ecotone
health insurance inc

# Member Benefits Booklet

## Ecotone Retiree Plan

Class G

Division 1

Diamond Health and Dental

**Effective Date:** Jan 1, 2023

## Contact

| | |
|---|---|
| Plan Administration Support | administration@simplybenefits.ca |
| General Inquiries | contact@simplybenefits.ca |
| Support | support@simplybenefits.ca |
| Phone Number | 1-877-815-7751 |
| Website | simplybenefits.ca |
| Address | 601-460 Doyle Ave Kelowna BC, V1Y 0C2 |

## Practice Management Software Setup information

| | |
|---|---|
| Carrier Name | Simply Benefits |
| BIN/Carrier ID/CDAnet ID | 610361 |
| Network | instream |
| CDAnet Message Version | 4 |

---

| | |
|---|---|
| Supported CDAnet Transactions | Claim<br>Claim Reversal<br>Predetermination<br>Request for Outstanding Transaction<br>Coordination of Benefits |

## Introduction

Your employer has entered into an agreement with Simply Benefits 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 group 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 master Policy and by applicable law.

In the event of any discrepancy between this booklet and the group Policy, the terms and provisions of the group Policy 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 your plan administrator or the third-party administrator, Simply Benefits at:

| | |
|---|---|
| Email: | support@simplybenefits.ca |
| Telephone: | 1-877-815-7751 |

## Important Notice

The group insurance contract consists of the Schedule of Benefits, the contractual provisions and any appendix attached to the contract.

A Schedule of Benefits is provided for each class of employees eligible for insurance. It briefly describes the insurance benefits that are included in the group insurance plan for each class. All information regarding the definitions, insurance terms and conditions, termination of insurance, applicable exclusions and reductions as well as claims are found in the contractual provisions.

Participants and their dependents, if any, are not entitled to any amount of insurance or benefits not expressly indicated in the Schedule of Benefits for the class of eligible employees to which the participant belongs.

The Schedule of Benefits, contractual provisions and any appendix are available on your Simply Benefits Portal, as well as your office Plan Administrator through your employer and/or the policyholder.

# Table of Contents


Contact 2

Introduction 3

Table of Contents 4

Schedule of Benefits 5

- Drugs 6
- Major Health 7
- Paramedicals 9
- Vision 10
- Out of Country and Province 11
- Dental 12

Benefits Details 13

- Drugs 14
- Major Health 16
- Vision 19
- Out of Country and Province 20
- Dental 26

Insurance Terms And Conditions 32

Providers 40

Respecting Your Privacy 41

# SCHEDULE OF BENEFITS

A summary of the benefits included in your employee benefits plan.

## Drug Coverage

| | |
|---|---|
| Reimbursement | 80% |
| Drug Plan Type | Mandatory Generic |
| Benefit Period | Calendar year |
| Overall Maximum (Calendar Year) | $10,000.00 |
| Preferred Provider | Pocket Pills |
| Preferred Provider Reimbursement | 90% |
| Eligibility | 0 month(s) continuous employment, 0 hrs/week |
| Diabetic Supplies and Accessories | Include syringes, lancets, test strips, pin needles and chemical reagent testing |
| Survivor Benefit | 24 months |
| Termination Age | Participant's death |

## Major Health

| | |
|---|---|
| Deductible | N/A |
| Reimbursement | 100% |
| Accidental dental | 100.00% |
| Ambulance | Reasonable & Customary |
| Cardiac Rehabilitation | $500.00 per calendar year |
| Hearing Aids | $500.00 per 60 consecutive months |
| Private duty nursing | $10,000.00 per calendar year |
| Hospital Benefit Reimbursement | 100% |
| Hospital Benefit Type | Semi private |
| Convalescent Hospital Reimbursement | 100% |
| Convalescent Hospital Daily Maximum | $40.00 |
| Convalescent Hospital Maximum Days | 180.00 |
| Apnea machine (CPAP) | $2,000.00, 1 per 60 consecutive months |
| Apnea machine supplies | Covered (Reasonable and Customary) |
| Apnea mask | 1 per calendar year |
| Artificial eye or limb; initial prosthesis | 1 per lifetime |
| Artificial eye or limb; repair & replacement | $1,000.00 per calendar year |
| Blood pressure monitor | $100.00 lifetime |
| Braces with rigid supports | 1 per calendar year |
| Compression stockings | $100.00 per calendar year |
| Crutches | Covered (Reasonable and Customary) |
| Custom-made foot orthotics | $300.00 per calendar year |
| Glucose monitoring equipment and supplies | $4,000.00 per calendar year |
| | Continuous Glucose Monitors (CGM) |
| | Blood Glucose Monitoring Systems (BMG) |
| | Glucose Monitoring Systems (GMS) |
| | Flash Type Monitors (FGM) |
| | Sensors, Receivers & Transmitters |
| | Patient must be insulin dependent Type 1 diabetic supported by a doctor's prescription. |
| External breast prosthesis | 1 per calendar year |
| Insulin pump | $5,000.00 every 5 calendar years |
| Insulin pump supplies | $3,500.00 per calendar year |
| IPP Breathing machine | Covered (Reasonable and Customary) |
| Orthopaedic Shoes | $300.00 per calendar year |
| Prosthetics | $25,000.00 lifetime |
| Ostomy supply | Covered (Reasonable and Customary) |
| Surgical bras | 2 per calendar year |
| TENS | $3,500.00 lifetime |
| Viscosupplementation | $600.00 per calendar year |
| Wheelchair; electric | $3,000.00 lifetime |
| Wheelchair; manual | $1,000.00 lifetime |
| Wigs, post-chemotherapy | $500.00 lifetime |

## Diagnostic Services

| | |
|---|---|
| Reimbursement | 100% |
| Diagnostic Services Maximum | $500.00 per calendar year |
| X-Rays | Covered (Reasonable and Customary) |

## Medical Referral

| | |
|---|---|
| Reimbursement | 50% |
| Medical Referral Maximum | $50,000.00 lifetime coverage |

## Paramedical

| | |
|---|---|
| Deductible | N/A |
| Coinsurance | 80% |
| Acupuncturist | $500 per calendar year |
| Audiologist | $500 per calendar year |
| Chiropodist | $500 per calendar year |
| Chiropractor | $500 per calendar year |
| Massage therapist | $500 per calendar year |
| Naturopath | $500 per calendar year |
| Occupational Therapist | $500 per calendar year |
| Osteopath | $500 per calendar year |
| Psychotherapist | $500 per calendar year |
| Physiotherapist | $500 per calendar year |
| Podiatrist | $500 per calendar year |
| Registered Dietician | $500 per calendar year |
| Psychologist | $500 per calendar year |
| Social worker | $500 per calendar year |
| Speech-language pathologist | $500 per calendar year |

## Vision Care

| | |
|---|---|
| Eye Exam Reimbursement | 100% |
| Eye Exam (child to age 18) | $100.00; 1 exam per period of 12 consecutive months |
| Eye Exam (adults) | $100.00; 1 exam per period of 24 consecutive months |
| Eye Glasses & Contacts Reimbursement | 100% |
| Eye Glasses & Contact Lenses (child to age 18) | $400.00; 1 per 12 consecutive months |
| Eye Glasses & Contact Lenses (adults) | $400.00; 1 per 24 consecutive months |

## Out of Country & Province

| | |
|---|---|
| AIG Policy Number | 9429103 |
| Maximum Number of Days | 60 Days |
| Maximum per insured | $1,000,000.00 per insured / per trip |
| Termination Age | 85 Years |

## Dental Care

| | |
|---|---|
| Benefit Period | Calendar year |
| Basic Reimbursement | 80% |
| Routine Reimbursement | 80% |
| Basic and Major Combined Maximum | $1,500.00 |
| Months to Recall | 6 months to recall |
| Units of Scaling | 10 units of scaling |
| Periodontics Reimbursement | 80% |
| Endodontics Reimbursement | 80% |
| Denture Reimbursement | 50% |
| Bridgework Reimbursement | 50% |
| Crowns Reimbursement | 50% |
| Eligibility | 0 month(s) continuous employment, 0 hrs/week |
| Survivor Benefit | 24 month(s) |
| Termination Age | Participant's death |

# BENEFITS DETAILS

Further information about your benefits coverage.

