this benefit is limited to $5,000. The benefit excludes the cost of a burial coffin, urn, or any funeral-related expenses, makeup, clothing, flowers, eulogy cards, church rental, etc.

2. A covered hospital, surgical, medical or emergency air ambulance expense is a fee incurred as a result of a service rendered under 1.a. or b. above, provided a fee would be payable for such service under the provincial health insurance plan if such a service was performed or rendered in your province of residence.

3. The amount of the reimbursement to you under this supplementary benefit is equal to the difference between:

    a. The fee scheduled under the provincial health insurance plan where you reside permanently; and
    b. The reasonable and customary charge in the area where you receive the covered services, as determined by GreenShield.

4. When it is demonstrated to GreenShield to be medically necessary for you or an eligible dependent to travel by an air ambulance to your province of residence, you will be reimbursed for the amount charged to the Covered Person and, when necessary, for the air fare of an accompanying medical attendant as well as the air fare of an accompanying spouse.

    Note: Most provincial health insurance plans require that a licensed physician contact their Central Ambulance Authority before an air ambulance can be used. (For further information contact your local provincial health insurance plan office).

5. This benefit does not make any payment toward:

    a. The cost of private hospital room, or
    b. Any portion of a scheduled fee which is uninsurable by law when such service is rendered in your province of residence.

E. GREENSHIELD TRAVEL ASSISTANCE

For **major emergency** treatment out of your province of residence arrangements have been made to guarantee the providers of the services (hospital, clinic or physician) that you have both provincial health insurance plan and Out-of-province Hospital, Surgical and Medical Expense Benefits coverage.

This guarantee of coverage has been arranged through an international travellers assistance and medical services organization called GreenShield Travel Assistance.

The following services are available 24 hours per day, 7 days per week through GreenShield's international medical service organization:

- Access to pre-trip assistance (prior to departure): Canada Direct Calling Codes; information about vaccinations; government issued travel advisories; and VISA/document requirements for entry into country of destination,
- Multilingual assistance,
- Assistance in locating the nearest, most appropriate medical care,
- Medical consultation and monitoring services to review appropriateness and quality of medical care,
- Monitoring of progress during treatment and recovery and confirming when the patient is medically fit for transportation when a transfer or repatriation is necessary,
- Emergency message transmittal services and assistance in establishing contact with family, personal physician and employer as appropriate*
- Translation services and referrals to local interpreters as necessary*
- Verification of insurance coverage facilitating entry and admission into hospitals and other medical care providers, special assistance regarding the coordination of direct payment of claims
- Coordination of embassy and consulate services*
- Management, arrangement and co-ordination of emergency medical transportation and evacuation as necessary*
- Arrangement for repatriation of remains*
- Arrangements for interrupted travel plans resulting from emergency situations including:
    - The return of unaccompanied travel companions*
    - Travel to the bedside of a stranded person*
    - Rearrangement of ticketing due to accident or illness and other travel related emergencies*
    - The return of stranded motor vehicles and related personal items*
- Legal referral and coordination of securing bail bonds and other legal instruments*
- Special assistance in replacing lost or stolen travel documents including passports*
- Courtesy assistance in securing incidental aid and other travel-related services*

* PLEASE NOTE: For those services marked with an asterisk, your coverage will provide for the arrangements involved in securing the services but **not the cost** of the services.

How GreenShield Travel Assistance Service Works For You:

- For assistance dial the appropriate toll free number which appears on your GreenShield identification card. Quote your group number and GreenShield identification number, found on your GreenShield identification card, and explain your medical emergency. **You must always be able to provide your GreenShield identification number and your provincial health insurance plan number.**
- As GreenShield is not able to guarantee assistance services in areas of political or civil unrest please contact GreenShield for pre-travel or claims inquiries.
- A multilingual assistance specialist will provide direction to the best available medical facility or physician which can provide the appropriate care.
- Upon admission to a hospital or when attending a physician for major emergency treatment, the provider (hospital, clinic, or physician) will be guaranteed that you have both provincial health insurance, and GreenShield out-of-province benefits. The provider may then bill GreenShield directly for these approved services eliminating most out of pocket expenses.
- Physicians will follow your progress to ensure that you are receiving the best available medical treatment. These physicians also keep in constant communication with your family physician and your family, depending on the severity of your condition.

Limitations

1. As of June 1, 2018, benefits will be eligible only if existing or pre-diagnosed conditions are stable (in the opinion of GreenShield Assistance Medical Team in accordance with the following definition) and the covered person is medically fit to travel at the time of departure from the covered person's province of residence. GreenShield reserves the right to review the covered person's medical information at the time of claim;

   Stable means that during the 90 days immediately preceding your departure:

   a. your pre-existing/pre-diagnosed medical condition:
      i. has been controlled by the consistent use of the same medications and dosages (excluding previously established changes in medication that occur as part of your ongoing treatment, or decreases in dosage resulting from an improvement in your pre-existing or pre-diagnosed medical condition) prescribed by a legally qualified medical professional;
      ii. has not, in the reasonable opinion of a legally qualified medical professional, required additional treatment for a recurrence, complications or any other reason related either directly or indirectly to your pre-existing or pre-diagnosed medical condition;

   b. you have not consulted a legally qualified medical professional for, or had investigated or diagnosed, a new medical condition for which you have not received medical treatment; and,

   c. you have not scheduled/are not awaiting any future appointments for non-routine examinations, tests or investigations (including results) for a potentially undiagnosed medical condition; and,

   d. you are not awaiting any surgical procedures for a potentially undiagnosed or diagnosed medical condition.

2. Eligible services must be required for the immediate relief of acute pain or suffering as a result of accidental injury or emergency while traveling. You will not be reimbursed for treatment or surgery which could reasonably be delayed until you return to your province of residence.

3. Reimbursement for eligible services in Canada will be made only if your provincial government health plan provides payment toward the cost of the services received.

4. Reimbursement for eligible services out of Canada will be made only if the out-of-Canada benefits of your provincial government health plan (where applicable) provides payment toward the cost of the services received.

5. Coverage becomes effective at the time you or your eligible dependent crosses the provincial border and terminates upon crossing the border into the province of residence on the return home. If travelling by air, coverage becomes effective at the time of aircraft take off in the province of residence and terminates when the aircraft lands in the province of residence on the return home.

6. Air ambulance services will only be eligible if:

   - Pre-approved by GreenShield, and
   - There is a medical need for you to be confined to a stretcher or for a medical attendant to accompany you during the journey, and
   - You are admitted directly to a hospital in your province of residence, and
   - Medical reports or certificates from the dispatching and receiving physicians are submitted to GreenShield, and
   - Proof of payment including air ticket vouchers or air craft carrier invoices are submitted to GreenShield.

7. Referral services are only eligible if the required medical treatment is not readily available in your province of residence, and prior approval is obtained from the Ministry of Health in your province of residence.

8. Repatriation is mandatory when it is determined that the Covered Person is medically fit to travel and appropriate arrangements have been made to admit the Covered Person into the provincial health care system. Reimbursement will be provided to a maximum of $1,000 for the cost of returning the Covered Person's personal use motor vehicle to their place of residence or nearest appropriate vehicle rental agency when the Covered Person is repatriated to their province of residence.

Exclusions

In addition to the General Overall Exclusions found in section VIII of this booklet, eligible services do not include and reimbursement will not be made for:

1. Charges for services over and above the usual, reasonable and customary charges in the area the services were received.
2. Transportation and lodging.
3. Repatriation of remains.
4. Rest cure, health spas, or travel for reasons of health.
5. Treatment or services for ongoing care, elective surgery or check ups - elective health services are defined as those services:
   - Where vacation or travel is solely for the purpose of obtaining treatment, or
   - Which can be planned or anticipated ahead of time, or
   - Which have not received "prior approval" from the provincial health plan ministry.

6. Services received from a chiropractor, chiropodist, podiatrist, or for osteopathic manipulation.
7. Benefits and services for which you receive reimbursement from a third party.

How to Claim Out-of-Province Benefits

Payment of an out-of-province hospital, surgical, medical or emergency air ambulance expense benefit by GreenShield is made only if the provincial health insurance plan in the province in which you reside offering coverage out of province or out of country (where applicable) makes a payment towards the service for which an out-of-province benefit is claimed. If your province of residence does not offer out of country coverage, then the prerequisite of payment by a provincial plan does not apply.

