Auto Sector Retiree Health Care Trust

asr TRUST
RETIREE HEALTH CARE

GMCL Retiree Health Care Benefits Plan

For Non-Canadian Residents
U.S. Grandparented Plan
(Closed Group)

As of March 1, 2023

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 Canada and General Motors retirees, surviving spouses and active employees represented by the CAW (now Unifor) as of June 8, 2009 for General Motors employees and May 4, 2009 for Chrysler Canada employees, along with their eligible dependents (the "Covered Group"). The asrTrust maintains a separate account for each retiree plan under its administration. This booklet including the terms used and the description of benefits only relates to the asrTrust-GMCL Retiree Health Care Benefits Plan.

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

The agreement between the CAW and General Motors to establish the asrTrust was the subject of class actions in 2011 in which a Quebec and Ontario Court approved representatives, who were independent of the CAW and General Motors and who represented the retirees and surviving spouses (the "Retiree Representatives"). The Retiree Representatives retained independent lawyers and received advice from their own actuary. The parties to the class proceedings, which included the Retiree Representatives, the CAW and General Motors, reached a settlement dated August 23, 2011 (the "Settlement"), which was approved by order of the Courts dated September 13, 2011 in the Ontario proceeding and September 19, 2011 in the Quebec proceeding (the "Approval Orders").

The Settlement and Approval Orders terminated General Motors' 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 General Motors under its collective agreements with the CAW (the "General Motors Health Care Program").

The asrTrust provides health benefits which are supplementary to and not covered by current government health care programs. The benefits payable by the asrTrust for former General Motors employees and their dependents are to be exclusively funded with the assets available to the asrTrust for the General Motors benefit plan. These assets consist of an initial cash contribution and promissory notes from General Motors as required by the Settlement and monthly member contributions. The initial cash contribution by General Motors together with the member contributions will not be sufficient to fund all the benefits previously provided by General Motors to the Covered Group. The asrTrust is dependent on receiving future payments from General Motors under the promissory notes, which is dependent on General Motors 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 General Motors Covered Group and will be maintained separate from General Motors' assets and will not be available to General Motors or its creditors if General Motors faces financial difficulties in the future, or be available to fund the benefits for the Chrysler Retiree Plan or any other benefit plan administered by the asrTrust.

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 General Motors 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 Amended and Restated Declaration of Trust made as of August 12, 2011, the form of which was approved by the Courts in the Approval Orders (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 "B" 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

The Benefit Plan does not include specific provisions applicable to non-resident participants. However, the Board of Trustees resolved to continue the health care benefits previously provided by General Motors for eligible retirees and their covered dependents residing outside of Canada on the same terms and conditions as of the Implementation Date for the asrTrust GMCL Benefit Plan (October 31, 2011), subject to modifications effective April 1, 2012 and any future changes made by the Trustees at their discretion. The terms and conditions applicable to non-residents' coverage for hospital, surgical, medical, hospital care, nursing home, out-of-country, prescription drug, dental, extended health services, vision, and hearing aid expense benefits are set out in this booklet and referred to as the "Non-Resident Plan".

All covered health expense benefits are administered by Green Shield Canada. The non-resident benefits are not insured. The asrTrust is liable for the payment of such non-insured benefits. Green Shield administers but does not insure the benefits. In the event that the asrTrust secures insurance coverage to provide the non-resident benefits after the date of this publication, the terms of the "Non-Resident Plan" shall be subject to and in accordance with any insurance policy or policies that may be purchased by the asrTrust to provide such coverage.

This booklet does not grant or create any rights or vested rights nor does it impose any obligations on Green Shield Canada, the asrTrust or the Trustees beyond those rights and obligations, if any, as set out in the Trust Agreement, the Benefit Plan and any underlying insurance policies and contracts.

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.

The asrTrust provides coverage for the health care benefits as set out in the Benefit Plan only to the extent that health care expenses and services are not covered by current government health care programs. The Benefit Plan will not provide increased coverage or provide benefits for any services or expenses that are no longer covered, or for which coverage is reduced, under any government health care program as a result of future changes in those programs, unless the Trustees in their sole discretion and subject to their obligations under the Trust Agreement, amend the Benefit Plan to provide for such coverage.

REQUIREMENT TO NOTIFY GREEN SHIELD CANADA

The asrTrust utilizes preferred provider networks and case management to control Benefit Plan costs. To allow the asrTrust to better manage these costs you are required to contact Green Shield Canada through the Green Shield Canada's Travel Assistance service at the numbers listed below immediately following any occurrence, in the U.S. or while travelling, requiring hospitalization or medical treatment covered by the Benefit Plan under Section II and Section III, prior to receiving treatment, except where advance notice cannot be reasonably provided due to medical or other exceptional circumstances. Failure to contact Green Shield Travel Assistance prior to receiving treatment may result in your claim being denied or reduced. For further information please contact Green Shield Travel Assistance toll free within Canada and the USA at 1-800-936-6226 or collect from all other countries at 0-519-742-3556. All claims must be submitted within 12 months of the date incurred to be eligible for reimbursement under the Benefit Plan.

FURTHER INFORMATION

Detailed information concerning the benefits for which you may be eligible, or regarding your health care claims reimbursement for all sections with the exception of Section II and Section III, may be obtained from Green Shield Canada toll free from within Canada and the US at 1 (877) 266-5494 or from elsewhere by calling 1-519-739-1854 and by selecting prompt 1. Claim submission forms are available online at **www.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 XIII of this booklet for specific Green Shield Canada contact information for inquiries and to obtain any of the forms referred to in this booklet.

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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, and extended health services coverage as described in this Booklet if you are part of the General Motors 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"). Except for the benefits set out in Section II for those Covered Persons who were residents of the U.S. prior to October 1, 2009 (referred to in this Booklet as the "U.S. Grandparented Plan"), non-residents are not entitled to coverage for hospital, surgical and medical expenses that are generally covered under a provincial hospital insurance plan such as the Ontario Hospital Insurance Plan for residents of Canada.