## Drug Coverage

**Prescription Drug Expenses**

A "**Prescription Drug**" means drugs, medicines, and diabetic supplies with a Drug Identification Number that require a Prescription By Law and are dispensed by a Pharmacist. Subject to the terms of this Plan, expenses related to Prescription Drugs, including, the cost of drugs, medicines and diabetic supplies that are dispensed by a Pharmacist and require a Prescription By Law, will constitute Eligible Expenses under this Health Benefit. Prescription Drug expenses may require approval under the Prescription Drugs Formulary Management Policy as outlined further in this Health provision.

The prescription charges are limited to the Lowest-Cost Alternative for eligible drugs and medicines when an inter-changeable Drug is available.

Charges are subject to any limitations and maximums specified in the Plan Summary.

**Prescription Drugs Formulary Management Policy**

The insurer reserves the right to manage its drug formularies and the coverage for Prescription Drugs provided under this Health provision through an evidence-based review process. This process evaluates drugs based on overall value, which includes (without limitation) consideration of:

a) clinical efficacy;
b) safety;
c) unmet need; and
d) affordability.

Without limiting the foregoing, formulary management includes the right to:

a) add a drug to the insurer's formularies;
b) exclude or remove a drug from the insurer's formularies regardless of any governmental approval or existing coverage under a Provincial Health Plan; and
c) place restrictions on a formulary drug as determined by the insurer. Restrictions may include, but are not limited to the insurer's:

    i) pre-approval of the drug before the claim can be reimbursed;
    ii) requirement to obtain the drug through a provider approved by the insurer;
    iii) limitation of the drug's day supply, depending on the drug's proven efficacy; and
    iv) requirement to obtain a lower-cost alternative of the same treatment such as a generic or biosimilar drug.

**Concurrent Drug Utilization Review**

Claims for drugs covered under this Benefit which are purchased in Canada and submitted electronically to the insurer are subject to concurrent drug utilization review at point-of-sale to determine if

a) an adverse interaction is possible between a prescribed drug and another drug you are already taking;
b) a prescribed drug may be harmful to a patient who is a Dependent Child or a senior;
c) a refill prescription is being filled too soon or too late;
d) a prescribed drug contains ingredients in the same therapeutic class as another drug currently being taken or that has recently been taken and the ingredients remain active in your system;
e) the prescribed therapy duration falls outside the drug manufacturer's recommended minimum and maximum limits;
f) the prescribed daily dosage of a drug falls outside the age band limits established by the drug manufacturer; and
g) a prescribed drug is intended solely for the use of a person of the opposite gender to that of the patient.

(such an assessment being the "**Concurrent Drug Utilization Review**")

Based on the outcome of the Concurrent Drug Utilization Review, the Pharmacist may refuse to dispense a drug as prescribed. Claims for drugs covered under this Benefit are not subject to Concurrent Drug Utilization Review if:

a) the drugs are dispensed at a pharmacy not properly equipped to provide the service; or
b) the drugs are extemporaneous preparations or compounds

The insurer makes no guarantees, representations, or warranties about the accuracy or completeness of the patient information provided for the Concurrent Drug Utilization Review or about the review results, nor is the insurer liable for any decision made by a Pharmacist as a result of, or in connection with, directly or indirectly, the review process.

**Prescription Drugs Limitations**

The insurer may, in its sole and unrestricted discretion, from time to time participate in and utilize available drug management strategies which, in its discretion, will ensure a cost-efficient method to protect access to Prescription Drugs you need, while ensuring benefits are safe, sustainable, effective, and affordable for Plan Sponsors ("**Drug Management Strategies**").

These Drug Management Strategies may include, without limitation, participating in third-party programs regarding drug pricing, drug utilization review, narcotic management, and migraine management. The terms and conditions of this Health Benefit will in all circumstances be subject to applicable rules, regulations, policies, procedures, terms, and conditions of such Drug Management Strategies.

**Prescription Drug Exclusions**

No amount will be payable under this Health Benefit for:

a) charges for the delivery and administration of medications, injectable drugs, serums, and vaccines;
b) over-the-counter drugs;
c) vitamins, minerals, dietary products, and supplements;
d) Ethical Drugs;
e) preventative vaccines; unless covered under the Schedule of Benefits
f) anti-obesity drugs; unless covered under the Schedule of Benefits
g) fertility therapy or drugs; unless covered under the Schedule of Benefits
h) erectile dysfunction drugs; unless covered under the Schedule of Benefits or
i) smoking cessation products; unless covered under the Schedule of Benefits

## Major Health

Your Provincial Health Plan provides basic health services such as hospital ward accommodations, fees for Physicians and other hospital practitioners, and any drugs or blood products you may need during your hospital stay. Your group Plan is designed to cover many additional medical expenses on a Reasonable and Customary basis for you and your family, over and above the coverage provided by your Provincial Health Plan.

**Eligible Expenses for Medical Services and Medical Supplies**

For the purpose of the Health Benefit, an "Eligible Expense" is defined as an expense incurred directly in relation to a Medical Service or Medical Supply, before any applicable payment limitations, such as deductibles, coinsurance, and maximums (as specified in the Plan Summary) are applied. Eligible Expenses are covered in accordance with the terms and conditions of this Plan, and are only covered under this Plan when all of the following apply in relation to the particular Medical Service or Medical Supply:

a) the Medical Service or Medical Supply must be a Medically Necessary treatment of an Illness or Injury;
b) the Medical Service or Medical Supply must be recommended by a Medical Practitioner within the scopeof their license;
c) the Eligible Expenses must be Reasonable and Customary charges, as determined by the insurer;
d) the Eligible Expenses are not covered under any Provincial Health Plan or Government-sponsored program; and
e) the Eligible Expenses can legally be covered under the Plan.

Any expense can be submitted to the insurer for an estimate of what the insurer, acting reasonably, anticipates the amount of coverage the insurer will provide for a specific expense (a "**Predetermination Estimate**")

Receipt of a Predetermination Estimate will not be binding on the insurer, and does not guarantee any specific, whether full or partial, reimbursement of any expense.

**Medical Services and Medical Supplies**

The medical services and medical supplies listed in this Medical Services and Medical Supplies provision are a non-exhaustive list of the types of services and supplies covered, strictly in accordance with the terms and conditions of this Health provision, under the Health Benefit. The insurer may, from time to time, and strictly in accordance with the terms and conditions of this Plan, cover additional types of medical services (such medical services, together with those listed in this Medical Services and Medical Supplies provision, being a "**Medical Service**") or additional medical supplies (such medical supplies, together with those listed in this Medical Services and Medical Supplies provision, being a "**Medical Service**") where, in the insurer's discretion, acting reasonably, it is appropriately covered by the Health Benefit.

Medical Services must be performed in Canada and Medical Supplies must be purchased in Canada to be eligible for coverage under this Health Benefit.

Medical Supplies must be dispensed by a pharmacy, medical facility, or medical supply retail store to be eligible for coverage under this Health Benefit.

The maximum amount payable in relation to any Medical Services or Medical Supplies will in no event exceed any maximums specified in the Plan Summary.

**Accidental Dental Injury**

Charges for the services of a Dental Practitioner for treatment of an Accidental Dental Injury to whole or sound natural teeth, including replacement of such damaged teeth, providing the accident causing such injuries occurred while covered. Expenses must be incurred within 1 year of the Accident.

Payments made in relation to an Accidental Dental Injury under this Health Benefit will be in accordance with the Dental Fee Guide for the province where services are rendered.

Where any 2 or more courses of treatment would produce professionally adequate results for a given condition, the insurer will pay benefits as if the least expensive course of treatment covered under this Health Benefit was used.

**Ambulance**

Ambulance expenses include charges for:

a) response only, without any subsequent transportation; and;
b) response and transportation in an Ambulance by ground vehicle or air transport from the emergency site to a Hospital where adequate treatment may be rendered.

