

HEALTH CARE BENEFITS PROGRAM



FORD MOTOR COMPANY OF CANADA, LIMITED

**EFFECTIVE SEPTEMBER 25, 2023
HOURLY AND SALARIED EMPLOYEES
WHO ARE INCLUDED IN A BARGAINING UNIT**

This booklet is a summary of Ford of Canada's Health Care Benefits Program (the "Program"). These plans are designed to provide health care benefits for salaried employees included in a bargaining unit, retirees from the salaried bargaining unit, hourly employees, hourly retired employees, surviving spouses and dependents.

It is to your advantage to know what benefits are available to you and your eligible dependents. Therefore, it is suggested that you read this booklet carefully. This booklet describes the Program, however, the terms and conditions are set forth in the Collective Agreement(s) between the Company and the Union. The Collective Agreement(s) will govern where there is any discrepancy between the language stated in this booklet and that in such Agreement(s).

The Health Care Benefits Program including: Vision Care, Hearing Aid, Dental Care, Prescription Drug, Out-of-Province Hospital-Medical Care, Long Term Care Facility Benefits, Prosthetic Appliances and Durable Medical Equipment and Paramedical coverage are funded by Ford of Canada and administered by Green Shield Canada.

Benefits become applicable to you on the date specified in the Collective Agreement(s).

This booklet describes the principal components of the Program, however, it is impossible to cover every situation that may arise. If you need further information, ask your Ford Benefit Representative or your Union Benefit Representative, who will be glad to be of assistance to you.

Benefits described in this book are based on eligibility of the covered individual to the applicable provincial plan in the province of residence. Individuals who choose to move their principle residence outside of Canada will not retain the same levels of coverage described in this booklet. For further information about what happens if you permanently leave Canada, please contact your Ford Benefit Representative.

Green Shield Canada

Customer Service **1-888-711-1119** or www.greenshield.ca

For: Claim forms
Replacement ID cards
Enquiries regarding coverage
Additional information on Green Shield's commitment to privacy and personal claim information

Mail Claim forms to:

Green Shield Canada

P. O. Box 1606

Windsor, ON N9A 6W1

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HEALTH CARE BENEFITS PROGRAM

EFFECTIVE DATES OF COVERAGE

Coverage starts the **1st day of the 4th month** following the month employment commenced

- Drug
- Out-of-Province
- Prosthetic Appliance & Durable Medical Equipment
- Long Term Care Facility
- Paramedical Coverage

Coverage starts the **1st day of the 13th month** following the month employment commenced

- Hearing Aid
- Dental
- Vision

The Carrier for all benefit programs is Green Shield Canada. Claim forms for the above benefits may be obtained at the location where you work or by calling the Green Shield Customer Service Centre at 1-888-711-1119. You can also visit www.greenshield.ca for additional information and personal claim information.

Note: Temporary Part-Time Employees coverage includes Drug, Out-of-Province, Prosthetic and Durable Medical Equipment and Paramedical only.

ELIGIBILITY AND PROOF OF ENROLLMENT

Enrollment in the Health Care Benefits Program is arranged during the employment procedure. For drug, out-of-province, prosthetic appliance and durable medical equipment, Long Term Care Facility and paramedical, coverage is effective the first day of the fourth month following the month in which employment commenced. For hearing aid, dental, and vision care, coverage is effective the first day of the thirteenth month following the month in which employment commenced.

Your identification card is proof of enrollment in the Health Care Benefits Program. Green Shield Canada is your administrator for your health care coverage.

ELIGIBLE DEPENDENTS

For purposes of this Health Care Benefits Program, the definition of eligible spouse and dependent children is as follows:

Spouse to whom the employee is legally married, or in the case of a common-law, the person who has been cohabiting and residing with the employee in a conjugal relationship for an immediately preceding continuous period of at least one year, and has been publicly represented by the employee as the employee's spouse. Where more than one 'spouse' exists, the employee shall designate the participant and provide the Company with proof of the relationship.

Eligible children shall include any unmarried child (a) of the employee, by birth, legal adoption, or legal guardianship, while such child legally resides with and is dependent upon the employee; (b) of the employee's spouse and who is residing in and a member of the employee's household. A child as defined in (a) and (b) above who does not reside with the employee, but for whom the employee is legally responsible and provides principal support, and who is reported as a dependent by the employee for income tax purposes would qualify as an eligible dependent.

Provided the child, as defined above, is unmarried and in full time attendance at school, shall remain eligible for benefit coverage until the end of the year in which he/she attains age 25. You are required to recertify eligibility of such over-aged dependents annually through your Personnel Services Representative.

A child as defined above will continue to be covered for benefits regardless of age if totally and permanently disabled, living with the employee, and upon *attaining* age 19 continues to be dependent upon the employee within the meaning of the Canadian Income Tax Act.

No person may be considered a dependent of more than two employees – see Co-ordination of Benefits.

ANNUAL RECERTIFICATION PROCESS

Beginning with the month your child turns 19 and each Fall thereafter, you will receive a letter requesting proof of continued eligibility for your child.

In order to continue coverage for dependent age 19 – 20 documentation as follows must be provided:

- Copy of the child's most recent tax return showing income equal to or less than the income threshold based on the Income Tax Act amount "Amount for an Eligible Dependent" deduction **or** a current dated tuition receipt or school document confirming enrollment in full-time attendance at school **and**
- Proof of residence* If child does not reside with employee copy of divorce or separation agreement must be provided confirming the employee's responsibility.

In order to continue coverage for dependents age 21 – 25 documentation as follows must be provided:

- Copy of current dated tuition receipt confirming enrollment in full-time attendance at school **and**
- Proof of residence* If child does not reside with employee copy of divorce or separation agreement must be provided confirming the employee's responsibility.

PROVINCIAL HEALTH INSURANCE PLAN

The provincial health insurance plan provides a wide range of basic benefits for physicians' services and hospital care in standard ward accommodations. Benefits under a provincial plan are available only to individuals who are residents of that province. Information concerning such benefits is provided in separate booklets published by the provincial health insurance plan.

HEALTHCARE QUARTERLY DEDUCTIBLE

A quarterly deductible will be required by all employees, retired employees and surviving spouses. The deductible will be reset quarterly and applied **January 1, April 1, July 1 and October 1**, of each year. The required quarterly healthcare deductible is as follows:

	Up to Age 65	On and After age 65
Employee	97.20	48.60
Retired Employee	24.30	12.15
Surviving Spouse	12.15	12.15

All employees, retirees and surviving spouses will be set up for healthcare with a deductible taken by Greenshield.

The deductible will be applied across all benefits but excludes (Out of province travel, Long term care and non-healthcare benefits. The deductible can be satisfied by claims processed for the employee and/or any dependent individually or collectively.

Effective January 1, 2024 the quarterly deductible is eliminated for all employees, retired employees and surviving spouses.

CHRONIC CARE HOSPITAL ACCOMMODATION BENEFITS

DESCRIPTION OF COVERED EXPENSES

- (a) Up to \$30.00 per day, for a maximum of 120 days, for accommodation in public chronic hospitals or chronic wing facilities of a public general hospital or in a bed designated as an Alternate Level of Care (ALC) bed.

- (b) In a public chronic hospital or chronic wing facilities of a public general hospital a maximum reimbursement of the current Ministry of Health rate up to \$60.00 per day will be paid toward the chronic care co-pay charge (\$47.53 for ALC co-pay) for a 120day period.
- (c) If a covered person continues in chronic care or ALC accommodation beyond 120 days, a maximum reimbursement up to the level provided under Long Term Care Facility Benefits will be allowed.

