# EMPLOYEE BENEFITS BOOKLET

Name of Group: Merrill House
Class 000: All Employees
Policy Number: 45618
Effective Date: May 1, 2022

Empire Life®

## INTRODUCTION

Your employer has entered into an agreement with Agile Benefits Inc. for Insurers to provide you with a plan of group insurance benefits.

This information booklet has been prepared in order to give you an informal summary of the benefits and provisions of your Plan. It does not constitute the Policy and is not a contract of insurance, nor does it confer or grant any contractual or other rights. All rights under this Plan will be governed solely by the provisions of the Policies issued by the Insurers and by applicable law.

In the event of any discrepancy between this booklet and the Policies, the terms and provisions of the Policies apply.

The booklet contains important information concerning your group insurance coverage. As at the print date, this is the most current version of your group insurance benefits and replaces any previous booklet.

Should you have any questions, please contact the Administrator, Agile Benefits Inc. at:

**235 Ardelt Ave, Unit 1A**
**Kitchener ON N2C 2M3**

# YOUR INSURERS, SERVICE PROVIDERS AND POLICY NUMBERS

| **Benefit** | **Insurance Company** (hereinafter called the Insurer)<br>***Service Provider*** | **Policy Number** |
|---|---|---|
| Basic Life | The Empire Life Insurance Company | 45618 |
| Dependent Life | The Empire Life Insurance Company | 45618 |
| Extended Health Care | The Empire Life Insurance Company<br>*ClaimSecure Inc.* | 45618 |
| Out-of-Province Of Residence Coverage (under Extended Health Care) | The Empire Life Insurance Company<br>*Trident Global Assistance* | 45618 |
| Dental Care | The Empire Life Insurance Company<br>*ClaimSecure Inc* | 45618 |
| Second Opinion Service | The Empire Life Insurance Company | 45618 |
| | *Teladoc Medical Experts*®<br>® Registered trademark of Teladoc Health Inc. | 45618 |
| Mental Health Navigator | The Empire Life Insurance Company | 45618 |
| | *Teladoc Medical Experts*®<br>® Registered trademark of Teladoc Health Inc. | 45618 |
| Telemedicine | The Empire Life Insurance Company | 45618 |
| | *Teladoc Medical Experts*®<br>® Registered trademark of Teladoc Health Inc. | 45618 |

## SCHEDULE OF BENEFITS

| | |
|---|---|
| **Eligibility Period:** | 3 month(s) continuous employment |
| **Minimum Hours Per Week:** | 20 hours |

### BASIC LIFE

| | |
|---|---|
| **Benefit:** | $25,000 |
| **Maximum Benefit:** | $25,000 |
| **No Evidence Limit:** | $25,000 |
| **Reduction:** | Reduces by 50% at age 65 |
| **Termination Age:** | Earlier of age 70 or retirement |
| **Waiver of Premium:** | After the 182 day waiting period |
| **Own Occupation Period:** | 2 years from the start of any benefit period for the purposes of the "Total Disability" definition for the Waiver of Premium Benefit. |

### DEPENDENT LIFE

| | |
|---|---|
| **Benefit:** | Spouse: $10,000<br>Child (from live birth): $5,000 |
| **Termination Age:** | Earlier of employee's age 70 or retirement |

## SCHEDULE OF BENEFITS

### EXTENDED HEALTH BENEFITS

**Benefit Period:** Calendar Year

**Survivor Benefit:** 24 Months

**Termination Age:** Earlier of age 70 or retirement

***For detailed descriptions and limitations for these benefits refer to the Extended Health Benefit section***

The Service Provider on behalf of the Insurer will pay for Eligible Expenses (up to the maximum outlined below or the **Reasonable and Customary Charge**, whichever is less), for a Person Insured, that are **Medically Necessary** for the treatment of a Sickness or injury.

The Extended Health Benefits provided under this Plan to any Person Insured who is a resident of a province that offers a public prescription drug plan will be administered in accordance with the requirements of applicable provincial prescription drug insurance legislation (e.g. *An Act Respecting Prescription Drug Insurance* in Quebec) and will meet any applicable minimum coverage standard, as determined by the Insurer.

Each Person Insured is covered for the following with an **unlimited** maximum, with any exceptions noted and subject to the Extended Health Benefit Provision.

**Drugs reimbursed at 80%**

**Deductible Amount**: Single: None
Family: None

| **Pay direct plan** | **Maximums and other limitations** |
|---|---|
| Mandatory Generic/Formulary Protect | Unlimited |
| Over-the Counter Products | Not covered |
| Smoking cessation drugs | Not covered |
| Fertility drugs | Not covered |
| Erectile dysfunction drugs | Not covered |
| Anti-obesity drugs | Not covered |

**Major Medical reimbursed at 100%**

**Deductible Amount**: Single: None
Family: None

| | **Maximums and other limitations** |
|---|---|
| **Accidental dental** | Unlimited |
| **Ambulance** | Unlimited |
| **Diagnostic tests** | Unlimited |
| **Hearing aid** | $500 per period of 60 consecutive months, per insured |
| **Private duty nursing** | $10,000 per calendar year, per insured |

## SCHEDULE OF BENEFITS

**Medical Supplies and Appliances (Major Medical reimbursement % and Deductible applies)**

- Medical Supplies and Appliances **require a separate Physician's referral for each supply or appliance prescribed**. The date of the Physician's referral and diagnosis must be within a six month period of submission of any claim. Only **Medically Necessary** supplies and appliances are covered under this Plan. Medical Supplies and Appliances prescribed solely for comfort, sports or recreational activities are not an Eligible Expense under this Plan. The Insurer and/or the Service Provider reserves the right to request additional information for any Medical Supply or Appliance prescribed.
- The Service Provider on behalf of the Insurer will pay for Eligible Expenses (up to the maximum outlined below or the **Reasonable and Customary charge**, whichever is less), for a Person Insured, that are **Medically Necessary** for the treatment of a Sickness or injury.
- Prior to making a purchase for a supply or appliance, a Person Insured should contact the Service Provider to obtain the Reasonable and Customary charge for a supply or appliance and a confirmation that such supply or appliance is covered under this Plan.

| | **Maximums and other limitations** |
|---|---|
| Apnea machine (CPAP, APAP) | $2,000, 1 per 60 consecutive months |
| Apnea machine supplies | Unlimited |
| Artificial eye; initial prosthesis | unlimited |
| Artificial eye; repair & replacement | unlimited |
| Artificial limb; initial prosthesis | unlimited |
| Artificial limb; repair & replacement | unlimited |
| Braces with rigid supports | unlimited |
| Compression stockings with a strength of 20 mmHg or higher | 4 pairs per calendar year |
| Crutches | Unlimited |
| Custom-made foot orthotics | $400 per calendar year |
| Blood Glucose Monitoring Machine | 1 per 48 consecutive months |
| External breast prosthesis | 1 per calendar year |
| Hospital bed | Unlimited |
| Insulin pump | 1 pump per 60 consecutive months |
| Insulin pump supplies | Unlimited |
| IPP Breathing machine | $2,000 per 60 consecutive months |
| IPP supplies | Unlimited |
| Orthopaedic shoes | $400 per calendar year |
| Ostomy supply | Unlimited |
| Surgical bras | 2 per calendar year |
| TENS | $700 per lifetime |
| Viscosupplementation | $600 per calendar year |
| Wheelchair; manual or medically required electric | $5,000 per 60 consecutive months |
| Wigs, post-chemotherapy | $300 per lifetime, per insured |

**Hospital Coverage**

| | **Coinsurance** | **Maximums and other limitations** |
|---|---|---|
| **Convalescent hospital** | 100% | Maximum of $25 per day, up to 120 days per insured, per disability |
| **Semi private hospital room** | 100% | Unlimited |
| **Specialized treatment facility** | None | Not Covered |

## SCHEDULE OF BENEFITS

**Paramedical Practitioners reimbursed at 80%**

**Deductible:** None

Provincial and territorial legislation specifies for each province or territory which paramedical practitioners are, or are not, regulated. In cases where the paramedical practitioner is not regulated, the Service Provider has set the required level of education, training and/or professional affiliations.