Coverage under the U.S. Grandparented Plan is automatically terminated if the Covered Person ceases to be a resident of the U.S. If the Covered Person becomes a resident of Canada coverage will be provided under the Canadian resident provisions of the Benefit Plan. If you become resident of any other country, you will be covered under the general Non-Resident Plan for non-residents outside of the U.S., which excludes Hospital, Surgical, Medical coverage as provided in Section II and Out of Country Health and Travel Assistance coverage. You must notify Green Shield of any change in your residency status to continue coverage and to receive the applicable booklet.

The General Motors Covered Group includes the following:

- A former employee of General Motors who, at June 8, 2009, had retired while covered by a Collective Agreement between General Motors and the CAW without breaking service, including certain eligible former employees employed in a divested business unit, and who elected to receive an immediate pension under the General Motors Pension Plan (but not including a former employee entitled to or receiving a deferred pension) (a "Retiree").

- An active employee of General Motors who, at June 8, 2009, was covered by a Collective Agreement between General Motors 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 June 8, 2009 and their retirement with an immediate pension under the General Motors 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 General Motors Pension Plan; or
    b. was eligible to retire and receive an immediate pension under the General Motors 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 General Motors Pension Plan at the time of death; or
    d. was an Active Employee covered by a Collective Agreement entitling his surviving spouse to health care benefits under the General Motors Health Care Program, whose surviving spouse was receiving health care benefits immediately prior to January 1, 2010.
    (a "Surviving Spouse")

- A person who on or after the date of the Court Approval Orders is the surviving dependent of two deceased persons who were, while living, a General Motors 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 and extended health services benefits coverage on the following dates:

- For Retirees, Surviving Spouses, their eligible dependents and Orphan Dependents, on the effective date of the Benefit Plan October 31, 2011.

- 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 General Motors Pension Plan.

- For a Surviving Spouse or Orphan Dependent(s) of a Covered Person who dies after October 31, 2011, 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;
   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 in "Eligible children include": below, until:

   a. the end of the calendar year in which they attain 21 years of age, except for eligible children covered in (b) or (c) below;

   b. the end of the calendar year in which they attain 25 years of age provided they legally reside with or are a member of your household and are registered as a full-time student in a school or university; or

   c. any age if they became totally and permanently disabled during a period they were eligible as a dependent under either (a) or (b), 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.

   Eligible children include:

   (1) Your children by birth, legal adoption or by Court Order while they are in your 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.

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 and extended health services 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 as a dependent within the meaning of the *Income Tax Act* (Canada) or was reported as a dependent in your Canadian Income Tax Return for the immediately preceding tax year.

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 Green Shield and adopted by the Trustees.

Sponsored dependents are not eligible for dental expense coverage.

E. WHEN DEPENDENT ELIGIBILITY CEASES

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

Dependent(s) Covered Under the U.S. Grandparented Plan

- the date your dependent ceases to be a resident of the U.S.

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;
- 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 as a dependent within the meaning of the *Income Tax Act* (Canada).

F. REPORTING CHANGES IN ELIGIBILITY STATUS

Please notify Green Shield immediately of any event affecting your eligibility or the eligibility of your dependents, including any change in your country of residence and/or citizenship.

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, benefit 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 General Motors Health Care Program, except where specifically noted otherwise.

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 General Motors Health Care Program, except where specifically noted otherwise.

H. PLAN CURRENCY

For the benefits set out in Section II, the maximum amounts and claim payments will be in U.S. currency. For all other benefits, all maximums are in Canadian currency and payments will be made in U.S. currency. Any claims submitted in any other form of currency will be reimbursed in Canadian funds. The exchange rate that will be used will be determined by Green Shield Canada based on the date the expense was incurred.

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

For the closed group of Covered Persons who were residents of the United States prior to October 1, 2009 the Non-Resident Plan provides reimbursement of eligible services as set out in this section.

You are required to apply for coverage under any voluntary government plan or basic health plan that is available to you and/or your dependents. Coverage under this Benefit Plan may be denied or reduced if you and/or your dependents do not take the necessary steps to enroll in any available government or basic health plan and will take into account benefits available under any such plan.

A. MEDICAL/SURGICAL SERVICES

Payment of reasonable and customary charges for medically necessary Physician Services for:

- surgery and anesthesia including pre and post-operative care, including stomach bypass subject to specific medical criteria;

- obstetrical delivery, including pre and post-natal care including office visits, provided a global fee is submitted for the entire care;
- in-hospital medical care or consultation and medically necessary technical surgical assistance (where technical surgical assistance is applicable);
- in-hospital rehabilitative medical care by the doctor in charge of the case and doctor's medical visits at the rate of 2 per week for up to 730 days in a federally approved nursing home or skilled nursing facility for general conditions;
- radiation therapy and chemotherapy for malignant conditions including the office visits on days of chemo injection and 3 follow-up visits within the next 21 days;
- professional charges (but not facility charges) up to $25,000.00 (U.S.) for heart, lung, pancreas and liver transplants;
- laser surgery which replaces a cutting procedure (to a maximum of the reasonable and customary charge for the alternative cutting procedure);
- treatment by a physician (GP or Specialist) in office or clinic, excluding the office / clinic visit portion of the charges. Home visits, routine treatment, treatment of the eye, removal of warts or ear wax are excluded. This benefit does not cover immunizations and allergy treatments (physician, testing and shots) or removal of lesions unless indicated as malignant or supported by surgical pathology;
- out-patient treatment of accidental injuries and acute medical emergencies at an approved hospital. A “medical emergency” is defined as a condition or occurrence where failure to seek treatment would result in an immediate threat to the health (or life) of the patient;
- surgical charge for voluntary sterilization (not reversal), excluding follow-up and office visit charges;
- out-patient psychiatric services including family counseling (subject to a co-payment of 10% for the 6th through the 10th visits and a 25% co-payment for all subsequent visits). Payment is limited to $1200.00 (U.S.) per person per calendar year in combination with expenses for out-patient psychiatric services charged by an approved facility. All services must be performed by a physician (but not by PhDs); and
- a maximum of $100.00 (U.S.) for psychological testing per person per calendar year, when performed by a physician (but not by PhDs.).