EXPENSES NOT COVERED

Semi-private acute care hospital coverage, accommodation in TB sanatoria, mental hospitals, hospitals for the chronically ill or chronic units of general hospitals (except as outlined in (b) and (c) above) or in Long Term Care Facility (except as provided for under the Long Term Care Facility Benefits).

LIMITATIONS

Payment of benefits is contingent upon the Provincial Health Insurance Plan in the province in which the patient resides accepting or agreeing to pay the ward or standard rate.

"OUT-OF-PROVINCE"

HOSPITAL, SURGICAL AND MEDICAL EXPENSE BENEFITS

GENERAL DESCRIPTION OF BENEFITS AND CONDITIONS

When you or your eligible dependents receive medical-surgical or hospital services outside of your province of residence and the fees for such services are in excess of the amounts allowed by your provincial hospital and medical-surgical plan, this plan will cover the difference between your provincial health plan allowance and the cost of the actual services provided.

Included in the benefit is emergency air ambulance coverage (including a medical attendant's and accompanying spouse's fare) which is provided from any location in North America directly to a hospital in the patient's province of residence, provided the Provincial Government Health Insurance Plan makes a payment towards the cost. For land ambulance see #2 on page 18.

This benefit is subject to the following conditions and limitations:

- 1) The medical-surgical or hospital services must be incurred as a result of accidental injury or emergency or referral by the patient's attending physician.
- 2) A fee must be scheduled in the applicable provincial health plan for the particular medical-surgical service provided.
- 3) A benefit must be provided under the applicable provincial health plan for the particular hospital services.
- 4) Excess medical-surgical or hospital fees will only be allowed as covered services to the extent that they are reasonable and customary in the area where covered services are received, as determined by the plan administrator.
- 5) The plan administrator shall make payment towards "out-of-province" medical-surgical and hospital services only subsequent to payment by the applicable provincial health plan in the patient's province of residence. Such subsequent payment is contingent upon prior payment by the provincial health plan toward any item of covered service for which payment is requested.

Payment guarantees for hospital, surgical and medical expenses incurred under this plan will be provided by Green Shield through Green Shield Travel Assistance (World Access Canada), in addition to special assistance regarding facilitating claims payment and funds transfers. Under some circumstances, World Access Canada will pay out-of-province hospital, surgical, medical expenses, to the provider or to yourself, if the expenses result in financial hardship, subject to proper claims submission. A call to Travel Assistance should be made immediately after the emergency 1-800-936-6226 USA or 1-519-742-3556 elsewhere.

World Access Canada, in serious medical emergencies, will include: i) an assistance specialist to ensure the patient is receiving the best possible medical treatment and/or; ii) if the patient's in-hospital treatment will continue beyond 5 days, a World Access physician, in consultation with the treating physician and the patient's family physician, will arrange for the patient and spouse to be repatriated by air or land ambulance to a hospital in the

patient's province. Up to \$1,000 will be allowed to return the patient's personal use motor vehicle to the patient's residence or nearest rental agency, as applicable. (See Travel Assistance brochure for further details.)

HOW TO CLAIM BENEFITS

When you incur covered expenses which have not been billed directly to your Provincial Health Insurance Plan or plan administrator, you should complete a claim form which may be obtained from the plan administrator. Attach the following required information to the claim form:

- 1) Detailed statement clearly stating the service received and the fee incurred for each service.
- 2) Copies of applicable provincial plan allowance.
- 3) If a referral, a letter from your attending physician in your province of residence stating the reason for your referral to a physician outside your province of residence.

Forward the completed claim form and other required information to the plan administrator.

PRESCRIPTION DRUG BENEFITS

DESCRIPTION OF COVERED EXPENSES

Your plan covers any substance listed in the Green Shield Canada Drug Formulary applicable to Ford. New prescription drug products are reviewed for inclusion into the Drug Formulary, based on their therapeutic value, lifesaving ability, and cost effectiveness. These include drugs, injectables, insulin and diabetic supplies (see Durable Medical Equipment), which can only be purchased on the prescription of a medical doctor for the personal use of the subscriber or eligible dependents under the plan. Eligible drugs may be confirmed with the plan administrator or with your pharmacist.

Certain drugs will only be considered a benefit under this program if the patient meets certain specific conditions – "Conditional Drugs". In order to be considered for benefit, your physician will be required to complete a form detailing your conditions including clinical evidence. This, in turn, must be submitted to the administrator for review and assessment of eligibility. After submission to the administrator, you or your dependent will be notified within 48 hours. The pharmacy may opt to assess the completed form and, if eligible, submit directly on your or your dependent's behalf.

Any drug or medicine that can be purchased without a prescription with the exception of insulins, nitrates, allergy serums, vaccines, antifungals and epinephrine kits for the treatment of anaphylaxis (e.g. EpiPen) are excluded from coverage.

Green Shield Preferred Pharmacy Network must be used for specialty drugs. A specialty drug includes any substance that is biologic, subsequent-entry biologic, biosimilar, or any medication that requires special handling, administration or monitoring as defined by Green Shield.

NOTE: This Plan does not cover patent or proprietary drugs and medicines, vitamins and vitamin preparations (unless injected) or drugs paid for by any other agency. Certain drugs, such as smoking cessation drugs, erectile dysfunction drugs and drugs for the treatment of infertility are subject to lifetime or annual maximums. Please check with the administrator.

HOW THE PLAN WORKS

The plan administrator will reimburse the full cost of all eligible drug expenses for each person covered by the plan, less a co-payment of 10% of the total allowed amount paid by the plan for each prescription dispensed by a pharmacist, doctor or hospital once the quarterly deductible has been satisfied.

- (1) when a drug prescribed for a covered person has a generic equivalent (regardless of interchangeability), the maximum benefit under the plan for such drug will be limited to the cost of the lowest priced generic drug, less the co-pay stated above, and;
- (2) If the covered person chooses the more costly drug, in lieu of the lowest priced generic drug, such person will be responsible for the difference in cost. Where there is documented evidence of an adverse reaction to a generic drug and Green Shield Canada is provided with a copy of the "Canadian Adverse Drug Reaction Monitoring Program" form completed by the physician that has been submitted to Health Canada the brand name drug will be reviewed for eligibility.
- (3) The 10% co-payment will be applied until the annual out-of-pocket maximums identified below are reached

Calendar year	Out-of-pocket Maximum
2012 and after	\$310.00

The covered person will still be required to pay for dispensing fees over the capped dispensing fee maximum of \$9.00

You may claim payment by submitting a claim form to the plan administrator and attaching your receipted bills. These bills must be official prescription receipts and clearly show the drug name, drug identification number (DIN) and quantity of the drug, the prescription number, the cost, the date of purchase and the patient's name. The covered person will be responsible for any additional charges assessed by the pharmacy over and above those paid by the plan, including any dispensing fee charge over \$9.00.

NOTE: In the event that a brand name prescription drug becomes available at a cost less than the lowest price generic drug, the brand name prescription drug will be the eligible benefit. Prescription drug benefits for residents of Ontario who are age 65 or older are available under the Ontario Drug Benefit Program. Residents who also have the Prescription Drug Plan are required to present their Ontario Drug Benefit (ODB) Card to their pharmacist. This will ensure that the pharmacist bills the ODB Program. However, if certain drug benefits are not available under the Ontario Drug Benefit Program, then they may be claimed in accordance with the terms of the Prescription Drug Plan. Most provinces provide similar coverage for seniors. The prescription drug plan 10% co-payment will also apply to retirees and ODB recipients up to the annual maximum identified above.

