PUBLIK™
RETIREE HEALTH PLANS

Product of

VIKING
Benefit Solutions
INC
EST.2006

EMPLOYEE BENEFITS BOOKLET

Publik Retiree Health Plan (SK)

Policy 58596

Class A1 – Deluxe with Dental

Powered by

SimplyBenefits

CONTACT

Plan Administration and Sales

Email	publik@vikingbenefit.ca
Phone	1-844-811-7672

Claims and App Support

Email	support@simplybenefits.ca
Phone	1-877-815-7751

Website	mypublik.ca
Address	PO Box 360, 310 8th Ave. Humboldt, SK S0K 2A0

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 Claim Reversal Predetermination Request for Outstanding Transaction Coordination of Benefits

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.

Language: "Employee" refers to you, the policy owner
"Employer" refers to Viking Benefit Solutions

TABLE OF CONTENTS

SCHEDULE OF BENEFITS

HEALTHCARE

Eligibility - 0 month(s) continuous employment, 0hrs/week
Benefit Period – Calendar year
Survivor Benefit – n/a
Termination Age – n/a

Annual deductible	
Prescription drugs	None
Extended healthcare	None

DRUG EXPENSES:	
Percentage of reimbursement	
Mandatory Generic drugs	90%, 100% if dispensed through PPN (PocketPills)
Maximum	$10,000 per calendar year
Prescription dispensing fees	n/a
Eligible prescription drugs and substitution	Prescription drug list: Standard list

HEALTHCARE EXPENSES:

The percentage of reimbursement and maximums for all Extended Healthcare Expenses are these described below, unless indicated otherwise.

Percentage of reimbursement	
– Healthcare professionals	100% overall
– All other extended healthcare expenses	100% overall
- Diabetic Sensors	100%
Type of maximum	
– Healthcare professionals	Eligible amounts
– All other extended healthcare expenses	Eligible amounts
Specialized Care Establishments	
Hospital	Semi-Private
Convalescent Hospital	$20 daily maximum, 90 days maximum
Diagnostic Services	$500
Vision	
Contact Lenses, Eye Glasses - Participant & Spouse	$300 combined per period of 24 consecutive months, per insured
Contact Lenses, Eye Glasses – Dependent Children	$300 combined per period of 12 consecutive months, per insured
Eye Examination – Participant & Spouse	$100 per exam per 24 consecutive months, per insured
Eye Examination – Dependent Children	$100 per exam per 12 consecutive months, per insured

HEALTHCARE PROFESSIONALS:	**$1,500.00 combined maximum for all practitioners per calendar year, per insured.**
Acupuncturist	No set maximum per practitioner, combined maximum for all practitioners outlined above.
Audiologist	No set maximum per practitioner, combined maximum for all practitioners outlined above.
Chiropodist	No set maximum per practitioner, combined maximum for all practitioners outlined above.
Chiropractor	No set maximum per practitioner, combined maximum for all practitioners outlined above.
Registered Dietician	No set maximum per practitioner, combined maximum for all practitioners outlined above.
Massage therapist	No set maximum per practitioner, combined maximum for all practitioners outlined above.
Naturopath	No set maximum per practitioner, combined maximum for all practitioners outlined above.
Occupational Therapist	No set maximum per practitioner, combined maximum for all practitioners outlined above.
Osteopath	No set maximum per practitioner, combined maximum for all practitioners outlined above.
Physiotherapist	No set maximum per practitioner, combined maximum for all practitioners outlined above.
Podiatrist	No set maximum per practitioner, combined maximum for all practitioners outlined above.
Psychologist	No set maximum per practitioner, combined maximum for all practitioners outlined above.
Speech Therapist	No set maximum per practitioner, combined maximum for all practitioners outlined above.
Social Worker	No set maximum per practitioner, combined maximum for all practitioners outlined above.

MEDICAL SUPPLIES AND SERVICES:

Blood glucose monitor	$200 per period of 36 consecutive months, per insured
Breast prosthesis	In excess of any amount payable under the public health insurance plan of the insured
Breathing assistance devices and oxygen	Reasonable and customary expenses
Compression stockings	2 pairs per calendar year, per insured
Foot orthoses	$250 per calendar year, per insured
Hair prosthesis (wig)	$500 lifetime, per insured
Hearing aid	$1,000 per period of 48 consecutive months, per insured
Hospital bed	Reasonable and customary expenses
Diabetic Sensors	Reasonable and customary expenses up to $4,000 combined per calendar year. Includes Freestyle and Dexcom Sensors only
Diabetic Supplies/Accessories	Reasonable and customary expenses.
Intrauterine device (IUD)	Reasonable and customary expenses
Orthopedic shoes	$250 per calendar year, per insured
Ostomy supplies	Reasonable and customary expenses
Post-surgical bra	2 per calendar year, per insured
Prosthetics	$25,000 lifetime maximum, per insured
Transcutaneous electrical nerve stimulator (TENS device)	Reasonable and customary expenses
Wheelchairs/Hospital Bed Rental	Reasonable and customary expenses

MISCELLANEOUS SERVICES:

Dental care following an accident	Reasonable and customary expenses up to $5,000
Nursing care	$15,000 per calendar year, per insured; up to am maximum of $25,000 lifetime per insured

OUT OF COUNTRY & PROVINCE

Maximum benefit	Standard – Benefit maximum $5 million CAD per insured, per trip (maximum $25,000 if not covered by provincial plan at time of claim)
Maximum number of days	90
Termination Age	80

EMPLOYEE FAMILY AND ASSISTANCE PROGRAM
(Provided by HumanaCare)

EFAP Benefit Description	HumanaCare is an integrated mental and physical wellness service provider, with a compassionate, holistic, employee family centric care model. HumanaCare provides access to clinically appropriate counselling to provide solutions to a short-term situation, this often means 4-8 counselling sessions but may require more or less. HumanaCare will ensure the individual is supported appropriately. For more details, please check Simply's employee portal under "resources."
How to access Humanacare EFAP	24/7 toll free number: 1-800-661-8193

SECOND OPINION
(Provided by HumanaCare)

Second Opinion Benefit Description	Through a simple phone call to HumanaCare, you will reach Medical Experts who will be able to review your medical information to give you answers to critical questions to empower you make the best decisions. Throughout the process you will be supported by a Nurse who can help make sense of the information and activate services and supports around you. For more details, please check Simply's employee portal under "resources".
How to access HumanaCare Second Opinion	24/7 toll free number: 1-800-661-8193

ELDERCARE
(Provided by HumanaCare)

EFAP Benefit Description	HumanaCare's Eldercare Advisory service provides tools to help caregivers address their particular challenges. Nurse-led. A personal consultation and map of care report is customized to each member's specific needs. Coaching, support, and planning are provided in key areas: • Current living situation and future planning • Existing health condition • Goals of care • Resource navigation Home care, including nursing and personal care, delivered by quality approved and monitored providers, is available on a 24/7 basis, across Canada. For more details, please check Simply's employee portal under "resources".
How to access HumanaCare EFAP	24/7 toll free number: 1-800-661-8193

VIRTUAL HEALTHCARE (MAPLE)
(Provided by MAPLE)

Virtual Healthcare Description

Maple (formerly Wello) Virtual Healthcare connects you to a clinician 24/7 for all your urgent and long term healthcare needs, via phone and video chat. Save time and stress when you need convenient access to:

- Medical diagnosis
- Prescriptions and requisitions
- Specialist referrals
- Mental health support
- Chronic illness management and prevention
- Health coaching and advice

Wello is brought to you by Simply Benefits and is available to your dependents as well.

For more details or to register, please check Simply's employee portal under "resources" or go to https://wello.ca/simplybenefits/

DENTAL

Eligibility:	0 month(s) continuous employment, 0hrs/week	
Deductible Amount:	Single $0 Family $0	
Coinsurance:	Basic Restorative Periodontics/Endodontics Major Restorative	100%, routine visits every 6 months 100% 50%
Benefit Period Maximum:	Basic Restorative Periodontics/Endodontics	$2,000 combined with Major per calendar year
	Major Restorative	$2,000 combined with Basic/Periodontics/Endodontics per calendar year
Dental Fee Guide:	Current	
Benefit Period:	Calendar year	
Dental Recall Frequency:	Every 6 months	
Dental Scaling:	8 units	
Termination:	n/a	

BENEFIT DETAILS

HEALTHCARE

PRESCRIPTION DRUGS AND MAJOR DRUG COMPONENT

Definitions

The following definitions apply specifically to prescription drug and extended healthcare insurance, in addition to the definitions provided in the General Definitions section.

a) **Brand name drugs**: Drugs for which there are generic equivalents.

b) **Generic drugs**: Drugs that are equivalent to *brand name drugs*.

c) **Insured's contribution not reimbursable by the public prescription drug insurance plan**: The *insured*'s contribution, in any form whatsoever, to paying prescription drug and pharmaceutical service costs required of individuals covered under a public plan.

d) **Prescription dispensing fees**: Professional fees charged by the pharmacy for preparing a prescription.

e) **Prior authorization drug list**: A list of prescription drugs for which the *insured* must obtain prior authorization before they are eligible under this *contract*. The Insurer establishes this list and may revise it at any time.

f) **Residential and long-term care centre**: A facility recognized as such by the government authorities in the *province* where it is located, or by the Insurer in the absence of such authorities. This facility must provide onsite *physician* and nursing services at all times. *Insured*s admitted to such facilities must no longer be able to live independently at home.

Rehabilitation centres are not considered to be residential and long-term care centres.

g) **Single source drugs**: Drugs for which there are no generic equivalents.

h) **User charge**: The portion of eligible expenses that the *insured* must pay for each prescribed drug or pharmaceutical service.

Purpose of the Coverage

The Insurer reimburses the reasonable and customary expenses for services, care, treatment and supplies that are medically required and necessary for treatment of the *insured*. In this respect, only expenses for services, care, treatment and supplies that are explicitly included in the *Schedule of Benefits* are eligible under this *contract*.

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*.

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 medical condition, the Insurer reserves the right to limit reimbursement of eligible expenses to the least expensive cost.

Prescription Drug Expenses

Eligibility conditions for prescription drug expenses

The Insurer reimburses prescription drug expenses if all of the following conditions are met:

a) The drug must bear a valid Drug Identification Number (DIN) issued by Health Canada and be available in the *insured*'s *province* of residence,
b) The drug must be obtained from a pharmacy only and be sold by a legally authorized healthcare professional,
c) The drug must be medically required and necessary for treatment of the *insured*,
d) The drug must be prescribed by a legally authorized healthcare professional in accordance with the manufacturer's directions for use or, if no such directions exist, in accordance with directions issued by government authorities,
e) The drug must be approved and recognized by the Insurer for its effectiveness and therapeutic value,
f) The drug must be obtained while the *insured* is covered under this benefit,
g) Drugs on the *prior authorization drug list* must meet the criteria determined by the Insurer. To this end, the required form must be completed by a healthcare professional at the *insured*'s expense. This form may be obtained from the Insurer.

Eligible prescription drugs

a) **Prescription drug list**

The list of prescription drugs and pharmaceutical services eligible for reimbursement under this *contract* is set out in the *Schedule of Benefits*. The prescription drugs and pharmaceutical services on the list are described below:

i) Provincial drug formulary: The Insurer reimburses prescription drugs and pharmaceutical services that are covered under the provisions of the public prescription drug insurance plan of the *insured*'s *province* of residence.

ii) Standard list: The Insurer reimburses prescription drugs and pharmaceutical services that may only be obtained on prescription from a healthcare professional.
In addition, *insured*s who are Quebec *residents* are also reimbursed for prescription drugs and pharmaceutical services covered under the provisions of the public prescription drug insurance plan.

iii) Extended list: The Insurer reimburses prescription drugs and pharmaceutical services that are prescribed by a healthcare professional.