If you have incurred out of pocket expenses, claims must be submitted to GreenShield Travel Assistance who will then coordinate with the provincial plan reimbursement of those approved, eligible expenses. To make a claim, submit to GreenShield Travel Assistance the Covered Person's name, address, GreenShield identification number, and provincial health plan number along with:

- A fully completed Emergency Medical Expense Claim Form. This Form is required to be completed and submitted for all cases, even where the provider has been paid directly by GreenShield Travel Assistance. The Form is sent directly to your address by GreenShield Travel Assistance but is also available on GreenShield's website at greenshield.ca.
- Original itemized receipts with detailed statements showing the services rendered and the fees charged for each service.
- If the fee for the services rendered is the result of a referral by your physician, you must receive pre-authorization from your provincial government health plan and GreenShield **prior to the commencement of any referral treatment.** Your provincial government health plan may cover this referral benefit entirely. Check with them prior to receiving any services. You must provide GreenShield with a letter from your attending physician stating the reason for the referral, and a letter from your provincial government health plan outlining their liability.

Note: All claims must be submitted to GreenShield Travel Assistance within 12 months from the date eligible services were received to be considered for reimbursement.

III. PRESCRIPTION DRUG EXPENSE BENEFITS

A. COVERED DRUGS

Covered drugs under the Prescription Drug Expense Benefits include those drugs for which a prescription from a physician or dentist is required by law and the drug is dispensed by a pharmacist. Covered drugs also include injectibles and pharmaceuticals, when dispensed by a pharmacist, and which are normally prescribed by physicians for the treatment of an illness. In addition, the Prescription Drug Expense Benefits provides a benefit for injectible medications and substances (including biological sera and vaccines) when administered and supplied by a physician and for shampoos and laxatives when they are prescribed for the treatment of cancer patients. Some covered drugs have limitations on the number of treatments or dollars allowed on an annual or lifetime basis.

Conditional Formulary Drugs

Certain drugs will only be considered a benefit under this program if the Covered Person meets certain specific conditions, these are known as 'conditional drugs'. In order to be considered for benefit payment, your physician will be required to complete a form that details your medical conditions including clinical evidence. This in turn, must be submitted to GreenShield for review and assessment of eligibility. If approved, you or your dependent will be notified. The pharmacy may opt to assess the completed form and if eligible to do so, submit directly to GreenShield on your behalf. The **"Prescription Drug Special Authorization Request Form"** is available by contacting GreenShield. Some conditional drugs have an automated review process for which no form completion is required.

Generic Equivalent

When a drug prescribed for a Covered Person has a generic equivalent, regardless of interchangeability, the maximum benefit under the Benefit Plan for such drug will be limited to the cost of the lowest priced generic drug less the co-pay mentioned below. In the event that a brand name prescription drug becomes available at a cost less than the lowest priced generic drug, the brand name prescription drug will be the eligible benefit.

When the Covered Person chooses the more costly drug in lieu of the lowest priced generic drug, such Covered Person will be responsible for the difference in cost. However, in cases where the Covered Person's physician specifically prescribes a more costly drug rather than a generic equivalent of the drug and provides GreenShield with a copy of the completed form that has been submitted to Health Canada through the "**Canadian Adverse Drug Reaction Monitoring Program**", the Benefit Plan will pay for the cost of the prescribed drug. This form is available online through Health Canada at www.hc-sc.gc.ca.

The asrTrust may have in place pricing agreements with drug manufacturers that will designate a specific product exclusive making all other brands ineligible (e.g. a brand product could be exclusive making its generic ineligible). If Covered Persons choose to be dispensed the ineligible product, the entire cost will not be eligible.

B. EXCLUSIONS AND LIMITATIONS

Certain medicines, items and other substances are not covered including:

- Any drug or medicine that can be purchased without a prescription with the exception of insulins, nitrates, vaccines, antifungals and epinephrine kits for the treatment of anaphylaxis;
- Proprietary and patent medicines;
- Natural health products;
- Formulations that can be sold in non-drug outlets and which are not normally considered by physicians as medicines for which a prescription is necessary or required;
- Any prescription dispensed by a physician, other than injectibles administered by a physician;
- Any prescription dispensed in a hospital;
- Vitamins, other than when injected by a physician, whether or not a prescription is issued by a physician for a medical reason;
- Injectibles or any medications which are supplied or administered under any federal, provincial, or municipal government or third party immunization programs;
- Blood and blood plasma;
- Prescriptions for an amount greater than the maximum limit for the prescribed pharmaceutical, as determined by GreenShield;
- First Aid supplies;

- Diaphragms, contraceptive gels or foams or appliances whether or not such prescription is given for medical reasons;
- Any charge by a physician for administering a covered drug;
- Covered drugs not intended for the personal use of a Covered Person;
- Prescriptions, which may be compensated under the workers' compensation legislation, or for which reimbursement may be obtained from a municipal, county, provincial or federal government agency or foundation;
- Diabetic supplies, including syringes, disposable syringes and needles, diabetic testing agents and insulin are paid at a reasonable usual and customary suggested retail price, except that, syringes, disposable syringes and needles will not be a covered expense under the Prescription Drug Expense Benefit for a period of five (5) years from the date that an insulin pressure injection device is approved by GreenShield as a covered durable medical equipment expense under The Prosthetic Appliance and Durable Medical Equipment Expense Benefit;
- New drugs will be added to the Benefit Plan only if they are recommended for inclusion by GreenShield's Pharmaceutical and Medical Consultants and (if necessary) an independent external scientific review agency.

C. MEDICAL CANNABIS

Medical cannabis, up to a maximum of $2,500 per calendar year, when use is authorized by a legally authorized physician (M.D.) or nurse practitioner for covered persons at least 25 years of age for the treatment of medical conditions approved for coverage, as determined by GreenShield. All claims for medical cannabis are subject to GreenShield's pre-authorization process.

Reimbursement for medical cannabis (including tax and shipping charges) will be considered as a treatment of last resort when all other standard medications and treatment options, including commercially available cannabinoids that have been issued a DIN by Health Canada, have failed or deemed inappropriate, and the medical cannabis is:

- a form that is considered legal for medical purposes as defined by federal legislation; and
- dispensed by a producer licensed by Health Canada.

Reimbursement will not be made for any equipment or supplies required to grow or harvest any plants, or produce any form of medical cannabis or cannabinoid, regardless if such form is approved for use by Health Canada, or any devices required to administer the product such as, but not limited to, pipes or vapourizers.

D. HOW TO CLAIM PRESCRIPTION DRUG BENEFITS

Benefits are provided for covered drugs which you receive on or after the effective date of coverage, even though your prescription order may have been issued prior to the effective date. Most claims will be submitted directly to GreenShield by your pharmacy. If you or your dependent has paid the pharmacy directly, please submit your original prescription receipt(s) along with a fully completed **Drug Claim Submission Form** to GreenShield. Claims for covered expenses must be submitted within 12 months of the date purchased to be considered for reimbursement.

The prescription drug cost allowed by the Benefit Plan limits the amount reimbursed for drug cost markup.

Prescriptions for maintenance drugs will be limited to a 30 day supply for the initial fill; thereafter, your Benefit Plan requires refills of the same maintenance drugs to be dispensed in 90 day supplies.

The prescription drug co-payment amount will be 0% of the total amount allowed by the Benefit Plan.

Covered Persons age 65 and over residing in Ontario

Prescription Drug Benefits for Covered Persons who are age 65 and over are available under the Ontario Drug Benefit Program.

When you turn 65, you will receive a letter from the Ministry of Health explaining the Ontario Drug Benefit Program. Most prescription drugs are covered under the Program with a deductible and/or copayment. For more information on the Ontario Drug Benefit Program please call 1-888-405-0405.

Prescription drugs that are covered benefits under the Ontario Drug Benefit Program are not covered benefits under the Prescription Drug Expense Benefits (except for the deductible) and will be automatically processed by the pharmacist under the Ontario Drug Benefit Program. If your pharmacist determines that the prescription drug is not a covered benefit under the Ontario Drug Benefit Program, the pharmacist will fill the prescription and submit a claim under the Prescription Drug Expense Benefits as described in C. above, provided that the drug is a covered benefit under the Benefit Plan as previously described in A. above.