**Cardiac Rehabilitation Program**

Charges for treatment rendered in connection with a cardiac rehabilitation program adhering to the standards of the Heart and Stroke Foundation of Canada, as they may change or be replaced from time to time, and prescribed by the attending Physician for rehabilitation within 6 months after any 1 or combination of the following:

1. myocardial infarction;
2. percutaneous coronary intervention (coronary angioplasty);
3. coronary artery bypass graft; or
4. heart valve surgery.

**Custom-Made Foot Orthotics**

Charges for custom-made foot orthotics. Custom-made foot orthotics are orthotics made from a three-dimensional model of the patient's foot and is fabricated from raw materials.

Custom-made foot orthotics must be dispensed by an orthotist, pedorthotist, podiatrist, chiropodist, or chiropractor to be eligible for coverage under this Health Benefit.

**Custom-Made Orthopedic Shoes**

Charges for custom-made orthopedic shoes. Custom-made orthopedic shoes are shoes made from a full casting of the patient's foot and ankle or a three-dimensional image of the plantar dorsal aspects of the foot and ankle. The shoe is fabricated from raw materials.

Custom-made orthopedic shoes must be dispensed by an orthotist, pedorthotist, podiatrist, chiropodist, or chiropractor to be eligible for coverage under this Health Benefit.

**Diagnostic Procedures**

Charges for diagnostic laboratory services and radiological treatments, including x-rays and radium therapy.

**Hospital Room and Convalescent Hospital Room**

Charges for Hospital Room Rate in excess of coverage under any applicable Provincial Health Plan, provided you or your Dependents were confined in the Hospital.

Charges for Convalescent Hospital Room Rate in excess of coverage under any applicable Provincial Health Plan, pro-vided you or your Dependents were confined in the Hospital.

**Paramedical Services**

Charges for the services of a Paramedical Practitioner within the scope of the Paramedical Practitioner's license and training.

**Professional Nursing Services**

When recommended by the treating Physician, charges for the services of a Professional Nurse which are rendered in the patient's home up to the maximum amount specified in the Schedule of Benefits. No amount will be paid for services which are custodial or services which do not require the skill level of a Registered Nurse.

A pre-authorization form for Professional Nursing Services must be completed by the treating Physician and submitted to the insurer.

**Medical Services and Medical Supplies Limitations**

The insurer will determine whether a Medical Supply should be purchased or rented. The determination will be made based on your or your Dependents' Medical Condition.

**Medical Services and Medical Supplies Exclusions**

In addition to the Claim Exclusions listed in the "Making a Claim" section in this booklet, no amount will be payable under this Health Benefit for:

a) services or supplies which are used for athletic or recreational purposes;
b) services or supplies not required for daily regular activities;
c) replacement batteries; and
d) services and supplies for maintenance and adjustments to medical equipment.

**Medical Referral for Treatment**

If medically necessary treatment is not available in Canada, the insurer provider will cover expenses relevant to the treatment in excess of your Provincial Health Plan provided that:

a) the treatment is ordered in writing by a Physician located in your or your Dependent's province of residence;
b) the treatment has been pre-approved by the insurer provider and your Provincial Health Plan. Additional expenses will only ben covered if your Provincial Health Plan is participating in the reimbursement; and
c) referrals cannot be due to waiting list or lack of resources, such as strike or lack of organ donations. If the condition is not immediately dangerous, in the opinion of a Physician, and treatment will soon be available in Canada, in the opinion of the insurer provider, you or your Dependents may be asked to wait for such treatment and coverage under this Out-of-Country Referral for Treatment provision will be denied.

**Health Coverage Exclusions**

No amount will be payable under this Health Benefit for:

a) any service or supply not listed as a payable benefit in the Plan;
b) any replacement of a prosthetic device, appliance, or other Medical Supply which has been broken, damaged, lost, or stolen;
c) any purchase of a duplicate prosthetic device, appliance, or other Medical Supply for the purpose of having a spare or alternate;
d) medical examinations for use by a third party;
e) services and supplies, including any Medical Services or Medical Supplies, received outside of Canada, unless the Emergency Out-of-Province or Out-of-Country Benefit is included in this Plan, and the expense is specified as eligible under that benefit;
f) any services or supplies, including any Medical Services or Medical Supplies, that are not usually provided to treat an Illness in the reasonable opinion of the insurer, including those that are experimental;
g) any form of medical cannabis for the treatment of any Medical Condition, regardless of whether it is authorized by way of a medical document or prescription from a legally authorized Medical Practitioner and obtained from a properly licensed producer pursuant to any federal or provincial legislation or regulation regarding access to or distribution of medical cannabis;
h) services or supplies, including any Medical Services or Medical Supplies, which are reimbursable under the Criminal Injuries Compensation Act or similar legislation;
i) confinement or treatment insured or insurable under any other group benefit or other insurance plans that are maintained by the Employer in conjunction with the Plan;
j) services and supplies, including any Medical Services or Medical Supplies, for which a government or government agency prohibits the payment of benefits; or
k) services and supplies, including any Medical Services or Medical Supplies, which are covered by a Provincial Health Plan, Workers Compensation, or any other government plan.

## Vision Care

The Vision Benefit covers Eligible Expenses for certain medical services and medical supplies, as outlined in this Health provision (the "**Vision Benefit**"). For the purpose of this Vision Benefit, an "**Eligible Expense**" is defined as an expense, before any applicable payment limitations, such as deductibles, coinsurance, and maximums (as specified in the Schedule of Benefits) are applied, incurred directly in relation to only the following:

a) If included in the Schedule of Benefits; charges for eye exams (including refractions) on the recommendationof an Optometrist or a Medical Practitioner within the scope of their license, provided the charges are not covered by the Provincial Health Plan; and
b) If included in the Schedule of Benefits; charges for frames, lenses, contact lenses, and laser eye surgery forvision correction, on the recommendation of an Optometrist or a Medical Practitioner within the scope of their license.

Eligible Expenses as per the Schedule of Benefits are only covered by the Vision Benefit when they:

a) are incurred and paid for in Canada;
b) are Reasonable and Customary;
c) are not covered under any Provincial Health Plan or Government-sponsored program; and
d) can legally be covered under the Plan.

# Out of Country & Province

**AIG Travel Guard**

Protection and assistance services that respond effectively to travel medical emergencies.
In Canada & USA, Toll Free:  1-877-204-2017
Outside Canada & USA (collect): +1-715-295-9967
Open 24 hours a day, 7 days a week for emergency assistance.

**IMPORTANT GUIDELINES**

**Why You Should Have Group Emergency Out of Province Insurance**

Accidental injury, unexpected illness, and severe weather are just some of the ways in which medical emergencies can arise while you are travelling abroad. Out-of-Province healthcare services are not typically covered under Cana da's public insurance program, and emergency situations are further complicated by differences in language and standards of care.

When you are outside your province of residence and require these services, your provincial health plan will usually make a payment towards your expenses, but that payment is usually limited to the amount that would have been paid for the same services in the province in which you reside. Unfortunately, there is often a tremendous difference between the cost of these services outside province and the amounts allowed by your health plan, which you would have to pay were it not for this valuable benefit.

This plan provides extensive coverage for many services rendered outside your province of residence. It is important to note that such expenses are covered if they were unexpected and of an emergency nature. The plan does not provide benefits for medical treatment if the purpose of your trip outside your province of residence is to obtain that medical treatment.

**Definitions**

The following is an explanation of commonly used terms in this section of the benefit booklet.

***Company*** means AIG Insurance Company of Canada.

***Dependent Child*** means a person who is either your natural child, adopted child or step-child or a child to whom you are in loco parentis and who is (i) under 21 years of age, unmarried and dependent upon you for maintenance and support and not employed for more than 25 hours per week ; or (ii) under 25 years of age, un married and enrolled in an Institution of Higher Learning and dependent upon you for maintenance and support and not employed for more than 25 hours per week; or (iii) by reason of mental or physical infirmity is incapable of self-sustaining employment and who is considered your Dependent Child within the terms of the Income Tax Act (Canada).