Substitution

a) **Substitution of the least expensive drug for the prescribed drug**

When substitution is included in the *Schedule of Benefits*, only the expenses for purchasing the least expensive equivalent of the prescribed drug are eligible. However, if the healthcare professional has indicated on the prescription that there is to be no substitution, reimbursement is based on the cost of the prescribed drug.

b) **Mandatory substitution of the least expensive drug for the prescribed drug**

When mandatory substitution is included in the *Schedule of Benefits*, only expenses for purchasing the least expensive drug equivalent to the prescribed drug are eligible, even if the healthcare professional has indicated on the prescription that there is to be no substitution.

An *insured* wishing to obtain reimbursement of the cost of a prescribed drug must have the required form completed by a healthcare professional, at the *insured*'s own expense, and submit it to the Insurer for review. This form may be obtained from the Insurer.

Provisions applicable to insureds age 65 or older

If the public prescription drug insurance plan of the *insured*'s *province* of residence provides for the reimbursement of drugs covered by this plan for persons *age* 65 or older, this public plan is deemed to be the first payor for reimbursement of these drugs.

Certain public prescription drug insurance plans offer *insured*s *age* 65 or older the option of being reimbursed under this *contract* for prescription drugs normally covered by the public plan. A *participant* who wishes to take advantage of this option must submit a request to this effect to the Insurer within 31 days following the date the *participant* or the *spouse* turns 65. Furthermore, the *insured* must cancel registration with the public prescription drug insurance plan.

The coverage offered by the Insurer for prescription drugs covered by the public plan may be conditional on paying an extra premium, as set out in the *Schedule of Benefits*. If an extra premium is not required, prescription drugs covered by the public prescription drug insurance plan are automatically reimbursed by the Insurer, and the *participant* is not required to file a claim.

An individual's decision to remain covered by the public prescription drug insurance plan is irrevocable.

Exclusions and reductions – Prescription drug expenses

The exclusions and reductions applicable to the health insurance benefit also apply to prescription drug insurance. Subject to any law applicable in the *insured*'s *province* of residence, the following prescription drugs and products are not eligible, with the exception of those that are explicitly included in the *Schedule of Benefits*.

Where prohibited by law, these exclusions and reductions do not render this insurance benefit less generous than the public prescription drug insurance plan.

a) Aesthetic, cosmetic, and personal hygiene products,
b) Nutritional supplements, food products and substances,
c) Drugs, hormones, products, and injections used for treating obesity,
d) Infant formula,
e) Growth hormones, however, upon presentation of a complete medical report to the Insurer, fees for growth hormones may be eligible for reimbursement,
f) Vitamins and homeopathic products,
g) Items related to the use of injectable drugs, such as cotton swabs, rubbing alcohol, automatic injectors or other similar equipment,
h) Sunscreens,
i) Drugs administered primarily for preventive purposes; for the purposes of this exclusion, a drug used to stabilize or regulate a pathological condition diagnosed by a healthcare professional is not considered to be used for preventive purposes,
j) Drugs or substances used to treat any sexual dysfunction,
k) Contraceptive jellies, foams, and devices,
l) Drugs administered in a *hospital*, whether or not the *insured* has been admitted,
m) Drugs and products of an experimental nature, administered within the context of a research project or obtained under a federal program providing special access to medical products,
n) Drugs that a *hospital* or outpatient clinic are required to supply under any law, regulation, standard or guideline adopted or issued by government authorities of the *insured*'s *province* of residence.

Other limitations may apply to certain eligible expenses when an indication to this effect is included in the *Schedule of Benefits*.

In addition, pharmaceutical services are subject to the maximums set by the public prescription drug insurance plan of the *insured*'s *province* of residence.

Subject to any law applicable in the *insured*'s *province* of residence, the Insurer reserves the right to adopt measures which exclude, limit or terminate reimbursement of the expenses for a prescription drug or change the eligibility criteria. Furthermore, the Insurer reserves the right to exclude a drug when its cost could significantly affect the risk covered under this insurance benefit or to modify the rates applicable to it.

Extended Healthcare Expenses

Eligibility conditions for extended healthcare expenses

The Insurer reimburses extended healthcare expenses if all of the following conditions are met:

a) The health care must be medically required and necessary for treatment of the *insured*'s medical condition or alleviating an injury, *illness* or disability and, unless otherwise indicated, not administered for preventive purposes.
b) The health care must be provided in accordance with current medical practice and the manufacturer's directions for use, or failing this, according to the directions for use issued by government authorities.
c) The health care must be provided while the *insured* is covered under this insurance benefit, even if care is already underway.
d) The health care must be provided by a person who does not reside with the *insured* or who is not a *close relative* of the *insured*.
e) The health care must be provided by a healthcare professional who is a member in good standing of a professional association governing the professional's practice that is recognized by government authorities, or if such an association does not exist, a professional association recognized by the Insurer.

Furthermore, only the expenses for care and treatment within the professional's field of expertise are eligible.

The Insurer reserves the right to require at any time a medical prescription or medical file for services, care, treatment, and supplies received by the *insured*.

Specialized care establishments

The *insured* must be covered under this insurance benefit on the start date of occupancy, *hospitalization* or a stay in one of the establishments described below.

a) **Hospital**

Expenses for *hospitalization* incurred in Canada, with no limit as to the number of days.

Exclusion: Expenses for telephone, television rental and parking costs are not eligible for reimbursement.

Healthcare professionals

Expenses incurred for care and treatment are eligible only if the healthcare professional is explicitly included in the *Schedule of Benefits*. Expenses for X-rays and medical reports prepared by a healthcare professional may also be eligible when included in the *Schedule of Benefits*.

When indicated in the *Schedule of Benefits*, the care or treatment must be prescribed by a healthcare professional who is legally authorized to do so.

Finally, expenses are eligible for only one type of care or treatment per day, per *insured*, per speciality exercised by the healthcare professional and as long as the care or treatment in question falls within the speciality of the professional.

Vision care

a) **Contact lenses**
Expenses for the purchase of contact lenses on recommendation by an ophthalmologist or optometrist to improve visual acuity.

Exclusion: The expenses for contact lenses required following an *illness* or cataract surgery are not eligible for reimbursement under this coverage.

b) **Eye examination**
Fees for a vision or eye examination performed by an ophthalmologist or an optometrist.

c) **Eyeglasses**
Expenses for the purchase of eyeglasses on recommendation by an ophthalmologist or optometrist to improve visual acuity.

Diagnostic services

Diagnostic services must be performed in a specialized establishment or laboratory recognized by government authorities. The Insurer considers that expenses for tests and services performed for screening, diagnostic or treatment purposes are eligible.

Medical supplies and services

Expenses are eligible only if the medical supplies and services are explicitly named in the *Schedule of Benefits*.

Also, reimbursement of expenses for the purchase, repair, adjustment or rental of a medical supply is based on the option deemed most economical by the Insurer.

a) **Accessories for shoes**
The purchase of prefabricated accessories added to ordinary shoes for correcting a foot defect. The accessories must be obtained from a specialized laboratory or establishment duly licensed in the *insured*'s *province* of residence.

b) **Aids for the activities of daily living**
The purchase or rental of equipment to support, improve and maintain the autonomy of an *insured* with an organ dysfunction or a motor or intellectual disability.

c) **Artificial limb or eye**
The purchase of an artificial limb or eye made necessary following the loss of a limb or an eye.

d) **Blood glucose monitor**
The purchase of a device used to measure blood glucose levels, including the travel case.

e) **Breast prosthesis**
The purchase of an external breast prosthesis following a mastectomy.

f) **Breathing assistance devices and oxygen**
The purchase, repair or rental of a breathing assistance device.
Breathing assistance devices include, but are not limited to, bilevel positive airway pressure devices (BiPAP), sleep apnea devices and oxygen cylinders and concentrators.

Expenses for the purchase of oxygen are also eligible.

g) **Compression stockings**
The purchase of compression stockings with support of 20 mmHg or more.

h) **Foot orthoses**
The purchase or repair of foot orthoses that are custom-made for the *insured* and obtained from a specialized laboratory or establishment duly licensed in the *insured*'s *province* of residence.

Fulfilling the medical prescription, doing the biomechanical analysis, as well as adjusting foot orthoses, must all be performed by a member in good standing of the professional association governing the practice of these activities that is recognized by government authorities, when required in the *province* in which the foot orthoses were obtained.

i) **Hair prosthesis (wig)**
The purchase of hair prosthesis (wig) required as a result of a medical condition.

j) **Hearing aid**
The purchase, repair or adjustment of a hearing aid.

Expenses for accessories required for using a hearing aid are also eligible.

Exclusion: Expenses for the purchase and replacement of batteries are not eligible for reimbursement.

k) **Hospital bed**
The purchase, repair or rental of a hospital bed similar to the type normally used in a *hospital*.

l) **Diabetic Sensors**
Reasonable & Customary expenses for Flash Glucose Monitor (Freestyle) and Continuous Glucose Monitor (Dexcom) Sensors up to the maximum illustrated in Schedule of Benefits

m) **Diabetic Supplies and Accessories**
Reasonable & Customary expenses of diabetic supplies and accessories including: syringes, lancets and chemical reagent testing

n) **Intrauterine device (IUD)**
The purchase of an IUD.

Exclusion: Expenses for the purchase of an IUD that are eligible under the prescription drug insurance portion of this insurance benefit.

o) **Orthopedic shoes**
The purchase, repair or adjustment of orthopedic shoes. Orthopedic shoes must be custom-made for the *insured* from a mould and designed to correct a foot defect or be open, flared or straight shoes. They must be obtained from a specialized laboratory or establishment duly licensed in the *insured*'s *province* of residence.

Fulfilling the medical prescription, doing the biomechanical analysis, as well as adjusting orthopedic shoes, must all be performed by a member in good standing of the professional association governing the practice of these activities that is recognized by government authorities, when required in the *province* in which the shoes were obtained.

p) **Ostomy supplies**
The purchase of ostomy supplies.

q) **Post-surgical bra**
The purchase of a post-surgical bra required following a mastectomy that can only be obtained from a specialized laboratory.

r) **Transcutaneous electrical nerve stimulator (TENS device)**
The purchase or rental of a transcutaneous electrical nerve stimulator.

s) **Wheelchairs (non-motorized or motorized)/Hospital Bed Rental**
Reasonable and Customary charges to a maximum of $10,000 per insured person every 5 years.

Miscellaneous services

a) **Ambulance service**
Expenses for emergency transportation by ambulance, including by air or rail if other means of transport are not possible, to the nearest *hospital* offering the care required by the *insured*'s medical condition.

Emergency transportation expenses are eligible in the following situations:

i) Expenses for transportation to the nearest *hospital* where appropriate care is available,
ii) Expenses for transportation from one *hospital* to another,
iii) Expenses for transportation from the *hospital* to the *insured*'s home when required by the medical condition.

b) **Dental care following an accident**

Professional fees of a *dentist* for treatment made necessary by an *accident* causing a fractured jaw or damage to healthy, natural teeth.

A tooth is considered to be healthy in the absence of pathological impairment, whether in the tooth itself or in adjacent structures. Furthermore, the tooth must not require additional restoration to remain intact or in place.

Expenses are eligible if all of the following conditions are met:

i) The *accident* occurred while the *insured* was covered under this coverage or equivalent coverage in force immediately before the effective date of this insurance benefit,
ii) Medical care begins within 12 months following the date of the *accident*,
iii) Medical care terminates within 36 months following the date of the *accident*.

c) **Nursing care**

Professional fees of a registered nurse or nursing assistant for medical care provided in the *insured*'s home. The nurse or nursing assistant must be a member in good standing of a professional association recognized by competent authorities in the *insured*'s *province* of residence.

Expenses are eligible only for care requiring the professional skills of a registered nurse or nursing assistant.

Exclusions and Reductions of Coverage

Subject to any law applicable in the *insured*'s *province* of residence, benefits are not payable if the expenses result directly or indirectly, in whole or in part, from one of the following situations:

- In Canada, except in Quebec, any condition arising during or as a result of the *insured*'s involvement in a criminal act or an act deemed to be criminal, including the act of driving a motor vehicle while impaired by alcohol or drugs or having a blood alcohol level in excess of the prescribed legal limit.