B. HOSPITAL SERVICES AND ACCOMODATION

Payment of in-patient charges:

- up to a maximum of $200.00 (U.S.) per day for a semi-private room in a federally approved hospital or facility, including:

    - up to 365 days of in-patient care in a hospital for general conditions, including maternity care. Coverage includes ancillary services, supplies, drugs, dressings, anesthesia, X-rays, lab tests, intensive care, and routine nursery care. This benefit does not cover hospital care primarily for observation, diagnostic evaluation (including x-rays and lab tests), physical therapy, electrocardiography, basal metabolism test, weigh reductions programs, ultrasound and nuclear medicine studies, take home drugs or supplies. Hospital stays for custodial, domiciliary, convalescent, rest care or substance abuse treatment are not covered; and
    - up to 730 days of needed rehabilitation care in an approved nursing home or skilled nursing facility for general conditions, reduced by the number of days of in-patient care in a general hospital preceding admission to the approved nursing home or skilled nursing facility (must be able to improve, not just maintain activity).

- for Hospice care at end of life under an approved hospice care program at an accredited and certified facility with a fixed rate per day that includes all services, provided prior authorization is received from Green Shield Travel Assistance (form to be completed). 2 hospice care days (either home or inpatient care) will be allowed for each hospital benefit day remaining, up to a maximum 210 days per lifetime. Covered person must accept hospice care as the sole treatment received for pain and symptom management.

Payment of out-patient charges for:

- necessary surgery, including charges from approved ambulatory facilities; and
- services in the outpatient department of a hospital, including treatment of accidental injuries and acute medical emergencies including a maximum of 23 hours of observation, surgery and use of an artificial kidney machine and similar equipment. Includes ancillary services: supplies, drugs, dressings, anaesthesia, x-rays, lab tests, routine nursery care. Includes the services of interns, residents, medical education directors and others employed in an administrative or teaching capacity, if billed by the facility.

C. DIAGNOSTIC SERVICES

Payment of charges for diagnostic services where medical diagnosis is present, excluding charges for office visits and routine services for:

- medically necessary diagnostic x-ray, laboratory testing and pathology services;
- laboratory testing for a PAP smear; and
- laboratory testing for PSA test.

D. GROUND AMBULANCE SERVICES

This benefit includes medically necessary transfers by ground ambulance between hospitals and transfers from hospitals to an approved facility for medical testing (e.g.: CT Scan, MRI). This benefit excludes coverage for 911 calls or home to hospital ambulance services.

In addition to the other benefits described in Sections VI, VII and VIII of this booklet, eligible Covered Persons under the U.S. Grandparented Plan are also entitled to coverage for the following:

E. DURABLE MEDICAL EQUIPMENT

This benefit includes:

- medically necessary durable equipment dispensed by an attending physician in the physician's office, such as a brace, not purchased elsewhere; and
- use of dialysis machine, respirator, and similar medical equipment.

F. IN HOME NURSING CARE

This benefit includes reimbursement of medically necessary charges for approved Home Care Programs for skilled nursing and home health care aides, including home physical therapy, available immediately (within 3 days) after release from hospital with physician prescribed home care only. Requires attending physician to specify required level of skilled care, approximate duration and amount of time assistance is needed per day. Up to 3 home care visits for each day of unused coverage under this plan for hospital accommodation to a maximum of 1095 visits.

G. PARAMEDICAL SERVICES

1. Medically necessary Physical Therapy, provided the covered person is able to improve and not just maintain function for:

    - Covered Persons under 20 years of age and over 64 years of age, reimbursement of expenses for physiotherapy provided on a hospital out-patient basis or at a designated centre for up to 60 treatments per condition; and

- Covered Persons between 20-64 years of age, reimbursement of expenses incurred for physiotherapy provided within 7 days following release from in-patient hospital stay (or immediately following removal of cast for casted fractures), or if home physiotherapy is necessary because the Covered Person is medically unable to leave his or her home.

2. Medically necessary Speech Therapy for Covered Persons under 6 years of age only, the speech therapy expense benefit provides reimbursement of expenses incurred for speech therapy for Covered Persons with congenital or severe developmental disorders when provided in or by an approved facility up to a maximum of 60 visits annually.

H. VISION EXPENSE BENEFITS

For Covered Persons who are under 20 years of age or over 64 years of age, Vision Expense Benefits provide coverage for vision examinations performed by a qualified optician, optometrist or ophthalmologist (including office visits) once every 12 months subject to a $7.00 (U.S.) co-payment.

For Covered Persons between 20-64 years of age the Vision Expense Benefit also provides coverage for vision examinations only for such Covered Persons with diabetes, retinal disease, glaucoma, cataracts, and the amblyopia/visual field defects, corneal disease and strabismus for one vision examination and one reassessment every 12 months.

I. HEARING EXPENSE BENEFITS

Hearing Expense Benefits include audiometric examinations and hearing aid evaluation tests performed by an Audiologist, including office visits, once in a 36 month period. Services associated with a Cochlear or Baha implant are covered but not the cost of the implant device.