***Employer*** means the Policyholder or an affiliate or subsidiary thereof, for which you are employed.

***Injury*** means bodily injury which is sustained by you or your eligible dependents as a direct result of an unintended unanticipated accident, occurring anywhere in the world outside your province of residence, provided such accident is external to the body and occurs while you or your eligible dependents insurance under this policy is in force while you or your eligible dependents are outside your province of residence.

***Insured Employee:*** means you, if you are an Active or Retired Member of the Policyholder.

***Insured Person:*** An Insured Employee and any additional Insured Persons as described in the Eligible Classes in the Policy Schedule Declarations.

***Medical Emergency:*** A condition caused by an Injury or Sickness which meets all of the following criteria: (1) there is present a severe or acute symptom requiring immediate care and the failure to obtain such care could reasonably result in serious deterioration of you or your eligible dependents condition or place your life in jeopardy; (2) the severe or acute symptom occurs suddenly and unexpectedly; and (3) the severe or acute symptom occurs while the policy is in force.

***Minor Ailment:*** Any Injury or Sickness which does not require:

a) the use of medication for a period of greater than 15 days;
b) more than one follow-up visit to a Physician;
c) hospitalization of surgical intervention;
d) referral to a specialist; and

which ends at least 30 consecutive dates prior to your Departure Date of a Trip. A chronic condition or any complication of a chronic condition is not considered a minor ailment.

***Pre-Existing Condition*** is any medical or physical condition, symptom, illness or disease for which Treatment was received or for which an ordinarily prudent person would have sought Treatment within ninety (90) days immediately prior to the Insured Person's Departure Date unless such condition was Stable and Controlled. A Pre-Existing Condition does not include:

a) the unchanged use of prescribed medication for a medical condition, symptom or problem which is Stable and Controlled;
b) treatment that is a medical or physical examination in which a Physician observes no change in a previously identified condition, symptom or problem and no new treatment is prescribed or recommended;
c) a Physician-prescribed decrease or cessation in cholesterol lowering medication;
d) a change in any medication from a brand name medication to a generic brand medication (provided the dosage is not modified); and
e) the adjustment in dosage of medication that is either Coumadin (warfarin) or insulin only to ensure correct blood levels are maintained provided

***Sickness:*** means the onset of sickness or disease requiring medical Treatment, care or advice while you or your eligible dependents are travelling anywhere in the world outside your province of residence while coverage under this Policy is in force.

***Spouse:*** means a person who is either legally married to you, or if there is no such person, is a person who, although not legally married to you, is cohabitating with you, and is publicly represented as your domestic partner in the community in which you reside.

***Stable and Controlled:*** Any medical condition (whether or not the diagnosis has been determined), other than a Minor Ailment, for which there has been:

a) no hospitalization; and
b) no new diagnosis, Treatment or prescribed medication; and
c) no Change in Treatment; and
d) no new, more frequent or more severe symptoms; and
e) no new test results showing deterioration; and
f) no referral to a specialist (made or recommended) and you or your eligible dependents are not awaiting surgery of results of further investigations performed by a Physician.

***Trip*** means travel by you or your eligible dependents outside your province of residence which commences on such the Departure Date which must commence after this policy Effective Date and before this policy Expiration Date.

**Benefits and Coverages**

The Company will pay for Reasonable and Customary medical expenses actually incurred by you or your eligible insured dependents for those services described below and required outside your province of residence, as a result of a Medical Emergency that occurs on a Trip provided such Medical Emergency occurs while this policy is in effect for such person.

The Benefit Description is a summary only and does not include all of the provisions, sub-limits, conditions and exclusions.

| Benefit | Maximum Per Insured Person | Benefit Description |
|---|---|---|
| OUT OF PROVINCE MEDICAL BENEFITS | $5,000,000 per trip<br>Maximum Trip Duration as per the Schedule of Benefits | If you or your eligible insured dependents suffer a Sickness or an Injury that results in emergency stay in a Hospital or medical or therapeutic services as specifically listed herein, the Company will pay benefits, for the period this contract is in force, not to exceed the Maximum for the actual expenses you or your eligible insured dependents incurred outside your province of residence. |
| EMERGENCY HOSPITAL CONFINMENT | Included in Overall Lifetime Maximum | If you or your eligible insured dependents suffer a Sickness or an Injury which results in an emergency confinement as a resident in-patient in a Hospital, including semi-private accommodation, for Reasonable and Customary charges made by the Hospital for services and supplies to the extent that such are medically necessary, the Company will pay benefits hereunder, subject to all limitations and conditions of your policy.<br>In the event you or your eligible insured dependents are confined to a Hospital at the end of your trip outside your province of residence and thus prevented from returning to your province of residence, insurance will continue for the period of such confinement, but in no event for more than 12 months from the date the first covered expense was incurred. |
| EMERGENCY MEDICAL AND THERAPEUTIC SERVICES | Included in OverallLifetime Maximum<br>Sub-limits noted in the Benefit Description | (a) the services of a Physician or legally qualified surgeon<br>(b) laboratory tests and X-ray examinations (not including MRI)<br>(c) MRI, for diagnostic purposes when Medically Necessary: $7,500 per Insured Person per Trip<br>(d) the services of a registered graduate nurse: 50 shifts not to exceed $100 per shift<br>(e) rental of crutches or a Hospital type bed, or the cost of splints, canes, slings, trusses, braces or other prosthetic appliances<br>(f) the services of a Physician who is an anesthetist<br>(g) drugs or medicines that require a Physician or legally qualified surgeon's written prescription<br>(h) services of a chiropodist, chiropractor, osteopath, physiotherapist or podiatrist: $300 for each class of practitioner<br>(i) expenses for accidental Injury to natural and sound teeth: $2,000 for any one accident<br>(j) out-patient services provided by a Hospital |
| REPATRIATION BENEFIT | $15,000 | Covers the expenses to return your body or your eligible insured dependent to your city of residence if you or your eligible insured dependents suffer a death while outside your province of residence. |
| IDENTIFICATION BENEFIT | $5,000 | Transportation of an Immediate Family Member to identify the body if you or your eligible insured dependents suffer a covered death, and a law enforcement agency requests such identification. |

| Benefit | Maximum Per Insured Person | Benefit Description |
|---|---|---|
| AUTOMOBILE RETURN | $1,000 per Trip | Return of private or rental vehicle used for your trip, to your province of residence or nearest rental agency if you or your eligible insured dependents become totally disabled due to a Sickness or Injury and you are unable to continue your Trip. |
| OUT-OF-POCKET EXPENSE BENEFIT | $150 per day / $1,500 per occurrence | Pays for reasonable and necessary commercial living expenses such as commercial accommodations and meals, incurred by you or your eligible insured dependents. |
| FAMILY TRANSPORTATION | $15,000 per accident<br>$250 per day for incidental travel | Pays for the expenses incurred for the transportation of an immediate family member to your hospital if you or your eligible insured dependents are confined to a hospital. |
| RETURN TRANSPORTATION FOR TRAVELLING COMPANION | $2,000 | If you or your eligible insured dependents are repatriated to your province of residence in accordance with the Repatriation Benefit or the Ground and Air Transportation Benefit, then the Company will pay a benefit of up the Maximum for the transportation of one Travel Companion to his/her home province of residence on a |
| RETURN AND ESCORT OF DEPENDENT CHILDREN | $5,000 | If you or your eligible insured dependents are repatriated to your province of residence in accordance with the Repatriation Benefit or the Ground and Air Transportation Benefit, then the Company will pay a benefit of up to the Maximum for the transportation of your Dependent Children under age 16 to their province of residence on a one-way economy air fare of a commercial flight, plus reasonable overnight hotel accommodation and meal expenses for the services of an attendant to escort your Dependent Child |
| GROUND TRANSPORTATION BENEFIT | $5,000 | Pays for the use of ground ambulance. |
| EMERGENCY AIR TRANSPORTATION BENEFIT | $300,000 | Pays if you or your eligible insured dependent's medical condition requires air transportation to the nearest hospital or to return to your province of residence. This service must be coordinated and approved by the Company. |

**Emergency Medical Assistance**

AIG provides worldwide emergency assistance for you and your eligible insured dependents while on a Trip except where local conditions render such assistance not feasible. In the event of a Medical Emergency covered by this Policy requiring hospitalization, the Company must be notified within 48 hours from the time of incident or expense claims may be denied or only partially covered.