Covered Persons age 65 and over residing in other Provinces/Territories

Outside of Ontario prescription drug coverage may be available to seniors under a provincial/territorial drug program similar to the Ontario Drug Benefit Program. You and your eligible dependents are required to enroll in the provincial/territorial drug program, if it is voluntary, and have your pharmacist dispense prescription drugs under the provincial/territorial program. The Benefit Plan will not provide benefits for drug expenses covered by the provincial/territorial program if you fail to register under the provincial/territorial program. For Covered Persons who are registered with their provincial/territorial program, benefits shall be provided under the Benefit Plan for covered drugs to the extent that coverage for such expenses is not covered by the provincial/territorial drug program.

IV. DENTAL EXPENSE BENEFITS

The Benefit Plan provides the following covered services when performed by a licensed dentist, denture therapist or dental hygienist (or comparable provider licensed in a province other than Ontario), when operating within the scope of their respective licenses.

A. COVERED DENTAL EXPENSES

1. The following covered dental expenses shall be paid at 100% of the dentist's, denture therapist's or dental hygienist's usual charge but not more than the amount specified in the current Provincial Dental Association Schedule of Fees (or when applicable, in the current Ontario Fee Schedule for Licensed Denture Therapists or the current Ontario Dental Hygienists Association Fee Guide for Dental Hygienists) or any other fee guide as authorized by the Trustees:

    a. Routine oral examinations and prophylaxis (cleaning of teeth), but not more than once in any period of nine (9) consecutive months;
    b. Topical application of fluoride, only for persons under twenty (20) years of age, unless a specific dental condition makes such treatment necessary;
    c. Space maintainers that replace prematurely lost teeth for eligible children under nineteen (19) years of age;
    d. Emergency palliative treatment (for the temporary relief of pain or discomfort);

e. Dental x-rays, including full mouth x-rays (but not more than once in any period of thirty-six (36) consecutive months), supplementary bitewing x-rays (but not more than once in any period of twelve (12) consecutive months) and such other dental x-rays as are required in connection with the diagnosis of a specific condition requiring treatment;
f. Extractions, including those performed in connection with orthodontic treatment;
g. Oral surgery, including surgery performed in connection with orthodontic treatment;
h. Amalgam, silicate, acrylic, synthetic porcelain, and composite filling restorations to restore diseased or accidentally injured teeth;
i. General anaesthetic and intravenous sedation when medically necessary and administered in connection with oral surgery;
j. Treatment of periodontal and other diseases of the gums and tissues of the mouth including periodontal splinting or ligation, provisional, intra coronal or extra coronal and a periodontal service. Periodontal appliance will be covered when provided for the treatment of bruxism (grinding of teeth) and performed by a licensed dentist. Coverage for benefits will be limited to one appliance in any 24 month period;
k. Endodontic treatment (treatment of diseased or infected tooth nerves), including root canal therapy;
l. Injection of antibiotic drugs by the attending dentist;
m. Repair or recementing of crowns, onlays, bridgework or dentures; or relining or rebasing of dentures more than six (6) months after the installation of an initial or replacement denture, but no more than one relining or rebasing in any period of thirty six (36) consecutive months;
n. Onlays, gold filings, or crowns restoration to restore diseased or accidentally injured teeth, but only when the tooth, as a result of extensive caries or fracture, cannot be restored with an amalgam, silicate, acrylic, synthetic porcelain, or composite filling restoration;
o. Porcelain veneers for eligible children under nineteen (19) years of age for treatment of teeth severely stained from the drug tetracycline or from endemic fluorosis and for all Covered Persons for treatment of the following conditions: amelogenesis imperfecta; Hutchinson's incisors; and enamel hypo-maturation;
p. Pit and fissure sealants for permanent molars for eligible children up to and including age 14.

2. The following covered dental expenses shall be paid at (i) 100% of the dentist's or denture therapist's usual charge, or (ii) 100% of the amount specified in the current Provincial Dental Association Schedule of Fees (or when applicable, in the current Ontario Fee Schedule for Licensed Denture Therapists, or any other fee guide as authorized by the Trustees), whichever of (i) or (ii) is less;

   a. Initial installation of fixed bridgework (including onlays and crowns as abutments);
   b. Initial installation of partial or full removable dentures (including precision attachments and any adjustments during the six (6) month period following installation);
   c. Replacement of an existing partial or full removable denture or fixed bridgework by a new denture or by new bridgework, or the addition of teeth to an existing partial removable denture or to bridgework, but only if satisfactory evidence is presented that:
      (1) The replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed; or,
      (2) The existing denture or bridgework was installed under this Dental Expense Benefit at least five (5) years prior to its replacement and the existing denture or bridgework cannot be made serviceable; or,
      (3) The existing denture is an immediate temporary denture which cannot be made permanent and replacement by a permanent denture takes place within twelve (12) months from the date of initial installation of the immediate temporary denture. Normally, dentures will be replaced by dentures but if a professionally adequate result can be achieved only with bridgework, such bridgework will be a covered dental expense.

d. Orthodontic procedures and treatment (including related oral examinations) consisting of surgical therapy, appliance therapy, and functional/myofunctional therapy (when provided by a dentist in conjunction with appliance therapy) for Covered Persons under twenty-one (21) years of age. If a course of treatment is in progress (continuous treatment) as of the twenty-first birthday, benefits will continue until the earlier of (1) completion of the treatment plan or (2) exhaustion of the orthodontic lifetime maximum;
e. Standard implantology and bone graft expenses are included effective January 1, 2022.

B. MAXIMUM BENEFIT

The maximum benefit payable for all covered dental expenses, except for orthodontic services, will be $6,000 per calendar year for each individual.

The maximum benefit payable for covered dental expenses in connection with orthodontics, as described in Section A.2.d. shall be $3,600 during the lifetime of each individual under twenty-one (21) years of age.

C. PRE-DETERMINATION OF BENEFITS

If a course of treatment can reasonably be expected to involve covered dental expenses of $200 or more, a description of the procedures to be performed and an estimate of the dentist's charges must be filed by GreenShield prior to the commencement of the course of treatment.

GreenShield will then notify the Covered Person of the estimated benefits payable. In determining the amount of benefits payable, consideration will be given to alternate procedures, services, or courses of treatment that may be performed for the dental condition concerned in order to accomplish the desired result, subject to the benefit maximums and limitations of the Dental Expense Benefits.

If a description of the procedures to be performed and an estimate of the dentist's charges are not submitted in advance, GreenShield reserves the right to make a determination of benefits payable taking into account alternate procedures, services or courses of treatment, based on accepted standard of dental practice. To the extent verification of covered dental expenses cannot reasonably be made by GreenShield, the benefits paid for the course of treatment may be for a lesser amount than would otherwise have been payable.

This pre-determination requirement will not apply to courses of treatment under $200 or to emergency treatment, routine oral examinations, x-rays, prophylaxis and fluoride treatments. Even when pre-determination is not required, however, you may request pre-determination of the estimated benefits payable, if you wish to know the portion, if any, of the dentist's charge that is your responsibility.

How pre-determination works:

1. You or your dependent should request that the dentist, after making the diagnosis, outline on the claim form the plan of treatment and the fee for each service to be rendered.

2. The claim form describing the treatment plan and any attachments (x-rays and study models if necessary) are to be forwarded by the dentist to GreenShield before treatment has begun. The treatment plan will be reviewed by GreenShield and a determination of estimated payable benefits will be made. The claim form, with allowable benefits indicated, will then be returned to the Covered Person.

3. To ensure that you understand the services that the dentist will be performing and the costs involved, you should discuss the certified pre-determination with your dentist before treatment starts.