J. EXCLUSIONS

Covered Hospital, Surgical, and Medical (HSM) expenses do not include and no benefits are payable for:

- physician's charges for office visits, regardless of specialty, except where specified above;
- all preventative and routine services including annual exams and routine tests unless accompanied by a prescription;
- physician's charge for a non-urgent emergency room visit;
- emergency room treatment, excludes follow-up visits and take home supplies or drugs;
- physician's services exclude home visits, immunizations/vaccinations, removal of ear wax and warts and other non-medically necessary services;
- private hospital rooms, even in a facility with only private rooms (reimbursement would be limited to the semi-private room allowance);
- hospital in-patient stays primarily for custodial care, substance abuse, observation, diagnostic evaluation, physical therapy, x-ray, lab, electrocardiography, basal metabolism test, weight reduction programs, ultrasound studies, nuclear medicine studies, convalescent care and rest care and prescription drugs or supplies for post-hospital treatment;
- anesthesia administered by a Certified Registered Nurses Assistant unless billed by the hospital or surgical facility;
- allergy testing and treatment, except emergency room care for a life threatening allergic reaction;
- lesion removal unless diagnosed as malignant or surgical pathology is performed;
- ambulance services for 911 calls from home or accident site;
- all treatment of the eye including surgery, except as provided under the Vision Expense Benefit in Section VI;
- maternity care by a mid-wife; or

- purchase or rental of medical equipment, except as permitted in item E within this section and under Prosthetic Appliances or Durable Equipment in Section VIII.

K. HOW TO CLAIM HOSPITAL, SURGICAL, AND MEDICAL (HSM) EXPENSE BENEFITS

To make a claim, submit to Green Shield Travel Assistance original, itemized receipts accompanied with either a Universal Billing Form (UB Form), or a Health Care Financing Administration Form (HCFA Form). These forms can be obtained from the Provider. See Section XIII for contact and mailing information.

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

III. OUT-OF-COUNTRY HOSPITAL, SURGICAL, AND MEDICAL EXPENSE BENEFITS

The out-of-country travel benefit will provide coverage for the first 30 days of travel only. Covered Persons will be responsible for all hospital, surgical and medical expenses incurred after 30 days from the commencement of the trip.

Coverage for out-of-country benefits is limited to one claim for covered expenses for a recurring medical condition.

You must contact Green Shield Canada Travel Assistance immediately following any occurrence requiring emergency out-of-country medical care and prior to receiving treatment, except where advance notice cannot reasonably be provided due to medical or other exceptional circumstances. Failure to contact Green Shield Travel Assistance prior to receiving treatment may result in your claim being denied or reduced.

Note: The 30 day travel limit is per trip. You need to return back to your place of residence for a minimum of 24 hours to reset the 30 day limit.

This supplementary benefit provides:

- 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 country of residence;

- a covered hospital, surgical, medical or emergency air ambulance expense is a fee incurred as a result of a service rendered under 1. above, provided a fee would be payable for such service under any government or basic health plan if such a service was performed or rendered in your country of residence;

- dialysis and INR checks;

- that the amount of the reimbursement is based on the reasonable and customary charge in the area where you receive the covered services, as determined by Green Shield; and

- when it is demonstrated to Green Shield to be medically necessary for you or an eligible dependent to travel by an air ambulance to your country of residence, that 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 government and basic health plans require that a licensed physician contact their Central Ambulance Authority before an air ambulance can be used. (For further information contact your government and/or basic health plan office).

Exclusions

This benefit does not make any payment for:

- the cost of private hospital room (payment would be limited to the semi-private allowance);
- any portion of a scheduled fee which is uninsurable by law when such service is rendered in your country of residence;
- the cost of a service for which no portion would have been reimbursed by the Ontario Health Insurance Plan;
- hospital and medical care for child birth occurring within 8 weeks of the expected delivery date from the date of departure or deliberate termination of pregnancy; or
- referral services for treatment outside of your country of residence.

A. GREEN SHIELD CANADA TRAVEL ASSISTANCE

For **major emergency** treatment outside your country of residence arrangements have been made to guarantee the providers of the services (hospital, clinic or physician) that you have coverage under a Non-Resident Plan.

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

Through Green Shield's international medical service organization, services are available 24 hours per day, 7 days per week for:

- multilingual assistance, pre-travel inquiries, claims inquiries, assistance in locating the nearest, most appropriate medical care and international preferred provider networks;
- program medical advisor (physician) consultative and advisory services, including second opinion and review of appropriateness and quality of medical care, and monitoring progress during treatment and recovery;
- emergency message transmittal services and assistance in establishing contact with family and personal physician as appropriate*;
- translation services and referrals to local interpreters as necessary*;
- verification of insurance coverage, facilitating entry and admission into hospitals and access to other medical care providers, and 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:
  i) the return of unaccompanied travel companions*;
  ii) travel to the bedside of a stranded person*;
  iii) rearrangement of ticketing due to accident or illness and other travel related emergencies*; and
  iv) 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*; and
- 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 Green Shield Canada's Travel Assistance Service Works for You

For assistance dial the appropriate number which appears on your Green Shield identification card. Quote your group number and Green Shield Canada identification number, found on your Green Shield identification card, and explain your medical emergency. **You must always be able to provide your Green Shield Canada identification number and any government or basic health plan number.**

As Green Shield is not able to guarantee assistance services in areas of political or civil unrest please contact Green Shield 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 coverage under a Non-Resident Plan. The provider may then bill Green Shield directly for approved services eliminating unnecessary 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.

B. LIMITATIONS

1. As of June 1, 2018, benefits will be eligible only if existing or pre-diagnosed conditions are stable (in the opinion of Green Shield 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. Green Shield 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 country of residence.

3. Coverage for services may be denied if you do not report the occurrence to Green Shield Travel Assistance prior to receiving medical treatment.

4. Reimbursement for eligible services will be made under this plan only if the Ontario Health Insurance Plan would have covered the cost of the services received.

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

6. Air ambulance services will only be eligible if:

   - pre-approved by Green Shield;
   - there is a medical need for you to be confined to a stretcher or for a medical attendant to accompany you during the journey;
   - you are admitted directly to a hospital in your country of residence;
   - medical reports or certificates from the dispatching and receiving physicians are submitted to Green Shield; and
   - proof of payment including air ticket vouchers or air craft carrier invoices are submitted to Green Shield.

7. 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 health care system in your permanent and primary place of residence. Benefits will not be paid for any expenses incurred if the Covered Person refuses to travel to their permanent and primary place of residence if it is determined by a Green Shield Travel Assistance physician, in consultation with the treating physician and the Covered Person's family physician, that the Covered Person is medically fit to travel. Reimbursement will be provided to a maximum of $1,000 (CDN) 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 permanent and primary place of residence.