In the event of a Medical Emergency, you or an individual acting on their behalf must call the Assistance Company listed in the Policy Schedule Declarations.

**Emergency Travel Assistance**

Travel Assistance is provided by AIG Assist. With centers worldwide they will:

- help you locate the most appropriate medical facility for you
- confirm coverage with AIG Assist and assure the hospital that you are covered
- guarantee payment for hospitalization, if necessary
- arrange for admission to a hospital
- provide translation services
- contact your own doctor for recommendations, when required
- contact your family and employer, when required
- arrange for/co-ordinate emergency medical evacuation
- co-ordinate your return home

**How to submit a claim?**

**Minor Expenses**

For expenses associated with minor medical emergencies (less than $250), keep your receipts and file your claims with your government health plan first and then with the Company by mail or email (ahclaimscan@aig.com).

**AIG Insurance Company of Canada**

120 Bremner Boulevard, Suite 2200

Toronto, ON M5J 0A8

**Major Expenses**

For major emergencies that require hospitalization or day surgery, AIG Assist will coordinate services between the Provider and the Company to insure direct billing of your expenses.

**General Policy Provisions**

**Effective Date**

Your coverage begins on the date you satisfy the eligibility requirements to become an Insured Employee.

**Termination Date**

Coverage ends on the earliest of:

1. 12:01 am the date following the Maximum Trip Duration of up to the number of days specified in the Schedule of Benefits; or
2. the date you or your eligible insured dependents return to your province of residence; or
3. the date you or your eligible dependents no longer satisfy the definition of an Insured Person; or
4. the date you or your eligible dependents attain the maximum age limit as per your applicable Class; or
5 the date the policy is terminated; or
6. the policy Expiration Date.

**Policy Exclusions**

The policy will not cover any losses caused in whole or in part by, or resulting in whole or in part from, the following:

a) Sickness or Injury sustained while you or your eligible insured dependents are on full-time active duty in the armed forces or organized reserve corps of any country or international authority;

b) Injury sustained while you or your eligible insured dependents are under the influence of alcohol and operating any vehicle or means of transportation or conveyance while your blood alcohol is over 80 milligrams in 100 millilitres of blood;

c) Injury sustained while you or your eligible insured dependents are under the influence of a drug or substance which is controlled as specified under the Controlled Drug and Substances Act (Canada) (even if such drug or substance is taken outside Canada) unless taken pursuant to the advice of and in strict accordance with the instructions of a Physician;

d) the abuse of medication or drugs or non-compliance with prescribed medical therapy or Treatment whether prior to or during you or your eligible insured dependents Trip;

e) Injury incurred while you or your eligible insured dependents are in the course of committing or attempting to commit, any act which if adjudicated by a court would be an indictable offence under the laws of the jurisdiction where the act was committed;

f) childbirth or any unexpected pregnancy complications after 31 weeks;

g) routine pre-natal care;
h) voluntary termination of pregnancy;
i) a child born during a Trip covered under this policy;
j) Sickness or Injury where the Trip is undertaken for the purpose of securing medical Treatment or advice for such Sickness or Injury;
k) Sickness or Injury due to participation in any professional sport;
l) suicide or any attempt at suicide;
m) intentionally self-inflicted Injury or any attempt at intentionally self-inflicted Injury;
n) an act of declared or undeclared war, civil war, rebellion, revolution or insurrection;
o) repair or replacement of the following except for the purpose of modifying the item because the Injury or Sickness has caused further impairment in the underlying bodily condition:

i) existing artificial limbs, artificial eyes or other prosthetic appliances or rental of existing durable medical equipment;
ii) new, or repair or replacement of, dentures, bridges, dental implants, dental bands or braces or other dental appliances, crowns, caps, inlays or onlays, fillings or any other treatment of the teeth or gums, except for repair or replacement of sound natural teeth damaged or lost;
iii) new eye glasses or contact lenses or eye examinations related to the correction of vision or related to the fitting of glasses or contact lenses;
iv) new hearing aids or hearing examinations;
v) rental of durable medical equipment where the total rental expense exceeds the usual purchase expense for similar equipment in the locality where the expense is incurred (but if, in the Company's sole judgment, Emergency Medical and Therapeutic Services for rental of durable medical equipment are expected to exceed the usual purchase expense for similar equipment in the locality where the expense is incurred, the Company may, but is not required to, choose to consider such purchase expense as a Reasonable and Customary charge in lieu of such rental expense);

p) Personal comfort or convenience items, such as but not limited to Hospital telephone charges, television rental, or guest meals;
q) Treatment or services when reimbursement or coverage by the Company would contravene any GHIP in Canada;
r) aexpenses incurred on an elective (non-emergency) basis;
s) any Treatment, investigation or surgery for a specific condition, or a related condition, which had caused you or your eligible insured dependents Physician to advise such person not to travel;
t) any services or supplies provided by an Immediate Family Member;
u) a Sickness or Injury that, at the time of departure, might reasonably be expected to require you or your eligible insured dependents to undergo Treatment, investigation, surgery or hospitalization;
v) any service, Treatment, surgery or stay in Hospital not required for the immediate relief of acute pain or suffering or which is not Medically Necessary;
w) any Treatment or surgery which reasonably could be delayed until you or your eligible insured dependents return to your province of residence;
x) anticipated medical Treatments required on an ongoing basis or for continued stabilization of a medical condition known to you or your eligible insured dependents prior to departure from your province of residence;
y) any sickness, injury or medical condition that was not Stable and Controlled 90 days prior to the Departure date;
z) that portion, if any, of any expenses for Treatment, advice or hospitalization which are not Reasonable and Customary;

**Important Notes**

This booklet, as may be amended, provides only a summary of the provisions for the out of province coverage and the Additional Benefits. The full coverage details are contained in the policy including, without limitation, eligibility, limitations, exclusions and termination provisions. In the event of a conflict between any term set out in this booklet and a term set out in the policy, to the extent of the conflict, it is the term of the policy which shall govern.

The booklet is provided for information purposes only and does not create or confer any contractual rights or obligations. Possession of this booklet alone does not mean that you or your dependents are covered. The policy must be in effect and you must satisfy all the requirements.

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the Insurance Act (for actions or proceedings governed by the laws of Alberta and British Columbia), The Insurance Act (for actions or proceedings governed by the laws of Manitoba), the Limitations Act, 2002 (for actions or proceedings governed by the laws of Ontario), The Limitations Act (for actions or proceedings governed by the laws of Saskatchewan) or other applicable legislation. For those actions or proceedings governed by the laws of Quebec, the prescriptive period is set out in the Quebec Civil Code.

Insurance is underwritten by AIG Insurance Company of Canada.

# Dental

**Definitions**

The following definitions apply specifically to dental care insurance, in addition to the definitions provided in the General Definitions section.

- Fee guide: The annual fee guide and description of dental treatment services approved by the dentists' association of the insured's province of residence. In the absence of fees recommended by an appropriate professional association, eligible expenses are limited to reasonable amounts that uninsured individuals would normally pay for the service, care, treatment and supply in question, taking into account standards that the Insurer deems applicable to the dentist's province of practice.
- Sextant or quadrant: Division of the dentition in six or four parts respectively.
- Unit: A period of 15 minutes or any portion thereof.

**Purpose of the Coverage**

The Insurer reimburses expenses incurred by the insured for services, care, treatment and supplies that are recommended by a dentist dentist and justified by current dental practice. In this respect, the only expenses eligible for reimbursement under this contract are expenses for services, care, treatment and supplies that are explicitly included in the modules described in the Schedule of Benefits

The description of eligible dental care expenses below is based on the fee guide in force at the time of the most recent update of the Insurer's contractual documents. However, for administration purposes, when applying the description of these fees, the Insurer takes into account changes to dental practice and updates to the guide.