D. LIMITATIONS

1. **Restorative:**

   a. **Gold, baked porcelain restorations, crowns and jackets**
   If a tooth can be restored with a material such as amalgam, payment of the applicable percentage of the charge for the procedure will be made toward the charge for another type of restoration selected by you or your dependent and the dentist. **The balance of the treatment charge remains your or your dependent's responsibility.**

   b. **Reconstruction**
   Payment based on the applicable percentage will be made toward the cost of procedures necessary to eliminate oral disease and to replace missing teeth. Appliances or restorations necessary to increase vertical dimension or restore the occlusion are considered optional and their **cost remains your or your dependent's responsibility.**

2. **Prosthodontics:**

   a. **Partial dentures**
   If a cast chrome or acrylic partial denture will restore the dental arch satisfactorily, payment of the applicable percentage of the cost of such procedure will be made toward a more elaborate or precision appliance that you or your dependent and your dentist may choose to use. **The balance of the cost remains your or your dependent's responsibility.**

   b. **Complete dentures**
   If, in the provision of complete denture services, you or your dependent and your dentist (or denture therapist) decide on personalized restorations or specialized techniques as opposed to standard procedures, payment of the applicable percentage of the cost of the standard denture services will be made toward such treatment and **the balance of the cost remains your or your dependent's responsibility.**

   c. **Replacement of existing dentures**
   Replacement of an existing denture will be a covered dental expense only if the existing denture is unserviceable and cannot be made serviceable. Payment based on the applicable percentage will be made toward the cost of services, which are necessary to render such appliances serviceable. Replacement of prosthodontic appliances will be a covered dental expense only if at least five (5) years have elapsed since the date of the initial installation of that appliance under this Dental Expense Benefits.

3. **Orthodontics:**

   a. 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, benefits for the services, to the extent remaining, shall be resumed.

   b. The benefit payment for orthodontic services shall be only for the months that coverage is in force.

4. **Periodontics:**

   a. The following periodontal services will be covered dental expenses **only if performed by a Periodontist:**

      (1) Gingival curettage
      (2) Periodontal splinting or ligation, provisional, intra coronal, or extra coronal
      (3) Occlusal equilibration
      (4) Periodontal scaling and root planing

   b. Periodontal scaling when performed by a general practitioner limited to 8 units every 12 months based on date of first paid claim.

   c. A temporomandibular joint (TMJ) appliance will be a covered adjunctive periodontal service **only when performed by a certified dental specialist** (i.e. periodontist, orthodontist, prosthodontist and oral surgeon).

   d. A periodontal appliance will be covered when provided for the treatment of bruxism and performed by a licensed dentist. Coverage will be limited to one appliance in any 24 month period.

E. EXCLUSIONS

Covered dental expenses do not include and no benefits are payable for:

1. Charges for services, treatment, appliances and supplies which are specified in the Provincial Dental Association Schedule of Fees but which are not set forth under Section A., Covered Dental Expenses;

2. Charges for treatment by other than a licensed dentist, denture therapist or dental hygienist;

3. Charges for veneers or similar properties of crowns and pontics placed on or replacing teeth, other than the ten upper and lower anterior teeth;

4. Charges for services or supplies that are cosmetic in nature, including charges for personalization or characterization of dentures;

5. Charges for prosthetic devices (such as bridges and crowns) and the fitting thereof which were ordered while the individual was not covered for Dental Expense Benefits or which were ordered while the individual was covered for Dental Expense Benefits but are finally installed or delivered to such individual more than sixty (60) days after termination of coverage;

6. Charges for replacement of a lost, missing or stolen prosthetic device;

7. Charges for failure to keep a scheduled visit with a dentist;

8. Charges for services or supplies which are compensable under workers' compensation or employer's liability law;

9. Charges for services rendered through a medical department, clinic or similar facility provided or maintained by your or your dependent's employer;

10. Charges for services or supplies for which no charge is made that the patient is legally obligated to pay or for which no charge would be made in the absence of dental expense coverage under this Benefit Plan;

11. Charges for services or supplies which are not necessary, according to accepted standards of dental practice, or which are not recommended or approved by the attending dentist;

12. Charges for services or supplies which do not meet accepted standards of dental practice, including charges for services or supplies which are experimental in nature;

13. Charges for services or supplies received as a result of dental disease, defect, or injury due to an act of war, declared or undeclared;

14. Charges for services or supplies from any governmental agency which are obtained by the individual without cost by compliance with laws or regulations enacted by any federal, provincial, municipal or other governmental body;

15. Charges for any duplicate prosthetic device or any other duplicate appliance;

16. Charges for any services to the extent for which benefits are payable under any health care program supported in whole or in part by funds of the federal government or any province or political subdivision thereof;

17. Charges for completion of any forms;

18. Charges for prescription drugs;

19. Charges for sealants (except as provided under A.1.p.) and for oral hygiene and dietary instructions;

20. Charges for a plaque control program;

21. Charges for services or supplies related to periodontal splinting, except that provisional splinting, intracoronal and provisional splinting-extracoronal will be covered services when performed by a Periodontist.

F. HOW TO CLAIM DENTAL BENEFITS

Dental claim forms, complete with instructions, are available from many dentists' offices. **Dental Claim Forms** are also available from GreenShield.

The form must be completed giving all details of the work done, signed by the dentist in order to certify that the work detailed has been completed, signed by you, and then forwarded by you to GreenShield. Payment will be made directly to you on the basis of you or your dependent's eligibility and covered dental expenses as outlined earlier in this booklet. Many dental offices will submit the claim to GreenShield for you either in a paper or electronic format. In this case, carefully review and approve the claim completed by the dental office before it is submitted on your behalf. Claims for covered expenses must be submitted within 12 months of the date of service to be considered for reimbursement.

V. VISION EXPENSE BENEFITS

The Vision Expense Benefit provides for:

- Reimbursement to a maximum of $140 for the cost of one vision examination, by a qualified optician, optometrist or ophthalmologist, once in a twenty-four (24) month period when this benefit is not provided under the Covered Person's provincial health care plan.
- Reimbursement for prescription eye glasses (frames and lenses) or contact lenses to a maximum of $350 for all covered vision expenses every 24 months.
- Reimbursement for Laser Eye Surgery to a lifetime maximum of $350, with no other reimbursement under the Vision Expense Benefit allowed for a 48 month period.
- Repairs (not replacements) at the usual and customary rates as determined by GreenShield.
- The benefit period begins on the initial date vision benefits are received.

Limitations

- If a Covered Person has received lenses and frames or contact lenses for which benefits were payable under the Chrysler Health Care Program or this Benefit Plan, subsequent benefits will be payable only if received more than 24 months after the date that benefits were initially paid in the prior period.
- If a Covered Person has received laser eye surgery for which benefits were payable under the Chrysler Health Care Program or this Benefit Plan, no other reimbursement under the Vision Expense Benefit shall be allowed for a 48 month period after the date that the laser eye surgery benefit was initially paid.
- Eligible children up to the age of 19 who have diabetes or other medical conditions requiring frequent lens changes (as substantiated by an ophthalmologist), will be eligible for new lenses whenever they have a prescription change.
- Contact lenses will be covered every 12 months, when the Covered Person's visual acuity cannot otherwise be corrected to at least 20/70 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.

Exclusions

- Charges for vision testing examinations for Covered Persons under age 20 and over age 64, or at any age for Covered Person’s with medical conditions or diseases affecting the eyes whereby the provincial health plan provides the covered benefit;
- Medical or surgical treatment;
- Drugs or medications;
- Lenses or frames furnished for any condition, disease, ailment or injury arising out of and in the course of employment;
- Lenses or frames ordered before coverage is effective or after coverage is terminated;
- Lenses or frames ordered while covered but delivered more than 60 days after coverage terminated;
- Charges for completion of any forms;
- Vision benefits which are not dispensed by an Optometrist, Optician or an Ophthalmologist;
- Follow up visits associated with the dispensing and fitting of contact lenses;
- Charges for eye glass cases;
- Lenses or frames which are not necessary according to or do not meet accepted standards of ophthalmic practice, which are experimental in nature, or which are not ordered or prescribed by the attending physician or optometrist;

- Charges for lenses or frames for which no charge is made that the Covered Person is legally obligated to pay, coverage is obtained without cost through any governmental body or for which no charge would be made in the absence of coverage;
- Charges for lenses or frames received as a result of eye disease, defect or injury due to an act of war, declared or undeclared;
- Services related to orthoptics (eye exercises) vision training, subnormal vision aids, aniseikonic lenses (special lenses to correct image size differences) and tonography (specialized pressure test).

How to Claim Vision Expense Benefits

Claims for covered eyewear and/or eye exams must be submitted to GreenShield on a fully completed **Vision Claim Form** along with the original receipt(s) and must be submitted within 12 months of the date of purchase or service to be considered for reimbursement.