  In Quebec, any condition arising during, stemming from or resulting from the *insured's* committing of or involvement in a criminal act liable for charges under the *Criminal Code of Canada* or the *Controlled Drugs and Substances Act,* or for any condition arising during, stemming from or resulting from the *insured's* committing of or involvement in an offence punishable on summary conviction with regard to sexual interference, invitation to sexual touching, possession of child pornography, luring a child, operation of a conveyance while ability is impaired by alcohol or drugs, failure or refusal to comply with any alcohol or drug testing or to provide breath or blood samples, assault, sexual assault, trafficking in substance, possession for purpose of trafficking, and production of a substance. This exclusion applies even if there is no conviction pronounced by a court having jurisdiction in the matter.
- The *insured*'s self-inflicted injury or self-mutilation, regardless of the reasons, causes or circumstances.
- A war or the *insured*'s involvement in a riot or a disturbance of the public order.
- The *insured*'s active service in the armed forces of any country.

Furthermore, benefits are not payable for the following:

- Any dental services, care, treatment, and supplies, except those that are explicitly included in this insurance benefit.
- Any adjustments to eyeglasses and contact lenses, or any sunglasses and safety glasses.
- Any services, care, treatment or supplies obtained as part of a weight loss program or obesity treatment.
- Any natural product.
- Any health assessment or medical examination.
- Any services, care, treatment and supplies the sole purpose of which is to facilitate the *insured*'s participation in sports or leisure activities, physical conditioning or training.
- Any services, care, treatment and supplies for aesthetic purposes, except those that are explicitly included in this insurance benefit.
- Any services, care, treatment and supplies of an experimental nature.
- Any expenses for kilometers driven and deliveries to or from a *hospital* or a healthcare professional's place of business.
- Any fees for missed appointments.
- Any fees for completing forms, obtaining medical documents or additional information required by the Insurer.
- Any fees for services, care, treatment and supplies provided free of charge or at no cost to the *insured*.
- Any services, care, treatment and supplies for which the *insured* was not required to pay or for which the *insured* would not have had to pay if not covered under this insurance benefit.
- Any services, care, treatment and supplies that are not explicitly included in this insurance benefit.
- Any expenses, or portion of expenses, in excess of reasonable and customary fees.
- Any expenses for which the *participant* has not provided proof documenting that they were incurred by the *insured*.
- Any services, care, treatment and supplies provided by a healthcare professional or service provider who:

  a) has been sanctioned for professional misconduct or unfair practices, or
  b) has been sanctioned by an official agency with respect to a law or a regulation, or
  c) does not meet industry standards for the profession, in the Insurer's opinion.

Conversion Privilege

The following provisions are applicable if the conversion privilege for health insurance is included in the *Schedule of Benefits*.

An *insured* who is no longer eligible for coverage under this insurance benefit may obtain, without evidence of insurability, an individual health insurance contract of the type issued by the Insurer at that time, provided a written request is sent to the Insurer within 60 days following the date eligibility terminates. Evidence of insurability is required for applications submitted after this deadline.

The individual health insurance contract of *insured*s who exercise their conversion privilege within the required time frame takes effect on the date their eligibility terminates under the health insurance benefit of this *contract*. If evidence of insurability is required, insurance becomes effective as of the date the Insurer approves such evidence.

OUT OF COUNTRY & PROVINCE

In case of an Emergency or if you need more information while travelling, please contact Orion Travel Insurance as follows:

- Toll Free Phone Number: 1-888-997-0152
- Collect Phone Number: 1-519-251-0152
- Email address: orionassistance@acmtravel.ca

Orion's team of specialists will ask you for the following information:

- Your name
- Your Group Policy Number with Orion (provided on the back of your drug card)

Orion Assistance is available 24 hours per day, 365 days per year.

Important: you must notify your employer about any personal situation changes or your provincial health plan. Your group benefits administrator will advise Orion of this change to ensure your coverage is adapted to your needs.

Orion Group Travel Benefits Plan coverage highlights

Emergency Medical Treatment

HOSPITAL ACCOMMODATION	$5 million
PHYSICIANS' FEES	$5 million
LABORATORY TESTS AND X-RAYS	$5 million
PRIVATE DUTY NURSING	$5 million
AMBULANCE SERVICE	$5 million
PRESCRIPTION DRUGS	$5 million
MINOR MEDICAL APPLIANCES	$5 million
PARAMEDICAL SERVICES	Up to $1,000 for all services/benefit year

In the event of an emergency call Orion Assistance immediately prior to receiving treatment. Depending on where you are travelling, there may be a unique toll-free number to assist you.

Please use the numbers to contact Orion from the country listed below. When contacting Orion Assistance, please provide your name, your group policy number, your employee ID, your Orion ID, your location and the nature of your emergency.

Country	**Toll-Free Number**
IN CANADA & MAINLAND U.S.	**1-888-997-0152**
AUSTRALIA	0011 800-8877-9000
BAHAMAS	1-800-389-0701
BERMUDA	1-800-204-8226
CAYMAN ISLANDS	1-800-204-8226
COSTA RICA	00 800-8877-9000
DOMINICAN REPUBLIC	1-800-203-9591
ITALY	00 800-8877-9000
JAMAICA	1-800-204-0004
MEXICO	001-800-248-8561
NEW ZEALAND	00800-8877-9000
SAINT LUCIA	1-800-300-3229
SOUTH AFRICA	00 800-8877-9000
THAILAND	001 800-8877-9000
UNITED KINGDOM	00 800-8877-9000
CALL COLLECT FROM ANYWHERE ELSE	**+1-519-251-0152**
EMAIL IF CALLING IS NOT POSSIBLE	**orionassistance@acmtravel.ca**

Eligibility For Insurance Coverage

To be eligible for coverage under the group policy you must as of your departure date on any trip be:

- be an eligible member of a PUBLIK Retiree Health Plan, including *spouses* and *dependents*;
- be a surviving dependent, in the case of death of an eligible *member*, who may choose to continue existing benefit coverage indefinitely, provided that they continue to meeting the remaining eligibility criteria;
- be an employee or council *member* who is still employed, including *spouses* and *dependents,* but has aged out from their employer's sponsored benefit program and will be losing their employer's group benefit plan coverage;
- be an ex-spouse or ex-common-law partner of the eligible *member*, who may choose to continue existing benefit coverage indefinitely, provided that they continue to meet the remaining eligibility criteria;
- be a surviving *dependent*, in the case of death of an eligible *member*, who may choose to continue existing benefit coverage indefinitely, provided that they continue to meeting the remaining eligibility criteria;
- be an eligible *member* of the *Policyholder*, including *spouses* and *dependents*, who are residing and/or working in Canada;
- covered under a Canadian provincial health insurance plan for the full duration of any trip,
- not have been diagnosed with a terminal illness for which a physician has estimated you have less than six months to live;
- not have been advised by a physician against travel;
- not require kidney dialysis; and

Group Policy Coverage

The effective date of coverage under this Group Policy is the date the Insured is entitled to receive benefits under this insurance.

The termination date of coverage under this Group Policy is the date the Insured is no longer entitled to receive benefits under this insurance.

The termination date of coverage is the earlier of:

- the date the Insured ceases to meet any of the eligibility for insurance coverage requirements as set out in this Certificate of Insurance; or
- the date member reaches termination age; or
- the date this Group Policy is terminated.

Trip Coverage

Your trip coverage starts: The actual date you leave your province of residence

Your tip coverage ends:

The earliest of:

- the actual date you return to your Canadian province of residence or territory; or
- the maximum number of days per trip within a benefit year has been reached as defined on the Schedule of Benefits

Except that if you are hospitalized while on a trip your trip coverage ends

- five days after any period of your hospitalization or, the day that is earlier than five days after you are released from hospital when you are deemed medically able to travel in the opinion of the Medical Director of Orion Assistance.

Insured Risks

This insurance provides payment for the reasonable and customary costs incurred by you for emergency medical treatment occurring outside your province of residence during a trip. Such expenses must be in excess of those reimbursable by your provincial health insurance plan and by any other insurance policy or health plan (group or individual) under which you are entitled to benefits.

Benefits

The following benefits are payable as part of a covered medical emergency to a maximum of $5 million per Family per trip provided such services are required to respond to a medical emergency, are unforeseen and medically necessary as per the terms and conditions of this policy:

- **Emergency Medical Treatment**
  - Hospital accommodation up to the semi-private room rate (or an intensive or coronary care unit where medically
  - necessary). If your trip coverage expires during your hospitalization, coverage is extended for a period of five days, or for the period of hospitalization plus five days after discharge from the hospital, or until you are deemed medically able to travel in the opinion of the Medical Director of Orion Assistance, whichever is earlier;
  - Physicians' fees;
  - Laboratory tests and X-rays prescribed by the attending physician and approved in advance by Orion Assistance. Note: This policy does not cover magnetic resonance imaging (MRI), cardiac catheterization, computerized axial tomography (CAT) scans, sonograms, ultrasounds or biopsies unless such services are approved in advance by Orion Assistance;
  - Private duty nursing (other than by an immediate family member) during hospitalization when ordered by the attending physician and approved in advance by Orion Assistance;
  - Local licensed ground ambulance service to the nearest hospital, physician or medical service provider in the event of a medical emergency (also covers local taxi fare in lieu of local ground ambulance service where an ambulance is medically necessary);
  - Drugs requiring a prescription by a physician, excluding those necessary for the continued stabilization of a chronic medical condition;
  - Casts, splints, trusses, braces, crutches, rental of wheelchair or other minor medical appliances when prescribed by a physician and approved in advance by Orion Assistance; and
  - Treatment by a chiropodist, chiropractor, osteopath, physiotherapist or podiatrist (other than an immediate family member), including X-rays, when approved in advance by Orion Assistance.
- **Emergency Dental Expenses**
  Reimbursement of:
  - emergency dental treatment (other than by an immediate family member) at trip destination to repair or replace sound natural teeth or permanently attached artificial teeth injured as the result of an accidental blow to the face, provided you consult a physician or dentist immediately following the injury;
  - necessary emergency dental treatment (other than by an immediate family member) described in a. above, that must be continued upon return to your province of residence, provided treatment is completed within 180 days from the date of the accident, to a maximum of $2,000; and specified on your schedule of benefits
  - other emergency dental treatment (other than by an immediate family member) at trip destination (excluding root canal treatment) to a maximum of $500.
- **Hospital Allowance**
  You are entitled to a hospital allowance of up to $50 per day to a maximum of $2,000 for your incidental expenses (for example, long distance calls, television rental) while hospitalized for at least 48 hours. This benefit will be **reimbursed** as a lump sum after your release from hospital and upon approval of your claim.
- **Return of Vehicle**
  When approved in advance by Orion Assistance:
  - reasonable expenses for the return of your private or rental vehicle in the event of your medical incapacitation, hospitalization, your death on a trip during or immediately following your hospitalization or your accidental death ; or
  - repatriation of the Insured(s) and one travel companion (if applicable) if private vehicle is stolen or inoperative due to an accident.

- **Family Transportation**
  When approved in advance by Orion Assistance, a return economy airfare for an immediate family member or close friend to attend your bedside (upon the recommendation of the attending physician) provided the hospitalization lasts at least three consecutive days. This benefit is provided immediately if you are mentally or physically handicapped, or under 26 years of age and dependent for support on the visiting immediate family member.

  The person attending your bedside will be covered under the same terms and conditions of your Out-of-Province/Out-of-Canada Travel Insurance. Reasonable out-of-pocket expenses incurred for commercial accommodation and meals, essential taxis and telephone calls by the attending immediate family member or close friend will be **reimbursed** to a maximum of $3,500, subject to a limit of $350 per day.