C. EXCLUSIONS

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

- effective September 1, 2012, charges for services incurred after the 30th day of the Covered Person's out-of-country trip;
- charges for services for recurring conditions;
- charges for services incurred out-of-country if it is determined that the Covered Person is medically fit to travel to their permanent and primary place of residence;

- charges for services over and above the usual, reasonable and customary charges in the area the services were received;
- transportation and lodging;
- repatriation of remains;
- rest cure, health spas, or travel for reasons of health;
- treatment or services for ongoing care, elective surgery or check-ups - elective health services are defined as those services:
  i) where vacation or travel is solely for the purpose of obtaining treatment;
  ii) which can be planned or anticipated ahead of time; or
  iii) which have not received "prior approval" from Green Shield Canada Travel Assistance.
- services received from a chiropractor, chiropodist, podiatrist, or for osteopathic manipulation; or
- benefits and services for which you receive reimbursement from a third party.

D. HOW TO CLAIM OUT-OF-COUNTRY BENEFITS

Payment of an out-of-country hospital, surgical, medical or emergency air ambulance expense benefit by Green Shield is made only after any government or basic health plan has made a prior payment towards the service for which an out-of-country benefit is claimed, if applicable.

Benefits will be reduced by amounts paid by any government or basic health plan. To make a claim, submit to Green Shield Canada Travel Assistance the Covered Person's name, address, Green Shield identification number, Travel Assistance group number and any government or basic health plan number along with:

- a fully completed Emergency Medical Expense Claim Form. This Form is required to be completed and submitted in all cases, even where the provider has been paid directly by Green Shield Canada Travel Assistance. The Form is sent directly to your address by Green Shield Canada Travel Assistance but is also available on Green Shield's website at www.greenshield.ca;
- original itemized receipts with detailed statements showing the services rendered and the fees charged for each service; and
- details of any payments made by government or basic health plans.

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

IV. PRESCRIPTION DRUG EXPENSE BENEFITS

A core principle of the asrTrust program is that coverage provided under the plan is supplemental to health coverage provided by any government or basic health program that is available to a plan member. This includes a requirement that all participants age 65 and older receive their primary coverage for drug expenses under government programs available to them. You are responsible for registering yourself and your dependents for coverage under any government or basic health plans for which you qualify. Failure to register for available government or basic plan coverage may result in the suspension of your benefit plan coverage under the asrTrust program.

A. COVERED DRUGS

Covered drugs under the Prescription Drug Expense Benefits are limited to those drugs included on the asrTrust GMCL Drug Formulary maintained by Green Shield 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 injectible 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 Green Shield for review and assessment of eligibility. If approved, you or your dependent will be notified. The **"Prescription Drug Special Authorization Request Form"** is available by contacting Green Shield. Some conditional drugs have an automated review process for which no form completion is required.

Covered Person Co-Payment

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

B. EXCLUSIONS AND LIMITATIONS

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

- 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 available to the Covered Person under any 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 Green Shield;
- 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 covered under any basic or government health plan, or 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 5 years from the date that an insulin pressure injection device is approved by Green Shield as a covered durable medical equipment expense under the Durable Medical Equipment Expense Benefit;
- new drugs will be added to the Benefit Plan only if they are recommended for inclusion by Green Shield Canada's Pharmaceutical and Medical Consultants and (if necessary) an independent external scientific review agency; or
- over-the-counter drugs (excluding laxatives and shampoos for cancer patients).

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 Green Shield. All claims for medical cannabis are subject to Green Shield'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. You are required to submit your original prescription receipt(s) along with a fully completed **General Claim Submission Form** to Green Shield. Receipts must separately identify the portion of the cost relating to any dispensing fees charged.

Pharmacies and Injectibles Supplied by a Physician

You will be required to pay the full cost of covered drugs dispensed by a pharmacy, or injectibles supplied by a physician, at the time of purchase. In order to claim reimbursement of the covered expense, it is necessary to obtain a detailed prescription receipt including the name, strength and quantity of the covered drug and separately identifies any dispensing fee charged. Forward this account and a request for repayment to Green Shield. The Covered Person will be responsible for any additional charges assessed by the pharmacy over and above those paid by the Benefit Plan.

If there is no dispensing fee included on the receipt Green Shield will apply the usual and customary dispensing fee from Ontario.

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

V. 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 the area where services are provided), when operating within the scope of their respective license.

A. COVERED DENTAL EXPENSES

Effective January 1, 2022, the Dentist, Hygienist and Denture Therapists current Ontario Association Schedule of fees used to determine the covered expenses will be the applicable fee schedule.

1. Effective January 1, 2022 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 applicable Ontario schedule of fees for:

    a. routine oral examinations and prophylaxis (cleaning of teeth), but not more than once in any period of 9 consecutive months;
    b. topical application of fluoride, only for persons under 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 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 36 consecutive months), supplementary bitewing x-rays (but not more than once in any period of 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;
    g. oral surgery;
    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 Temporomandibular Joint appliance as an adjunctive 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 of dentures; or relining or rebasing of dentures more than 6 months after the installation of an initial or replacement denture, but no more than one relining or rebasing in any period of 36 consecutive months; and
    n. pit and fissure sealants for permanent molars for eligible children up to and including age 14.

2. Effective January 1, 2022 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 applicable Ontario schedule of fees, whichever of (i) or (ii) is less for:

    a. initial installation of fixed bridgework (including inlays, onlays and crowns as abutments);
    b. repair or recementing of crowns, inlays, onlays, bridgework;
    c. inlays, 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;

d. porcelain veneers for eligible children under 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;
e. initial installation of partial or full removable dentures (including precision attachments and any adjustments during the 6 month period following installation); and
f. 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; and
   (2) the existing denture or bridgework was installed under this Dental Expense Benefit at least 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 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.
g. Standard implantology and bone graft expenses including the structure, installation and crown (initial and replacement crown) are included effective January 1, 2022.