VI. HEARING AID EXPENSE BENEFITS

The Hearing Aid Expense Benefit covers:

1. The dispensing fee and acquisition cost of a hearing aid and ear mould once every thirty-six months provided that:

    - A physician who specializes in performing medical examinations of the ear (an otologist), or a physician who specializes in treatment of the ear, nose and throat determines that the Covered Person has a loss of hearing acuity which can be compensated by a hearing aid;
    - Hearing aids are prescribed as a result of hearing aid evaluation tests to determine the make and model of hearing aid that would best improve the loss of hearing acuity and only when such test is performed by a physician or certified audiologist and only when indicated by the most recent audiometric examination;
    - The hearing aid provided by the dealer is the make and model prescribed by the audiologist and is certified as such by the audiologist; and

2. The cost of necessary repairs to a hearing aid purchased under the Hearing Aid Expense Benefit.

Hearing Aid Expense Benefits are provided for hearing aids of the following functional design: in-the-ear, behind-the-ear, (including air conduction and bone conduction types) on-the-body, in-the-canal, digital, programmable, and binaural type hearing aids.

If a binaural hearing aid system (consisting of two complete hearing aids) is prescribed and an in-depth review of the claim by GreenShield shows that such a system is necessary to compensate adequately for the loss of hearing acuity it will be considered a covered Hearing Aid Expense Benefit.

Exclusions

Covered hearing aid expense does not include and no benefits are payable for:

- Medical examinations, audiometric examinations or hearing aid evaluation tests;
- Medical or surgical treatment;
- Drugs or other medications;
- Hearing aids provided under any applicable workers' compensation law;
- Hearing aids ordered before coverage is effective or after coverage is terminated;

- Hearing aids ordered while covered but delivered more than 60 days after termination;
- Charges for hearing aids for which no charge is made to the Covered Person or for which no charge would be made in the absence of hearing aid expense benefits coverage;
- Charges for hearing aids which are not necessary, according to professionally accepted standards of practice, or which are not recommended or approved by the physician;
- Charges for hearing aids that do not meet professionally accepted standards, including charges for any services or supplies that are experimental in nature;
- Charges for hearing aids received as a result of ear disease, defect or injury due to an act of war, declared or undeclared;
- Charges for hearing aids provided by any governmental agency that are obtained by the Covered Person without cost by compliance with laws or regulations enacted by any federal, provincial, municipal or other governmental body;
- Charges for hearing aids to the extent benefits are payable under any health care program supported in whole or in part by funds of the federal government or any province or political subdivision thereof;
- Replacement of hearing aids that are lost or broken unless at the time of such replacement the Covered Person is otherwise eligible under the frequency limitations set forth herein;
- Charges for the completion of any forms;
- Ineligible replacement parts for hearing aids;
- Charges for hearing aid repairs covered under the manufacturer's warranty; and
- Eyeglass-type hearing aids, to the extent the charge for such hearing aid exceeds the covered hearing aid expense for one hearing aid under covered benefits described above.

How to Claim Hearing Aid Expense Benefits

When a hearing aid or hearing aid repair is obtained from any provider, you should present your identification card (issued by GreenShield). The provider will complete GreenShield's **Audio Claim Form** and will bill GreenShield directly. GreenShield will reimburse the provider on the basis of acquisition cost of the hearing aid plus a dispensing fee and for the cost of any necessary repairs based on the provider's reasonable and customary charge for such service. Claims for covered expenses must be submitted within 12 months of the date of purchase or service to be considered for reimbursement.

VII. EXTENDED HEALTH SERVICES BENEFIT

The Extended Health Services Benefit provides for:

A. PARAMEDICAL EXPENSE BENEFIT

The Paramedical Expense Benefit provides for reimbursement of covered Chiropractic, Podiatry, Chiropody, Naturopathy, Massage Therapy and Physiotherapy Treatment Expenses, incurred by you or your eligible dependents after the annual benefit for treatments covered by your provincial health insurance plan, if any, has been exhausted. The Paramedical Expense Benefits are outlined below:

1. Chiropractic treatments will be reimbursed to a maximum of $500 every calendar year per Covered Person. Benefits will be coordinated with those provided by provincial health plans where applicable.

2. Treatments provided by a Practitioner of Podiatry and a Practitioner of Chiropody will be reimbursed to a combined maximum of $500 every calendar year per Covered Person. Benefits will be coordinated with those provided by provincial health plans where applicable.
3. Naturopathy treatments will be reimbursed to a maximum of $500 every calendar year per Covered Person.
4. The services of a Registered Massage Therapist will be reimbursed to a maximum of $500 every calendar year per Covered Person.
5. Treatments provided by a Physiotherapist will be reimbursed to a maximum of $1,500 every calendar year per Covered Person.

Exclusions

- Charges for radiographs (x-rays);
- Charges for failure to keep a scheduled visit;
- Charges for completion of any insurance forms;
- Services in connection with occupational disease or injury;
- Paramedical coverage does not include and no benefits are payable:
  i) For remedies, supplies, vitamins, herbal medications or preparations;
  ii) Where the service is necessary as a result of a motor vehicle accident, unless there is no such coverage under a motor vehicle insurance policy or such coverage has been exhausted; and
  iii) If the Covered Person is a resident of a long term care facility, unless such services otherwise provided by the long term care facility have been exhausted.

How to Claim Paramedical Expense Benefits

When you or an eligible dependent incur a Paramedical Expense(s) both you and the paramedical practitioner must complete a **Related Professional Services Form**, which may be obtained from the paramedical practitioner or GreenShield. The completed form can be forwarded to GreenShield by either you or your practitioner along with the receipt issued by the paramedical practitioner. The receipt must include the date(s) of service, cost per treatment, and the provider's registration number. Claims for covered expenses must be submitted within 12 months of the date of service to be considered for reimbursement.

B. IN HOME NURSING AND SUPPORT SERVICES

In Home Nursing and Support Services will be provided up to a combined maximum of $100,000 every calendar year under the provisions as outlined below:

1. In Home Nursing Services

The Nursing Expense Benefit provides for the in home nursing services of a Graduate Registered Nurse (RN) or Registered Practical Nurse (RPN) for you or your eligible dependents when there is a clear medical necessity for such nursing services. The Covered Person will be reimbursed for the amount charged to the Covered Person for such services provided that:

(a) The nursing services are prescribed by a physician and the physician and/or appropriate party responsible for accessing applicable government programs and/or funding indicates:
  (i) The level of nursing skill required;
  (ii) The amount of time in each day required for nursing services; and
  (iii) The approximate length of time that nursing services are required.
(b) The RN or RPN is not a relative.

(c) The RN or RPN is currently registered with the appropriate nursing association when the services are performed.
(d) The Covered Person is not in an institution (i.e. hospital, nursing home, home for the aged, etc.).
(e) The rate charged for nursing care does not exceed the usual and customary charges for the applicable geographic area.
(f) All applicable provincial or federal government assistance (based on age, disability, income, etc.) is applied for. In determining the necessity for the nursing services and ensure all available coordination with government programs, GreenShield will undertake an independent nursing service assessment.

2. In Home Support Services

The Covered Person will be reimbursed for the in home services of a Personal Support Worker (PSW), commonly referred to as a health care aide, for the amount charged for such service provided that:

(a) The PSW has a certificate from an accredited program and is employed by a provincially recognized, bonded health care provider.
(b) The PSW is not a relative.
(c) All applicable community, provincial or federal government assistance (based on age, disability, income, etc.) is applied for.

Failure to comply with any of the foregoing may result in non payment of the claim.

Should any Covered Person reach the annual maximum provided for these services, and remain eligible for in home nursing care under item 1. above, coverage will be continued at up to two (2) hours per day for the nursing services of a Registered Nurse (RN).

How to Claim In Home Nursing and Support Services Benefits

All in home nursing and support services require pre-authorization. Please contact GreenShield for more information. Claims for covered expenses must be submitted within 12 months of the date of service to be considered for reimbursement.

C. PSYCHOLOGIST EXPENSE BENEFIT

The Psychologist Expense Benefit provides for reimbursement of expenses for counselling services incurred by you or your eligible dependent for personal, family or marital problems. Counselling must be provided by a Registered Clinical Psychologist, Master of Social Work, Psychotherapist or Social Worker/Counsellor. The Covered Person will be reimbursed to an annual maximum of $750 for all covered practitioners combined.