Each paramedical service has a Reasonable and Customary amount and a limit of one visit per day. Payment will not be made for services or supplies that were received or purchased from a provider that is not approved by the Service Provider.

| **Paramedical Practitioners** | **Maximums and other limitations** |
|---|---|
| Acupuncturist | $300 per calendar year |
| Chiropodist/Podiatrist (includes X-rays) | $300 per calendar year |
| Chiropractor (includes X-rays) | $300 per calendar year |
| Clinical Psychologist/Social Worker (MSW required) | $300 per calendar year |
| Massage therapist | $300 per calendar year |
| Naturopath | $300 per calendar year |
| Osteopath (includes X-rays) | $300 per calendar year |
| Physiotherapist | $300 per calendar year |
| Registered Dietician | $300 per calendar year |
| Social Worker (MSW required) | $300 per calendar year |
| Speech therapist | $300 per calendar year |

**Per Visit Maximum:** Unlimited
**Physician's Referral Required:** None

**Eye Exams reimbursed at 100%**

**Deductible:** None

| | **Maximums and other limitations** |
|---|---|
| **Eye exam, to age 18** | $100 per 12 consecutive months, per covered person |
| **Eye exam, age 18 and older** | $100 per 24 consecutive months, per covered person |

## Out of Province of Residence Coverage reimbursed at 100%

**Deductible:** None

### Out of Province of Residence – Emergency Coverage – $5,000,000 lifetime maximum (combined)

- one period is 90 continuous days from the date of departure.
- the Travel Emergency Assistance Program services will only apply to a Person Insured who is travelling on business or vacation outside of his province of residence.

| | Maximums and other limitations |
|---|---|
| Emergency Charges for Other Eligible Medical Expenses | |
| Emergency Hospital In-Patient Room Charges | |
| Emergency Hospital Out-Patient Charges | |
| Emergency Physicians Charges | |
| Medical transport | |
| Out of country | |
| Repatriation of remains | |
| Return of dependent children | |
| Trip delay | |
| Vehicle return | |
| Visit of Family Member - Travel | |
| Visit of Family Member - Meals/Accommodation | $200 per day |

### Out of Province of Residence – Referral Coverage – $15,000 lifetime maximum (combined)

| | Maximums and other limitations |
|---|---|
| Out of province; referral; hospital | $150 per day |
| Out of province; referral; other | |
| Out of province; referral; physician | |

## SCHEDULE OF BENEFITS

### DENTAL

| | | |
|---|---|---|
| **Deductible Amount**: | Single: None<br>Family: None | |
| **Coinsurance:** | Basic Restorative/ Periodontics/Endodontics | 80% |
| **Benefit Period Maximum:** | Basic Restorative/ Periodontics/Endodontics | $1,000 per benefit, per covered person, all services combined |
| **Dental Fee Guide:** | Based on the general practitioners' fee guide of the province where treatment is given. Current year fee guide. | |
| **Survivor Benefit:** | 24 months | |
| **Benefit Period:** | Calendar Year | |
| **Dental Recall Frequency:** | Every 9 months | |
| **Dental Scaling:** | 10 Units | |
| **Termination Age:** | Earlier of age 70 or retirement | |

## Additional Services

### Teladoc Medical Experts®

You and your eligible Dependents receive access to Teladoc Medical Experts' leading experts to help find a specialist, get a medical second opinion, and get a digital copy of medical records. To use this service, contact Teladoc Medical Experts at 1 877 419-2378 or visit Teladoc.ca

### Mental Health Navigator

Teladoc Medical Experts® provides you and your eligible Dependents with Mental Health Navigator. This virtual service provides expert mental health guidance to help determine if you have the right diagnosis or treatment plan. To use this service, contact Teladoc Medical Experts at 1 877 419-2378 or visit Teladoc.ca

### Telemedicine

Teladoc® provides you and your eligible Dependents with 24/7/365 virtual access to Canadian licensed physicians. Teladoc can help treat a range of conditions - such as the flu, allergies, rashes and more - by phone or video, and can provide prescriptions when medically necessary. Physicians will not prescribe narcotics, controlled substances or nontherapeutic drugs and will not treat medical emergencies.

If you have extended health benefits, you can set up your profile with Teladoc in one of three ways: download the Teladoc telemedicine app, visit teladoc.ca, call 1 888 983-5236.

Disclaimer

## GENERAL PROVISIONS

### DEFINITIONS

**"Actively at Work"** will mean, any day you are actively at work performing all the usual and customary duties of your job for the scheduled number of hours for that day. This includes scheduled non-working days and periods of continuous paid vacation if you were actively working on the last scheduled working day. You are not considered actively at work if you are receiving disability benefits.

**"Eligibility Period"** means the period of continuous employment with your Employer which you must complete before you are eligible for benefits under this Plan.

**"Government Health Insurance Plan"** means the provincial or federal legislation and the regulations pursuant to such legislation, as amended from time to time, which provide government sponsored hospital, drug, dental or other medical care benefits for Residents of Canada, including but not limited to provincial Dental Care Plans, provincial Health Insurance Plans, provincial Hospital Insurance Plans, provincial Medicare Plans, federal or provincial medical or dental care and services Acts, and the Canada Health Act.

**"Leave of Absence"** means a period of absence from work for which the dates are fixed by legislation or by mutual agreement between you and your Employer.

**"Motorized Vehicle"** means a vehicle that is drawn, propelled or driven by any means other than muscular power, including but not limited to an automobile, motorcycle, boat, snowmobile, all terrain vehicle, personal watercraft or farm equipment.

**"Person Insured"** means you and your insured Dependents.

**"Physician"** means a physician or surgeon or a specialist medical doctor duly qualified and legally licensed by the jurisdiction in which he operates, who prescribes and administers medical treatment and drugs professionally or performs surgery within the scope of his licence, and who specializes in a particular branch of medicine and who is neither insured for benefits under this Plan nor related by blood or marriage to the Person Insured.

**"Pregnancy/Parental Leave of Absence"** means any formal pregnancy or paternal leave taken pursuant to Provincial or Federal Law or pursuant to mutual agreement between you and your Employer.

**"Reasonable and Customary"** means, with respect to charges for medical or dental services, supplies or treatment incurred by a Person Insured, not in excess of the general level of charges made by other providers of similar standing in the locality or geographical area where the charge is incurred, when furnishing comparable medical or dental services, supplies or treatment, with due consideration given to the nature and severity of the condition involved, as determined by the Service Provider.

**"Resident"** means a person who is legally entitled to be or to remain in Canada and who makes his/her home, and is ordinarily present, in a province or territory of Canada and who is insured under a Government Health Insurance Plan

### ELIGIBILITY

You are eligible for coverage under this Plan if you:

- have satisfied the Eligibility Period;

- have not reached the Termination Age of each respective benefit as specified in the Schedule of Benefits;
- are a Resident who is regularly scheduled to work the Minimum Hours Per Week; and
- are Actively at Work.

## EVIDENCE OF INSURABILITY

If your written request for coverage is received within 31 days of being eligible, Evidence of Insurability will only be required for any amounts in excess of the respective No Evidence Limits, as specified on the Schedule of Benefits.

Should your written request for coverage be received after 31 days of becoming eligible for coverage and the Plan is mandatory, premiums are payable from the date you became eligible. If however, the Plan is non-mandatory, you will be required to submit Evidence of Insurability for all insurance. Coverage will not become effective until evidence has been reviewed and approved. For further information, please contact the Administrator.

## COORDINATION OF BENEFITS

If your Plan includes Extended Health or Dental benefits and if either you or your dependents are entitled to benefits under this Plan and any other plan for the same expense, the amount payable will be co-ordinated and/or reduced under this Plan to ensure the total amount payable under all plans does not exceed the amount of the expense incurred. For further information, please see your Plan Administrator or your Personnel Department.

## LIMITATION OF ACTIONS

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract ( the Policy) is absolutely barred unless commenced within the time set out in the Insurance Act (for British Columbia, Alberta and Manitoba), the Limitations Act, 2002 (for Ontario), or other applicable legislation (for all other provinces and territories).

## TERMINATION OF COVERAGE

Your benefits will terminate whenever one of the following first occurs:

- termination of employment; or
- premiums are not submitted on your behalf; or
- the Policy is terminated; or
- you no longer satisfy one or more of the eligibility requirements above.

## PAYMENT OF CLAIMS

All claim forms are available from your employer's group plan administrator.

### Health Insurance
### Prescription drugs – Direct electronic claims payment

When making prescription drug purchases, you present your service card to the pharmacist. The Service Provider will automatically issue payment for the insured portion of prescription drug expenses. There is no need to fill out a claim form, and you only have to pay the uninsured portion of prescription drug expenses (including any applicable deductible).

## Other medical expenses

You must submit a duly completed, signed and dated claim form to the Service Provider. It is important to follow the directions on the form and enclose original receipts and paid invoices for the expenses incurred. You should keep copies for your records as the originals will not be returned. In the event of hospitalization, you show your service card at the time of admission, and the hospital centre will then file a claim directly with the Service Provider.

For dental and extended health claims, claim forms must be submitted within 365 days from the date the claim was incurred or within 90 days of Policy termination, whichever comes first.