Extended Supply

Generally, no more than a 100-day supply of drugs can be dispensed at one time. For retirees travelling outside of Canada on holiday, a special request for additional supplies may be made. Contact the Green Shield Customer Service Centre for assistance. Please advise at least two weeks prior to your anticipated departure.

Note: Only quantities of 30 days are allowed when a covered drug has been prescribed for the first time; this includes all DIN's and brands of the covered drug.

Maintenance Medical Refills will be based on the Maintenance Medical Fill Limit policy administered by Green Shield. This policy limits the number of refills to five (5) per year for maintenance drugs as defined by Green Shield. Refills will be dispensed at a minimum of ninety (90) day supply after the initial fill.

DENTAL EXPENSE BENEFITS PROGRAM

Covered dental expenses will be reimbursed based on the Provincial Dental Association fee guide in effect one (1) year prior to the date Covered Dental Expenses are incurred.

I. Covered Dental Expenses

- (a) The following Covered Dental Expenses will be paid at (i) 100% of the dentist's, denture therapist's or licensed dental hygienist's usual charge, or (ii) 100% of the amount specified therefor in the Provincial Dental Association Schedule of Fees in (or, when applicable, in the Provincial Fee Schedule for Licensed Denture Therapists), in effect one (1) year prior to the date Covered Dental Expenses are incurred, whichever of (i) or (ii) is less:
 - 1) Routine oral examinations and prophylaxis (one unit of scaling and one unit of cleaning of teeth performed at the same visit), but not more than once in any period of nine consecutive months. (See Limitations IV.D);
 - 2) Topical application of fluoride for persons under 20 years of age unless necessary for a specific dental condition;
 - 3) Space maintainers that replace prematurely lost teeth for children under 19 years of age;
 - 4) Emergency palliative treatment (to alleviate pain and discomfort);
 - 5) 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 nine consecutive months) and such other dental x-rays as are required in connection with the diagnosis of a specific condition requiring treatment;
 - 6) Extractions;

- 7) Oral surgery;
 - 8) Amalgam, silicate, acrylic, synthetic porcelain, and composite filling restorations to restore diseased or accidentally injured teeth;
 - 9) General anaesthetics and intravenous sedation when medically necessary and administered in connection with eligible oral or dental surgery;
 - 10) Treatment of periodontal and other diseases of the gums and tissues of the mouth;
 - 11) Periodontal appliance for bruxism (night guard) code 43611 and 43612, but not more than one appliance in any 24 month period.
 - 12) Endodontic treatment (treatment of diseased or infected tooth nerves), including root canal therapy;
 - 13) Injection of antibiotic drugs by the attending dentist;
 - 14) Repair or recementing of crowns, inlays, onlays, bridgework or dentures; or relining or rebasing of dentures more than six months after the installation of an initial or replacement denture, but not more than one relining or rebasing in any period of 36 consecutive months;
 - 15) Inlays, onlays, gold fillings, or crown restorations 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;
 - 16) Porcelain veneers for treatment of the following conditions: amelogenesis imperfecta; Hutchinson's incisors; and hypo maturation;
 - 17) Temporomandibular Joint (TMJ) appliance (code 43711 and 43712; as of January 1, 2003 codes 14711 and 14712) when service is performed by a Certified Dental Specialist (e.g. Periodontist, Orthodontist, Prosthodontist or Oral Surgeon);
 - 18) Pit and fissure sealants for permanent molars for children up to and including age 14;
- (b) The following Covered Dental Expenses will be paid at (i) 50% of the dentist's or denture therapist's usual charge, or (ii) 50% of the amount specified therefor in the Provincial Dental Association Schedule of Fees (or when applicable, in the Provincial Fee Schedule for Licensed Denture Therapists), in effect two (2) years prior to the date Covered Dental Expenses are incurred, whichever of (i) or (ii) is less:
- 1) Initial installation of fixed bridgework (including inlays and crowns as abutments);
 - 2) Initial installation of partial or full removable dentures (including precision attachments and any adjustments during the six month period following installation);
 - 3) 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:
 - (a) the replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed; *or*
 - (b) the existing denture or bridgework cannot be made serviceable and if the existing denture or bridgework was installed under the Dental Expense Benefits Program, at least five years have elapsed prior to its replacement; *or*
 - (c) 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.
 - 4) Orthodontic diagnostic procedures and treatment (including related oral examination), consisting of surgical therapy, appliance therapy, and functional/myofunctional therapy (when provided by a dentist in conjunction with appliance therapy) for covered persons under 21 years of age. Benefits will be paid for covered persons after attainment of age 21 for continuous treatment which began prior to age 21.
 - 5) Effective January 1, 2013, implantology expenses up to the cost of dental bridgework as described in (1) above. Effective January 1, 2017, implantology includes standard implantology expenses including the structure, installation and crown (initial and replacement) (Note: A dental predetermination must be submitted for this type of treatment).

II. MAXIMUM BENEFITS

The maximum benefit payable for all Covered Dental Expenses incurred during any 12-month period beginning October 1 and ending the following September 30, except for orthodontic services, will be \$3,000 for each individual. Effective October 1, 2023, the maximum benefit payable for all Covered Dental

Expenses incurred during any 12-month period beginning October 1 and ending the following September 30, except for orthodontic services, will be \$3,200 for each individual.

Effective October 1, 2020, the maximum benefit payable for Covered Dental Expenses in connection with orthodontics, as described in section I(b)(4), including related oral examinations, will be \$3,800 during the lifetime of each individual.

III. PRE-DETERMINATION OF BENEFITS

1. If a course of treatment is expected to involve Covered Dental Expenses of \$200 or more, a description of procedures to be performed and an estimate of the dentist's charges must be filed with the plan administrator prior to the commencement of the course of treatment (see Section VI, How to Obtain Dental Expense Benefits).
2. Pre-determination is not required for a course of treatment under \$200 or for routine oral examinations, x-rays, prophylaxis, topical fluoride treatments or emergency treatment.
3. Upon receipt of the standard dental treatment plan form, the plan administrator will notify you and the dentist of the benefits certified as payable based on the course of treatment.
4. If a description of the procedures to be performed and an estimate of the dentist's charges are not submitted in advance, the plan administrator reserves the right to make a determination of benefits payable taking into account alternate procedures, services, or courses of treatment, based on accepted standards of dental practice.
5. To assure that you understand the services the dentist will be performing, and the costs involved, you should discuss the certified pre-determination with your dentist *before treatment starts*.

IV. LIMITATIONS

A. Restorative

(1) Gold, baked porcelain restorations, crowns and jackets.

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

(2) 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 the responsibility of the patient.*

B. Prosthodontics:

(1) 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 may choose to use. *The balance of the cost remains the responsibility of the patient.*

(2) Complete dentures

If, in the provision of complete denture services, the patient and the 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 service will be made toward such treatment and *the balance of the cost remains the responsibility of the patient.*

(3) Replacement of existing dentures

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

C. Orthodontics

- (1) If orthodontic treatment is terminated for any reason before completion the obligation to pay benefits will cease with payment to the date of termination. If such services are resumed, benefits for the services, to the extent remaining, shall be resumed.
- (2) The benefit payable for orthodontic service shall be only for the months that coverage is in force.