For eligible dependent children under the age of fourteen (14), a benefit will also be provided toward the cost of a psychological assessment, excluding charges for forms and reports, performed by a registered clinical psychologist. This benefit is provided once for each eligible dependent, to a lifetime maximum of $500. The amount reimbursed for a psychological assessment will be included in the annual maximum set out above.

Exclusions

Charges for completion of any forms, reports, or follow up correspondence.

How to Claim Psychologist Expense Benefits

When you or an eligible dependent incur a Psychologist or Master of Social Work expense you must complete a **Related Professional Services Form**, which may be obtained from the provider or GreenShield. The completed form can be forwarded to GreenShield by either you or the provider along with the receipt issued by the registered clinical psychologist or social worker. The receipt must include dates of service, cost per treatment and the provider's registration number. Claims for covered expenses must be submitted within 12 months of the date of service to be considered for reimbursement.

D. SPEECH THERAPY EXPENSE BENEFIT

The Speech therapy expense benefit provides for reimbursement of expenses incurred by you or your eligible dependent. Reimbursement of covered expenses is subject to an annual maximum of $1,100 for you or your eligible dependent, including reimbursement for a one time only initial assessment fee to a maximum of $125 provided all provincial and federal government programs and/or assistance have been applied for and accessed and the therapy is provided by a Speech Language Pathologist or Speech Therapist.

Exclusions

- Charges for the cost of subsequent hearing aid tests;
- Other assessment tools;
- Any supplies including handbooks or tapes;
- Charges for forms, reports or follow up correspondence.

How to Claim Speech Therapy Expense Benefits

When you or an eligible dependent incur a Speech Therapist expense you must complete a **Related Professional Services Form**, which may be obtained from the provider or GreenShield. The completed form can be forwarded to GreenShield by either you or the provider along with the receipt issued by the registered Speech Pathologist/Therapist. The receipt must include the dates of service, cost per treatment and the Pathologist/Therapist registration number. Claims for covered expenses must be submitted within 12 months of the date of service to be considered for reimbursement.

E. PROSTHETIC APPLIANCES

External prostheses and orthotic appliances are provided when replacing all or part of the functions of a permanently inoperative or malfunctioning body part. Reimbursement is provided on a usual, reasonable and customary charge basis when prescribed by a legally qualified medical practitioner unless specified otherwise below, and dispensed or sold by a facility or dealer of such appliances. The legally qualified medical practitioner must include a description of the equipment as well as the reason for use or the diagnosis. Also included is the replacement, repair, fitting and adjustment of such appliances.

The following items are included as covered benefits:

- Artificial arms, legs, eyes, ears, noses, larynxes, prosthetic lenses, aniseikonic lenses, above or below knee or elbow prostheses, external cardiac pacemakers, and terminal devices, such as hand or hook;
- Rigid or Semi-rigid supporting devices (such as braces for the legs, arms, neck or back), splints, trusses; and appliances essential to the effective use of an artificial limb or corrective brace;
- Ostomy sets and accessories, catheterization equipment, urinary sets, external breast prostheses and orthopedic shoes;
- Parenteral nutrition artificial gut system and implantable urethral sphincter;
- Wig or hairpiece when hair loss is due to chemotherapy or radiation treatment, alopecia, hypothyroidism, traumatic scalp injury and scalp fungal infection;
- Cochlear implant repairs and supplies;
- Visco-supplementation therapy when medically required as a result of severe or moderate osteoarthritis and only when documentation is provided as to why surgery is not a viable alternative. The benefit will be limited to a treatment cycle maximum of $300 and a total treatment maximum of $1,200 per 36 month period.

Exclusions

- Dental appliances, hearing aids and, except as provided above, eyeglasses;
- Non-rigid appliances and supplies such as elastic stockings, garter belts, and supports and corsets.

F. DURABLE MEDICAL EQUIPMENT

Purchase, rental and repair (excluding routine maintenance) of durable medical equipment is provided on a usual, reasonable and customary charge basis when prescribed by a legally qualified medical practitioner unless specified otherwise below and when such equipment is reasonable and necessary for the treatment of an illness or injury, or to improve the functioning of a malformed body member.

The equipment must be an item able to withstand repeated use, primarily and customarily used to serve a medical purpose for which it is prescribed, generally not useful unless you are ill or injured and is appropriate for use in your home.

The following items are included as covered benefits:

- Hospital beds, rails, cradles and trapezes;
- Crutches, canes, patient lifts, walkers, and wheelchairs or electric powered scooters in lieu of wheelchairs;
- Bedpans, commodes, urinals - if the Covered Person is bed confined;
- Raised toilet seats for all medical conditions;
- Oxygen sets;
- Decubitus (ulcer) care equipment, dialysis equipment, dry heat and ice application devices;
- Intravenous stands, intermittent pressure units, neuromuscular stimulants, sitz baths, traction equipment, vaporizers and standard whirlpool baths including installation costs up to a maximum of $500;
- Digital electronic pacemaker monitor when prescribed by a physician for a Covered Person with a cardiac pacemaker;
- Automatic blood pressure monitor when prescribed by a physician;
- Rental of electromagnetic coil bone growth stimulator;

- Blood glucose meters in cases of evidence of poor diabetic control and where the monitor is not available free of charge from the pharmacy upon presentation of a prescription for blood glucose test strips;
- Effective August 1, 2018 the following covered expenses will be reimbursed at 90% with a 10% co-payment subject to an annual maximum of $2,000 ($4,000 effective January 1, 2022) applicable to all diabetic testing and monitoring equipment and supplies:
  - Glucose monitoring systems (GMS) such as continuous and flash type monitors subject to medical pre-authorization and reimbursed to the cost of a blood glucose meter;
  - Disposable GMS supplies (used with the monitor), such as, but not limited to sensors and transmitters;
- Disposable and cloth diapers for all incontinent persons;
- For Covered Persons with Type 1 diabetes, the following is eligible when prescribed by a physician and all provincial coverage is exhausted:
  a. Pressure injection devices for insulin or insulin infusion pumps, once every 5 years up to a maximum of $1,000:
     - For insulin infusion pump only – eligible for Covered Persons 19 years of age and over only.
  b. Insulin infusion pumps – once every 5 years up to a maximum of $5,500 for Covered Persons:
     - 18 years of age and under only.
     - If approved, the aforementioned $1,000 allowance is not eligible.
  c. Insulin infusion pump supplies – up to a maximum of $50 per month for Covered Persons 19 years of age and over OR $250 per month for Covered Persons 18 years of age and under.
- Soft casts to a maximum of $30 per cast;
- Reusable underpads for wheel chairs to a maximum of 6 per year;
- One pair of custom made corrective footwear per year (excluding off-the-shelf orthopedic footwear) to a maximum of $750 per year;
- Geriatric chairs on a one time only basis to a maximum of $2,000;
- Bathtub rails up to a lifetime maximum of $100;
- Up to two (2) pairs of custom made foot orthotics in any 36 month period to a maximum cost of $400. The orthotics must be purchased from a provider who is a member in good standing of the GreenShield Automotive Preferred Provider Service Agreement (PPO) for custom made foot orthotics;
- Up to 4 pairs of compression stockings per year to a maximum cost of $800 per year ($1,000 per year for custom made stockings), providing the following conditions are met:
  a. physician's prescription includes eligible medical condition, class of compression, and style of stocking;
  b. prescribed compression is 20mmHg or greater;
  c. pre-determination of eligibility is obtained from GreenShield for custom made stockings.

The decision to purchase or rent such equipment will be based on the legally qualified medical practitioner's estimate of the duration of need as established by the original prescription. However, the rental price cannot exceed the purchase price. When the equipment is rented and the rental extends beyond the original prescription, the legally qualified medical practitioner must re-certify (via another prescription) that the equipment is reasonable and medically necessary for treatment of the illness or injury. When a re-certification is not submitted, benefits will cease as of the original duration of need date or 30 days after the date of death, if earlier.