**Reimbursement Terms and Conditions**

Eligible expenses for services, care, treatment and supplies are reimbursed according to the terms and conditions indicated in the Schedule of Benefits. For the first contract year and in the case of a group not covered by this insurance benefit under the previous contract, any maximum mentioned in the schedule is proportional to the number of months between the effective date of the contract and the end of the calendar year.

These expenses are eligible up to a maximum of the suggested fees for general practitioners for the reference year specified in the Schedule of Benefits.

When deductible carryover is included in the Schedule of Benefits, any amounts paid for the deductible during the last three months of a calendar year are subtracted from the deductible applicable in the following year.

When more than one type of service, care, treatment or supply exists for the Insured's dental condition, the Insurer reserves the right to limit reimbursement of eligible expenses to the least expensive cost.

**Treatment plan**

In the event of major restorative services or orthodontic care, when such coverage is included in the Schedule of Benefits, it is recommended that the insured submit a detailed treatment plan to the Insurer before beginning treatment. After reviewing the treatment plan, the Insurer informs the insured of the reimbursement amount available in accordance with the provisions of this contract.

**Dental Care Expenses**

Eligibility conditions for dental care expenses:

The Insurer reimburses dental care expenses if all of the following conditions are met:

- The dental care must be recommended by a dentist and in compliance with current dental practice.
- The dental care must be provided by a dental care professional who is legally authorized to practice.
- The dental care must be provided while the insured is covered under this insurance benefit, even if the treatment plan was approved by the Insurer before the termination date of coverage.

The Insurer reimburses expenses incurred by the insured for services, care, treatment, and supplies that are recommended by a dentist and justified by current dental practice. In this respect, the only expenses eligible for reimbursement under this contract are expenses for services, care, treatment, and supplies that are explicitly included in the modules described in the Schedule of Benefits.

The description of eligible dental care expenses below is based on the fee guide in force at the time of the most recent update of the Insurer's contractual documents. However, for administration purposes, when applying the description of these fees, the Insurer takes into account changes to dental practices and updates to the guide.

## Basic

**Routine Care:**

**Clinical oral examinations:**

- Complete oral examination: One examination per period of 36 consecutive months.
- Recall examination and Periodontal recall examination: One examination per period indicated in the Schedule of Benefits.
- Oral examination for children, not payable under the public health insurance plan of the province of residence: One examination per period of 12 consecutive months.
- Emergency examination or specific examination: One of these examinations per period of 6 consecutive months. insured
- Complete periodontal examination, examination of stomatognathic system dysfunctions or prosthodontic examination: One of these examinations per period of 36 months.
- Periodontal recall examination.

**Radiographs:**

- Radiographs, intraoral;
- Periapical

Exclusions and limitations: Reimbursement of expenses for bitewing radiographs is limited to what is indicated in the Schedule of Benefits. In addition, reimbursement of expenses for a complete series or panoramic radiograph is limited to once per period of 36 consecutive months.

Expenses for cephalometric radiographs and hand and wrist radiographs are eligible under Orthodontic care, when this care is included in the Schedule of Benefits.

**Lab examinations and tests:**

- Pulpal test
- Test, dental caries susceptibility
- Cytological test
- Photographs, diagnostic. Reimbursement is limited to three photographs per period indicated in the Schedule of Benefits
- Biopsy of soft or hard tissue (by incision, excision or puncture)
- Test, bacteriologic
- Consultation

**Preventive Services:**

- Polishing of coronal portion of teeth: One treatment per period indicated in the Schedule of Benefits
- Topical application of fluoride. One application per period indicated in the Schedule of Benefits
- Finishing restorations and removal of surplus subgingival filling material
- Pit and fissure sealants for dependent child under age 16
- Interproximal disking and enameloplasty
- Scaling: units of time per period indicated in the Schedule of Benefits
- Space maintainers for dependent child under age 19
- Control of oral habits for dependent child under age 19

**Restorative Services:**

**Restorations:**

- Sedative filling
- Recontouring and polishing of traumatized tooth
- Bonding and cementation of broken tooth chip
- Amalgam restorations
- Composite or resin restorations
- Veneer application - chairside
- Diastema closure
- Retentive pins
- Full preformed restorations

Limitation: Expenses for replacing a restoration are eligible only if a minimum period of 12 months has elapsed since the previous restoration was performed.

**Endodontics:**

- Endodontic emergency
- General endodontic treatments
- Root canal therapy
  Limitation: Root canal therapy is limited to one standard treatment per tooth every 5 years. Such frequency will be determined by the date of the final root canal treatment as the date the expense was incurred.
- Endodontic surgery.
- Bleaching of a non-vital tooth
  Limitation: Reimbursement of expenses for bleaching of a non-vital tooth is limited to two sessions per calendar year.

**Other endodontic services:**

- Supplement for endodontic treatment through a crown
- Unsuccessful attempt to complete root canal treatment

**Periodontics:**

- Treatment of acute infection or inflammation
- Desensitization
  Limitation: Reimbursement of desensitization expenses is limited to three units per calendar year or two sessions per calendar year, according to the insured's province of residence.

**Minor occlusal equilibration:**
Limitation: Reimbursement of minor occlusal equilibration expenses is limited to six units of time per calendar year or six sessions per calendar year, according to the insured's province of residence.

**Major occlusal equilibration**
Limitation: Reimbursement of major occlusal equilibration expenses is limited to three units of time per calendar year or one sessions per calendar year, according to the insured's province of residence.

**Periodontal services, surgical**
Limitation: Reimbursement of root planning expenses is limited to the number of units specified for this plan in the Schedule of Benefits.

**Periodontal procedures, adjunctive:**

- Splint
- Intraoral appliance to control parafunction
  Limitation: Reimbursement of expenses for the purchase of an intraoral appliance is limited to one appliance per period of 60 consecutive months. Reimbursement of expenses for repairs and relines is limited to one time per calendar year.
- Irrigation
- Application of antimicrobial agents

**Oral surgery**

- Removal of erupted teeth and suturing
- Surgical removals, with the exception of the surgical exposure of tooth, including orthodontic attachment
- Removal and curettage of tumor, cyst, or intraosseous granuloma
- Surgical incision and drainage
- Soft tissue laceration or through and through laceration, repair
- Hemorrhage, control
- Remodeling and recontouring of oral tissues

Exclusion: Expenses for the preservation of the ridge after extraction or alveolar ridge reconstruction are not eligible for reimbursement.

**General services**

- Local anesthesia for diagnostic purposes
- Conscious sedation
- Special office visit after regular office hours

Exclusions and limitations: Expenses for the services listed above are eligible for reimbursement only if performed more than six months after insertion of the denture and at least 36 consecutive months after the last reline or rebase, whichever applies. However, expenses for these services are not eligible if performed on a transitional denture.

## Major

- **Diagnostic Casts**
- **Removable Prosthodontics:**
  - Complete denture
  - Partial denture
  - Remake, partial dentures

    Exclusion: Expenses for maxillofacial prosthesis are not eligible for reimbursement.

- **Fixed Prosthodontics:**
  - Veneer - laboratory processed
  - Gold foil
  - Metal, porcelain, resin or ceramic inlays and onlays
  - Retentive pins for inlays and onlays
  - Individual crown and complementary services
  - Reconstruction, tooth in preparation for crown
  - Removal, recementation and repairs of crown, inlay, onlay or veneer
  - Radicular post
  - Fixed bridges and complementary services:
    - Pontics
    - Abutments
    - Removal
    - Sectioning
    - Solder indexing
    - Recementation
    - Repairs
  - Supplement for restoration of a tooth or inlays or onlays under an appliance or supporting an existing removable partial denture
  - Full preformed crowns

- **Other prosthetic services:**
  - Telescoping crown unit
  - Semi-precision or precision attachment

**Dentures, complementary services**
- Minor adjustments
- Remount and equilibration
- Repairs
- Structure additions to the partial denture
- Reline and rebase
- Therapeutic tissue conditioning
- Resetting of teeth

**Exclusions and Limitations**

Expenses for the purchase of a fixed or removable prosthesis are eligible only if the extraction justifying the purchase was performed while the insured was covered under this insurance benefit.