- **Meals and Accommodation**
  When approved in advance by Orion Assistance and in the event that:

  - Your scheduled return date is delayed due to sickness or injury of an accompanying family member or travel companion, or yourself; or
  - an accompanying family member or travel companion or you must be relocated for the purpose of obtaining treatment for a medical emergency,

  you and one travel companion (if applicable) are eligible for reimbursement for a meals and accommodation allowance of $350 per day after the scheduled return date or relocation date to a maximum of $3,500 for commercial accommodation and meals, essential taxis and telephone calls. If sickness or injury delays your return more than 10 days beyond the scheduled return date, this allowance will only be paid upon submission of proof that you or the accompanying family member or travel companion was admitted and confined to a hospital for at least 72 hours within the 10 day period.

- **Medical Transportation**
  When approved in advance by Orion Assistance:

  - up to the cost of a one-way economy airfare to your province of residence; or
  - the fare for additional airline seats to accommodate a stretcher to return you to your province of
  - residence; or
  - where medically necessary and approved in advance by Orion Assistance as a covered expense , air ambulance (paid in advance) to the nearest appropriate hospital or to a hospital in your province of residence, for the purpose of obtaining immediate medical treatment; and
  - repatriation to the point of departure in economy class of each Insured and one travel companion (if applicable) in the event of your medical repatriation.

- **Qualified Medical Attendant**
  Fees for a qualified medical attendant (other than an immediate family member) to accompany you, when recommended by the attending physician and approved in advance and arranged by Orion Assistance. This includes return economy airfare and overnight lodging and meals (where necessary).

- **Trip Interruption and Delay**
  If the trip is interrupted or delayed due to a sickness or injury of an Insured, a one-way economy transportation will be arranged to enable each Insured and one travel companion (if applicable) to rejoin the trip or return home.

  If the Insured chooses to rejoin the trip, further expenses incurred which are related directly or indirectly to the same sickness or injury, will not be paid.

- **Return of Excess Baggage**
  When approved in advance by Orion Assistance, up to $500 for the return of your excess baggage. This benefit is payable if you are returned to your departure point by us by any medical repatriation or in the event of your death on a trip following your hospitalization or accidental death.

- **Domestic Services**
  When you have been repatriated under the **Medical Transportation** Benefit and when approved in advance by Orion Assistance, **reimbursement** up to a maximum of $250 per trip in total for the Insured employee and all of his or her dependents on the trip for domestic services such as housekeeping to your principal residence.

- **Medical Follow up in Canada**
  When you have been repatriated under the **Medical Transportation** Benefit, after being hospitalized during your trip, **reimbursement** for the following is covered in your province of residence within 15 days of the repatriation:

  - up to $1,000 for semi-private room in a hospital or rehabilitation centre or convalescent home;
  - up to $50 per day for up to 10 days for home nursing care when medically necessary;
  - up to $150 for the rental of crutches, standard walker, canes, trusses, orthopaedic corset, oxygen; and
  - up to $250 for ambulance or taxi services to receive medical care.

- **Escort and Return of Children**
  When approved in advance by Orion Assistance in the event an Insured parent or legal guardian (on the trip) must be medically repatriated or hospitalized:

  - organization, escort and payment up to the cost of a one-way economy airfare for the return of Insured child(ren). This benefit is limited to child(ren) under the age of 19 unless the child(ren) is mentally or physically handicapped; or

  - **reimbursement** for services of a caregiver (other than an immediate family member) contracted by you for your Insured child(ren). This benefit is limited to child(ren) under the age of 19 unless the child(ren) is mentally or physically handicapped. Provision of an attendant will be arranged by Orion Assistance.

- **Child Care**
  When approved in advance by Orion Assistance, in the event their parent or legal guardian is attending the bedside of an Insured who is hospitalized at their trip destination, **reimbursement** of up to $1,000 for child care provided in your province of residence by someone other than an immediate family member. This benefit is limited to child(ren) under the age of 19 unless the child(ren) is mentally or physically handicapped.

- **Non-Medical Emergency Evacuation**
  Emergency mountain, sea or other remote location evacuation of you to the nearest accessible point by professional services up to $5,000.

- **Return of Remains**
  Subject to prior approval by Orion Assistance, in the event of your death on a trip following your hospitalization or accidental death, reimbursement of:

  - the actual cost incurred for:
    i. preparation of the deceased Insured; and
    ii. return of the deceased Insured in the common carrier's standard transportation container to the scheduled point of departure; or
    iii. up to $5,000 for burial or cremation at the place of death.

  In addition, and subject to prior approval of Orion Assistance, return transportation for an immediate family member or close friend to identify the deceased Insured. The person identifying the deceased Insured will be covered under the same terms and conditions of your Certificate of Travel Insurance, but for no longer than three days. Reasonable out-of-pocket expenses for commercial accommodation and meals, essential taxis and telephone calls by the attending immediate family member or close friend will be reimbursed to a maximum of $350 per day to a maximum of three days.

- **Pet Return, Pet Care and Commercial Kennel Costs:**
  When approved in advance by Orion Assistance, **reimbursement** up to a:

  - maximum of $500 for one-way transportation of your pet(s) and/or service animal(s) to your province of residence in the event you are hospitalized at your trip destination and cannot return on your scheduled return date or you are returned to your province of residence by any repatriation or death benefit provided by this Certificate;

  - maximum of $300 for emergency veterinary services in the event your pet(s) and/or service animal(s) suffers an accidental bodily injury while accompanying you on the trip; and

- maximum of $100 per policy for commercial kennel costs for your pet(s) and/or service animal(s) when you are not able to return on your scheduled return date.

- **Prescription Assistance**
  Assistance to co-ordinate replacement at your trip destination of lost or stolen essential prescription medication (excluding birth control pills or other non-vital prescription medication). Costs of replacement are your responsibility.

- **Vision Care**
  Reimbursement up to $300 for the replacement at your trip destination of prescription eyeglasses due to theft, loss or breakage during your trip and assistance to co-ordinate the replacement.

- **Hearing Aid**
  Reimbursement up to $200 for the replacement at your trip destination of a hearing aid due to theft, loss or breakage during your trip and assistance to co-ordinate the replacement. Does not include batteries or ear molds.

- **Terrorism Coverage**
  You are entitled to **reimbursement** of covered expenses when an act of terrorism directly or indirectly causes you a loss for which benefits would otherwise be payable in accordance with the terms and conditions of this Certificate.

- **Message Centre**
  Transmission of urgent messages to family and/or employer by multilingual Orion Assistance co-ordinators in the event that awkward time zones or telephone difficulties prevent you from contacting home. Leave urgent messages as a contact point for travel companions if you lose touch with one another.

- **Lost Document and Ticket Replacement:**
  Assistance in contacting local authorities to help an Insured replace lost or stolen passports, visas, tickets or other travel documents.

Conditions

These conditions apply to all insurance coverages under this Certificate:

- In the event of a medical emergency please call Orion Assistance immediately.
- Coverage may never extend beyond maximum number of days per trip within the Group Benefit Year
- If any benefit is duplicated under a similar benefit in this Certificate or any other of our group or individual policies, or under any other similar coverage with another insurer, the maximum you are entitled to is the largest amount specified under any one benefit or insurance coverage. The total amount paid to you from all sources cannot exceed the actual expenses you incur.
- Where not specified, airfares are one-way and economy class.
- If we pay your health care provider or reimburse you for covered expenses, we will seek reimbursement from your Canadian provincial health plan and from any other medical reimbursement plan under which you may have coverage. You may not claim or receive in total more than 100% of your total covered expenses.
- You or someone acting on your behalf must, unless it is otherwise not possible, first contact Orion Assistance in advance any surgery or invasive procedure (including, but not limited to, cardiac catheterization). You must inform your attending physician to call Orion Assistance, except in extreme circumstances where such action would delay surgery required to resolve a life-threatening medical crisis.
- During a medical emergency (whether prior to admission or during a covered hospitalization), we reserve the right to:
  - transfer you to one of our preferred health care providers; and/or
  - return you to your province of residence, for the medical treatment of your sickness or injury. If you choose to decline the transfer or return when declared medically able by the Medical Director of Orion Assistance, we shall have no liability for expenses incurred for such sickness or injury after the proposed date of transfer or return.
- We are not responsible for the availability, quality or results of any medical treatment or transportation, or the Insured's failure to obtain medical treatment or hospitalization.

- Once you are deemed medically able to return to your province of residence (with or without a medical escort) either in the opinion of the Medical Director of Orion Assistance or by virtue of discharge from hospital, your medical emergency is considered to have ended, whereupon any further consultation, treatment, recurrence or complication related to the medical emergency will no longer be eligible for coverage under this Certificate.

- Any benefits payable for acts of terrorism are excess to all other recovery sources including, but not limited to, alternative or replacement travel options offered by airlines, tour operators, cruise lines and other travel suppliers and other insurance coverage (even when such coverage is described as excess) and are payable only after you have exhausted all such other recovery sources.

Any benefits payable are subject to an overall aggregate maximum limit relating to all in-force Certificates and Policies issued by us, including this group policy. Coverage is available for up to two acts of terrorism within a calendar year and the maximum payable for each act of terrorism is $8 million.

If total claims resulting from one or more acts of terrorism exceed the applicable aggregate maximum limit stated above, then each Insured is entitled to his/her pro rata share of such aggregate maximum limit.

If, in our judgment, the total of all payable claims under one or more acts of terrorism may exceed the applicable aggregate maximum limit, your prorated claim will be paid after the end of the calendar year in which you qualify for benefits.

Exclusions

No coverage shall be provided under the group policy or under this Certificate and no payment shall be made for any claim resulting in whole or in part from, or contributed to by, or as a natural and probable consequence of any of the following:

- i. Under Age 70 - Any *sickness, injury* or *medical condition* that is not *stable* ninety (90) *days* prior to departure from *your* province of residence.

  ii. Ages 70 -80 - Any *sickness, injury* or *medical condition* that is not *stable* one hundred and eighty (180) *days* prior to departure from *your* province of residence.

- Any hospital/medical expenses exceeding a maximum of $25,000 if you are not covered by a Canadian provincial health plan at time of claim.

- Sickness, death or injury as a result of the abuse of medication, drugs, alcohol or any other toxic substance during the trip. Alcohol abuse includes having a blood alcohol level in excess of 80 milligrams of alcohol per 100 milliliters of blood.

- A sickness, injury or related condition during a trip undertaken for the purpose of obtaining treatment or surgery.

- A sickness, injury or related condition for which future investigation or treatment (except routine monitoring) is planned before your trip.

- i. Your routine prenatal care or childbirth at any time during your trip;
  ii.. Any costs for your child(ren) born during your trip;
  iii. Complications, conditions or symptoms of pregnancy during the nine weeks prior to or after the expected delivery date.

- Death or injury sustained:
  - during your professional participation in any sport; or
  - your participation in any motorized or mechanically assisted speed contests.

- Treatment, surgery, medication, services or supplies that are not medically necessary, or that you elect to have provided outside your province of residence when medical evidence indicates that you could return to your province of residence to receive such treatment. The delay to receive treatment in your province of residence has no bearing on the application of this exclusion.

- The replacement cost of an existing prescription, whether by reason of loss, renewal or inadequate supply, or the purchase of drugs and medications (including vitamins) which are commonly available without a prescription or which are not legally registered and approved in Canada. Orion Assistance will assist you with replacement of the Prescription Assistance Benefit.

- i. Cardiac catheterization, angioplasty and/or cardiovascular surgery including any associated diagnostic test(s) or charges unless approved in advance by Orion Assistance prior to being performed, except in extreme circumstances where such surgery is performed as a medical emergency immediately upon admission to hospital; and/or
  ii. Magnetic resonance imaging (MRIs), computerized axial tomography (CAT) scans, sonograms, ultrasounds or biopsies unless approved in advance by Orion Assistance.

- Services in connection with alternative medical treatments or general health examinations, regular care of a chronic condition, the continuing care and/or medical treatment of an acute sickness or injury after the initial medical emergency has ended (as determined by the Medical Director of Orion Assistance) or a medical consultation where the physician observes no change in a previously noted condition, symptom or problem.