D. Periodontics

The following dental procedures are restricted to those services rendered by a periodontist:

- (1) *Periodontal scaling (Code 11111 to 11117, 11119; and root planing (code 43421 to 43426, 43429)* - involves deep scaling and cleaning of teeth below the gum line;
- (2) *Gingival curettage (code 42111)* - the next stage following (1) above, involving scraping and scaling pockets around the teeth;
- (3) *Occlusal equilibration (code 43311, 43312, 43313, 43314, 43319; as of January 1, 2003 codes 16511, 16512, 16513, 16514, 16517, 16519)* - involves grinding the biting surface of the tooth to allow the teeth to meet properly when biting;
- (4) *Provisional Splinting (code 43111, 43211, 43231, 43241, 43261, 43271)* - involves splinting teeth to provide stability.

V. EXCLUSIONS

Covered Dental Expenses do not include and no benefits are payable for:

- (a) Charges for services, treatment, appliances and supplies which are specified in the Provincial Dental Association Schedule of Fees but which are not set forth under Section I, Covered Dental Expenses, and Section IV, Limitations;
- (b) Charges for treatment by other than a dentist, except that (1) scaling or cleaning of teeth and topical application of fluoride may be performed by a licensed dental hygienist if the treatment is rendered under the supervision and guidance of the dentist and (2) a denture therapist licensed under the Ontario Denture Therapists Act, 1974 (or a comparable provider licensed in a province other than Ontario) may provide such services, appliances and supplies as are authorized by his/her license;
- (c) Charges for veneers or similar properties of crowns and pontics placed on or replacing teeth, other than the ten upper and lower anterior teeth, and coverage described in Section I;
- (d) Charges for services and supplies that are cosmetic in nature, including charges for personalization or characterization of dentures;
- (e) Charges for prosthetic services (including dentures, bridges and crowns and implants) and the fitting thereof which were ordered while you or your dependent were not insured for Dental Expense Benefits, or which were ordered while you or your dependent were insured for Dental Expense Benefits, but are finally installed or delivered to such individual more than 60 days after termination of coverage;
- (f) Charges for replacement of a lost, missing or stolen prosthetic device.
- (g) Charges for failure to keep a scheduled visit with a dentist;
- (h) Charges for replacement or repair of an orthodontic appliance;
- (i) Charges for services or supplies which are compensable under the Workplace Safety and Insurance Act or any other Employer's Liability Law;
- (j) Charges for services rendered through a medical department, clinic or similar facility provided or maintained by your employer or your dependent's employer;
- (k) 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;
- (l) 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;
- (m) 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;
- (n) Charges for services or supplies received as a result of dental disease, defect, or injury due to act of war, declared or undeclared;
- (o) Charges for services or supplies from any governmental agency which are obtained by the individual without cost by compliance with laws or regulations enacted by any federal, provincial, municipal or other governmental body;

- (p) Charges for any duplicate prosthetic device or any other duplicate device;
- (q) Charges for any services to the extent for which benefits are payable under any health care program supported in whole or in part by funds of the federal government or any province or political subdivision thereof;
- (r) Charges for completion of any insurance forms;
- (s) Charges for prescription drugs;
- (t) Charges for oral hygiene and dietary instructions;
- (u) Charges for a plaque control program;
- (v) Charges for services or supplies related to periodontal splinting, except as described in Section IV.D;
- (w) Charges for the treatment of Temporomandibular Joint Dysfunction (TMJ Dysfunction), except as described in Section I.

VI. HOW TO OBTAIN DENTAL EXPENSE BENEFITS

If you and the dentist wish to have payment made directly to the dentist, forward the completed claim form to the administrator assigning benefits to the dentist. Any charges not covered by the Dental Plan are your responsibility.

If payment is to be made directly to you, *remember to discuss the charges with your dentist.* Then the form must be completed giving all details of the work done, signed by the dentist in the place provided on the claim form that the work detailed has been completed, and then forwarded by you to the administrator at the address shown on the claim form. Payment will be made directly to you on the basis of the benefits as outlined in the contract.

VII. TERMINATION OF DENTAL EXPENSE COVERAGE

Coverage shall cease for the subscriber (and eligible dependents) at the end of the month in which the employee last worked other than by reason of quit, discharge or layoff.

VIII. NO CONVERSION OF DENTAL EXPENSE COVERAGE

Dental Expense Coverage cannot be converted to an individual policy following termination.

IX. BENEFITS OUTSIDE CANADA

The administrator will pay for covered dental expense provided outside Canada on the same basis as if such services were provided in Canada.

VISION EXPENSE BENEFITS PROGRAM

This plan provides the following benefits to subscribers and eligible dependents once in any consecutive 24-month period, providing that a medical doctor, ophthalmologist or optometrist has prescribed these benefits, and provided that the purchase is made while coverage is in force:

Reimbursement for prescription eyeglasses (frames and/or lenses) or contact lenses to a maximum of:

Single Vision Lenses	\$300
Bi-focal Lenses	\$355
Multi-focal Lenses	\$425
Contact Lenses	\$310

Repairs (not replacements) at the usual and customary rates as determined by the plan administrator will be allowed in addition to the above scheduled amounts.

Coverage for eye examinations (routine eye exam, digital retinal imaging, visual field diagnostic test or optical coherence tomography), to a maximum of \$120 per exam, up to a combined maximum of \$200 in a twenty-four (24) month period, provided by either an optometrist or physician (as defined in III) for patients aged 20 through 64 when the benefit is not covered by the person's provincial health care plan.

There is a maximum lifetime reimbursement of \$450 for laser eye surgery. A covered person receiving this benefit is eligible if they have not had a claim for contacts or glasses within 24 months. They will not be eligible for any other vision care benefit for 48 months.

Limitations

Frequency:

- (i) Lenses and frames may be claimed every 24 months up to the maximums stated above. Lenses and frames received under the Company's prescription safety glasses program for which no benefits were received under this Program shall not be considered lenses and frames received under this Program.
- (ii) A covered person with diabetes or other medical conditions requiring frequent lens changes (as substantiated by an ophthalmologist) are eligible for new lenses with every prescription change.
- (iii) Contact lenses will be covered every 12 months, when the covered person's visual acuity cannot otherwise be corrected to at least 20/70 in the better eye, or when medically necessary due to keratoconus, irregular astigmatism, irregular corneal curvature or physical deformity resulting in an inability to wear normal frames.
- (iv) Repairs to frames are not subject to frequency limitations.

Exclusions

Covered Vision Expense does not include and no benefits are payable for:

- (a) Vision examinations, except as described above;
- (b) Medical or surgical treatment;
- (c) Drugs or medications;
- (d) Procedures determined by the Program carrier to be special or unusual, such as, but not limited to, orthoptics, vision training, subnormal vision aids and aniseikonic lenses;
- (e) Lenses or frames furnished for any condition, disease, ailment or injury arising out of and in the course of employment;
- (f) Lenses or frames ordered:
 - (i) before the covered person became eligible for coverage; or
 - (ii) after termination of coverage;
- (g) Lenses or frames ordered while insured but delivered more than 60 days after coverage terminated;
- (h) Charges for lenses or frames for which no charge is made that the covered person is legally obliged to pay or for which no charge would be made in the absence of Vision Expense Benefits coverage;
- (i) Charges for lenses or frames which are not necessary, according to accepted standards of ophthalmic practice, or which are not ordered or prescribed by the attending physician or optometrist;
- (j) Charges for lenses or frames which do not meet accepted standards of ophthalmic practice, including charges for any such lenses or frames which are experimental in nature;
- (k) Charges for lenses or frames received as a result of eye disease, defect or injury due to an act of war, declared or undeclared;
- (l) Charges for lenses or frames from any governmental agency which are obtained by the covered person without cost by compliance with laws or regulations enacted by any federal, provincial, municipal or other governmental body;
- (m) Replacement of lenses or frames which are lost or broken unless, at the time of such replacement, the covered person is otherwise eligible under the frequency limitations set forth; and
- (n) Charges for the completion of any insurance forms.
- (o) Vision benefits which are not dispensed by an Optometrist, an Optician or an Ophthalmologist;
- (p) Follow up visits associated with the dispensing and fitting of contact lenses; and
- (q) Charges for eye glass cases.