B. MAXIMUM BENEFIT

The maximum benefit payable for all covered dental expenses (excluding Orthodontics) will be $3,000 (CDN) per calendar year for each individual.

C. PRE-DETERMINATION OF BENEFITS

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

Green Shield 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, Green Shield 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 Green Shield, 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 (CDN) 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 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 Green Shield before treatment has begun. The treatment plan will be reviewed by Green Shield 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 usual and customary charge for that procedure will be made toward the charge for a more expensive type of restoration selected by you or your dependent and the dentist. **The balance of the alternate treatment charge selected by you or your dependent 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 5 years have elapsed since the date of the initial installation of that appliance under this Dental Expense Benefits.

3. **Orthodontics:**

   As of April 1, 2012 expenses for Orthodontic treatments are not covered by the Benefit Plan, except for Orthodontic expenses incurred after that date for treatment plans approved by Green Shield prior to April 1, 2012 provided that treatment commences within 60 days from the approval date if these expenses were eligible for the Dental Expense Benefit prior to April 1, 2012.

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; and
      (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:

- charges for services, treatment, appliances and supplies which are specified in the Ontario Dental Association Schedule of Fees but which are not set forth under Section A., Covered Dental Expenses;
- charges for treatment by other than a licensed dentist, denture therapist or dental hygienist;
- charges for veneers or similar properties of crowns and pontics placed on or replacing teeth, other than the ten upper and lower anterior teeth;
- charges for services or supplies that are cosmetic in nature, including charges for personalization or characterization of dentures;
- 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 60 days after termination of coverage;
- charges for any orthodontic procedure;
- charges for replacement of a lost, missing or stolen prosthetic device;
- charges for failure to keep a scheduled visit with a dentist;
- charges for services or supplies which are compensable under workers' compensation or employer's liability law;
- charges for services rendered through a medical department, clinic or similar facility provided or maintained by your or your dependent's employer;

- 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;
- 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;
- 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;
- charges for services or supplies received as a result of dental disease, defect, or injury due to an act of war, declared or undeclared;
- 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 governmental body;
- charges for any duplicate prosthetic device or any other duplicate appliance;
- 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 any governmental body;
- charges for completion of any forms;
- charges for prescription drugs;
- charges for sealants (except as provided under A.1.n.) and for oral hygiene and dietary instructions;
- charges for a plaque control program;
- 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;
- charges for any dental service that is not contained in the procedure codes developed and maintained by the Canadian Dental Association in effect at the time the service is provided; or
- charges for any dental services related to:
  i) restorations necessary for wear, acid erosion, vertical dimension and/or restoring occlusion (except for covered services related to occlusion correction);
  ii) appliances related to treatment of myofacial pain syndrome including all diagnostic models, gnathological determinants, maintenance, adjustments, repairs and relines;
  iii) posterior cantilever pontics/teeth and extra pontics/teeth to fill in diastemas/spaces; or
  iv) service and charges for sleep dentistry.

F. HOW TO CLAIM DENTAL BENEFITS

Dental Claim Forms, complete with instructions, are available from Green Shield.

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 Green Shield. 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 Green Shield 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.

VI. VISION EXPENSE BENEFITS

Reimbursement for covered expenses under this benefit category will be reimbursed at 100% with a 0% co-payment.

Vision Expense Benefits provide the following:

1. For Covered Persons between ages 20 to 64, reimbursement to a maximum of $140.00 for 100% of the cost of one vision examination, by a qualified optician, optometrist or ophthalmologist, once in a 24 month period when this benefit is not provided under the Covered Person's provincial health care plan.

2. Reimbursement of 100% up to a combined total maximum of $350.00 (CDN) for all covered vision expenses every 24 months for:
   - prescription eye glasses (frames and lenses), contact lenses every 24 months; and
   - laser eye surgery (with no other vision benefit payment allowed for 48 months).

3. Reimbursement of 100% of the cost for repairs (not replacements) of prescription eye glasses and lenses at the usual and customary rates as determined by Green Shield, up to a combined maximum of $350.00 (CDN) every 24 months.

The benefit period begins on the initial date vision benefits are received.

Exceptions

1. Covered Persons who have diabetes or other medical conditions requiring frequent lens changes (as substantiated by an ophthalmologist), will be reimbursed 100% of the cost for new lenses whenever they have a prescription change, subject to a maximum of $350.00 (CDN) for each new pair of lenses.

2. Contact lenses will be covered every 12 months for 100% of the cost to a maximum of $350.00 (CDN), 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.

Limitations

1. If a Covered Person has received the maximum reimbursement for lenses and frames or contact lenses for which benefits were payable under the General Motors 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.

2. If a Covered Person has received laser eye surgery for which benefits were payable under the General Motors 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.

Exclusions

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

- 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 any applicable government or basic health plan provides the covered benefit, except as provided under the hospital, medical and surgical benefit under Section II in this booklet;
- medical or surgical treatment (except for laser surgery as provided under 1. above);
- 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; or
- services related to orthoptics (eye exercises) vision training, subnormal vision aids, aniseikonic lenses (special lenses to correct image size differences) except as provided in Section VIII, and tonography (specialized pressure test).

How to Claim Vision Expense Benefits

Claims for covered eyewear and/or eye exams must be submitted to Green Shield 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.

VII. HEARING AID EXPENSE BENEFITS

Reimbursement for covered expenses under this benefit category are limited to one hearing aid of any type per ear every 3 years based on date of first paid claim. Expenses will be reimbursed at 100% with a 0% co-payment.

Hearing Aid Expense Benefits cover the following:

1. The dispensing fee and acquisition cost of a hearing aid and ear mold once every 3 years based on date of first paid claim 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; and
- the hearing aid provided by the dealer is the make and model prescribed by the audiologist and is certified as such by the audiologist.

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 Green Shield 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.