Exclusions

- Deluxe equipment such as motor driven wheelchairs and beds, except when such deluxe features are necessary for the effective treatment of a Covered Person's condition and required in order for the Covered Person to operate the equipment;
- Items that are not primarily medical in nature or are for comfort and convenience (e.g. bedboards, over bed tables, adjust-a-bed, bathtub lifts, telephone arms, air conditioners, etc.);
- Disposable supplies (e.g. infusion pumps, sphygmomanometer, stethoscope, etc,);
- Physician's equipment, including infusion pumps, sphygmomanometer, stethoscope, and similar equipment as determined by GreenShield;
- Exercise and hygienic equipment, including exercycles, Moore Wheels, bidets, toilet seats, bathtub seats, and other similar equipment as determined by GreenShield;
- Self-help devices that are not primarily medical in nature (e.g. elevators, sauna baths, etc,);
- Arch supports;
- Off the shelf foot orthotics;
- Items previously provided to a member of your household under the Chrysler Health Care Program or this Benefit Plan if such originally prescribed item can continue to be used to serve a similar medical purpose (e.g. bedpan, commode, urinal, sitz bath, raised toilet seats, vaporizer, standard whirlpool bath, etc,).

How to Claim Prosthetic Appliances, Durable Medical Equipment and Medical Devices Benefits

Your claim for prosthetic appliances and durable medical equipment must include the following:

1. An Authorization Form for Prosthetic Appliances and Durable Medical Equipment is to be completed by the Covered Person's legally qualified medical practitioner for wheelchairs, hospital beds, custom made braces, whirlpools, patient lifts and custom made shoes.

   Note: The estimated duration of need for durable medical equipment must be clearly indicated by the legally qualified medical practitioner on the authorization form and this form must be forwarded to GreenShield for approval. GreenShield will return this authorization form either approving or rejecting it. All other covered items require a legally qualified medical practitioner's prescription with a diagnosis submitted with the claim.

2. A completed **Claim Form for Medical Devices** accompanied by the itemized receipt(s) for the prosthetic appliance or durable medical equipment receipts must show the Covered Person's full name and address, the date of purchase or rental, a complete description of the appliance or equipment and amount paid.

   Both the claim form and the authorization form may be obtained from the legally qualified medical practitioner or GreenShield.

Claims for covered expenses must be submitted within 12 months of the date incurred to be considered for reimbursement.

G. NUTRITIONAL SUPPLEMENTS

Reimbursement for Nutritional Supplements for you or your dependent will be provided with prior approval when it is considered to be the sole source of nutrition and the following criteria are met:

a) Prescribed by a physician,
b) The Covered Person has an oropharyngeal or gastrointestinal disorder and/or,

c) The Covered Person has a maldigestion or malabsorption or significant stomach failure where food is not tolerated and/or,
d) The Covered Person must have a primary diagnosis of cancer and be actively receiving chemotherapy, radiation therapy, or palliative care. The benefit will be limited to the lesser of 220 servings or $500 per year and available only when used in conjunction with in home nursing care,
e) All applicable provincial and federal government assistance is applied for,
f) A re-evaluation of the Covered Person's condition is done on a semi-annual basis.

Exclusions

Nutritional supplements do not include, and no benefits are payable for other expenses, including, but not limited to:

- Prescribed weight loss supplements in the treatment of obesity;
- Food allergies;
- Meal replacement;
- Body building;
- Convenience;
- Replacement for breast feeding;
- Individuals able to tolerate some solid foods and require only supplementation in addition to food.

How to Claim Nutritional Supplement Benefits

A completed **Claim Form for Medical Devices** accompanied by itemized receipts must be submitted to GreenShield showing the Covered Person's full name, address, the date of purchase, and the amount paid. Claims for covered expenses must be submitted within 12 months of the date of purchase to be considered for reimbursement.

H. EMERGENCY AIR AND LAND AMBULANCE EXPENSE BENEFITS

1. Emergency Air Ambulance Services

When it is medically necessary for a Covered Person to travel by an air ambulance from a location in North America to the Covered Person's province of residence, the Benefit Plan will reimburse the amount charged to the Covered Person (up to the usual, reasonable and customary rate for the area where the service was received as determined by GreenShield) and, when necessary, for the air fare of an accompanying medical attendant as well as the air fare of an accompanying spouse provided that:
(a) There is a demonstrated need for the Covered Person to be confined to a stretcher or for a medical attendant to accompany the Covered Person during the journey,
(b) The Covered Person is admitted directly to a hospital in their province of residence,
(c) The Covered Person's provincial government health insurance plan makes a payment towards the cost, if available,
(d) Medical reports or certificates from both the dispatching and receiving physicians are submitted, and,
(e) Proof of payment including air ticket vouchers or air charter invoices are submitted.

2. Land Ambulance Services

A benefit will be provided for travel by a licensed land ambulance service (municipal, hospital, private or volunteer) for a Covered Person either in their province of residence or out of their province of residence providing one of the following conditions is met:

(a) It is medically necessary to transport a Covered Person one way or round trip from the home to the medical facility for treatment or testing, or
(b) The Covered Person requires a transfer from one hospital to another hospital due to specific medical conditions, which require treatment or testing at an alternate medical facility.

The amount of coverage provided will be equal to the patient co-payment charge, if any, up to the usual, reasonable and customary rate for the area where the service was received (as determined by GreenShield) when the provincial or government health insurance plan, if available, makes a payment towards the cost.

When the provincial or government health insurance plan does not make a payment towards the cost, the amount of coverage provided will be equal to the patient co-payment that would have been charged for services covered by OHIP.

Exclusions

- Charges that exceed the usual, reasonable and customary rate;
- Charges for an emergency air or land ambulance trip not authorized by the Covered Person's provincial government health insurance plan;
- Charges for completion of any forms.

How to Claim Emergency Air and Land Ambulance Benefits

When you or an eligible dependent incur a covered emergency air or land ambulance expense you must submit to GreenShield a completed claim form (available from GreenShield) along with the receipt issued by the licensed ambulance service that shows both the amount of the co-payment charged to the Covered Person and the amount paid towards the cost of the emergency air or land ambulance trip by the Covered Person’s provincial government health insurance plan. Claims for covered expenses must be submitted within 12 months of the date of service to be considered for reimbursement.

I. PROSTATE SPECIFIC ANTIGEN (PSA) TESTS

Reimbursement for one (1) prostate specific antigen (PSA) test annually, to a maximum of $15 for covered males age 50 and older (when not covered by a provincial health plan).

How to Claim Benefits

A completed **Claim Form for Medical Devices** accompanied by itemized receipts must be submitted to GreenShield showing the Covered Person’s full name, address, the date of test, and the amount paid. Claims for covered expenses must be submitted within 12 months of the date of service to be considered for reimbursement.

J. CANCER ANTIGEN (CA-125) TESTS

Reimbursement for 1 cancer antigen (CA-125) test annually.

How to Claim Benefits

A completed **Claim Form for Medical Devices** accompanied by itemized receipts must be submitted to GreenShield showing the Covered Person's full name, address, the date of test, and the amount paid. Claims for covered expenses must be submitted within 12 months of the date of service to be considered for reimbursement.

K. OPTOMETRIC DIAGNOSTIC SERVICES

Effective January 1, 2022 when prescribed by a legally qualified medical practitioner, covered expenses will be reimbursed at 100% with a 0% co-payment.

The following services are included as covered benefits:

- IOL Master / Cataract examination – limited to $100 every calendar year;
- Other types of optometric diagnostic services for cataracts, IOL's, and eye drop dispenser – limited to $250 per lifetime.

How to Claim Benefits

A completed **Claim Form for Medical Devices** accompanied by itemized receipts must be submitted to GreenShield showing the Covered Person's full name, address, the date of service or purchase, and the amount paid. Claims for covered expenses must be submitted within 12 months of the date of service to be considered for reimbursement.

VIII. HEALTH CARE SPENDING ACCOUNT (HCSA)

The HCSA will provide the following:

Your Plan Covers:	**Maximum Plan Pays:**
Lump sum per plan member	as determined by your plan sponsor
Benefit Year: January 1 to December 31	

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 asrTrust.

Your HCSA is provided by asrTrust and administered by GreenShield.

Your HCSA is a spending account funded by asrTrust that you can use to pay for health and dental expenses that are not covered by your group benefit plan or your provincial health plan.

At the beginning of each benefit year, a predetermined lump sum amount as shown in the Schedule of Benefits 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 will 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 include but are not limited to those that qualify for medical expense tax credits under the Canada Revenue Agency (CRA) Income Tax guidelines. It also includes the amount of the deductible and the percentage not covered by the group benefit plan or the amount in excess of group benefit plan maximums.

For a list of eligible medical expenses, visit our website at greenshield.ca, or for more information about eligible expenses you can consult a CRA office or visit the CRA website.