HOW TO OBTAIN VISION EXPENSE BENEFITS

Forward a completed vision care claim form to the administrator with your prescription and receipt of payment.

HEARING AID EXPENSE BENEFITS PROGRAM

This plan provides for the following benefits to subscribers and eligible dependents once in any 36 consecutive month period, provided that:

- (a) A medical doctor, who specializes in performing medical examinations of the ear, i.e. an otologist, or a medical doctor who specializes in the treatment of the ear, nose and throat, i.e. an otolaryngologist, has determined the patient has a loss of hearing acuity which can be compensated for by a hearing aid, and
- (b) A person qualified in the rehabilitation of those with impaired hearing, i.e. an audiologist, subsequent to hearing aid evaluation tests prescribes the type of hearing aid that would best improve the loss of hearing acuity, and
- (c) A dealer that sells hearing aids prescribed by an audiologist to improve hearing acuity supplies to the subscriber or eligible dependent for his/her personal use, hearing aids of the following design:
 - in-the-ear, behind-the-ear (including air conduction and bone conduction types) on-the-body, in-the-canal, and completely-in-the-canal hearing aids, aids included may be digital or programmable;
 - binaural hearing aid system will be covered based on accepted professional standards to adequately compensate for loss of hearing acuity.

The Acquisition Cost of the Hearing Aid, the Dispensing Fee, Repairs, Audiometric Examinations and Hearing Aid Evaluation or Re-Evaluation tests are covered benefits.

LIMITATIONS

1. If the subscriber or dependent requests unusual services from the dealer, they shall be obliged to pay the full additional charge.
2. The hearing aid prescribed must be based on the most recent audiometric examination and hearing aid evaluation test.
3. The hearing aid provided by the dealer is the make and model prescribed by the audiologist and is certified as such by the audiologist.
4. No more than one acquisition cost of the hearing aid and one dispensing fee are eligible for payment in any period of 36 consecutive months during which coverage is in force.
5. Hearing aids must be purchased for the sole use of the subscriber or eligible dependent.
6. Audiometric examinations, hearing aid evaluation or re-evaluation tests are limited to \$96.00 per test once per benefit year.

EXCLUSIONS

No hearing aid expense benefit will be paid if the patient purchases the hearing aid from a provider who does not have a written agreement with the administrator. Contact the administrator to confirm your purchase is from a participating hearing aid provider.

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

- (a) Medical examinations;
- (b) Medical or surgical treatment;
- (c) Drugs or other medication;
- (d) Hearing aids, audiometric examinations or hearing aid evaluations/re-evaluations provided under any applicable Workers' Compensation law;
- (e) Hearing aids ordered or audiometric examinations or hearing aid evaluations/re-evaluations conducted:
 - (i) before the covered person became eligible for coverage, or
 - (ii) after termination of coverage;
- (f) Hearing aids ordered while covered but delivered more than 60 days after termination of coverage;
- (g) Charges for hearing aids, audiometric examinations or hearing aid evaluations/re-evaluations 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;
- (h) Charges for hearing aids, audiometric examinations or hearing aid evaluations/re-evaluations which are not necessary, according to professionally accepted standards of practice, or which are not recommended or approved by the physician;

- (i) Charges for hearing aids, audiometric examinations or hearing aid evaluations/re-evaluations that do not meet professionally accepted standards, including charges for any services or supplies that are experimental in nature;
- (j) Charges for hearing aids, audiometric examinations or hearing aid evaluations/re-evaluations received as a result of ear disease, defect or injury due to an act of war, declared or undeclared;
- (k) Charges for hearing aids, audiometric examinations or hearing aid evaluations/re-evaluations provided by any governmental agency that are obtained by the covered person without any cost by compliance with laws or regulations enacted by any federal, provincial, municipal or other governmental body;
- (l) Charges for hearing aids, audiometric examinations or hearing aid evaluations/re-evaluations to the extent benefits therefor are payable under any health care program supported in whole or in part by the funds of the federal government or any province or political subdivision thereof;
- (m) 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;
- (n) Charges for the completion of any insurance forms;
- (o) Replacement parts for and repairs of hearing aids;
- (p) Persons enrolled in alternative plans; and
- (q) Eyeglass-type hearing aids, to the extent the charge for such hearing aid exceeds the covered hearing aid expense for the hearing aid(s) as described above.

HOW TO OBTAIN HEARING AID EXPENSE BENEFITS

Have your participating supplier of hearing aids complete a claim form on your behalf and have it forwarded to the plan administrator at the address shown on the claim form.

However, if you are eligible for limited or full coverage under any government program; i.e. Ontario Assistive Devices Program, have your participating supplier submit the claim to the government before submitting to the administrator.

When payment is made to the participating supplier a copy of the paid claim form will be sent along with the payment. The patient will receive a copy of the claim from the supplier when the patient receives the hearing aid.

PROSTHETIC AND DURABLE MEDICAL EQUIPMENT EXPENSE BENEFITS PROGRAM

The following benefits are to be paid on the basis of the usual, reasonable and customary charges made by a provider or supplier of prosthetic appliances or durable medical equipment, provided that such appliances and equipment have been prescribed by a physician and dispensed or sold by a facility or a dealer of such appliances or equipment.

PROSTHETIC APPLIANCES

1. External prostheses and orthotic appliances which replace all or part of a body or organ (including contiguous tissue) or replace all or part of the functions of a permanently inoperative or malfunctioning body organ. Benefits shall also be payable for the replacement, repairs, fittings and adjustments of such devices.
To be covered under this benefit, however, the advice in writing of the attending physician must include a description of the equipment as well as the reason for use or the diagnosis.
2. Included in the external prostheses and orthotic appliances for which benefits shall be payable are:
 - (a) Artificial arms, legs, eyes, ears (including cochlear implant), noses, larynxes, prosthetic lenses (for people lacking an organic lens or following cataract surgery); aniseikonic lenses; above or below knee or elbow prostheses; external cardiac pacemakers; terminal devices, such as a hand or hook, whether or not an artificial limb is required;
 - (b) 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;
 - (c) Ostomy sets and accessories (including disposable gloves), catheterization equipment, urinary sets, external breast prostheses (including surgical brassieres) and orthopaedic shoes (when used as an integral part of an orthotic appliance).
 - (d) Visco-supplementation therapy for up to \$300 per treatment cycle to a maximum of \$1,200 every three years under certain specific conditions. Treatment must be prescribed and administered by an

orthopedic surgeon. Surgery must not be a viable alternative. Use of this benefit will limit eligibility to a custom-made knee brace under this plan.

3. Exclusions from the benefit provided under this section include, but are not limited to:
 - (a) Dental appliances, hearing aids and, except as provided above, eyeglasses;
 - (b) Non-rigid appliances and supplies such as elastic stockings, garter belts, supports and corsets.