For extended health claims incurred outside of your province of residence, you should first submit a claim to your provincial health plan, then submit a copy of the provincial health plan payment along with your claim form to the Administrator. However, should your Plan include Travel Emergency Assistance coverage and you have an emergency while travelling, 24 hour assistance is available by calling one of the phone numbers that appear on your Benefit Card and identifying yourself by the information on the card. An operator at the Service Provider will assist you. Claims will be paid after the proof of claim is received. All other benefits will be paid as directed by you on the claim form.

Please note: Under some circumstances, Extended Health Benefits may not be payable until the Government Health Insurance Plan concerned has paid its' yearly maximum. Check with the Administrator if you require further details

## Life Insurance

The beneficiary must contact the Plan Administrator to obtain all required claim forms and submit a claim for the insured amount to the Administrator. You have 90 days to submit the required proof of any death claim. Any death benefit due will be paid to the named beneficiary, if living. Otherwise, it will generally be paid to the estate.

## Disability Insurance

Benefits are payable to you after expiry of the elimination period provided proof of claim has been received and your claims has been approved. The claim form must be completed by you, the employer and the attending physician, then forwarded to the Administrator as soon as possible. You have 90 days to submit the required proof of any disability claims.

## Fraudulent or False Claims

The Insurer reserves the right to audit all claims at any stage even if payment has already been made, and to take any necessary action to detect and investigate fraudulent or false claims under the Policy.

Notwithstanding any other Provision of the Policy, the Insurer may suspend all rights and all benefits of you and your Insured Dependents, without prior notice, upon 1) the initiation of a claim investigation by the Insurer 2) the discovery of a claim discrepancy, or 3) receipt of a claim that includes any false, inaccurate, incomplete or misleading information material to the claim.

If the Insurer reasonably determines that the Person Insured has:
(a) submitted or allowed to be submitted a claim that includes any false, inaccurate, incomplete or misleading information material to the claim, and/or
(b) failed to co-operate in good faith during the claim investigation by the Insurer or the Service Provider, and/or

(c) failed to provide evidence to support the claim to the satisfaction of the Insurer or the Service Provider,

The Insurer may, at its reasonable discretion and without prior notice, immediately terminate all rights and all benefits of you and your Insured Dependents under the Policy.

If the claim has been paid to you, the Insurer may exercise any rights available under the Policy and it may recover any overpaid amounts from any amounts owed to you under any Provision of the Policy.

The Insurer also reserves the right to undertake criminal prosecution and/or pursue civil action.

## ACCESS TO PERSONAL INFORMATION

At the Insurer, the Service Provider and the Administrator, we create enrolment, medical and claims files in order to determine the amount of coverage you and/or your dependents (if applicable) are eligible for and to process any claims you or your dependents may incur. The information contained in these files, which is used by various departments, may allow you and/or your dependents to be identified. However, any file containing your medical status is accessible only to authorized individuals within our Medical Underwriting and Claims Departments.

Subject to the exceptions established by applicable law, you may request access to your files either in person, by showing proper identification at the Insurer's Head Office, or by contacting the Insurer's Head Office in writing with your request. You have the right to rectify any information which is incorrect (dependent on the circumstance, proof may be required) in your file and also to have any information reproduced and transmitted to you for a reasonable charge. If you prefer, you may contact the Administrator with your request and they will communicate your request to the Head Office of the Insurer. Telephone numbers and mailing addresses for the Insurers Head Office can be obtained from the Administrator.

You may request a copy of your group insurance enrolment form or application and any record or written statement not otherwise part of the application that you provided to the Administrator or the Insurer as evidence of insurability. On reasonable notice you may also request a copy of the Policy. First copies will be provided at no cost to you but a fee may be charged for subsequent copies.

## LIFE INSURANCE BENEFIT

### DEFINITIONS

**"Annual Salary"** means, where used in this Provision and on the Schedule of Benefits, the regular annual fixed gross remuneration or its annual equivalent you receive from your employer but will not include, unless otherwise approved by the Insurer, overtime pay, commissions, overridings, bonuses, allowances, dividends or any form of remuneration which is not predetermined.

Notwithstanding the above, and subject to approval by the Insurer, if your Annual Salary is derived in whole or in part from commission and/or bonus, Annual Salary will also include the average annual commission and/or bonus (based on your employer's bonus program) received over the preceding 2 calendar year(s) by you from your employer. Commissions and/or bonuses will be verified by your employer along with satisfactory T4 and/or T4A tax forms provided to the Insurer.

In the event you have not been employed by your employer, and have not received commissions and/or bonus over the preceding 2 calendar year(s), your income will be calculated based on estimates provided by your employer, from time to time, as approved by the Insurer in writing.

The estimate, to be verified with your employer when a claim is submitted, must reflect a reasonable expectation of the total income to be earned, including commission and/or bonus, if applicable. The benefit payable will be based on the lesser of:

a) actual earnings, and
b) estimated level of earnings on which premiums were paid.

### AMOUNT OF INSURANCE

The amount of your Basic Life Insurance coverage is described on the Schedule of Benefits page. You may be required to submit Evidence of Insurability. If you are, you will only be insured for the No Evidence Limit until the evidence is approved.

### DEATH BENEFIT

The amount of life insurance for which you are covered will be payable upon your death to your last named beneficiary.

### APPOINTMENT OF BENEFICIARY

Your beneficiary will be as designated in your individual group enrolment form filed with your Employer and/or the Administrator, or, if applicable, as designated under your previous carrier's coverage. The group enrolment form may be electronically signed and transmitted by you using a process pre-approved in writing by the Insurer. If your designation is carried over from your previous carrier's coverage we recommend you review the existing designation to ensure it reflects your current intention. The most recent designation will apply.

You may name anyone you please as your beneficiary, and you may change your beneficiary at any time, subject to the laws of your province by filing written notice with the Administrator. If you do not appoint a beneficiary, or if your beneficiary predeceases you, the death benefit will be payable to your estate.

### WAIVER OF PREMIUM

If you become Totally Disabled, as defined below, you may qualify to have your life insurance continue until you reach age 65 without payment of any premiums. To be eligible, you must be disabled before your 65th birthday or your retirement, whichever occurs first, and you must have been unable to work

throughout the Elimination Period as shown in the Schedule of Benefits before the premium will be waived.

**"Total Disability/Totally Disabled"** means during the Elimination Period and the Own Occupation Period, if any, as shown on the Schedule of Benefits page, such a continuous state of incapacity resulting from injury or sickness that you will be completely prevented from performing the essential duties of your own occupation at your own or any workplace. After the expiration of the Own Occupation Period, if any, it means such a continuous state of incapacity resulting from injury or sickness that you will be completely prevented from engaging in any gainful occupation or from performing any work for remuneration or profit for which you are reasonably fitted by education, training or experience.

The availability of work will not be considered by the Insurer in assessing your Total Disability.

If you must hold a permit or licence, including a driver's licence, to perform your duties, you will not be considered Totally Disabled solely because such a permit or licence has been withdrawn or not renewed.

## LIVING BENEFIT

If you are under age 62 and suffer a terminal illness from which death is expected within 24 months and you have been approved for the Waiver of Premium Benefit above, you may qualify for a Living Benefit. A Living Benefit is an advance payment of a portion of the amount of your Basic Life coverage described on the Schedule of Benefits page.

The Living Benefit consists of 50% of the amount of your Basic Life coverage to a maximum of $50,000.

Upon your death, the Death Benefit will equal the sum insured on your date of death less the Living Benefit paid and the interest accrued on the Living Benefit.

## CONVERSION PRIVILEGE

Should you leave your Employer's service while the Policy is in force and before you turn 65 years old, you may arrange to convert that portion of your Life Insurance, without medical examination, to an individual policy of any one of the standard level premium Life, Term to Age 65 or One Year Term plans then being issued by the Insurer, provided application for the converted policy is made within 31 days of termination of employment. The amount will be limited to the lesser of:

a) the amount of your Life Insurance to a maximum of $200,000 (or the amount required by provincial legislation, if applicable); and
b) the difference between your amount of Life Insurance in effect upon termination and the amount of life insurance for which you are or become eligible for within the 31 day conversion period.

## EXCLUSIONS

No Optional Benefit is payable if death is a result of suicide and occurs within two years of this coverage becoming effective or within two years of the effective date of any increase in the Optional Benefit.

# DEPENDENT LIFE INSURANCE

## DEATH BENEFIT

This benefit insures your spouse and children for the amount of coverage shown on the Schedule of Benefits. If your spouse or one of your children dies you will receive this amount.

## ELIGIBLE DEPENDENTS

Dependents eligible for this benefit include your spouse or common-law spouse (1 year cohabitation) and your unmarried dependent children under the age of 21 or 25 years if attending school on a full time basis (26 years if a resident in the province of Quebec). Upon written request, your common-law spouse will be eligible immediately if a child is born to you and your common-law Spouse.

## WAIVER OF PREMIUM

The premium payable under this Provision will be waived during the period for which the Life Insurance premium is waived due to your becoming Totally Disabled.