Exclusions

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

a) premiums paid to provincial medical or hospitalization plans; and
b) medical costs for which you or your dependent are reimbursed or entitled to be reimbursed under a provincial health insurance plan, your group benefit plan or your spouse's group benefit plan.

How to Claim Health Care Spending Account Benefits

Your 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 the member portal (the GSC Customer Service Centre is unable to arrange set up of this function).

Auto-Coordination with HCSA

Once you have accessed the member portal 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 this claim form if you want your eligible expenses paid from your GSC health and/or dental plan first, and any unpaid portion of your eligible expenses paid from your HCSA.

All HCSA claims must be received by GSC no later than 365 days after the end of the benefit year, or, no later than 90 days after your termination date or your date of death.

IX. GENERAL OVERALL EXCLUSIONS

Eligible services 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 any of:
   - an act of war, declared or undeclared;
   - participation in a riot or civil commotion;
   - committing a criminal offence.

2. Failure to keep a scheduled appointment with a licensed medical/dental practitioner.

3. Services or supplies which are cosmetic in nature.

4. Charges for the completion of any forms and/or insurance reports.

5. Services or supplies which do not meet accepted standards of medical/dental/ophthalmic practice, including charges for services or supplies which are experimental in nature.

6. Services or supplies normally paid through any provincial government health plan, workers' compensation plan, 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.

7. Services or supplies 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.

8. Services or supplies which are not recommended or approved by the attending physician/dentist.

9. Services or supplies that you are not obligated to pay for or for which no charge would be made in the absence of benefit coverage under this Benefit Plan.

10. Services or supplies which are legally prohibited by the government from coverage.

11. The replacement of lost, missing or stolen items, or items which are damaged due to negligence.

12. Covered expenses for which a claim is not filed within 12 months of the date incurred.

X. COORDINATION OF BENEFITS

The Benefit Plan provides benefits in full, or a reduced amount which, when added to the benefits payable and the cash value of services provided by any "Other Plans", will equal 100% of "Allowable Expenses" incurred by the person for whom claim is being made. "Allowable Expenses" include any necessary and reasonable charges for items of expense which are covered in whole or in part under the Benefit Plan or the Other Plan to which this provision applies but exclude plan co-payments. "Other Plans" include any plan of medical or dental coverage provided by group insurance or other arrangement of coverage for individuals in a group whether or not the plan is insured.

To administer this provision, and to determine whether GreenShield will reduce benefits, it is necessary to determine the order in which the various plans will pay benefits. This will be determined as follows:

1. A plan with no coordination of benefits provision will pay its benefits before a plan which contains such a provision;
2. A plan which covers an individual other than as a dependent will pay its benefits before a plan which covers the individual as a dependent;
3. A plan which covers an individual as a dependent of the covered person with the earliest day and month of birth in the calendar year will pay its benefits first;
4. Where the above do not establish the order of payment, the benefits shall be pro-rated between or amongst the plans in proportion to the amounts that would have been paid under each plan had there been coverage by just that plan.

The asrTrust and GreenShield may release or obtain any information and make or recover any payments it considers necessary to administer this provision.

XI. SUBROGATION (THIRD PARTY LIABILITY)

In the event of any payment for services under the Benefit Plan, GreenShield will be subrogated to all the Covered Person's rights of recovery against any person or organization except against insurers on policies of insurance issued to and in the name of the Covered Person, and the Covered Person will execute and deliver such instruments and papers as may be required and do whatever else is necessary to secure such rights. The Covered Person may take no action which may prejudice GreenShield's subrogation rights and all sums recovered by the Covered Person by suit, settlement or otherwise in payment for services covered under the Benefit Plan must be paid over to GreenShield to be retained for the exclusive benefit of the asrTrust.

XII. TERMINATION OF HEALTH CARE BENEFITS PLAN COVERAGE

Coverage and eligibility for benefits under the Benefit Plan terminates automatically on the earliest of the following dates:

- For all Covered Persons:
    - The date of termination of the Benefit Plan or the asrTrust, in accordance with the Trust Agreement;
    - The date on which a Covered Person ceases to be eligible as outlined in I. A. of this booklet and the eligibility provisions of the Benefit Plan;
    - The date the Benefit Plan is amended to terminate eligibility for coverage for any classification of the Covered Group under a particular benefit or benefits;
    - The date coverage is terminated for failing to provide evidence as required to substantiate eligibility of a Covered Person for coverage under the Benefit Plan;
    - Their date of death;
    - The effective date that the same or similar benefit(s) as the benefit(s) provided to a Covered Person under the Benefit Plan is provided or made available by provincial, territorial or federal law, but only with respect to the particular benefit(s);
- For a Covered Person who requests cancellation of coverage for them self or any enrolled dependent(s), on the last day of the month in which cancellation is requested;
- For a Covered Person who is required to pay monthly health care contributions who fails to make payment when required, coverage for the Covered Person and their enrolled dependents will cease on the last day of the month for which the previous payment applied;
- For enrolled dependents, the date a dependent no longer meets the eligibility conditions for coverage. For example: in the event of death, divorce, attainment of maximum age of enrolled children, loss of dependency qualification under the Income Tax Act of Canada, entrance into military service, etc. (Section I.E. in this booklet describes when dependent eligibility ceases);
- For sponsored dependents the date they cease to qualify as such, or the last day of the month for which contributions for coverage of the sponsored dependent have been made;
- For a Surviving Spouse the date eligibility ceases;
- For a retiree, who returns to active employment with Chrysler on a full-time basis and their enrolled dependent(s), the date of re-employment with Chrysler.

XIII. INQUIRIES AND CLAIM SUBMISSION

For general inquiries about benefits, eligibility, dependents, and to make changes, please contact GreenShield. You will need to provide the personal identification number found on your GreenShield identification card for service.

Should you have any specific questions relative to the covered benefits under your Health Care Benefits Plan or if you require claim filing information, you may call; or write GreenShield, and provide your GreenShield identification number, as follows:

GreenShield

Written Inquiries:
8677 Anchor Dr.
P.O. Box 1612
Windsor, Ontario
N9A 7A7

Telephone Inquiries:
Toll Free (Across North America)
1 (877) 266-5494
Local in Windsor
(519) 739-1133 Ext.: 6835

Refer to the appropriate benefit section in this booklet for the name of the form required for claiming each type of benefit. **All claims must be received by GreenShield no later than 12 months from the date the eligible benefit was incurred.**

You may also obtain information on how to file claims, print claim forms, sign up for direct deposit, and access many other services using Subscriber Online Services by visiting GreenShield on line at **greenshield.ca**.

XIV. COMMITMENT TO PRIVACY

In order to administer the Benefit Plan, the asrTrust and its agents, including GreenShield, are required to collect, maintain and disclose personal information relating to you and your dependents. The asrTrust and GreenShield are committed to maintaining your privacy and will only collect, maintain and disclose 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 the asrTrust from error and fraud
- To administer the Benefit Plan including the collection of required health care contributions
- To locate you or your dependents if we do not have up-to-date contact information
- For design and financial management of the Benefit Plan
- To provide ongoing access to other services at GreenShield

Use and disclosure of your personal information is restricted to the Board of Trustees of the asrTrust and its employees, GreenShield and other authorized service providers and Unifor. When required by law, personal information may also be disclosed to authorized agencies including law enforcement agencies and the Canada Revenue Agency for tax purposes.

Consent

When you enrolled in the Chrysler Health Care Program or this Benefit Plan, your personal information was obtained and used only with your consent. Under the Court Approval Order establishing the asrTrust, your personal information may have been transferred from Chrysler to the asrTrust to enable it to assume the responsibility for administering your health care benefits.

The collection, maintenance and disclosure of your personal information is based on your consent. 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 existing members of the Chrysler Covered Group, including dependents, we will continue to use and disclose your personal information previously collected in accordance with the Court Approval Order and the GreenShield Privacy Code, unless you inform the asrTrust or GreenShield otherwise we will infer that consent has been obtained by your continued claims under the Benefit Plan.

Withdrawal of Consent

You can withdraw your consent any time 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, the asrTrust and GreenShield will no longer be able to administer your benefit coverage. If so, GreenShield will explain the situation to you to help you with your decision.

For further information on the GreenShield privacy policies and procedures, please refer to the GreenShield web site at greenshield.ca.

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