Expenses for the replacement of a fixed or removable prosthesis are eligible only if the insured can demonstrate to the Insurer's satisfaction that:

- The replacement is required following the extraction of teeth performed after the initial insertion of the fixed or removable prosthesis; or
- The fixed or removable prosthesis cannot be repaired. In addition, if the prosthesis was inserted while this insurance benefit was in force, expenses for replacement are eligible only if a minimum period of five years elapsed before this replacement.

Reimbursement of expenses for the replacement of a fixed or removable prosthesis is limited to the cost of a prosthesis equivalent to the one possessed by the insured before reimbursement of the first replacement.

Reimbursement of expenses for an equilibrated prosthesis or implant-supported prosthesis is limited to the cost of an equivalent standard prosthesis.

# Insurance Terms and Conditions

## ELIGIBILITY FOR COVERAGE

**Employee**

For you to become eligible as a Covered Person under the Plan, you must have coverage under a Provincial Health Plan. You are eligible for coverage:

a) on the effective date of the Plan if you satisfy the Waiting Period, and work for the Required Number of Hours, outlined in the Eligibility Requirements specified in the Schedule of Benefits (the " **Eligibility Requirements** "); or
b) after the effective date of the Plan on the date you meet the Eligibility Requirements specified in the Schedule of Benefits.

**Dependent Spouse**

For your Spouse to become a Covered Person under the Plan, they must have coverage under a Provincial Health Plan. A Dependent Spouse is defined as:

a) your legal spouse;
b) the person you have been continuously living with in a role like that of a marriage partner for less than 12 months, if the person is the parent of your child by birth or adoption; or
c) your common-law partner living with you in a conjugal relationship for at least 12 continuous months.

Only one Spouse is eligible for coverage or benefits under this Plan. The Spouse that is covered under the Plan will be as the person you indicate on the applications for coverage under the Plan. Where this information is not contained on your application, the person who qualifies last under the Plan's definition of Spouse will be the eligible Spouse. If your Spouse changes, you must update your information in connection with the Plan.

**Dependent Child**

For your Dependent Child to become a Covered Person under the Plan, they must have coverage under a Provincial Health Plan. Your Dependent Child may include your natural or adopted child, stepchild, or a child under your legal guardianship, who is:

a) unmarried;
b) not employed on a full-time basis;
c) not eligible for coverage as an Employee under this or any other group plan; and
d) less than 21 years of age, or, if a full-time student at an accredited school, college, or university less than 25 years of age; or

A newborn child will become covered as an eligible Dependent under this Plan from the moment of live birth.

A child covered under this Plan who is incapacitated due to a mental or physical disability on the date they reach the age when they would otherwise cease to be an eligible Dependent will continue to be an eligible Dependent under this Plan.

A child is considered incapacitated if they are incapable of engaging in any substantially gainful activity and are de-pendent on the Plan Member for support, maintenance, and care due to a mental or physical disability.

The insurer may require written proof of the Dependent's condition as often as may reasonably be necessary.

## Application for Coverage

When you first apply for coverage:

You must complete all applicable sections of the online Enrollment Form, applying for coverage on all your eligible Dependents, and submit it to Simply Benefits. To be a Covered Person under the Plan, your application should be signed and submitted to Simply Benefits no later than 31 days after the completion of your Waiting Period.

Enrollment Forms signed or submitted after these 31 days will be considered Late Applications and will require you or your Dependents to submit Medical Evidence. Your acceptance into the Plan is based on the health information provided, is subject to the terms and conditions contained in the group contract between your Employer and the insurer, and is not guaranteed.

When you have a change in family status:

- If your family status changes from single to duo or to family, your coverage can be changed to add your new Dependent(s) to this Plan. If you complete the applicable sections in the Group Change Form and submit it to Simply Benefits within 31 days of the effective date of your change in family status, your Dependent(s) will be added without any Medical Evidence. If you notify Simply Benefits more than 31 days after the effective date of your change in family status, Simply Benefits will require your Dependent(s) to submit Medical Evidence.

- If you do not wish to change your level of coverage because you already have family coverage, but need to add a new Dependent, complete applicable section of the Group Change Form to register your new De-pendent. Without this notification, claims for your new Dependent will be unnecessarily delayed.

- If you wish to change your level of coverage from family or duo to single due to divorce or the death of a Dependent, complete the applicable sections of the Group Change Form and submit it to Simply Benefits. If it is received within 31 days of the effective date of the change, Simply Benefits will credit premiums back to the effective date of the change. If you notify Simply Benefits more than 31 days after the effective date of the change, Simply Benefits will make the change effective the day notification is received, and no premium credit will be given. If your family is covered by your Spouse's plan for Health or Dental Benefits and your family loses this coverage, your family maybe eligible for immediate enrollment under this Plan. To ensure immediate enrollment, you must notify Simply Benefits of the loss in coverage within 31 days. Otherwise, Simply Benefits will require your Dependents to submit Medical Evidence.

Beneficiaries you designated under a prior plan have not been transferred to this Plan.

Beneficiary designations in respect of Quebec Residents only:

a) Your designation, in a form of writing other than a will, of your married or civil union spouse as Beneficiary cannot be changed, unless otherwise stipulated. The designation of any other person as beneficiary can be changed unless otherwise stipulated in a separate form of writing other than a will;
b) Designations and revocations are valid only from the day the insurer is advised of such changes in writing. Where several irrevocable designations of Beneficiaries are made separately and at different times, they are given priority according to their dates of receipt by the insurer. The insurer is discharged by payment in good faith in accordance with these rules to the last known person entitled to it;
c) Separation from bed and board does not affect the rights of your spouse; and
d) Divorce or nullity of marriage or the dissolution or nullity of a civil union causes any designation of your spouse to lapse.

**Coverage Effective Date**

You must first complete a period of continuous active employment with your Employer before your coverage becomes effective. This period of time is known as your Waiting Period and it must be satisfied before you can be considered eligible for coverage. Refer to the Schedule of Benefits for information on your Waiting Period.

When you complete your online Enrollment Form:

a) during the Waiting Period, your coverage will become effective when the Waiting Period has been satisfied;
b) more than 31 days after you or your Dependents first become eligible for coverage, you will be required to submit Medical Evidence. The insurer will review this information and determine if you or your Dependents are eligible for coverage. If your enrollment is approved, your coverage is effective on the day the insurer gives its approval.

If you are away from work because of Illness or Injury on the day that your coverage should be effective, or the day when an increase in your coverage should take effect, your coverage effective date or increased coverage effective date will be delayed until you return to work for 1 full day.

**Coverage Termination**

Your coverage will end on the earliest of:

a) the date you no longer have Provincial Health Plan coverage;
b) the date you are no longer eligible for coverage under an eligible Class;
c) the date you enter active service with the armed forces of any country;
d) the date the Plan terminates, or the date coverage terminates for an eligible Class to which you belong;
e) the date you reach the Coverage Termination Age, as specified under each coverage in the Plan Summary; or
f) the date you die.

Prescription Drug expenses incurred in the 31 days prior to the termination date of the Plan will be limited to an amount equal to a 30-day supply of such a drug.

**Termination of Dependent Coverage**

Coverage for your Dependent(s) will end on the earliest of:

a) the date your coverage terminates;
b) the date your Dependent is no longer eligible for coverage under the provisions of the Plan; or
c) the date written notification is received from you to cease Dependent coverage because your Dependents which are a Covered Person are covered under another group plan for benefits similar to those under the Plan.

**Survivor Extension**

If you die while covered for Health or Dental Benefits, coverage will be continued for your surviving Covered De-pendents for 24 months without premium.

This coverage will terminate on the earliest of:

a) the date the Covered Dependent no longer qualifies for coverage;
b) the date the Covered Dependent obtains similar coverage elsewhere; or
c) the date the Plan terminates.

# MAKING A CLAIM

**Forms and Submission**

You can submit a claim for Prescription Drugs, Paramedical Practitioners, Vision, and Dental using Simply Benefits Member portal.

If you have a Pay Direct Drug card plan, prescription drug claims can be submitted by your Pharmacist after presenting your Simply Benefits identification card and prescription from your Physician.