## CONVERSION PRIVILEGE

If your Dependent Life Insurance coverage under this benefit ceases because you are no longer eligible for insurance under the Policy, your Spouse (and Insured Dependents, as required by provincial legislation, if applicable) may convert the amount of the Dependent Life Insurance benefit terminated without medical evidence, to an individual policy. This individual policy may be issued on any one of the standard level premium Life plans then being issued by the Insurer. Application for the individual policy must be made while the group policy is in force and within 31 days after the earlier of:

- the date you die, or
- the date you cease to be insured, or
- your Spouse's 65th birthday.

Insured Dependent conversion privilege applies only where required by provincial legislation. The spousal conversion privilege applies in all provinces and territories.

## EXTENDED HEALTH BENEFIT

### DEFINITIONS

Where used in this Provision,

**"Accident"** for the purpose of the Extended Health Benefit provision means a single, sudden, violent, unintended, unexpected, external event that causes an injury or Sickness, independent of any other cause.

**"Benefit Card"** if any, will mean an identification type card issued by the Administrator, for the purpose of participating in a pay direct drug reimbursement program or Dental Benefits.

**"Dispensing Fee"** if any, will mean the fee charged by a pharmacist for the preparation and dispensing of drugs.

**"Eligible Expense"** will mean any charge for Medical Care actually incurred by a Person Insured while this Provision is in effect. Such Medical Care must be an insured benefit (as determined in this provision), and such charge must be Reasonable and Customary as determined by the Service Provider for the insured benefit.

**"Emergency"** will mean a sudden, unexpected Accident which occurs or an unforeseen Sickness or injury which begins while the Person Insured is traveling outside of his province of residence and requires immediate medical attention. Emergency includes non-elective Medical Care for immediate relief of severe pain, suffering or disease which cannot be delayed until the Person Insured returns to his province of residence. Such Emergency no longer exists when, in the opinion of the attending Physician, the Person Insured is able to return to his province of residence. Emergency does not include medical attention for the monitoring of a chronic or stabilized condition while the Person Insured is traveling outside of his province of residence (e.g. blood tests to monitor the thickness of the blood while taking blood thinning medications).

**"Medical Care"** will mean any necessary medical investigation, tests, diagnosis, treatment, services, care, attendance, consultation, medical advice, planned or pending surgery, drugs and medicines (either prescription or non-prescription), or referral to another health care professional, as a result of a diagnosed or undiagnosed medical condition. Medical Care must be ordered by a Physician or other authorized health care professional in the treatment of the Sickness or injury.

**"Medically Necessary"** will mean a treatment, service or supply which is generally accepted by the medical profession as essential, effective and appropriate in the diagnosis of, care or treatment of a specific medical condition.

**"Paramedical Practitioners"** shall mean providers currently licensed or certified to practise their profession by the appropriate licensing or registration authority of the jurisdiction in which the services of such practitioners are rendered, and who are not insured for benefits under this Plan. If no such licensing or registration authority exists in any jurisdiction, each such practitioner practising in such jurisdiction must have a certificate of competency from the professional body which establishes standards of competency for such practitioner's profession and is deemed valid by the Service Provider. A Social Worker is required to hold a Master of Social Work degree. In no event will benefits provided under the terms of this Provision be paid for services rendered by any practitioner which are not within the scope of such practitioner's profession.

**"Sickness"** will mean illness or disease.

**"Stable"** will mean that during the three month period before the departure date the Person Insured has not:

- received Medical Care or been under evaluation for new symptoms or conditions uncovered in a medical examination;
- experienced a worsening or increased frequency of symptoms or examination findings related to the medical condition, disease or illness – diagnosed or undiagnosed if the Person Insured has been seen by a Physician or other health care professional in relation to the symptoms;
- been prescribed medication or recommended a change in Medical Care related to the medical condition by a Physician or other healthcare professional, including changes in medication that

are made as part of an ongoing Medical Care but not including a reduction in medication (prescribed or non-prescribed) due to an improvement in the medical condition;
- been admitted to or received Medical Care at a hospital for the medical condition; or
- been advised of future non-routine tests, investigations, surgery or new Medical Care planned for a previously identified medical condition or future medical appointment planned with respect to an undiagnosed medical condition.

## ELIGIBLE EXPENSES

The Extended Health Benefit under this Plan covers all eligible expenses described on the following pages which are not covered by your Government Health Insurance Plan.

The eligible expenses:
- must be incurred while you are insured under the Plan,
- must be Reasonable and Customary and Medically Necessary in the treatment of Sickness or injury,
- must be ordered by a qualified doctor who is neither insured for benefits under the Plan nor related to the Person Insured's family by blood or marriage,
- must be submitted within 365 days after the date the expense was incurred or within 90 days of the termination of insurance, whichever is earlier.

All eligible expenses may be subject to a deductible amount, a coinsurance amount and a maximum benefit amount.

Eligible drug expenses will not include any costs in excess of the Reasonable and Customary amount for that drug. Any Dispensing Fee, if applicable, which exceeds the maximum Dispensing Fee will not be covered. Such excess is not considered an eligible drug expense under the Plan. Please refer to **NOTE** on the Drug Component page.

## DEDUCTIBLE AMOUNT

The Benefit Period Deductible Amount, if any, as shown in the Schedule of Benefits Page, is the amount that you are responsible for, in each Benefit Period, before health benefits are payable under this Plan.

The Per Prescription Deductible Amount, if any, as shown in the Schedule of Benefits Page, will be applicable to each prescription for eligible expenses for drugs and neither the Single nor the Family Deductible Amount will be applicable to such eligible expenses.

## COINSURANCE AMOUNT

The Coinsurance Amount, as shown on the Schedule of Benefits page, is the percentage of eligible expenses paid by your Plan less the Deductible Amount, if any.

## LIFETIME MAXIMUM

The Lifetime Maximum, as shown on the Schedule of Benefits, is the total aggregate amount payable per person, for eligible expenses incurred inside or, if insured, outside of your Province of Residence, for all periods in which you have been insured under this Benefit, whether consecutive or not.

## PUBLIC PRESCRIPTION DRUG PLAN

The Extended Health Benefits provided under this Provision to any Person Insured who is a resident of a province that offers a public prescription drug plan will be administered in accordance with the requirements of applicable provincial prescription drug insurance legislation (e.g. An Act Respecting Prescription Drug Insurance in Quebec) and will meet any applicable minimum coverage standard, as determined by the Service Provider.

## EXTENSION OF BENEFITS

If you (or your dependent, if applicable) are totally disabled when your Extended Health Benefit terminates, eligible expenses that you incur as a result of the disability will be paid for up to 90 days following termination during the continuation of disability or to the date you become eligible for benefits under another plan, if earlier.

## SURVIVORS' HEALTH BENEFITS

In the event of your death while you are insured for health benefits under this Plan, the insurance for your surviving insured dependents at your death will continue in force without premium payment but not beyond the earliest of:

a) the period indicated on the Schedule of Benefits from your death,
b) the date of death of the survivor, or
c) the date that the survivor no longer qualifies as a dependent, if a child.

## DEPENDENTS

Dependents eligible for Extended Health Benefits are your spouse or common-law spouse; and, unmarried wholly dependent children under the age of 21 years; or 25 years if attending school on a full time basis (26 years if a resident in the province of Quebec); or unmarried wholly dependent children of any age who are mentally or physically handicapped (please contact the Administrator for details to extend coverage for handicapped dependents).

There must be a minimum and continuous cohabitation period of 1 year before a common-law spouse is recognized. Upon written request, your common-law spouse will be eligible immediately if a child is born to you and your common-law spouse.

Dependents must reside in Canada to qualify for benefits. However, children who are temporarily residing outside of Canada because they are attending an accredited academic institution may also be eligible for benefits, contact the Administrator for details.