- Medical care or surgery that is cosmetic in nature.

- Cataract surgery or services provided by a naturopath or an optometrist or in a convalescent home, nursing home, rehabilitation centre or health spa, except for the Medical Follow-Up In Canada

- Air ambulance services unless approved in advance and arranged by Orion Assistance.

- Upgrading charges or cancellation penalties for airline tickets, unless approved in advance by Orion Assistance.

- Damage to or loss of sunglasses (non-prescription), contact lenses, or prosthetic teeth or limbs, and resulting prescription thereof.

- Emergency medical benefits in your province of residence except for Domestic Services Benefit and the Medical Follow-up in Canada Benefit.
- An official travel advisory was issued by the Canadian government stating "Avoid non-essential travel or Avoid all travel" regarding the country, region or city of your destination, before your effective date.
    - This exclusion does not apply to claims for an emergency or a medical condition unrelated to the travel advisory.
    - This exclusion does not apply to emergency medical insurance claims when:
        i. the travel advisory stating "Avoid non-essential travel" is in effect and is due to COVID-19 (SARS-CoV-2); and
        ii. you have received at least one Health Canada approved COVID-19 vaccination at least 14 days prior to your departure date (except where you do not meet the minimum age requirements for a COVID-19 vaccination, as defined by Health Canada).

If conditions (i) and (ii) are satisfied and when the travel advisory stating "Avoid non-essential travel" is in effect and is due to COVID-19 (SARS-CoV-2), the maximum benefit payable for reasonable and customary costs incurred as a result of emergency medical treatment related to COVID-19 (SARS-CoV-2) and related complications is:

- $2.5 million CAD, per Insured, when you have received at least one Health Canada approved COVID-19 vaccination at least 14 days prior to departure; or
- $5 million CAD per Insured, when you have received all vaccine doses of Health Canada approved COVID-19 vaccinations at least 14 days prior to departure.

The maximum benefits payable for all policy coverages insured under the policy and policy endorsements remains at $5 million CAD per Insured.
You must adhere to COVID-19 vaccination protocols / schedules including receiving all vaccine doses as defined by the Ministry of Health of your province or territory of residence. To view the travel advisories, visit the Government of Canada Travel site.

- Noncompliance with prescribed medical treatment or therapy.

- Commission or attempted commission of a criminal, criminal-like, illegal or negligent act by you.

- Any act of war.

- Any loss resulting from a specific or related medical condition which you contracted in a country during your trip when, before your trip start date, a written formal or official warning was issued by Global Affairs Canada, advising Canadian residents not to travel to that country, region or city.

- Despite any provision to the contrary within this Certificate or any amendment thereto, this Certificate does not cover any liability, loss, cost or expense whatsoever which is directly or indirectly caused by, resulting from, arising out of or in connection with any acts of terrorism perpetrated by biological, chemical, nuclear or radioactive means, regardless of any other cause contributing concurrently or in any other sequence to the liability, loss, cost or expense.

- Payment for repatriation under the Trip Interruption and Delay Benefit, , when the original ticket may be used. Original tickets will become the property of Orion Travel Insurance Company (Ontario) in the event of a repatriation.

- Reimbursement of the cost of the original ticket when reimbursing the cost of a one-way economy air-fare back to the departure point. This exclusion is only applicable to the Trip Interruption and Delay Benefit.

Orion Assistance

Orion Assistance is available 24 hours per day, 365 days per year.

What to do if you need Orion Assistance

Have your group policy number with you at all times and contact Orion Assistance.

The telephone number(s) are listed on your Insurance Card

What Happens when you call Orion Assistance?

Prior to receiving all relevant medical information, we will handle your emergency assuming you are eligible for benefits under the group policy. If it is later determined that a term, limitation, condition and exclusion, general and/or specific, applies to your claim, you will be required to reimburse us for any payments we have made on your behalf.

Orion Assistance will work closely with you to:

- direct you to an appropriate physician, hospital, dentist, pharmacist or appropriate medical facility at your trip destination, wherever possible;
- provide multilingual interpreters to communicate with physicians and hospitals;
- monitor your care so that only appropriate, medically necessary treatment is given and to ensure that your medical needs are met;
- contact your family and physician on your behalf;
- pay hospitals, physicians and other medical providers directly, whenever possible;
- approve and arrange air ambulance transportation when medically necessary;
- inform you of any expenses that at the time, it is apparent, are not covered or explain the terms and provisions of this Certificate as they relate to your medical emergency.

Where a claim is payable we will arrange, wherever possible, to have any medical expenses billed directly to Orion Assistance.

Why are you required to call Orion Assistance ?

- If you call Orion Assistance you will receive information about medical treatment or services which are not considered medically necessary as defined in this Certificate. If the medical treatment or services are not medically necessary they are not covered.
- Orion Assistance must be contacted in advance for certain benefits. Check the particular benefits section to see which benefit(s) this applies to.
- If you pay eligible expenses directly to a health service provider without prior approval by Orion Assistance, these services will be reimbursed to you on the basis of the reasonable and customary costs that would have been paid directly to such provider by us. Medical charges that you pay may be higher than this amount, therefore you will be responsible for any difference between the amount you paid and the reasonable and customary costs reimbursed by us.

Limitation on Orion Assistance Services

Orion Assistance reserves the right to suspend, curtail or limit services in any area or country in the event that war, political instability, or hostility, renders the area inaccessible by Orion Assistance. Orion Assistance will use its best efforts to provide services during any such occurrence.

You may contact Orion Assistance prior to your departure to confirm coverage for your trip destination.

How To File A Claim

Payment to Medical Providers

Orion Assistance will pay hospitals, physicians and other medical providers directly, whenever possible. While most medical providers will agree to accept direct payment from us, there are some providers who will require that you pay them directly.

Where direct payment cannot be arranged, we will **reimburse** eligible expenses on the basis of reasonable and customary costs.

Please note that some benefits are only **reimbursable** on your return. Check the particular benefit section to see which benefit(s) this applies to.

Submitting your Claim

You must substantiate your claim by providing the documents described below and other supporting documentation as requested by us. (We are not responsible for charges levied in relation to any such documents.)

Active Care Management Inc.
PO Box 308 Station A
Windsor, Ontario N9A 6K7
Email: orionclaims@acmtravel.ca

Emergency Medical Claims

- A completed Medical Expenses Claim Form (provided by Orion Assistance upon notification of claim).
- For accidental dental expenses you must provide an accident report from the physician or dentist.
- Original itemized bills from the licensed medical provider(s) stating the patient's name, diagnosis, date and type of treatment, and the name, address and telephone number of the provider, as well as the original transaction documents proving that payment was made to the provider. (Copies of itemized bills are accepted only if the Insured has already dealt directly with your Canadian provincial health plan).
- Original prescription drug receipts from the pharmacist, physician or hospital indicating the name of the prescribing physician, prescription number, name of preparation, date, quantity and total cost.
- For out of pocket expenses, an explanation of expenses accompanied by the original receipts.
- Other supporting documentation as requested by us.

All Other Claims

For forms and instructions, contact Orion Assistance at the telephone number(s) located on your Insurance Card and Welcome Letter.

Definitions

ACM or **Active Care Management Inc.** means the company appointed by the Insurer to provide the assistance and claims services under this policy.

Act of Terrorism means any activity occurring within a 72 hour period, save and except an act of war against persons, organizations, property (whether tangible or intangible) or infrastructure of any nature by an individual or a group based in any country that involves the following or preparation for the following:

- use, or a threat to use, force or violence; or
- commission, or a threat to commit, a dangerous act; or
- commission, or a threat to commit, an act that interferes or disrupts an electronic, information or mechanical system; and the effect or intention of the above is to:
- intimidate, coerce or overthrow a government (whether de facto or de jure) or to influence, affect or protest against its conduct or policies; or
- intimidate, coerce or put fear in the civilian population or any segment thereof; or
- disrupt any segment of the economy; or
- further political, ideological, religious, social or economic objectives to express (or express opposition to) a philosophy or ideology.

Act(s) of war means hostile or warlike action, whether declared or not, in a time of peace or war, whether initiated by a local government, foreign government or foreign group, civil unrest, insurrection, rebellion or civil war.

Benefit Year means a 12-month period beginning on the effective date described on theWelcome Letter.

Caregiver means a person you have entrusted with the care of your dependent(s) on a permanent, full-time basis and whose services cannot reasonably be replaced.

Child(ren) means an employee's unmarried and dependent natural, adopted or step-child(ren) under 26 years of age (under age 19 for Escort of Insured Children benefit), who are not employed on a full-time basis OR who are full-time students at a post-secondary institution OR mentally or physically handicapped child(ren) of any age, all of whom reside with the employee and depend on the employee for support and who is/are not eligible for insurance as an employee under the group policy or any other group policy.

Common carrier means a conveyance (bus, taxi, train, boat, airplane or other vehicle) which is licensed, intended and used to transport paying passengers.

Day(s) means 24 consecutive hours beginning at 12:01 a.m.

Departure date means the date you left your Canadian province of residence for your trip.

Dependent means an employee's spouse or child(ren) who is/are insured under a Canadian provincial health plan, provided that the employee has dependent coverage under his/her Plan Sponsor's group policy.

Employee means a person who is hired on a permanent full-time or part-time basis, has satisfied any qualifying period for employer group benefit coverage.

Experimental or investigative means not approved or broadly accepted and recognized by the Canadian medical profession, as an effective, appropriate and essential treatment of a sickness or injury, in accordance with Canadian medical standards.

Family member means the employee and/or his/her dependent spouse and/or the employee's dependent natural child(ren), adopted child(ren) or step-child(ren).

Government Health Insurance Plan (GHIP) means a Canadian provincial or territorial *government health insurance plan*.

Group Policy means this document, the group policy, the Welcome Letter and any riders, amendments or documentations to the group insurance contract all of which form the entire group policy.

Hospital means a medical facility which is legally accredited to provide medical, diagnostic and surgical treatment to in-patients during the acute phase of their sickness or injury, which is primarily engaged in the aforesaid activities and which operates under the supervision of a staff of physicians and has a registered nurse continuously on duty. The hospital must not be licensed as a home for the aged, rest home, nursing home, convalescent hospital, health spa, rehabilitation centre or treatment facility for drug or alcohol abuse and/or addiction.

Hospitalization or **hospitalized** means you are admitted to a hospital and are receiving medical treatment on an in-patient basis while on a trip.

Immediate family member means spouse (legal or common-law), natural, adopted, foster or step-child(ren), brother, sister, step-brother, step-sister, parent, step-parent, grandparent, grandchild(ren), aunt, uncle, nephew, niece, son-in-law, daughter-in-law, parent-in-law, brother-in-law, sister-in-law, legal guardian, legal ward or key employee of the Insured.

Injury means accidental bodily harm which results in loss unrelated to sickness or any other cause and which occurs while this coverage is in effect. The injury must be sufficiently serious to prompt a reasonably prudent person to consult a physician for the purpose of medical treatment and for the physician to certify in writing the necessity of cancelling, interrupting or delaying the trip.

Insured means individually the employee and each of his/her eligible dependents and **Insureds** means the employee and his/her eligible dependents.

Insurer means Orion Travel Insurance Company.

Medical emergency means the unforeseen and emergent occurrence of symptoms for a sickness or injury which, unless treated immediately by a physician, may lead to death or to serious impairment of your health.

Medical treatment means any reasonable procedure which is medical, therapeutic or diagnostic in nature, which is medically necessary and which is prescribed by a physician. Medical treatment includes hospitalization, basic investigative testing, surgery, prescription medication (including prescribed as needed) or other treatment directly related to the sickness, injury or symptom.