DURABLE MEDICAL EQUIPMENT

1. Hospital beds (with or without mattresses), rails, cradles and trapezes;
2. Crutches, canes, patient lifts, walkers, wheelchairs, portable wheelchair ramps up to a lifetime maximum of \$1,500 and stair lifts up to a maximum of \$3,780 (when approved authorization or claim for walker or wheelchair is on file);
3. Bedpans, commodes, urinals - if patient is bed confined and portable toilets for a patient who has otherwise qualified for a commode;
4. 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), including travel CPAP machine and supplies up to a maximum of \$2,000 every 5 calendar years (when not covered by a provincial plan);
5. Decubitus (ulcer) care equipment, dialysis equipment, dry heat and ice application devices, I.V. stands, intermittent pressure units, neuromuscular stimulants, sitz baths, traction equipment, vapourizers, standard whirlpool baths (maximum installation cost \$500);
6. Rental of electromagnetic coil bone growth stimulators;
7. Home glucose monitors (glucometers, dextrometers) when there is evidence of poor diabetic control;
8. Rental of electric power scooter in lieu of a wheelchair in situations where the patient is unable, by disability, to operate a wheelchair;
9. Wig or hairpiece, including duplicates, when hair loss is caused by chemotherapy or radiation treatment, alopecia (excluding the following natural non-medical conditions causing hair loss; luminaris, male pattern baldness, prematura, senilis and totalis), hypothyroidism, traumatic scald and scalp fungal infection;
10. Disposable diapers and cloth diapers for all incontinent persons;
11. Insulin pressure injection devices (excluding disposable cartridges) or an insulin pump, are covered once every five years to a maximum of \$1,000 when used in lieu of needles and syringes.
12. Glucose Monitoring System (GMS) such as continuous and flash type monitors to an annual maximum of \$4,000. Disposable GMS supplies used with the monitor, but not limited to sensors and transmitters are included and subject to this annual maximum of \$4,000;
13. For covered individuals with Type 1 diabetes reimbursement will be provided for an insulin infusion pump up to \$5,500 once every five years. Infusion pump supplies will be covered to a maximum of \$400 per month. Individuals approved for this benefit will not be eligible for the benefit described in #11 above.
14. Raised toilet seats for all medical conditions;
15. Soft casts to a maximum of \$30 per cast;
16. Reusable underpads for wheelchairs to a maximum of 6 per year;
17. One pair of custom made corrective footwear per year (excluding off-the-shelf orthopaedic footwear) to a maximum of \$750 per year;
18. Geriatric chairs on a one time only basis to a maximum of \$2,000.
19. Bath tub rails up to a lifetime maximum of \$100; bath benches up to a lifetime maximum of \$155.00.
20. Custom-made foot orthotics to a maximum of \$400.00 in any 36-month period.

The Durable Medical Equipment must be:

- (i) Prescribed by a licensed physician;
- (ii) Reasonable and necessary for the treatment of an illness or injury, or to improve the functioning of a malformed body member;
- (iii) Able to withstand repeated use;
- (iv) Primarily and customarily used to serve a medical purpose;
- (v) Generally not useful to a person in the absence of illness or injury;
- (vi) Appropriate for use in the home.

In addition, the Durable Equipment must satisfy the following general conditions:

- (a) The rental price of the durable medical equipment shall not exceed the purchase price. The decision to purchase or rent shall be based on the physician's estimate of the duration of need as established by the original prescription.
- (b) When the durable medical 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 the treatment of the illness or injury. In the event the 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.
- (c) When the durable medical equipment is purchased, benefits shall be payable for repairs except that routine periodic maintenance is excluded.

EXCLUSIONS

- (i) Deluxe equipment such as motor driven wheelchairs and beds, except when such deluxe features are necessary for the effective treatment of a patient's condition and required in order for the patient to operate such equipment without assistance;
- (ii) Items that are not primarily medical in nature or are for comfort and convenience (e.g. bed boards, over bed tables, adjust-a-bed, bathtub lifts, telephone arms, air conditioners, etc.);
- (iii) Physician's equipment (e.g. infusion pumps, sphygmomanometer, stethoscopes etc.);
- (iv) Disposable supplies (e.g. disposable sheaths and bags, elastic stockings, etc.);
- (v) Exercise and hygienic equipment (e.g. exercycle, Moore wheel, bidet, toilet seats (other than raised toilet seats for cancer patients), bathtub seats, etc.);
- (vi) Self-help devices that are not primarily medical in nature (e.g. elevators, sauna baths, etc.);
- (vii) Arch support, including off-the-shelf foot orthotics.

LIMITATIONS

Covered Prosthetic Appliance and Durable Medical Equipment Expense does not include and no benefits are payable for:

- (a) Prosthetic appliances or durable medical equipment furnished for any condition, disease, ailment or injury arising out of and in the course of employment;
- (b) Charges for prosthetic appliances or durable medical equipment for which no charge is made that the covered person is legally obligated to pay or for which no charge would be made in the absence of Prosthetic Appliance and Durable Medical Equipment Expense benefits coverage;
- (c) Charges for prosthetic appliances or durable medical equipment (or items or special features related thereto) which are not necessary, according to accepted standards of medical practice, or which are not ordered or prescribed by the attending physician;
- (d) Charges for prosthetic appliances or durable medical equipment which do not meet professionally accepted standards, including charges for any such appliances or equipment which are experimental in nature;
- (e) Charges for prosthetic appliances or durable medical equipment received as a result of disease, defect or injury due to an act of war, declared or undeclared;
- (f) Charges for prosthetic appliances or durable medical equipment from any governmental agency which are obtained by the covered person without cost by compliance with laws or regulations enacted by any federal, provincial, municipal or other governmental body;
- (g) Charges for prosthetic appliances or durable medical equipment to the extent for which benefits are payable under any health care program supported in whole or in part by funds of the federal government or any province or political subdivision thereof;
- (h) Charges for the completion of any insurance forms.

HOW TO OBTAIN PROSTHETIC APPLIANCE AND DURABLE MEDICAL EQUIPMENT EXPENSE BENEFITS

The Assistive Devices Program (ADP) of the Ontario Ministry of Health is the first payer for any items approved under their Program. Green Shield will pay the balance provided the item is an otherwise covered expense.

Details of the ADP Program may be obtained by telephoning (416) 327-8804 or Toll Free 1-800-268-6021 or by writing:

*Assistive Devices Program
5700 Yonge Street, 7th Floor
North York, Ontario M2M 4K5*

If the item is covered under the ADP, the Ontario Ministry of Health will contribute 75% of the cost, up to a maximum contribution base. You may claim the remaining expense from Green Shield by completing a Claims Attachment form (available from your local Personnel Services Representative) and forwarding it to Green Shield, together with a copy of the supplier's itemized statement identifying ADP payment or a copy of the ADP payment.

If your claim is rejected by the Ontario Ministry of Health, you must obtain an authorization form, complete the employee information, have your physician complete his/her section and submit to Green Shield for approval. Green Shield will provide notification indicating whether your request is approved or not approved. If approved, you may then purchase/rent the appliance/equipment. A claim form with itemized receipts must be completed and submitted to Green Shield for reimbursement or you may have the supplier bill Green Shield directly.

NOTE: The estimated duration of need for durable medical equipment must be clearly indicated by the physician on the authorization form.

For medical equipment in excess of \$500 three separate quotations must be submitted to Green Shield. This requirement is waived if an item has been approved under the Assistive Devices Program.