## CHARGES NOT COVERED

Payment will not be made for charges for:

- Medical Care resulting from suicide, attempted suicide, or intentional self-inflicted injury;
- Medical Care resulting from the voluntary or intentional inhalation or administration of drugs, poison, poisonous substances, gas or fumes;
- Medical Care for which benefits are payable under any other Benefit Provision of this Plan;
- Medical Care resulting from insurrection, war, invasion, enemy acts, civil war, rebellion, revolution, military power, usurped power, or hostilities of any kind, whether war is declared or not;
- Medical Care resulting from any armed conflict or service in the armed forces;
- Medical Care resulting from voluntary participation in a riot or any disturbance of the public order;
- Medical Care for which the Person Insured is entitled to indemnity or compensation in accordance with the provisions of any provincial workplace safety legislation (e.g. Workplace Safety and Insurance Act, 1997) or similar legislation, unless prohibited by any Government Legislation;
- Medical Care payable in whole or in part by a government under any Government Health Insurance Plan or which would have been payable had the Person Insured been insured thereunder or had proper application been made;
- Medical Care to the extent that the applicable government jurisdiction prohibits the payment of any benefits;
- Medical Care resulting from the participation in, or attempt to participate in, a criminal offence, under any applicable law, whether or not convicted of such offence;

- Medical Care provided by a medical or dental department maintained by an employer, an association, labour union, trustee or similar type of group;
- medical screening or examinations required for the use of a third party;
- broken appointments, transportation costs (including travelling time) of the practitioner or the completion of claim forms required by this Provision;
- services provided through telephone or other means of telecommunication, except if such services are provided in accordance with the regulations, practices or procedures as set out by the respective provider's college or association and are deemed to be Eligible Expenses, as determined by the Service Provider;
- Medical Care, the charge for which the Person Insured is not legally required to pay, or for which there is no charge, or for which there would have been no charge but for the existence of insurance;
- Medical Care which is not necessary according to generally accepted standards of medical practice;
- Medical Care rendered for cosmetic purposes (as determined by the Service Provider), except when such Medical Care is necessitated by accidental injury;
- Medical Care for the replacement of an appliance which has been lost, mislaid or stolen or to provide any duplicate appliance;
- supplies ordered or services rendered prior to the date the person became a Person Insured;
- shipping and handling charges; or
- infant formulas or caloric supplements, regardless of whether such formula or supplement contains vitamins or minerals; or
- services or supplies that were received or purchased from a provider that is not approved by the Service Provider.

## HOSPITALIZATION COMPONENT

Inpatient hospital confinement, in your province of residence, for room and board and other hospital services in a semi-private and/or private room accommodation as shown on the Schedule of Benefits page with no limit on the number of days of confinement.

Coverage will be provided for the difference between the hospital's ward and semi-private rates and/or private rates, including Government imposed hospital deterrent charges (where legislation permits insurance of such charges).

### Convalescent Hospital - Covered Expenses

The charges made by a convalescent hospital for room, board and other necessary services, in excess of the charge for ward accommodation, up to the daily amount indicated on the Schedule of Benefits Page, will be considered eligible expenses. However, the Person Insured must be admitted to the convalescent hospital within fourteen days following a period as a bedpatient of at least three days duration in a hospital. Expenses will be deemed as covered only where convalescent hospitalization is required by the attending Physician.

Benefits will be paid for the maximum period indicated on the Schedule of Benefits Page during any one period of disability.

All confinements in a convalescent hospital will be considered as one period of disability unless separated by at least ninety days.

In order to qualify under these covered expenses, a convalescent hospital must be approved by the appropriate Government Hospital Authority and be located in Canada.

Charges for custodial care in a convalescent hospital, nursing home or similar institution will not be considered eligible expenses.

A Convalescent Hospital is not a home for the aged, blind, or deaf, a domiciliary care home, a maternity home, or a home for alcoholics, drug addicts, or the mentally ill.

## DRUG COMPONENT

### Formulary Protect – FPRT

Plan type:

- In the case of a Mandatory Generic Plan, the pharmacist will only be reimbursed for the lowest priced substitutable drug, as provided for in the Provincial Drug Benefit Formulary. A Mandatory Generic plan does not allow for "No Substitution".

Plan Inclusions:

- Most drugs which by law or convention require a physician's or dentist's prescription and that are not considered Specialty;
- Insulin supplies which includes needles, syringes and diagnostic tests;
- Most injectable including serums, vaccines, and injectable vitamins;
- Extemporaneous compounds prepared by a pharmacist where at least one of the products within the compound is covered by the drug plan.

Plan Exclusions:

- Any drug or medication which may be purchased without a prescription. This further excludes over-the-counter (O.T.C.) products whether prescribed or not;
- Diabetic supplies such as swabs, rubbing alcohol, lancets, control solution, etc.;
- Fertility drugs are not covered even if prescribed for therapeutic use;
- Anti-smoking agents are not covered even if prescribed for therapeutic use;
- Anabolic steroids are not covered even if prescribed for therapeutic use;
- Items deemed cosmetic even if a prescription is legally required;
- Sexual function drugs including erectile dysfunction drugs;
- Contraceptives other than oral;
- Injectibles for the purpose of weight loss;
- Catastrophic drugs for rare diseases, typically government funded;
- Hospital drugs defined as medications, such as, but not limited to, intravenous infusion or intrathecal injections, that are administered by a healthcare professional or requires hospital and/or healthcare professional monitoring, regardless of the site of administration;
- All Specialty Drugs. A Specialty Drug is typically used for the treatment of complex and chronic conditions, and has an expected annual cost of greater than $10,000.

**NOTE: The Dispensing Fee varies by province of residence and is capped based on a reasonable and customary charge in each province.**

### Fertility Drugs, Anti-Smoking Agents & Sexual Dysfunction Drugs

a) Fertility Drugs

Fertility Drugs dispensed by a Physician or pharmacist and only available on the prescription of a Physician, pharmacist or other authorized healthcare professional, where applicable based on provincial legislation, are eligible under this Plan as outlined on the Schedule of Benefits.

b) Anti-Smoking Agents

Anti-Smoking Drugs dispensed by a Physician or pharmacist and only available on the prescription of a Physician, pharmacist or other authorized healthcare professional, where applicable based on provincial legislation, are eligible under this Plan as outlined on the Schedule of Benefits.

c) Sexual Dysfunction Drugs

Sexual Dysfunction Drugs dispensed by a Physician or pharmacist and only available on the prescription of a Physician, pharmacist or other authorized healthcare professional, where applicable based on provincial legislation, are eligible under this Plan as outlined on the Schedule of Benefits.

## MAJOR MEDICAL COMPONENT

Payment will be made for the following eligible expenses that you incur in your province of residence.

### Medical Supplies and Appliances

- Medical Supplies and Appliances **require a separate Physician's referral for each supply or appliance prescribed**. The date of the Physician's referral and diagnosis must be within a six month period of submission of any claim. Only **Medically Necessary** supplies and appliances are covered under this Plan. Medical Supplies and Appliances prescribed solely for comfort, sports or recreational activities are not an Eligible Expense under this Plan. The Service Provider reserves the right to request additional information for any Medical Supply or Appliance prescribed.
- The Service Provider on behalf of the Insurer will pay for Eligible Expenses (up to the maximum outlined on the Schedule of Benefits or the **Reasonable and Customary charge**, whichever is less), for a Person Insured, that are **Medically Necessary** for the treatment of a Sickness or injury.
- Prior to making a purchase for a supply or appliance, a Person Insured should contact the Service Provider to obtain the Reasonable and Customary charge for a supply or appliance and a confirmation that such supply or appliance is covered under this Plan.

This Plan will rent or purchase at the option of the Service Provider, the following durable medical equipment, subject to any applicable deductible, coinsurance and maximum as outlined on the Schedule of Benefits:

- aerosol equipment, mist tents and nebulizers for cystic fibrosis, acute emphysema, chronic obstructive bronchitis or chronic asthma,
- apnea monitors for respiratory disrhythmias,
- artificial eyes, including repair and replacement,
- artificial limbs, including the repair and replacement of basic cosmetic prostheses but excluding prostheses equipped with or requiring battery-power, electronics, motors or computers (e.g. myoelectrical limbs),
- bed rail,
- braces with rigid supports, fitted at a medical supply facility duly authorized under provincial regulations, if applicable,
- diabetic monitoring and administration equipment,
- external breast prosthesis, and two surgical brassieres per Benefit Period, post mastectomy,
- apnea machine (CPAP), intermittent positive pressure breathing machine,
- head halter,
- standard hospital beds, excluding electric hospital beds,
- custom-made foot orthotics, made from plaster cast models, foam moulds or 3D scans of the Person Insured's foot,
- shoulder harnesses,
- traction apparatus,
- transcutaneous electronic nerve stimulator (TENS),
- trapeze bars,
- standard wheelchairs, or where medically necessary, electrical wheelchairs

Under no circumstances will maintenance of any **durable medical equipment** be an eligible expense.

This Plan will lend or provide at the option of the Service Provider, for the rental or purchase of the following supplies and appliances, subject to any applicable deductible, coinsurance and maximum as outlined on the Schedule of Benefits:

- casts,
- canes and walkers,
- cervical collar,
- Clinitest, Dextrostix, or similar home chemical testing supplies for diabetics, if excluded under Drug Component,
- colostomy apparatus and supplies,
- crutches,
- ileostomy apparatus and supplies,
- insulin, if excluded under Drug Component,
- insulin syringe, monojet type, if excluded under Drug Component,
- pressure garments for burns,
- compression sleeves for lymphoedema following surgery,
- lancet, if excluded under Drug Component,
- orthopaedic shoes individually designed and constructed to medical specifications, or adjustments only made to stock shoes for orthopaedic purposes
- oxygen and oxygen supplies,
- splints, excluding dental splints,
- compression stockings with a strength of 20 mmHg or higher,
- stump socks,
- urethral catheters,
- Viscosupplementation prescribed by a Physician and limited to two sets of three injections to the maximum as outlined on the Schedule of Benefits per knee,
- wigs following chemotherapy or radiation treatment for cancer.