Medically necessary in reference to a given service or supply, means such service or supply:

- is appropriate and consistent with the diagnosis according to accepted community standards of medical practice;
- is not experimental or investigative in nature;
- cannot be omitted without adversely affecting your condition or quality of medical care;
- cannot be delayed until your return to your province of residence; and
- is delivered in the most cost effective manner possible, at the most appropriate level of care and not primarily by reason of convenience.

Member means a person who is a PUBLIK *member* and meets the eligibility requirements of the policy. Any Person who is covered by this policy as a *member* may not be covered as a *dependent.* The surviving spouse, ex-spouse or *ex-common law partner* of a *member*, who meets eligibility requirements, shall be deemed to be a *member.*

Orion Assistance means the claims and assistance service provider, appointed by us from time to time to perform all assistance services and administer claims on our behalf under the group policy.

Pet(s) means domestic dog(s), service animal(s) and/or cat(s) only.

Physician means a medical practitioner licensed to prescribe and administer medical treatment or a surgeon licensed to perform surgery:

- who was thus licensed at the time of treatment and who remains so;
- whose legal and professional standing, within the jurisdiction where treatment was rendered, is equivalent to that of a doctor of medicine (M.D.) licensed to practice in any province or territory of Canada; and
- who is not an immediate family member.

Professional means a person who is engaged in a specific activity and receives remuneration.

Reasonable and customary costs means costs incurred for approved, eligible medical services or supplies that do not exceed the standard fee of other providers of similar standing in the same geographical area, for the same treatment of a similar sickness or injury.

Service Animal(s) means any dog(s) that is individually trained to do work or perform tasks for the benefit of an Insured with a disability, including a physical, sensory, psychiatric, intellectual or other mental disability. The work or tasks performed by a service animal must be directly related to the Insured's disability.

Sickness means a disease or disorder of the body which results in loss while this coverage is in effect. The sickness must be sufficiently serious to prompt a reasonably prudent person to consult a physician for the purpose of medical treatment and for the physician to certify in writing the necessity of cancelling, interrupting or delaying the trip.

Speed contest means an organized activity of a competitive nature in which speed is a determining factor in the outcome of the event.

Spouse means the person to whom you are legally married or with whom you have resided with and whom you present publicly as your spouse.

Stability means:

- There has not been any new treatment prescribed or recommended, or change(s) to existing treatment including a stoppage in treatment; and
- There has not been any change to any existing prescribed drug (including an increase, decrease, or stoppage to prescribed dosage), or any recommendation or starting of a new prescription drug; and
- The medical condition has not become worse; and
- There have not been any new, more frequent or more severe symptoms; and
- There has been no hospitalization or referral to a specialist; and
- There have not been any tests, investigation or treatment recommended, but not yet complete, nor any outstanding test results; and
- There is no planned or pending treatment. All of the above conditions must be met for a medical condition to be considered stable

Terminal illness means that you have a medical condition for which a physician has estimated that you have less than six months to live.

Travel companion means a person accompanying you on the trip, who shares accommodation or transportation with you and who has paid such accommodation or transportation in advance of your departure date. A maximum of six persons will be considered a travel companions (including the Insured).

Treated means that you have been hospitalized, have been prescribed (including prescribed as needed), have taken or are currently taking medication.

Trip means travel undertaken by the employee or his or her eligible dependents taken outside such person's Canadian province of residence. A trip must commence after the employee or his or her eligible dependents are eligible for coverage. A trip is deemed to end on the date the "Trip Coverage Ends" as further described on page 1 of this Certificate.

Vehicle means any private or rental automobile, motorcycle, mobile home or trailer.

We, **us** or **our** means Orion Travel Insurance Company.

You, **your** and **yourself** refers individually to the employee and to each of his/her eligible dependent(s).

General Terms Of Agreement

These general terms of agreement apply to all coverages described herein.

You agree that we and Orion Assistance have:

- your consent to verify your Canadian provincial health insurance plan card number and other information required to process your claim, with the relevant government and other authorities;
- your authorization to physicians, hospitals and other medical providers (where applicable) to provide to us and Orion Assistance any and all information they have regarding you while under observation or treatment, including your medical history, diagnoses and test results;
- your agreement to the collection, use and if necessary, disclosure of the information available under a. and b. above from and to other sources, as may be required for the consideration and if applicable, processing of your claim including but not limited to for co-ordination of benefits obtainable from other sources; and
- the right to collect from you any amount we have paid on your behalf to medical providers or any other parties in the event that you are found to be ineligible for coverage or that your claim is invalid or benefits are reduced in accordance with any provisions of this group policy.

Deductible
No deductible applies to the insurance coverages described herein.

Where Coverage is applicable

Coverage is applicable worldwide, except in countries at war or countries where political instability or hostility renders the area inaccessible by Orion Assistance services. You may contact Orion Assistance prior to your departure date to confirm coverage for your trip destination.

Payment of Benefits

All payments under the group policy are payable to you or on your behalf. Benefits for loss of life are made to your estate. You do not have the right to designate persons to whom or for whose benefit insurance money is to be payable.

Any benefits paid will be payable in Canadian funds. Where benefits are payable in foreign currency, the rate of exchange is based on the rate effective on the date when the benefit is paid. No sum payable shall bear interest. All benefit limits indicated are in Canadian currency.

Rights of Subrogation

We have the right to proceed at our own expense in your name against third parties who may be responsible for giving rise to a claim under the group policy or who may be responsible for providing indemnity or benefits similar to this insurance. We have full rights of subrogation. You will co-operate fully with us and not do anything to prejudice such rights. If you institute a demand or action for a covered loss, you shall immediately notify us so that we may safeguard our rights.

Co-ordination of Benefits

If, at the time of loss, you have insurance from another source, or if any other party is responsible for benefits also provided under the group policy, we will pay eligible expenses only in excess of those covered by that other insurer or other responsible party, including credit cards, private or provincial auto plans or any other insurance, whether collectable or not. If, however, that other insurance is also "excess only", we will co-ordinate payment of all eligible claims with that other insurer. All co-ordination follows guidelines set by the Canadian Life and Health Insurance Association.

In no case will we seek to recover against employment related plans if the lifetime maximum for all in-country and out-of-country benefits is **$100,000** or less. If your lifetime maximum is greater than **$100,000**, we will co-ordinate benefits only above this amount.

Misrepresentation and Non-disclosure

The Insured's entire coverage under this Certificate shall be voidable if we determine, whether before or after loss, that any Insured has concealed, misrepresented or failed to disclose any material fact or circumstance concerning his or her interest therein, or if the Insured shall refuse to disclose information or permit the use of such information, pertaining to any of the Insureds under this policy of insurance.

Arbitration

We and the Insured(s) hereto agree that any dispute, controversy or claim arising out of or relating to this policy, including any question regarding its existence, interpretation, validity, breach, termination or claim made pursuant to it, shall be submitted to an arbitrator in the Canadian province in which this policy was issued. The laws of the Canadian province in which the policy was issued shall apply in the determination of any such dispute, controversy or claim. The decision of the arbitrator shall be final and no party may appeal the decision to any court.

Applicable Law

This policy of insurance is governed by the law of the Canadian province of residence of the Insured.

Notice on Privacy and Confidentiality

To protect the confidentiality of the employee's and/or dependent's information, Orion Travel Insurance Company and Orion Assistance will establish a "financial services file" from which this information will be used to administer services and process claims. Access to this file will be restricted to those Orion Travel Insurance Company/Orion Assistance employees, mandataries, administrators or agents who are responsible for the assessment of risk (underwriting), marketing and administration of services and the investigation of claims, and to any other person you authorize or as authorized by law. These people, organizations, and service providers may be in jurisdictions outside Canada, and subject to the laws of those foreign jurisdictions.

Your file is secured in our offices or those of Orion Assistance. You may request to review the personal information it contains and make corrections by writing to: Privacy Officer, Orion Travel Insurance Company, 60 Commerce Valley Drive East, Thornhill, Ontario L3T 7P9.

Other Conditions

Waiver

We shall be deemed not to have waived any condition of the group policy or this Certificate, either in whole or in part, unless the waiver is clearly expressed in writing and signed by the Insurer.

Notice and Proof of Claim

The Insured, or a beneficiary entitled to make a claim, or the agent of any of them shall:

- within 90 days from the date a claim arises under the contract on account of an insured risk, furnish to Orion Assistance such proof as is reasonably possible in the circumstances of the happening of the accident or the commencement of the sickness or injury, and the loss occasioned thereby, the right of the claimant to receive payment, his or her age, and the age of the beneficiary; and
- if so required by Orion Assistance, furnish a satisfactory certificate as to the cause or nature of the accident, sickness, injury or insured risk for which the claim may be made under the contract and as to the duration and/or extent of loss.

Failure to Give Notice or Proof

Failure to give notice of claim or furnish proof of claim, within the time prescribed by this statutory condition, does not invalidate the claim if:

- the notice or proof is given or furnished as soon as reasonably possible and in no event later than one year from the date of the accident or the date the claim arises under the contract, on account of sickness or injury if it is shown that it was not reasonably possible to give notice or furnish proof within the time so prescribed; or
- in the case of the death of the person insured, if a declaration or presumption of death is necessary, the notice or proof is given or furnished no later than one year after the date a court makes the declaration.

Limitation of Arbitration Proceedings

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 (AB, BC and MB), the Limitations Act, 2002 (ON), or other applicable legislation under the contract is absolutely barred unless commenced within the time set out in the Limitations Act, 2002.

DENTAL

Definitions

The following definitions apply specifically to dental care insurance, in addition to the definitions providedin 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 provinceof 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 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 practise.
- 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 practice and updates to the guide.

BASIC DENTAL

Routine Care:

Clinical oral examinations

- Complete oral examination: One examination per period of 36 consecutive months
- 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 periodof six consecutive months
- Complete periodontal examination, examination of stomatognathic system dysfunctions or prosthodontic examination: One of these examinations per period of 36 consecutive months
- Periodontal recall examination

Radiographs

- Radiographs, intraoral
- Radiographs, extraoral, with the exception of scans and temporomandibular joint radiographs

Exclusions and limitations: Reimbursement of expenses for radiographs is limited to two sessions per period of 12 consecutive months. In addition, reimbursement of expenses for panoramic radiographs is limited to one radiograph 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.

Laboratory examinations and tests

- Pulpal test
- Test, bacteriologic
- Test, dental caries susceptibility
- Biopsy of soft or hard tissue (by incision, excision or puncture)
- Cytological test
- Photographs, diagnostic
- Consultation

Preventative Services

- Polishing of coronal portion of teeth: One treatment per period indicated in the Scheduleof Benefits
- Topical application of fluoride for dependent child under age 16: 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 restoration
- Composite or resin restoration
- Veneer application – chairside
- Diastema closure
- Retentive pins
- Supplement for restoration of a tooth or inlays or onlays under an appliance or supporting an existing removable partial denture
- Full preformed crowns
- 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 following the date of the final root canal treatment as the date the expense was incurred

- o Endodontic surgery
- o Bleaching of a non-vital tooth

Limitation: Reimbursement of expenses for bleaching 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 session per calendar year, according to the insured's province of residence.

Periodontal services, surgical

Limitation: Reimbursement of root planing expenses is limited to six units of time per calendar year or one treatment per tooth, per period of 24 consecutive months, according to the insured's province of residence.

Periodontal procedures, adjunctive:

- Splint
- Intraoral appliance to control parafunction

Limitations: 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, includingorthodontic attachment
- Remodeling and recontouring of oral tissues

Exclusion: Expenses for the preservation of the ridge after extraction are not eligible forreimbursement.

- Removal and curettage of tumor, cyst, or intraosseous granuloma
- Surgical incision and drainage
- Soft tissue laceration or through and through laceration, repair
- Hemorrhage, control

General services

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

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 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 servicesare not eligible if performed on a transitional denture.

MAJOR DENTAL

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

Other prosthetic services:

- Telescoping crown unit
- Semi-precision or precision attachment

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 initialinsertion 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.