Reimbursement of Hearing Aid Expenses is limited to the lesser of the usual, reasonable and customary charges for the area the expenses are incurred or the amount that would have been paid if the hearing aid or related product was provided by an authorized dealer in Canada, as determined by Green Shield.

Exclusions

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

- medical examinations, audiometric examinations or hearing aid evaluation tests except as provided under the hospital, medical and surgical benefit under Section II in this booklet;
- 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 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 any governmental body;
- 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; or
- 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 Green Shield). Fully complete Green Shield's **Audio Claim Form** and submit to Green Shield directly. Green Shield will reimburse you based on the 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, but in any event reimbursement will not exceed the amount that would have been allowed for the same covered expenses provided by an authorized dealer in Canada. Claims for covered expenses must be submitted within 12 months of the date of purchase or service to be considered for reimbursement.

VIII. EXTENDED HEALTH SERVICES BENEFITS

Extended Health Services Benefits provide for:

A. PARAMEDICAL EXPENSE BENEFITS

Covered expenses (other than expenses for the Psychologist Expense Benefit or for a Physiotherapist) will be reimbursed at 100% with a 0% co-payment for these benefits and will be subject to a combined maximum for all covered practitioners of $750.00 (CDN) per calendar year.

Paramedical Expense Benefits provide for reimbursement for medical necessary services of the following practitioners who are licensed by a regulatory agency or a registered member of a professional association and that association is recognized by Green Shield Canada, that are incurred by you or your eligible dependents after the annual benefit for treatments covered by any government or basic health care plan available to you, if any, has been exhausted. Coverage under Paramedical Expense Benefits is outlined below:

1. Chiropractic treatments. Benefits will be coordinated with those provided by any government or basic health care plan where applicable.
2. Treatments provided by a Practitioner of Podiatry and, when prescribed by a physician, a Practitioner of Chiropody.
3. Naturopathy treatments when provided by a Doctor of Naturopathy.
4. The services of a Registered Massage Therapist, when treatment is prescribed by a physician.
5. The Psychologist Expense Benefit provides for reimbursement of expenses for counseling services incurred provided by a Registered Clinical Psychologist, Master of Social Work, Psychotherapist or Social Worker/Counsellor. The amount reimbursed, including the cost for a psychological assessment, will be reimbursed at 100% with a 0% co-payment and will be subject to an annual maximum of $750 for all covered practitioners combined.
6. The Speech therapy expense benefit provides for reimbursement of expenses incurred when there is a clear medical necessity for such therapy as prescribed by a physician.
7. Treatments provided by a Physiotherapist for active treatment only when medically necessary reimbursed at 100% with a 0% co-payment and will be subject to an annual maximum of $1,500.
8. Services for nutritional counseling in an individual or group setting when prescribed by a physician and provided by a registered Dietician.
9. Acupuncture treatments provided by a licensed Acupuncturist.
10. Treatments provided by a registered practitioner of Osteopathy.

Exclusions

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

- charges for radiographs (x-rays);
- charges for failure to keep a scheduled visit;
- 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;
- charges for the cost of subsequent hearing aid tests used in connection with speech therapy;
- other assessment tools used in connection with speech therapy;
- any supplies including handbooks or tapes used in connection with speech therapy; or
- charges for completion of any forms, reports, or follow-up correspondence.

How to Claim Paramedical Expense Benefits

When you or an eligible dependent incur a Paramedical Expense(s) both you and the practitioner must complete a **Related Professional Services Form**, which may be obtained from Green Shield. The completed form can be forwarded to Green Shield by either you or your practitioner along with the receipt issued by the 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. PROSTHETIC APPLIANCES

Effective January 1, 2022 covered expenses will be reimbursed at 100% with a 0% co-payment.

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 physician and dispensed or sold by a facility or dealer of such appliances. The physician 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.

Covered Benefits Include:

- 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 (including surgical brassieres) and orthopedic shoes (when used as a part of an orthotic appliance);
- parenteral nutrition artificial gut system and implantable urethral sphincter;
- wig or hairpiece including duplicates when hair loss is due to chemotherapy or radiation treatment, alopecia, hypothyroidism, traumatic scalp injury and scalp fungal infection and limited to a lifetime benefit of two wigs in a two year period, for covered persons diagnosed by a physician with transgenderism, to a maximum of $400 (CDN) per wig;
- cochlear implant repairs and supplies; and

- 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 (CDN) and a total treatment maximum of $1,200 (CDN) per 36 month period. The benefit is not eligible when prescribed in conjunction with/or within one year of the provisions of a custom-made knee brace under this plan.

Exclusions

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

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

C. DURABLE MEDICAL EQUIPMENT

Effective January 1, 2022 covered expenses will be reimbursed at 100% with a 0% co-payment.

Purchase, rental and repair (excluding routine maintenance) of durable medical equipment is provided on a usual, reasonable and customary charge basis, and when prescribed by a physician 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.

Covered Benefits Include:

- 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 and respirators (If the prescription is for oxygen, the physician must indicate how it is to be administered and what apparatus is to be used);
- 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 (CDN);
- 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;
- home glucose monitors (Glucometers and Dextrometers) 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 January 1, 2022 the following covered expenses will be subject to an annual maximum of $4,000 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;

- allowance of up to $1,000 (CDN) for pressure injection devices for insulin or insulin pump once every 5 years when such devices are used in lieu of needles and syringes;
- allowance of up to a maximum of $5,500 (CDN) for insulin infusion pump once every 5 years (when not covered by any available government or basic health plan) and insulin infusion pump supplies up to a maximum of $250 (CDN) per month, for eligible dependents age 18 and under, providing the following conditions are met:
  i) insulin infusion pump is prescribed by a physician as a result of Type 1 diabetes;
  ii) physician's prescription includes the required number of injections per day, diagnosis, blood sugar levels, and hemoglobin count; and
  iii) individuals approved for the $5,500 (CDN) benefit will not be eligible for the aforementioned $1,000 (CDN) allowance;
- soft casts to a maximum of $30 (CDN) 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 (CDN) per year;
- geriatric chairs on a one time only basis to a maximum of $2,000 (CDN);
- bathtub rails up to a lifetime maximum of $100 (CDN);
- up to 2 pairs of custom made foot orthotics in any 36 month period to a maximum cost of $400 (CDN); and
- up to 2 pairs of compression stockings every 4 months to a maximum of 6 per year from the date of first purchase.