**Ambulance Service**

This Plan will cover the cost of emergency transportation to and from hospital by a licensed ambulance. In addition, when the circumstances dictate, coverage is provided for licensed air ambulance or by commercial air fare to the nearest hospital qualified to render the necessary emergency medical care.

**Private Duty Nursing Care**

This Plan will cover the cost of services of a registered graduate nurse, registered nursing assistant, a certified nursing assistant, or a licensed practical nurse who is duly qualified and who is not related to the Person Insured or a member of the Person Insured’s family and who is not a resident in the Person Insured’s home. The services must:

- be provided in a Person Insured's home, and such home is not an Institution,
- be recommended in writing by a Physician,,
- be approved in advance by the Service Provider,
- be for short-term treatment for a severe injury or acute illness or to promote recovery from surgery. For clarity, no benefits will be paid for chronic care and/or long-term medical conditions, and
- be limited to the minimum number of hours and level of skill needed to provide each essential nursing service, as determined by the Service Provider.

These services are payable up to the maximum shown on the Schedule of Benefits; however, no benefits will be paid for; homemaking, companionship or counselling services, supportive care (bathing, dressing, feeding), child-care duties or house-keeping duties.

The Service Provider reserves the right to request additional information at the time of claim and in relation to an ongoing claim.

**Diagnostic Laboratory Procedures**

Payment will be made for eligible Diagnostic Laboratory Procedures, ordered by a Physician, and provided by a private medical laboratory.

These services are payable up to the maximum shown on the Schedule of Benefits. Eligible procedures are:

- Blood Work,
- Colonoscopy,
- Computerized Axial Tomography (CAT scan),
- Electrocardiogram (ECG),
- Magnetic Resonance Imaging (MRI),
- Positron Emission Tomography (PET),
- Mammogram,
- Testing of Urine and other bodily fluids and tissues,
- Ultrasound.

For the province of Quebec, diagnostic and laboratory tests are covered when performed in a private lab or pharmacy even if there is coverage under the provincial government plan. These tests include Magnetic Resonance Imaging (MRI) and CT scan.

Allergy testing performed by a laboratory is excluded.

**Paramedical Practitioners**

This Plan will include coverage for various Paramedical Practitioners, provided the services are not completed by a relative. These services are payable up to the maximum shown on the Schedule of Benefits.

Payment will be considered an eligible expense prior to reaching the maximum under any Government Health Insurance Plan, unless prohibited by law.

**Dental Benefits for Accidents**

This Plan will include coverage for the services of a dentist or oral surgeon to repair or replace sound natural teeth damaged as a result of a direct accidental blow to the mouth and not by an object wittingly or unwittingly placed in the mouth, including the setting of a fractured or dislocated jaw; however, no payment will be made for services, supplies or treatment rendered for a full mouth reconstruction, for vertical dimension correction, or for correction of temporomandibular joint dysfunction. Payment will be made for such accident provided (1) the accident occurs while you are insured under this benefit, and (2) the services are rendered within 365 days of such accident and while you are insured for this benefit.

**Hearing Aids**

This Plan will include the cost of the purchase and repairs of (excluding batteries or routine maintenance of) hearing aids. These services are payable up to the maximum shown on the Schedule of Benefits.

## Eye Exams

In provinces where routine eye exams are covered under the applicable provincial Government Health Insurance Plan, no payment will be made for routine eye exams under this Plan.

In all other provinces, claim payment will be made for one routine eye exam, performed by an Optometrist or Ophthalmologist, up to the amount indicated on the Schedule of Benefits page.

## OUT OF PROVINCE OF RESIDENCE COVERAGE

(1) **Referral Coverage** - the following services will be included up to the Lifetime Maximum for Out of Province of Residence Referral Coverage as outlined on the Schedule of Benefits. The services must not be available in the Person Insured's province of residence and prior approval must be obtained from the Person Insured's Government Health Insurance Plan and the Insurer.

(a) **Hospital Confinement** - This Plan will pay up to the maximum as shown on the Schedule of Benefits for each day of confinement for room and board and other hospital services for reasonable and customary semi-private accommodation outside of the Person Insured's province of residence less the amount payable for those days of confinement under the Government Health Insurance Plan for the Person Insured's province of residence.

(b) **Doctors' Services -** This Plan will pay the actual charges rendered outside of the Person Insured's province of residence following referral by his doctor in his province of residence. The amount payable will be an amount equal to an amount paid by the Government Health Insurance Plan of the Person Insured's province of residence; however, the benefit payable from all plans will not exceed 100% of the actual incurred expense.

(c) **Other Medical Care** - Payment will be made for other medical care listed as an Eligible Expense under the same conditions and limits as if incurred in the Person Insured's province of residence.

(d) **Hospital Out-Patient Services -** No payment will be made for Hospital out-patient services under Referral Coverage.

(2) **Emergency Coverage** -the following services will apply to a Person Insured who is 1) travelling on business or vacation outside of his province of residence, and 2) insured for the duration of the travel period under a Government Health Insurance Plan, for the period as shown on the Schedule of Benefits. However, if the Person Insured is hospitalized as a result of a covered Emergency, during the period as shown on the Schedule of Benefits, coverage will continue until the date of discharge from the hospital, provided coverage has been extended under the Government Health Insurance Plan in the Person Insured's province of residence. Eligible Expenses will be allowed up to the Lifetime Maximum for Out of Province of Residence Emergency Coverage outlined on the Schedule of Benefits.

(a) **Hospital In-Patient Confinement** - This Plan will pay for room and board and other hospital services for emergency treatment of a Sickness or injury. The amount payable will equal the daily charges for each day of confinement for Reasonable and Customary semi-private accommodation outside of the Person Insured's province of residence less the amount payable for those days of confinement under the Government Health Insurance Plan in the Person Insured's province of residence.

(b) **Hospital Out-Patient Services** - Payment will be made for Hospital Out-Patient Services that are provided for an Emergency.

(c) **Doctors' Services** - This Plan will pay an amount equal to the amount of Reasonable and Customary charges and fees in excess of the amount paid or payable under the Government Health Insurance Plan in the Person Insured's province of residence.

(d) **Other Medical Care** - Payment will be made for other medical care listed as an Eligible Expense under the same conditions and limits as if incurred in the Person Insured's province of residence.

(e) **Travel Emergency Assistance Program**
Your extended health benefits package already covers you for extensive and comprehensive benefits while you are travelling outside of your province of residence. The Travel Emergency Assistance Program provides you and your dependents (if applicable) with fast and easy accessibility to your health care benefits plus plenty of "extras".

The Insurer and the Service Provider have made an agreement to provide assist services and claim payment services for travel emergencies. If you have an Emergency while travelling, you can let us worry about paying the bills and arranging appropriate transportation home.

If you or one of your dependents (if applicable) suffer a travel Emergency, we offer 24 hour access to the Service Provider. Just call one of the numbers that appear on your Benefit Card and identify yourself by the information on the front of your card. A multilingual coordinator will assist in providing the following benefits:

(i) **24 Hour Access** - Multilingual assistance by telephone, telex and facsimile services is available 24 hours a day, 365 days a year. This includes interpretation services in most major languages.

(ii) **Medical Referral** - Referral to a Physician, Dentist or appropriate medical facility will be provided for medical emergencies.

(iii) **Medical Transportation** - Transportation to the nearest appropriate medical facility or to Canada will be provided if Medically Necessary to any maximum shown on the Schedule of Benefits per Emergency.

(iv) **On-Site Hospital Payment** - A verification of insurance coverage and arrangement for payments will be provided. Services that require the payment of $200 or less are to be paid by the Person Insured and receipts kept for reimbursement.

(v) **Repatriation of Remains** - In the event of the death of a Person Insured, arrangements approved by the Service Provider will be made for the preparation and transportation of the body back to the Person Insured's province of residence. Expenses will be reimbursed up to any maximum shown on the Schedule of Benefits.

(vi) **Return of Dependent Children** - The return of unattended dependents under the age of 16 will be provided if a Person Insured is hospitalized. Payment arrangements for economy class transportation of these Dependents to their place of residence in Canada will be made if the original ticket is void. A qualified escort will be provided if necessary.

(vii) **Trip Delay** - If a Person Insured's scheduled return trip has been missed due to the hospitalization of that Person Insured, economy class transportation will be provided to the place of departure if the original ticket is void and arrangements for changing the original ticket cannot be made with the carrier.