GENERAL DEFINITIONS

For the purposes of this *contract*, some of the terminology used in the description of the insurance terms and conditions and benefits, as well as that of the general provisions, is defined in this section. Additional definitions are also found in the sections concerning the insurance benefits to which they specifically apply.

Accident: A sudden and unforeseeable event resulting exclusively from an external cause that, directly and independently of any other cause, results in bodily injury that is confirmed by a *physician*. Attempted suicide is not considered to be an accident, whether or not it results in bodily injury.

Actively at work: An *employee* is considered to be actively at work when physically and mentally able to carry out the essential duties of the *employee*'s own occupation.

An *employee* who is not *totally disabled* is also considered to be actively at work during:

a) Statutory holidays,
b) Vacation periods,
c) Days that are not part of the work schedule,
d) Temporary absences from work authorized by the *employer*.

Age: The age of the person in question on the last birthday when calculated or on the day that an event covered by this *contract* occurs.

Calendar year: The period beginning January 1 of a given year and terminating on December 31 of the same year.

Close relative: The *spouse*, child, father, mother, stepfather, stepmother, father-in-law, mother-in-law, brother, sister, brother-in-law, sister-in-law, stepdaughter, daughter-in-law, stepson, son-in-law, grandparents, and grandchildren of the *insured*.

Contract: This master contract, any endorsements, the specifications, the Insurer's quote, subsequent agreements, the *Insurance Proposal*, the *Schedule of Benefits*, any appendices attached to the contract, *participants*' enrolment applications and any required evidence of insurability constitute the entire contract between the Insurer and the Policyholder.

Contract year: The period between the *contract* effective date and the renewal date that immediately follows, as well as any 12-month period between two renewal dates, subject to an alternative agreement in that regard between the Insurer and the Policyholder.

Deductible: The portion of eligible expenses for which the *insured* is not entitled to any reimbursement from the Insurer.

Dentist: A person who is a member of a professional dental association recognized by competent authorities in the *province* where the person practices.

Dependent: The *participant*'s *spouse* or *dependent child*, as defined in this *contract*.

Dependent child: An unmarried child of the *participant* or the *participant*'s *spouse* over whom they exercise parental authority or would do so if the child were a minor, and for whom they provide full financial support. The child must also:

a) have reached the minimum *age* indicated in the *Schedule of Benefits* for each applicable insurance benefit,
b) be under the maximum *age* indicated in the *Schedule of Benefits* if not a full-time student, or
c) be under the maximum *age* indicated in the *Schedule of Benefits* if duly registered as a full-time student at a recognized educational institution. If so, the *participant* must provide the Insurer with evidence that the child is enrolled in such an institution at the beginning of each school year, or
d) have reached the *age* of majority and be *totally disabled* or have a functional impairment recognized by competent authorities in the *participant*'s *province* of residence. The disability or impairment must have begun at a time when the child met one of the above criteria and must have persisted since that date. In addition, the child must reside with the *participant*, or the *participant*'s *spouse*, who exercises parental authority over the child or is the legal guardian, if the child is a minor. The Insurer may request evidence of the disability or impairment at any time.

Parental authority for a person other than the *participant*'s or *spouse*'s child must be confirmed by a court judgment or established in accordance with any other legally recognized document to this effect in the *participant*'s *province* of residence.

Elimination period: A continuous period of *total disability* that must elapse before the *participant* is entitled to disability benefits. The length of the elimination period is indicated in the *Schedule of Benefits*.

Notwithstanding the above, any period during which the *participant* is *actively at work* is considered to be a continuation of the elimination period, provided this period does not exceed 10% of the elimination period. The length of the elimination period is then extended by the period during which the *participant* was *actively at work*.

Employee: A person hired by the *employer* who:

a) is actively at work, and
b) meets the definition of eligible employee set out in the *Schedule of Benefits.*

Employer: The Policyholder of this *contract* or any employer whose *employees*, or a class of whose *employees*, are represented by the Policyholder.

Hospital: A general or specialized institution recognized as such by the competent authorities in the *province* where it is located, whose main purpose is to provide short-term care and treatment to inpatients. The hospital must also provide *physician* and nursing services at all times.

Self-financed private hospitals, nursing homes, homes for the aged or the chronically ill, residential and long-term care centers, rehabilitation centers and addiction treatment centers are not considered to be hospitals.

Hospitalization: Occupancy of a room or a ward in a *hospital* as an inpatient confined to a bed who is admitted for the treatment of an *illness* or treatment of the consequences of an *accident* or to undergo surgery.
A period of occupancy during which the *insured* is receiving services that could be dispensed by a residential and long-term care or rehabilitation center, whether or not there is availability in such a center, is not considered hospitalization.
For the purposes of any disability insurance benefit, the minimum period of hospitalization is 18 hours, as calculated from the time of admission.

Illness: An alteration of the physical or mental state of health, characterized by a set of signs and symptoms corresponding to general or local disorders that are due to internal or external causes. An organ donation or any complications resulting from pregnancy are also considered an illness.

The illness must be confirmed by a *physician* and be subject to medical follow-up.

Insurance Proposal: The group Insurance Proposal signed by the Policyholder and any subsequent modification or renewal agreement.

Insured: This term refers to either the *participant* or eligible *dependents* as defined in this section.

Insurer: La Capitale Civil Service *Insurer* Inc.

When applicable in the *contract*, the terminology "*Insurer*" means « Third Party Administrator ». The Third Party Administrator performs administrative tasks for the *Insurer* such as adjudication of Health and Dental Care insurance benefits, enrollments, modifications to *participants*' files, issue of insurance certificates and other tasks that fall within its responsibility.

Simply Benefits is the Third Party Administrator appointed by the *Insurer* for this *contract*

Net salary: The *employee*'s *salary* less federal and provincial tax and contributions to any government pension plan, employment insurance and any government parental insurance plan.

Participant: An *employee* who is eligible for insurance and is covered under this contract. A *self-employed worker* is also considered to be a participant under this *contract* if indicated so in the *Schedule of Benefits*.

Percentage of reimbursement: The percentage of reimbursable expenses that the Insurer pays to the *participant* for health or dental care benefits, when these insurance benefits are included in this *contract*.

Physician: A physician duly licensed to practice medicine in the location where the services are provided.

Previous contract: Any group insurance contract(s) in force immediately prior to the effective date of this *contract* that covered the *employer*'s *employees* and any *dependents*.

Province: Any province or territory of Canada.

Reasonable and customary (R&C) limits refer to the maximum allowable amount that an insurance carrier or claims payor will reimburse for a particular service or item. This amount reflects the average cost associated with this service or product in a specific geographical area.

Recurrence of total disability: Any subsequent period of *total disability* due to the same cause as that of the previous disability or to related causes. A subsequent period of *total disability* that is due to a different cause but begins within one business day of the previous disability is also considered to be a recurrence of total disability.

Furthermore, in order to be considered by the Insurer as a recurrence of total disability,

a) During the long-term disability insurance benefit elimination period or, if the *participant* is not covered under this benefit, during the first six months of *total disability*: the *recurrence of total disability* must occur while the *participant* was *actively at work* for a period of no more than the number of days indicated in the definition of *recurrence of total disability* in the *Schedule of Benefits*.

b) Thereafter: the *recurrence of total disability* must occur while the *participant* was *actively at work* for a period of no more than the number of days indicated in the definition of recurrence of total disability in that schedule.

Regular schedule: The number of hours normally worked by the *participant* on a weekly basis; otherwise on any other basis established by an individual employment contract or a labour agreement.

Resident: The *participant* or *dependent* whose principal residence is located in Canada and who resides there a sufficient number of days during a *calendar year* to maintain eligibility for the public health insurance plan of the *province* of residence.

Retirement date: The date on which an *employee* is eligible for retirement, at the latest on the date that the criteria for retirement without actuarial reduction have been met, according to the pension plan in which the *employee* participates or the *employer*'s existing labour agreement or, in the absence of such agreement, the *employer*'s usual practice.

Salary: For the purposes of administering insurance benefits, the applicable definition of salary is indicated in the *Schedule of Benefits*.

If the *employer* bases the statement of salary on the *employee*'s average salary and/or dividend income, this average is determined as follows:

a) If the *employee* has completed two or more years of continuous service with the same *employer*, the average salary and/or dividend income is determined based on the last two years of service.

b) If the *employee* has completed from one to two years of continuous service with the same *employer*, the average salary and/or dividend income is determined based on the length of service.

c) If the *employee* has completed less than one year of continuous service, the salary and/or dividend income is that stated by the *employer*.

For the purposes of calculating the insurance or benefit amount to which the *participant* may be entitled under the *contract*, the salary is the lesser of the following two amounts:

i. The salary according to the definition indicated in the *Schedule of Benefits*,

ii. The last salary declared to the Insurer by the *employer* and used when determining payable premiums.

Schedule of Benefits: A summary of the insurance benefits included in the Policyholder's group insurance *contract*. The *Schedule of Benefits* specifies certain insurance terms and conditions, the insurance benefits provided under this *contract*, the payable insurance and benefit amounts and the insurance benefit termination dates applicable to each class of eligible *employees*. This schedule is found in the booklet issued for *participants*.

A full description of insurance benefits, exclusions, restrictions, terms and conditions are found in the following sections of this *contract*.

Self-employed worker: A person who is not an *employee* of the *employer*, but who offers services to the *work provider* on an exclusive basis, according to the terms of a binding contract.

Spouse: The person who, on the date of the event giving entitlement to insurance or benefit amounts:

a) is married to or in a civil union with the *participant*, or
b) has been living in a conjugal relationship with the *participant* for at least one year, or for less than one year if this person is the parent of the *participant*'s child (common-law union).

Note that the status of spouse is forfeited in the event of the following situations:

i. In the case of a marriage, the *participant* and spouse have been separated for 90 days or more or have obtained a divorce.
ii. In the case of a civil union, the *participant* and spouse have been separated for 90 days or more or have obtained dissolution of the union by a notarized act or court decision.
iii. In the case of a common-law union, the *participant* and spouse have been separated for 90 days or more.

If the *participant* has one spouse who meets the definition and another spouse who meets the definition, the *Insurer* recognizes the person designated as the spouse in a written notice from the *participant*. Only one spouse is eligible for insurance benefits under this *contract* at any one time.

Statutory leave: A temporary absence from work as defined by any applicable law. Maternity, parental, compassionate, and leaves for family reasons may be considered statutory leaves authorized by law.

Total disability or totally disabled: During the own-occupation period indicated in the definition of total disability in the *Schedule of Benefits*: a state of incapacity resulting from an *illness* or an *accident* that requires continuous medical care. This state of incapacity must prevent the *participant* from carrying out the essential duties of the *participant*'s own occupation in any workplace, including another department or location with the same *employer* or a different *employer*'s workplace.

Following that period: a state of incapacity resulting from an *illness* or an *accident* that prevents the *participant* from carrying out any gainful employment for which the *participant* is reasonably qualified by education, training or experience.

Total disability is established regardless of the existence or availability of such employment.

Participants who are required to hold a permit or licence issued by government authorities to perform the duties of their own occupation are not considered totally disabled solely because the permit or licence was revoked for legal or administrative reasons or as a preventive measure.

Total disability beginning more than 31 days following an *accident* is deemed to be the result of *illness*.

Work provider: The *employer* and any other work provider represented by the Policyholder of this *contract* to whom one or more *self-employed worker*s provide services on an exclusive basis.

GENERAL PROVISIONS

Eligible employees	All permanent employees working a minimum of 0 hours per week.
Dependent child - Minimum age	From birth for all insurance benefits except life insurance and AD&D; from 24 hours of life for life insurance and AD&D.
Dependent child - Maximum age	Up to age 21, if not a full-time student; up to age 25, if a full-time student.

INSURANCE TERMS AND CONDITIONS

Extension of coverage for dependents of a deceased participant	Please consult with your Plan Administrator. This extension of coverage concerns Health Care and Dental Insurance (where applicable) .