The decision to purchase or rent such equipment will be based on the physician'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 physician 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

Covered durable medical equipment expenses do not include and no benefits are payable for:

- 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 including disposable sheaths and bags, elastic stockings, and other similar supplies as determined by Green Shield;
- physician's equipment, including infusion pumps, sphygmomanometer, stethoscope, and similar equipment as determined by Green Shield;
- exercise and hygienic equipment, including exercycles, Moore Wheels, bidets, toilet seats, bathtub seats, and other similar equipment as determined by Green Shield;
- self-help devices that are not primarily medical in nature (e.g. elevators, sauna baths, etc.);
- arch supports;
- off the shelf foot orthotics; or
- items previously provided to a member of your household under the General Motors 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 physician 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 physician on the authorization form and this form must be forwarded to Green Shield for approval. Green Shield will return this authorization form either approving or rejecting it. All other covered items require a physician'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 practitioner or Green Shield.

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

D. NUTRITIONAL SUPPLEMENTS

Effective January 1, 2022 covered expenses will be reimbursed at 100% with a 0% co-payment.

Reimbursement for Nutritional Supplements for you or your dependent will be reimbursed 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 (CDN) per year (from the date of the first paid claim) and available only when used in conjunction with in home nursing care;
e) all applicable government benefits and available assistance are applied for; and
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; or
- 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 Green Shield 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.

E. PROSTATE SPECIFIC ANTIGEN (PSA) TESTS

Reimbursement for 1 prostate specific antigen (PSA) test annually, to a maximum of $35 (CDN) for covered males age 50 and older (when not covered under Section II of this plan or any government or basic health plan).

How to Claim Benefits

A completed **Claim Form for Medical Devices** accompanied by itemized receipts must be submitted to Green Shield 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.

F. 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 Green Shield 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.

IX. GENERAL OVERALL EXCLUSIONS

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

- services or supplies received as a result of disease, illness or injury due to any of:
  i) an act of war, declared or undeclared;
  ii) participation in a riot or civil commotion; or
  iii) committing a criminal offence;
- failure to keep a scheduled appointment with a licensed medical/dental practitioner;
- services or supplies which are cosmetic in nature;
- charges for the completion of any forms and/or insurance reports;
- 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;
- services or supplies normally paid through any government health plan, workers' compensation plan, assistive devices program, any other government agency, or any basic health plan 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;

- services or supplies from any governmental agency which are obtained without cost by compliance with laws or regulations enacted by any governmental body;
- services or supplies which are not recommended or approved by the attending physician/dentist;
- 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;
- services or supplies which are legally prohibited by the government from coverage;
- the replacement of lost, missing or stolen items, or items which are damaged due to negligence; or
- 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 be up to 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 Other Plans 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 Green Shield 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 none of the above establishes 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 Green Shield 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, Green Shield as agent of the asrTrust 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 Green Shield's or the asrTrust’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 Green Shield 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:
  i) the date of termination of the Benefit Plan or the asrTrust, in accordance with the Trust Agreement;
  ii) 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;
  iii) 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;
  iv) 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;
  v) their date of death; or
  vi) 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 any government plan, but only with respect to the particular benefit(s);
- 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;
- 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;
- 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);
- 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, if earlier;
- a Surviving Spouse the date eligibility ceases;
- a retiree who returns to active employment with General Motors on a full-time basis and their enrolled dependent(s), the date of re-employment with General Motors; and
- the U.S. Grandparented Plan, the date the Covered Person ceases to be a U.S. resident. Coverage will continue under the Canadian section of the Benefit Plan if you become resident of Canada or the general Non-Resident Plan for non-residents outside of the U.S.

XIII. INQUIRIES AND CLAIM SUBMISSION

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

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

CanAssistance Inc.
(Section II
& Section III)
1981 McGill College Avenue
Suite 105
Montreal, Quebec
H3A 0H6
Canada

Telephone Inquiries:
Toll Free (within North America)
1-800-936-6226
Collect from all other countries
0-519-742-3556

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

Green Shield Canada
8677 Anchor Dr.
P.O. Box 1606
Windsor, Ontario
N9A 6W1

Telephone Inquiries:
Toll Free (within North America)
1-877-266-5494
From elsewhere call
1-519-739-1854

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 Green Shield Canada 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 (for Canadian accounts only), and access many other services using Subscriber Online Services by visiting Green Shield on line at **www.greenshield.ca**.

XIV. COMMITMENT TO PRIVACY

In order to administer the Benefit Plan, the asrTrust and its agents, including Green Shield Canada, are required to collect, maintain and disclose personal information relating to you and your dependents. The asrTrust and Green Shield 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 Green Shield.

Use and disclosure of your personal information is restricted to the Board of Trustees of the asrTrust and its employees, Green Shield Canada and other authorized service providers and Unifor. When required by law, personal information may also be disclosed to authorized agencies including law enforcement and taxation agencies.

Consent

When you enrolled in the General Motors Health Care Program or this Benefit Plan, your personal information was obtained and used only with your consent. Under the Court Approval Orders establishing the asrTrust, your personal information may have been transferred from General Motors 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 General Motors Covered Group, including dependents, we will continue to use and disclose your personal information previously collected in accordance with the Court Approval Orders and the Green Shield Canada Privacy Code, unless you inform the asrTrust or Green Shield 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 Green Shield will no longer be able to administer your benefit coverage. If so, Green Shield will explain the situation to you to help you with your decision.

For further information on the Green Shield privacy policies and procedures, please refer to the Green Shield Canada web site at www.greenshield.ca.

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Printed January 2022