(viii) **Visit of a Family Member** - If a Person Insured, while travelling alone, is hospitalized and the expected period of hospitalization is more than 7 days, round-trip economy class transportation to the location for one member of the immediate family will be provided. For the purposes of this provision, “immediate family” constitutes a parent, spouse, child, brother or sister. Expenses for meals and accommodation for the visiting family member will also be reimbursed up to any maximum for travel, meals and accommodation shown on the Schedule of Benefits.

(ix) **Return of Vehicle** - Assistance is provided in the return of a Person Insured's vehicle to the place of departure or to the nearest rental agency during a medical Emergency. Expenses for return of vehicle will be reimbursed up to any maximum shown on the Schedule of Benefits.

(x) **Legal Referrals** - Legal referrals will be provided and assistance is available in arranging cash advances from credit cards or family and friends to enable the posting of bail and payment of legal fees if necessary.

(xi) **Lost Document and Ticket Replacement** - Assistance will be provided in contacting local authorities and in the arrangement for the replacement of lost passports, travel tickets and visas.

(xii) **Message Centre** - The use of a message centre will facilitate the exchange of messages between a Person Insured and his family, friends and business associates during a period of Emergency. The centre will hold messages for fifteen days.

**Services described in (i) – (xii) inclusive are subject to an overall combined lifetime maximum as shown on the Schedule of Benefits.**

A Person Insured must contact the Service Provider immediately following the occurrence of any medical Emergency and prior to receiving any Medical Care, except where advance notice cannot reasonably be provided due to medical or other exceptional circumstances. Failure to contact the Service Provider prior to receiving Medical Care may result in your claim being denied or reduced.

No coverage will be provided if a Person Insured experienced symptoms or sought Medical Care for a medical condition within the three month period immediately prior to the travel departure date, which results in a medical Emergency during the travel period.

Coverage may be provided for pre-existing medical conditions provided the medical condition is Stable prior to travel and medical attention is not anticipated or foreseen during the travel period.

The Insurer reserves the right to request clinical notes and records from the Person Insured’s primary care Physician or any other health care professional who provided Medical Care to the Person Insured.

**Limitations and Exclusions – Out of Province of Residence Coverage**

Travel for the purpose of receiving Medical Care is excluded, even on the recommendation of a medical advisor, subject to the Out of Province of Residence – Referral Coverage section.

A Person Insured must be insured under a Government Health Insurance Plan for the duration of the travel period. It is the responsibility of the Person Insured to inquire prior to his departure whether his Government Health Insurance Plan coverage is extended for the duration of his travel period.

## EXTENDED HEALTH BENEFIT

Coverage under this benefit is limited to amounts that are in excess of those covered by the Government Health Insurance Plan.

This Out of Province of Residence Coverage is a secondary plan which means coverage under this benefit is limited to amounts that are in excess of all other coverage provided under any other plan or insurance that provides similar benefits. Benefits will be coordinated with any other plans in accordance with the Canadian Life and Health Insurance Association Guideline G17, so claims paid do not exceed one hundred percent (100%) of the allowable expenses paid.
The Travel Emergency Assistance Program services will apply only to designated countries which may change from time to time. It is the responsibility of the Person Insured to inquire prior to his departure whether services are provided in a specific country.

The Insurer assumes no responsibility for any medical or legal advice given to or for the benefit of a Person Insured; such advice includes, but is not limited to, medical or legal advice given by any Physician, health care professional, paralegal and/or lawyer.

The Insurer will not be liable for the negligence or wrongful acts or omissions of any other person or entity providing direct service to or for the benefit of a Person Insured in accordance with the above services, including but not limited to any Physician, health care professional, paralegal and/or lawyer.

No coverage is provided for any Emergency related to i) a pregnancy or delivery including infant care, after the 32nd week of pregnancy, or, ii) the deliberate inducement of a miscarriage.

No coverage is provided for any Emergency during a pregnancy if the Person Insured's medical history indicated a higher than normal risk of an early delivery or complications.

No coverage is provided for any Eligible Expense for continuing Medical Care, recurrence or complication relating to a condition or conditions incurred while a Person Insured is travelling outside their province of residence, if (i) it has been determined by a medical advisor that the Person Insured was deemed medically fit to return to his province of residence, and (ii) the Person Insured refuses to travel to their province of residence for Medical Care and/or chooses to continue with their travel plans.
There must be a minimum of 90 continuous days between the date a Person Insured returns to his province of residence before again travelling outside his province of residence; otherwise, no payment will be made for any Medical Care, recurrence, continuation or complication of any medical condition for which a claim payment was made for such medical condition, during the immediate previous trip out of province.

No coverage is provided for any medical condition for which symptoms were ignored or for which medical advice was not followed or the recommended Medical Care was not carried out.

No coverage is provided for Medical Care for any Accident sustained by a Person Insured while participating in a dangerous sport or activity. Dangerous sports and activities include, but are not limited to: off-trail skiing and snowboarding, bobsled, luge, skeleton, motor vehicle racing, obstacle jumping, rock climbing, mountain climbing, parachuting, gliding, hang-gliding, skydiving, bungee jumping, canyoneering, scuba diving without certification, spelunking, any sport or activity for which remuneration is provided, any sport or activity for which money prizes are awarded, and any extreme sport or activity. This limitation does not apply to sports and activities normally offered to members of the general public without requiring any special qualifications or training.

No coverage is provided for Medical Care for any Accident that results from the operation of a Motorized Vehicle while a Person Insured's ability to drive is impaired as a direct result of Substance Abuse or while having drug or alcohol levels that exceed the maximum levels allowable by law in the jurisdiction where the Accident occurred. Substance Abuse includes, but is not limited to: (i) the abuse of medication

(prescribed or non-prescribed), drugs or alcohol; (ii) the use of illegal or experimental drugs or products; (iii) any other drug addiction or substance abuse disorder; and (iv) any condition arising from the abuse of such medication, drugs or alcohol.

For clarity, the Limitations and Exclusions section of the general Extended Health Benefit Provision also apply to the Out of Province of Residence Coverage.

# DENTAL BENEFIT

## AMOUNTS AND LIMITS

You are not required to use a specific dentist or dental clinic; you are free to use the dentist of your choice provided the dentist and any person duly qualified to perform any of the services rendered (e.g. dental hygienist) is not insured for benefits under this Plan nor related by blood or marriage.

This benefit reimburses you for charges incurred by you or your dependents (if applicable) for dental services, subject to any deductible, coinsurance and maximum benefit that may apply as outlined on the Schedule of Benefits. To be eligible for reimbursement, the charges must:

- be not in excess of the suggested Dental Fee Guide as shown on the Schedule of Benefits except if rendered by a Dental Mechanic or Dental Hygienist, then not in excess of the official Fee Guide for Dental Mechanics or Dental Hygienists, if applicable;
- be incurred while you are insured;
- be Reasonable and Customary;
- be recommended as necessary by a Physician, Dentist, or Oral Surgeon;
- be rendered by a Physician, Dentist, Oral Surgeon or Dental Assistant under the direct supervision of a Dentist, Oral Surgeon or Physician, or be rendered by a Dental Mechanic or Dental Hygienist.

All eligible charges **must be submitted** within the time period described in "Payment of Claims".

## TREATMENT PLAN

When the cost of a proposed treatment is expected to exceed $300 or when dental treatment involves Orthodontic Services or a Child under the age of two, we strongly recommend that a Treatment Plan be submitted before any treatment is started. The Treatment Plan is prepared by your dentist and outlines the treatment required as well as the cost of the proposed treatment. the Service Provider will then identify any age restrictions, benefit limitations, deductibles, coinsurance or maximum limits that may apply and thus avoid any misunderstanding as to the extent of your coverage. If you do not proceed with treatment within 90 days another Treatment Plan should be submitted.

## DEDUCTIBLE

The Benefit Period Deductible Amount, if any, as shown on the Schedule of Benefits page is the amount that you are responsible for, in each Benefit Period, before Dental Benefits are payable under this Plan. Orthodontic Services, if insured, do not require a Deductible amount.

## COINSURANCE

The Coinsurance Amount, as shown on the Schedule of Benefits page, is the percentage of eligible expenses paid by your Plan less the Deductible Amount, if any.

## MAXIMUM BENEFITS

The Schedule of Benefits describes the Maximum Benefit for each of the various levels of coverage. Maximums per Benefit Period are the maximum amounts payable per person for you

and your Insured Dependents (if applicable) in each Benefit Period, except for Orthodontic Services if included, which has a Lifetime Maximum as shown on the Schedule of Benefits.

The maximum benefit payable for all benefits, excluding any Orthodontic benefits, will be limited to $250 if you are late entering the Plan during the first 12 months of coverage. If Orthodontic Services are included in your Plan, the maximum benefit payable for these services will be $300 during the first 3 years of coverage when you are late entering the Plan and when you are otherwise entitled to these benefits.