EXTENDED HEALTH CARE SERVICES (EHS)

The services described below are considered covered extended health care services (EHS) supplementary to the basic hospital, surgical, medical expense benefits covered elsewhere:

1. (a) The services of a Registered Nurse or Registered Practical Nurse are covered when prescribed by a physician for a patient who is not in an institution (i.e. hospital, Long Term Care Facility, etc.). The services are limited to any combination of six (6) hours per day. There must be a clear medical necessity for a Registered Nurse or Registered Practical Nurse before consideration would be given to recognizing these charges. All government programs for nursing services must have been accessed prior to benefits being paid under this program. The administrator will advise you on the procedure required to obtain prior approval and how to obtain reimbursement.
(b) The services of a Personal Support Worker (PSW) are covered when prescribed by a physician and only when used in conjunction with applicable federal or provincial programs. The PSW must have a certificate from an accredited program and be employed by a provincially recognized, bonded health care provider. Reimbursement will be up to \$25 per hour to a maximum of five (5) hours per week.
*Benefits reimbursed under sections (a) and (b) above will be limited to a total annual maximum of \$12,000.00.
2. Medically essential land ambulance services both in and out of the province of residence will be fully covered at the usual, reasonable and customary rate charged for the service in the area where the service was received, provided the patient's Provincial Government Health Insurance Plan makes a payment, if available, towards the cost (for air ambulance see out-of-province coverage).
3. Psychologist services will be provided for employee or eligible dependent requiring counseling services for personal, family or marital problems. Counseling must be provided by a regulated health professional who is a member in good standing with the applicable regulatory College and who is licensed to practice in the province/territory as a psychologist, psychotherapist or a Master of Social Work and will be reimbursed at a rate of \$100 per visit to an annual maximum of \$1,000.00 per benefit year per participant. For eligible dependent children only, psychological assessment performed by a registered clinical psychologist may be reimbursed to a maximum of three (3) times in a lifetime up to a maximum of \$500.00 per assessment. Any amounts claimed for psychological assessments will be included in the annual maximum of set out above for the year in which it is claimed.
4. Speech therapy services provided by a Speech Language Pathologist or Speech Therapist are covered to an annual maximum of \$1,100.00 (including \$125.00 for the initial assessment) per participant after all government programs have been accessed.
5. Nutritional Supplements are covered for conditions such as neuromuscular disorder, pancreatic insufficiency; or for cancer patients under certain specific circumstances to the lesser of \$500 or 220 servings.
6. Prostate-Specific Antigen (PSA) testing – reimbursement will be provided towards the cost of PSA testing to a maximum of \$60.00 per test annually, for covered male persons age fifty (50) and older.

7. Medical Cannabis – In cases where it is medically necessary due to illness or a concomitant medical condition, medical cannabis is a covered benefit when prescribed by a physician. The following conditions must be met prior to approval:
1. The individual must be 25 years of age or over;
 2. The individual must have chronic neuropathic pain or spasticity due to multiple sclerosis or nausea due to cancer chemotherapy or chronic social or generalized anxiety disorder or chronic insomnia or chronic pain or epilepsy; and
 3. It is deemed to be a last resort treatment for the above.

This benefit will be limited to an annual maximum of \$500.00 per benefit year per plan participant.

PARAMEDICAL BENEFITS

1. Chiropractor - up to \$25.00 per visit up to an annual maximum of \$465.00-. In provinces where chiropractic treatments are covered by a provincial benefit plan, reimbursement shall be at a maximum rate of \$15.00 per visit until the applicable provincial benefit plan is exhausted and at a maximum rate of \$25.00 per visit thereafter, to an annual maximum of \$465.00.

	Maximum Reimbursement Rate per Visit	\$15.00	\$25.00
1	Provincial Plan exhausted (or where there is no provincial plan) and under \$465 maximum		*
2	Provincial Plan not exhausted and under \$465 maximum	*	

2. Naturopath – up to \$25.00 per visit to an annual maximum of \$325.00.
3. Podiatrist/Chiropract – up to \$11.45 per visit following the exhaustion of the provincial plan to an annual maximum of \$325.00.
4. Registered Massage Therapist – up to \$75.00 per visit to an annual maximum of \$300.00.
5. Physiotherapist – up to \$100.00 per visit to an annual maximum of \$400.00. Benefits will be co-ordinated with those provided by the provincial health plans where applicable, and will not be provided where available under a provincial plan.
6. Occupational Therapist – Effective January 1, 2021, the services of an Occupational Therapist are an eligible benefit when prescribed by a physician for dependent children suffering from physical, mental or cognitive disorders, and when not covered through the applicable provincial health plan, up to an annual maximum of \$500 per year.

Coverage for the above paramedical practitioner services is applicable after the exhaustion of all government programs.

Annual Maximums for the above paramedical benefits will be based on a calendar year from January 1st to December 31st.

EXCLUSIONS

The above listed paramedical benefits do not include and no benefits are payable:

- (a) for remedies, supplies, vitamins, herbal medications or preparations;
- (b) 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
- (c) if the covered person is a resident of a long term care facility, unless such services otherwise provided by the long term care facility has been exhausted.

HOW TO OBTAIN PARAMEDICAL BENEFITS

Complete a claim form and submit it to the address shown on the claim form along with confirmation of services from a qualified paramedical provider.

LONG TERM CARE FACILITY BENEFITS

A. LONG TERM CARE FACILITY BENEFITS FOR EMPLOYEES RESIDENT IN ONTARIO

This benefit will provide subscribers and eligible dependents coverage for each day a covered person resides in a Long Term Care Facility, as an approved resident as determined under the *Long Term Care Act 1994* as amended or replaced.

The benefit payment for the patient co-payment expense of an approved Long Term Care Facility shall be as follows:

For residents who enter a Long Term Care Facility between January 1, 2006 and December 31, 2008, the benefit payment will be the difference between the daily allowance paid to the Long Term Care Facility by the Province of Ontario for a standard ward room and the Long Term Care Facility's daily charge to a maximum of \$1,724.32 per month regardless of the type of accommodation occupied.

For residents who enter a Long Term Care Facility between January 1, 2009 and December 31, 2010, the benefit payment will be the difference between the daily allowance paid to the Long Term Care Facility by the Province of Ontario for a standard ward room and the Long Term Care Facility's daily charge to a maximum of \$1,543.95 per month regardless of the type of accommodation occupied.

For residents who enter a Long Term Care Facility between January 1, 2011 and December 31, 2013, the benefit payment will be the difference between the daily allowance paid to the Long Term Care Facility by the Province of Ontario for a standard ward room and the Long Term Care Facility's daily charge to a maximum of \$1,200.00 per month regardless of the type of accommodation occupied.

For residents who enter a Long Term Care Facility on or after January 1, 2014, the benefit payment will be the difference between the daily allowance paid to the Long Term Care Facility by the Province of Ontario for a standard ward room and the Long Term Care Facility's daily charge to a maximum of \$800.00 per month regardless of the type of accommodation occupied.

Benefits shall be provided upon submission of proof satisfactory to the administrator that a covered person has been approved as provided under the Act and a payment of an allowance for such care was made on behalf of such person by the Province of Ontario for each such day for which benefits under the program are claimed.

EXCLUSIONS

1. Benefits will not be provided to persons eligible for or receiving same or similar benefits from any branch of any federal, provincial or municipal government or any other third party, regardless of whether the covered person has or has not contributed toward providing such benefit.
2. Daily benefits will not be paid under this plan if the covered person is absent from the home. However, a covered person who would qualify to receive long term care service may continue to receive benefits for up to two (2) calendar days following admission to a public general hospital.

HOW TO OBTAIN LONG TERM CARE FACILITY BENEFITS

Before any Long Term Care Facility benefits are payable, the following information must be supplied to the plan administrator:

- (i) A copy of 'Authorization for Admission to a Long Term Care Facility' form as completed by the Community Care Access Centre (CCAC) naming the facility and confirming that the patient is a resident
- (ii) A copy of the Ministry of Health 'Application for Reduction in Long Term Care Facility Accommodation Fees' as completed by the LTC facility for those in a ward or standard accommodation

In many cases the Long Term Care Facility will bill the plan administrator directly on a monthly basis. In the event the facility in which the covered person resides does not directly bill the plan administrator, a claim form may be obtained from Green Shield..