**Proof of Claim**

The insurer will require proof of your claim. Obtaining proof will be at your expense. The proof required will depend on the circumstances and context of your claim, including type of claim. Some examples of proof are:

a) receipts or bills;
b) medical or dental reports;
c) x-rays; and
d) prescriptions

If you have a Pay Direct Drug card plan, prescription drug claims can be submitted by your Pharmacist after presenting your Simply Benefits identification card and prescription from your Physician.

**Date Expenses Incurred for Services**

While the coverage for the benefit is in force, the expense for a service is incurred on the date the service is performed.

If a procedure involves multiple appointments, the expense is incurred on the date the procedure is completed. If the coverage for the benefit terminates and the procedure is not complete, only the expense relating to the procedures performed while the coverage was in force will be eligible.

**Date Expenses Incurred for Services**

While the coverage for the benefit is in force, the expense for a supply is incurred on the date the supply is received.

If the supply must be ordered, the expense will be considered incurred on the date payment was made for the supply.

**If You Are Covered Under Two Benefit Plans**

The insurance industry has set guidelines for coordinating your Health and Dental Benefits with another insurance program, such as your Spouse's plan. Coordination of benefits allows you to potentially claim under both plans for up to a combined maximum of 100% of the eligible expense. For instance, if your plan covers 80% of the cost of an eligible expense, the 20% not covered may be claimed under your Spouse's plan, depending on their plan. Check to ensure that your Spouse's plan provides Health and Dental coverage, that your family is covered under your Spouse's plan, and that the plan allows for coordination of benefits.

If Dependents are covered under two plans, claims for Dependent children are submitted first to the plan that covers the Spouse whose birthday falls earliest in the calendar year. Any part of the claim not covered under the first plan can-then be submitted to the other Spouse's plan. For example, if your birthday falls in January and your Spouse's birthday falls in March, you should submit your children's claims to your plan first. Proof of your plan's reimbursement along with copies of any expense receipts would then be sent to your Spouse's plan for reimbursement of the balance if the expense is covered under their plan.

**Recovery of Claim Amounts from a Third Party**

Where coverage exists for Plan Member Health, or Dental Benefits under the Plan and under a third-party plan, the insurer may pay you benefits eligible under the Plan while the entitlement for third-party benefits is being concluded by the third party, if you enter into a reimbursement agreement with the insurer thereby agreeing to:

a) take all steps necessary to receive from the third-party plan benefits for which you are entitled; and
b) repay the insurer the amount received from the third-party plan for these same benefits.

The insurer reserves the right to pursue recovery directly from third parties on your behalf.

**Claim Exclusions**

No benefit will be paid under the Plan for claims arising directly or indirectly from, as a result of, or in connection with:

a) charges for a missed, late, or cancelled appointment;
b) charges for the completion of forms;
c) expenses considered to be facility fees, service fees, block fees, or tray fees;
d) treatment or care for cosmetic purposes, except when directly attributable to an Illness or Injury;
e) experimental treatment or care;
f) expenses incurred for ordinary living expenses such as room, board, travel, or clothing;
g) services performed by a person ordinarily resident in the home of the Covered Person or related to the Covered Person by birth or marriage;
h) the committing of or an attempt to commit an offence under the Criminal Code(Canada), RSC 1985, C-46, as amended, or under the criminal laws of any other jurisdiction (where the events giving rise to the claim occurred in such other jurisdiction), whether or not the Covered Person is charged for or convicted of an offense;
i) use of any prohibited or controlled substance, including but not limited to any substances listed under the Controlled Drugs and Substances Act(Canada), SC 1996, c 19, as amended, restated, or replaced including all Schedules or any substance listed under comparable legislation in another jurisdiction if such use occurred in that jurisdiction, unless taken as prescribed by a licensed Physician;
j) an incident occurring during the use or operation by the Covered Person of a Vehicle, Off-road vehicle, vessel, or aircraft while the Covered Person was under the influence of any intoxicant, any prohibited or controlled substance, or cannabis;
k) war, insurrection, the hostile actions of any armed forces, or participation in a riot or civil commotion, whether the Covered Person is an active or passive participant; or
l) medical or surgical care which is not Medically Necessary, except when attributable to an Illness or Injury.

Refer to the benefit sections of this booklet for additional exclusions (together with the claim exclusions listed above, the "**Claim Exclusions**").

**Claim Submission Deadlines**

Claims received outside the time frames specified under this Claim Submission Deadlines section will be denied.

Claim forms and proof that benefits are payable must be submitted by you or on your behalf and received by the insurer as follows:

a) for a Health or Dental claim, within 365 days from the date that service or supplies were rendered.

If your coverage with the insurer terminates, you only have 90 days from the date of termination or the above 365-day rule, whichever day comes first, to submit your Health or Dental claim.

**Legal Action**

Subject to the terms and conditions of the group contract between your Employer and the insurer, every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the insurance legislation applicable to your province of residence.

## ACCESS TO PERSONAL INFORMATION

At Simply Benefits we create enrollment, 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 the insurer 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 our Head Office, or by contacting our 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 Simply Benefits with your request and we will communicate your request to the insurer.

You may request a copy of any record or written statement not otherwise part of the application that you provided to Simply Benefits as evidence of insurability.

## ACCESS TO PERSONAL INFORMATION

At Simply Benefits we create enrollment, 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 the insurer 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 our Head Office, or by contacting our 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 Simply Benefits with your request and we will communicate your request to the insurer.

You may request a copy of any record or written statement not otherwise part of the application that you provided to Simply Benefits as evidence of insurability.

# Providers

| Benefit | Provider |
|---|---|
| Out Of Country | **AIG** |
| Drugs | **Wawanesa** |
| Major Medical | **Wawanesa** |
| Paramedicals | **Wawanesa** |
| Vision | **Wawanesa** |
| Dental | **Wawanesa** |

# Respecting Your Privacy

At Simply Benefits, protecting your privacy is a priority.

When you request or obtain any product or service from Simply Benefits, we need certain personal information. Personal information may be needed about you, your spouse or dependents if applicable, depending on the product or service. We use this information to evaluate insurance risk, to determine eligibility, to administer your plan, or to adjudicate and manage claims. We only collect information that is pertinent and necessary to the effective conduct of our business.

Your consent is required. Your express consent may be provided in writing, verbally, or electronically. When you request, obtain, or use any of our products or services, the transfer of information necessary to meet your needs may also be by your implied consent. You may withdraw your consent, but doing so may prevent us from being able to provide you with your requested product or service.

Whenever practical, your information will be collected directly from you. We also collect information about you through our authorized representatives or third party service providers. Other sources of information may include other insurers or financial institutions, government and governmental agencies, your employer, or your plan administrator. We will in some cases ask an independent source to verify and supplement personal information.

Where health information about you is required, we may collect such information directly from you, or from sources such as your doctor, healthcare professional or hospital, but only with your consent.

We will limit the use and disclosure of your personal information by our organization, our subsidiaries and affiliated companies, and with your insurers. From time to time we may need to share some of your information with our authorized representatives or third party service providers. The use and disclosure of your personal information is done only where necessary to perform our duties and where required by our contractual obligations and/or the law.

We have developed and continue to enhance security measures and procedures designed to protect your personal information from unwarranted intrusion, theft, accidental release, loss, or unauthorized disclosure, use, copying, or modification. When we destroy your personal information, we will use appropriate safeguards.

You have the right to access your personal information. With satisfactory verification of your identity, Simply Benefits will provide you with the information you request. If your request is made through a third party, we will need satisfactory proof of your consent and authorization to release information to that party, and we will ensure their entitlement to such information. There are certain legal exceptions to your right of access. Should your request fall into such a category, we will inform you of the reason for not providing access and any recourse you may have. Generally, we will provide access to medical information only through the appropriate healthcare professional.

A copy of Simply Benefits' Privacy brochure is available at your request.

| | |
|---|---|
| **Phone Number** | 1-877-815-7751 |
| **Website** | simplybenefits.ca |
| **Address** | 601-460 Doyle Ave Kelowna BC, V1Y 0C2 |