## DEPENDENTS

Dependents eligible for Dental Benefits are your spouse or common-law spouse; and, unmarried wholly dependent children under the age of 21 years; or 25 years if attending school on a full time basis (26 years if a resident in the province of Quebec); or unmarried wholly dependent children of any age who are mentally or physically handicapped (please contact the Administrator for details to extend coverage for handicapped dependents).

There must be a minimum and continuous cohabitation period of 1 year before a common-law spouse is recognized. Upon written request, your common-law spouse will be eligible immediately if a child is born to you and your common-law spouse.

Dependents must reside in Canada to qualify for benefits. However, children who are temporarily residing outside of Canada because they are attending an accredited academic institution may also be eligible for benefits, contact the Administrator for details.

## OUTSIDE OF CANADA COVERAGE

While travelling outside the country, this coverage will apply for the services of a duly qualified dentist, subject to the maximums and coinsurance factor, and/or deductibles as outlined on the Schedule of Benefits page. Non-emergency dental care will be subject to the current Provincial Dental Association fee guide. Emergency dental care is not subject to this limitation. These benefits include coverage for pre-existing conditions.

## SURVIVORS' DENTAL BENEFITS

In the event of your death while you are insured for dental benefits under this Plan, the insurance for your surviving insured dependents at your death will continue in force without premium payment but not beyond the earliest of:

a) the period indicated on the Schedule of Benefits from your death
b) the date of death of the survivor
c) the date that the survivor no longer qualifies as a dependent, if a child.

## LIMITATIONS & EXCLUSIONS

When alternate courses of treatment are available to attain a desired result, the amount of eligible expense will be based on the least expensive course of treatment that will produce a professionally adequate result.

No payment will be made for dental care expenses resulting from:

- suicide, attempted suicide, or intentional self-inflicted injury;
- the voluntary or intentional inhalation or administration of drugs, poison, poisonous substances, gas or fumes;
- services, supplies or treatment for which benefits are payable under any other Benefit Provision of this Plan;
- services, supplies or treatment resulting from insurrection, war, invasion, enemy acts, civil war, rebellion, revolution, military power, usurped power or hostilities of any kind, whether war is declared or not;
- services, supplies or treatment resulting from any armed conflict or service in the armed forces;
- services, supplies or treatment resulting from voluntary participation in a riot or any disturbance of the public order; or
- services, supplies or treatment for which the person insured is entitled to indemnity or compensation in accordance with the provisions of any workplace safety legislation (e.g. Workplace Safety and Insurance Act, 1997) or similar legislation;
- services, supplies or treatment payable in whole or in part by a government under any Government Health Insurance Plan (or which would have been payable had the person insured been insured thereunder or had proper application been made);
- services, supplies or treatment or to the extent that the applicable government jurisdiction prohibits the payment of any benefits;
- services, supplies or treatment resulting from participation in or attempt to participate in, a criminal offence, under any applicable law, whether or not convicted of such offence;
- services, supplies or treatment provided by a dental or medical department maintained by an employer, an association, labour union, trustee or similar type of group;
- dental screening or examinations required for the use of a third party;
- broken appointments, transportation costs (including travelling time) of the practitioner, advice received by telephone or other means of telecommunication or the completion of claim forms required by this Provision;
- services, supplies or treatment, the charge for which the person insured is not legally required to pay or for which there is no charge or for which there would have been no charge but for the existence of insurance;
- services, supplies or treatment rendered for dietary or nutritional counselling for the control of dental caries or for dental plaque control;
- services, supplies or treatment which is not yet approved by the Canadian Dental Association or which is clearly experimental in nature;
- services, supplies or treatment which are not necessary according to generally accepted standards of dental practice;
- laboratory charges exceeding 50% of the fixed fee for the procedure in the Dental Association Fee Guide specified in the Schedule of Benefits;
- services, supplies or treatment of the type normally intended for sport or home use (i.e. mouthguards);
- services, supplies or treatment rendered for cosmetic purposes (as determined by the Service Provider) including, but not limited to, facing or veneers on crowns, or pontics posterior to the second bicuspids and alterations, extractions or replacement of sound teeth to change appearance except when such services, supplies or treatment are necessitated by Accidental Dental Injury and are incurred within 365 days after the date of the injury;
- services, supplies or treatment rendered for the correction of any congenital or developmental malformation which is not a Class I, II or III malocclusion (including the replacement of congenital missing teeth);

- services, supplies or treatment rendered for a full mouth reconstruction, for a vertical dimension correction or for correction of a temporal mandibular joint dysfunction;
- services, supplies or treatment for the replacement of an existing prosthetic device or other appliance which has been lost, mislaid or stolen, including, but not limited to, fixed bridgework and removable partial or complete dentures;
- services, supplies or treatment to provide any duplicate prosthetic device or any other duplicate appliance;
- services, supplies or treatment performed in conjunction with a procedure that is not eligible for payment; or
- services, supplies or treatment that were received or purchased and were not approved by the Service Provider.

## ELIGIBLE CHARGES

This Plan will cover the dental procedures outlined on the following pages up to the level of the Provincial Dental Association fee guide as outlined on the Schedule of Benefits provided the coverage has been shown to be included on the Schedule of Benefits.

### Basic Restorative

(1) **Clinical Oral Examination**
- Complete oral examination: 1 exam per 36 consecutive months
- Recall oral examination: 1 exam per period indicated in the Schedule of Benefits
- Specific oral examination: 2 exams per 12 consecutive months
- Emergency examination: 2 exams per 12 consecutive months

**(2) Radiographs**
- Intra oral films:
  - Bitewing films; 1 per 12 consecutive months
  - Occlusal films
  - Periapical films
- Extra oral films:
  - 1 Complete Series or Panoramic film per 36 consecutive months

(3) **Laboratory Tests**
- Cytological tests/analyses
- Histopathological tests/analyses
- Microbiological tests/analyses

(4) **Preventative Services**
- Topical application of fluoride: 1 treatment every recall examination period
- Oral hygiene instruction: 1 per 36 consecutive months
- Polishing: 1 unit per recall examination period
- Scaling/Root Planning: number of units per Benefit Period indicated in the Schedule of Benefits
- Interproximal disking
- Pit and fissure sealants

(5) **Space Maintainers**

- Space maintainers & maintenance of space maintainers

(6) **Minor Restorative Services**
- Non-bonded amalgam restorations. Bonded amalgam restorations are paid up to the cost of non-bonded amalgam restorations;
- Prefabricated restorations (prefabricated crowns) for primary teeth only;
- Tooth coloured restorations. White fillings on molar teeth are also fully covered.
- Caries/trauma/pain control
- Prefabricated posts
- Retentive pins.

(7) **Repairs or Fixed Bridges and Crowns**
- Repairs of crowns/bridgework
- Recementation of crowns/bridgework

(8) **Rebase, Reline and Removable Denture Repairs**
- Denture repairs
- Denture rebase 1 per arch per 36 consecutive months
- Denture reline 1 per arch per 36 consecutive months

(9) **Oral Surgical Services**
- Alveoloplasty – simple
- Antral surgery
- Extractions & residual root removal
- Fractures
- Frenectomy
- Hemorrhage control
- Surgical excision
- Surgical exposure
- Surgical incision
- Treatment of salivary glands
- Vestibuloplasty

(10) **Adjunctive General Services**
- Deep sedation
- General anaesthesia
- Nitrous oxide
- Nitrous oxide with oral sedation
- Parenteral conscious sedation
- Therapeutic injections

**Periodontics/Endodontics**

(1) **Periodontic Services**
- Periodontal re-evaluation / evaluation
- Periodontal appliances and maintenance: 1 appliance per arch per 36 consecutive months
- Management of oral disease

- Desensitization
- Occlusal equilibration
- Periodontal abscess or periocoronitis
- Periodontal surgery – flap approach – osteoplasty
- Periodontal surgery – flap approach – osseous defect
- Periodontal surgery – gingival curettage
- Periodontal surgery – gingivoplasty
- Periodontal surgery – gingivectomy
- Periodontal surgery – grafts – connective tissue
- Periodontal surgery – grafts – soft tissue
- Proximal wedge

(2) **Endodontic Services**

- Routine initial root canal therapy. Complicated root canal therapy is limited to the cost of routine root canal therapy. Retreatment of root canal is covered only if at least 36 consecutive months have elapsed from the date of the initial root canal therapy. No coverage for primary teeth.
- Apexification
- Apicoectomy
- Bleaching of endodontically treated teeth
- Hemisection
- Intentional removal and implantation
- Isolation of endodontic tooth
- Open & drain
- Pulpectomy
- Pulpotomy
- Retrofilling
- Root amputation