B. LONG TERM CARE FACILITY BENEFITS FOR EMPLOYEES RESIDENT OUTSIDE ONTARIO (WITHIN CANADA)

This benefit will provide subscribers and eligible dependents coverage for long term care for the patient co-payment expense for each day the covered person is certified by the administrator as meeting the same requirements necessary to receive extended care benefits under the *Health Insurance Act of Ontario*. The covered person must reside in and receive daily care in an approved Long Term Care Facility which is licensed or registered under the laws of the province in which it is located.

The payment for the patient co-payment expense in any such facility will be the lesser of the usual charge payable by the patient, or the co-payment amount up to the level, which would have been payable had such patient been in a licensed facility in the Province of Ontario.

Benefits will be payable only on submission of proof satisfactory to the plan administrator that, if an eligible subscriber or dependent had resided in the Province of Ontario, such subscriber or dependent would have been eligible to receive long term care and a payment of an allowance for such care would have been made to the facility for the covered person by the Ontario Ministry of Health for each day benefits are claimed.

EXCLUSIONS

1. Benefits will not be provided to persons eligible for or receiving same or similar benefits from any branch of any federal, provincial or municipal government or any other third party, regardless of whether the covered person has or has not contributed toward providing such benefit.
2. Daily benefits will not be paid under this plan if the covered person is absent from the home. However, a covered person who would qualify to receive long term care service may continue to receive benefits for up to two (2) calendar days following admission to a public general hospital.

HOW TO OBTAIN LONG TERM CARE FACILITY BENEFITS

Before any Long Term Care Facility benefits are payable, submission of proof satisfactory to the carrier that the same requirements are met as necessary to receive long term care benefits under the *Health Insurance Act of Ontario*.

The following information must be supplied to the plan administrator:

- The name of the facility with confirmation that the covered person is resident
- Proof of facility requirements based on type of facility and type of care provided
- Authorization of admission from applicable provincial placement service
- Any income assessment as required

The completed claim forms should be forwarded to the plan administrator, although in many cases the facility will bill directly on a monthly basis.

C. GENERAL

Subscribers and eligible dependents must make their own arrangements for admission to a facility. The plan administrator cannot assist or recommend any facility providing long term care benefits covered under this plan. Benefits are not payable for care in a facility outside of Canada.

CONTINUATION OF COVERAGES WHILE AWAY FROM WORK OR FOLLOWING TERMINATION OF EMPLOYMENT

COVERAGE DURING LAYOFF

If you are laid off, your Health Care Benefits coverage will be provided by the Company for you and your eligible dependents, without cost to you, on the basis of the greater of:

- (i) one full calendar month of layoff (for which you receive no pay) not to exceed twenty-four months, for each full four weeks of Regular Benefits to which your Credit Units under the Supplemental Unemployment Benefit Plan would entitle you to, on the basis of your seniority and the Credit Unit Cancellation Base as of the last day you worked prior to layoff;**
or

* *If you are initially credited with Credit Units under the SUB Plan during a layoff, your entitlement will be established as of the date such Credit Units are credited.*

- (ii) the number of months provided under a seniority-related formula. For details of this seniority-related formula you should refer to your Collective Agreement.

Upon termination of your Company-paid coverage, you may continue your group coverage at your own expense for an additional 12 months.

COVERAGE WHILE ON LEAVE OF ABSENCE, SUSPENSION OR STRIKE

If you are suspended, or on strike, Health Care Benefit coverage (excluding dental) for yourself and your eligible dependents will be continued by the company for one month following the month in which the suspension or strike commenced.

If you are on a company approved leave of absence, health care benefit coverage will be continued by the company for one month following the month in which the leave commenced. You may maintain group coverage by paying your premiums to the company for a further period of 12 months.

SICKNESS OR ACCIDENT

If you are absent from work because of sickness or accident, your Health Care Benefit coverage will be continued by the Company for you and your eligible dependents while you continue to be absent from work because of a sickness or accident. Coverage begins with the month following the month in which the absence begins and continues for a period equal to your seniority at the time the leave commenced or to age 65 if you have 10 or more years of service.

MATERNITY/PARENTAL LEAVE OF ABSENCE

If you are on an authorized maternity/parental leave of absence, your Health Care Benefit coverage will be continued by the Company for the duration of the leave. If you request and are approved for a personal leave of absence upon completion of your authorized maternity/parental leave of absence, you may maintain group coverage by paying your premiums to the Company for the duration of the leave.

REINSTATEMENT

Should your Health Care Benefit coverage cease to be paid by the Company during leave of absence, suspension, layoff or strike, the Company will again pay for the coverage on the first of the month following the date of your return to work.

TERMINATION

Health Care Benefit coverage terminate at the end of the day in which you resign or are discharged. If you are discharged, suspended or suffer loss of seniority under specified sections of the Collective Agreement, and you have a grievance pending to protest your loss of seniority, your Health Care Benefit coverages will be continued to the end of the month following the month in which you are last at work and you may, during the period of disposition of the grievance concerning such action, maintain your Health Care Benefit coverages by paying the necessary

premiums to the Company. If your seniority is reinstated or the suspension reduced you will be reimbursed by the Company for any contributions which you made and which the Company would have made under the normal provisions of the insurance program.

In the event your grievance is withdrawn and you are undergoing substance abuse treatment, you may maintain group coverage by paying your premiums to the Company for the duration of the treatment.

RETIREMENT

If you were hired before September 24, 2012, Health Care Benefit coverage will continue for you and your eligible dependents when you retire.

Retirement Health Care Benefit coverage as outlined in this booklet are not applicable for employees hired on or after September 24, 2012.

TRANSFER OF COVERAGE IN THE EVENT OF DEATH

- (a) The surviving spouse of a deceased retired employee, and the surviving spouse of a deceased employee who was eligible for Early or Normal retirement at the time of death are eligible for Company-paid continuance of Health Care Benefit coverage. To be eligible for Early retirement an employee must have 30 years of pension creditable service, be age 60 with at least 10 years of pension creditable service or have age plus service equal to 85 points.
- (b) If an employee not eligible for retirement should die, the Company will continue Health Care Benefit coverage for the full period the surviving spouse is otherwise eligible to receive Survivor Income Benefits.
- (c) The Company will continue drug-dental-vision-hearing aid expense coverages for a surviving spouse of an employee whose loss of life results solely by employment with the Company, and results from an accident. Such coverage will not include dental, vision or hearing aid expense coverages if the employee had less than one year of seniority or service at the time of death, and shall terminate upon the remarriage of the surviving spouse.
- (d) Dependents of the surviving spouse may be eligible for coverage if covered at the time of death of the employee/retiree provided they continue to meet the definition of "dependent".

Note: Where more than one spouse exists at time of the employee's death, coverage will continue for the spouse enrolled in the program by the retiree prior to his/her death.

COORDINATION OF BENEFITS (including vision expenses)

Under this provision your Health Care Benefits program 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 plan, will equal 100% of allowable expenses incurred by yourself or your eligible dependents. This provision also applies when both spouses are employed by the Company and are eligible for program benefits.

SUBROGATION

In the event of any payment for services made by the administrator under your Health Care Benefits Program, such administrator shall acquire all the employee's or dependent's rights of recovery as a result of settlement or judgment brought against any person or organization, except against insurers or policies issued in the name of the employee or dependent.



Ford Motor Company of Canada, Limited

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