- **Eligibility Conditions**
  - **Employees**

    Employees are eligible for insurance benefits when they meet all of the following conditions:

    a) The *employee* must belong to one of the classes of eligible *employees* set out in the *Schedule of Benefits*,
    b) The *employee* must be losing coverage under their employer sponsored group insurance plan,
    c) The *employee* must be a *resident* of Canada, and
    d) The *employee* must be eligible for the public health insurance plan in the *employee*'s *province* of residence.

  - **Dependents**

    An *employee*'s *dependents* are eligible for insurance benefits when they meet all of the following conditions:

    a) The *employee* must have met the eligibility conditions,
    b) *Dependents* must meet the criteria set out in the definitions of *spouse* or *dependent child*, as applicable, under this *contract*,
    c) *Dependents* must be a *resident* of Canada, and
    d) *Dependents* must be eligible for the public health insurance plan of their *province* of residence.

- **Enrolment**
  - **Employees**

    The Insurer must receive the duly completed enrolment application within 60 days following the date the *employee* meets the eligibility conditions.

  - **Dependents**

    The Insurer must receive the duly completed enrolment application within 60 days following the date the *dependents* meet the eligibility conditions.

- **Effective Date of Coverage**
  - **Employees**

    Subject to receipt by the Insurer of the enrolment application within the required time frame, the *employee*'s coverage takes effect on the latest of the following dates:

    a) The effective date of this *contract*,
    b) The date the *employee* meets the eligibility conditions,

  - **Dependents**

    Subject to receipt by the Insurer of the enrolment application within the required time frame, *dependents*' coverage takes effect on the latest of the following dates:

    a) The effective date of this *contract*,
    b) The date the *dependents* meet the eligibility conditions,
    c) The date the Insurer approves any required evidence of insurability for the applicable insurance benefit.

    Under no circumstances can insurance for *dependents* take effect before that of the *employee*.

- **Effective Date of a Coverage Status Change for Inforce Coverage if the Family Situation Changes**

Any change in coverage status takes effect on the date that the family situation changes, subject to receipt of a request to that effect by the Insurer within 31 days following the date of such change.

For the purposes of this *contract*, the following changes to a family situation may justify a change in coverage status:

- Birth or adoption of a child,
- Marriage, civil union or cohabitation, in accordance with the criteria set out in the definition of *spouse* under this *contract*,
- Divorce, marriage annulment, dissolution of the civil union or de facto separation, in accordance with the criteria set out in the definition of *spouse* under this *contract*,
- Termination of the *dependent*'s eligibility, in accordance with the criteria set out in the definition of *dependent* under this *contract*.

If the Insurer does not receive a request for a coverage status change within the required time frame, this change takes effect on the date the Insurer receives the request.

- **Termination of Insurance**

  - **Participants**

    The *participant*'s coverage terminates on the earliest of the following dates:

    a) The date the *participant*'s employment ends,
    b) The *participant*'s *retirement date*,
    For the purposes of this *contract*, a *participant* who becomes disabled before *age* 65 is considered to be retired on the date of the 65th birthday.

    A *participant* who becomes disabled after *age* 65 is considered to be retired on the date the long-term disability insurance *elimination period* ends. If the *participant* is not covered under this insurance benefit, the *participant* is considered to be retired at the end of a period of six consecutive months of disability following the date *total disability* begins.

    c) The date the *participant* ceases to be a *resident* of Canada,
    d) The date the *participant* ceases to be eligible for the public health insurance plan in the *participant*'s *province* of residence,
    e) The date the Insurer receives written notice from the *participant* wishing to cease participation in an optional insurance benefit,
    f) The date of the *participant*'s death,
    g) The due date of any premium that is not paid to the Insurer before expiry of the grace period provided for in this *contract* and after any legally required notice to such effect has been sent within the prescribed time frame,
    h) The date the Insurer obtains evidence that the *participant* is attempting to fraudulently obtain, or is assisting an *insured,* or another *participant,* to fraudulently obtain, insurance or benefit amounts under this *contract*, whether or not participation in such insurance benefit is mandatory and regardless of any other recourse available to the Insurer.

  - **Dependents**

    The *dependent*'s coverage terminates on the earliest of the following dates:

    a) The date the *participant*'s coverage terminates,
    b) The date the *dependent* reaches the *age* for termination of insurance set out in the *Schedule of Benefits*, if there is any such indication,
    c) The date the *dependent* no longer meets the criteria set out in the definition of *dependent* under this *contract*,
    d) The date the *dependent* ceases to be a *resident* of Canada,
    e) The date the *dependent* ceases to be eligible for the public health insurance plan in the *dependents*' *province* of residence,
    f) The due date of any premium that is not paid to the Insurer before expiry of the grace period provided for in this *contract* and after any legally required notice to such effect has been sent within the prescribed time frame,
    g) The date the Insurer receives written notice from the *participant* wishing to terminate participation of one or all *dependents* in any insurance benefit.

- **Extension of Coverage for Dependents of a Deceased Participant**

The following provision is applicable to the extension of coverage for *dependents* of a deceased *participant* benefit.

Following the death of a *participant*, *dependents*' coverage maybe extended. Please consult with your Plan Administrator for more details

- **Provisions Pertaining to a Change of Insurers**

There is continuity of coverage between this *contract* and the *previous contract* for *participants* and their *dependents* who were covered under the *previous contract*.

As a result, the *participant* and *dependents* who were covered under the *previous contract* cannot be denied enrolment or payment of insurance or benefit amounts by the Insurer due solely to a pre-existing condition that did not apply or that was not included in the *previous contract,* or because the *participant* was not *actively at work* on the effective date of this *contract*.

Participants and their *dependents* who were covered under the *previous contract* are automatically covered under this *contract* as of the cancellation date of the *previous contract*, if termination of the *participant*'s prior insurance is due solely to the cancellation of the *previous contract*, and the *participant* belongs to a class of eligible *employees* under this *contract*.

Subject to any applicable law and the Guidelines issued by the Canadian Life and Health Insurance Association, the Insurer is not liable for the payment of insurance and benefit amounts which may be owed to a *participant* covered under the clauses of a *previous contract* pertaining to extension of coverage, *recurrence of total disability*, waiver of premiums, the conversion privilege or any other applicable provision provided for in that *previous contract.*

CLAIMS

- **General Provisions**

All insurance and benefit amounts payable under the insurance benefits of this *contract* are paid to the *participant*. In the event of the *participant*'s death, any insurance amounts are paid to the designated beneficiary.

Before paying an insurance or benefit amount, the Insurer reserves the right to have the *insured* or the body examined and request that an autopsy be performed, unless prohibited by law. In addition, the Insurer may require submission of all medical information and files regarding the diagnosis, treatment or services received by an *insured*, before or after the effective date of insurance.

- **Recovery**

The Insurer reserves the right to recover:

a) Any insurance or benefit amount paid in error to a *participant* or for a *dependent*.

b) Any insurance or benefit amount obtained by the *participant* or for a *dependent* to which the *participant* was not eligible nor entitled under this *contract*, and that the Insurer would not have paid had it not been for an omission, non-disclosure or misrepresentation by the *participant* or a *dependent*.

c) Any amount paid to a third party who was not entitled to such amount due to an omission, non-disclosure or misrepresentation by the *participant*, a *dependent* or the Policyholder.

d) Any overpayment made to the *participant* or for a *dependent*.

- **Right of set-off**

If the overpayment cannot be recovered from the *participant*, the Insurer reserves the right to set off any amount of future benefits payable to the *participant* or for a *dependent* until the overpayment has been fully recovered.

The Insurer reserves the right of set off whether or not there is a beneficiary designation and whether or not this designation is revocable or irrevocable.

- **Subrogation**

a) **General provision**
The Insurer is subrogated to all rights of the *participant* against a third party that is liable for an event giving rise to a claim under this *contract*, up to a maximum of the amount paid to the *participant* by the Insurer.

- **Termination of this contract or cancellation of an insurance benefit**

Subject to the provisions regarding a change of insurers, the termination of this *contract* or the cancellation of an insurance benefit cannot be set up against any claim related to:

a) Death occurring while this *contract* was in force,
b) Death due to a *total disability* occurring while this *contract* was in force,
c) Death or dismemberment due to an *accident* occurring while this *contract* was in force,

- **Legal action against the Insurer**

No legal action can be taken against the Insurer regarding any claims submitted:

a) During the 60 days following the deadline for submitting a claim, subject to applicable statutory time limits,

b) During the 60 days following the deadline indicated by the Insurer when evidence of insurability or additional information is required, subject to applicable statutory time limits,

c) For Alberta, British Columbia, and Manitoba *residents*: Legal action against the Insurer for the recovery of insurance money payable under this *contract* is absolutely barred unless commenced within the time limits set out in the *Insurance Act*,

d) For Ontario *residents*: Legal action against the Insurer for the recovery of insurance money payable under this *contract* is absolutely barred unless commenced within the time limits set out in the *Limitations Act, 2002*,

e) For *residents* of other *provinces*, legal action or proceedings cannot be taken against the Insurer after expiry of the time limits set out in any applicable provincial legislation.

- **Incontestability**

  Even if there was no intent to commit fraud, any error or omission in the evidence of insurability submitted by the *insured* may invalidate the insurance coverage or amount during the first two years following the effective date of insurance or the amount increase.

- **Non-assignment**

  An *insured*'s rights under this *contract* may not be assigned or seized, and no assignment by an *insured* of entitlement to benefits or to payment of a benefit under this *contract* is binding on the Insurer.

- **Health Care Insurance**

All claims must be submitted to the Insurer within 12 months following the date expenses are incurred. Any claim submitted to the Insurer more than 12 months after the date on which the expenses were incurred is denied.

If the *contract* or the insurance benefit is terminated, claims must be submitted within three months following the termination date, regardless of when the expenses were incurred.

Official receipts or paid invoices must be enclosed with the claim. Expenses are considered as being incurred on the date the services, care, treatment, or supplies were provided. For certain expenses, the *insured* is required to enclose the medical prescription with the claim.

- **Prescription drugs, extended healthcare, and dental care**

a) **Claims submitted by a healthcare professional**
In some cases, *insured*s may have their claims submitted by certain healthcare professionals who have been pre-approved by the Insurer, such as pharmacists and *dentists*. The Insurer pays the covered portion of eligible expenses to the healthcare professional at the time of the transaction. The *insured* must pay the portion of expenses for which the *insured* is responsible to the healthcare professional, according to the provisions of this *contract*.

b) **Claims submitted to the Insurer**

The *insured* may pay the total expenses incurred for the services of the healthcare professional. The *insured* may then use one of the following methods to forward the claim to the Insurer:

i) Mobile app,
ii) Online from the secure site,
iii) By mail, by sending the completed claim form.

c) **Coordination of benefits**

i) Extended insurance coverage supplementary to any government insurance plan

The payment of benefits under prescription drug, extended healthcare, and dental care coverage supplements any government insurance plans. As a result, eligible benefits under this *contract* are reduced by the amount of any benefits payable under any government insurance plan, whether or not the *insured* submits a claim.

ii) Coordination of benefits with any other group or individual insurance contract providing similar insurance benefits.

Benefits under prescription drug, extended healthcare and dental care coverage are payable for the portion of expenses over and above those covered by benefits paid under any other group or individual insurance contract to ensure that the total reimbursement does not exceed the expenses actually incurred by the *insured*.

In the event an *insured* is eligible to receive benefits under this *contract* and under another group insurance contract, coordination of benefits is done by the Insurer in accordance with the Guidelines issued by the Canadian Life and Health Insurance Association.

PROVIDERS

LaCapitale insures the following benefits:

- Healthcare
- Dental

Orion insures the following benefits:

- Out of Country

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, 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, health care 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 health care professional.

A copy of Simply Benefits' Privacy brochure is available at your request. To find out how to access your file or if you have any questions, please contact us at:

Simply Benefits Corp.
601-460 Doyle Ave
Kelowna, BC
V1Y 0C2
Toll-free: 1-877-815-7751