Group Benefits Plan

CULE Retirees

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COUGHLIN
employee benefits specialists

Keep this Booklet in a Safe Place

Your group benefits provide an important supplement to your income and valuable protection to you and your family.

This booklet outlines the specific terms of your group benefit plan as well as the coverage levels of each benefit. Be sure to keep this booklet in a safe place for future reference.

Although all information provided herein is meant to be exact and accurate, this document has no legal value. Only the terms and conditions of the group insurance policy and any applicable laws will be used to settle legal issues.

The insurers and administrators of these benefits are as follows:

Benefit	Insurer / Administrator	Policy Number	Appendix
Extended Health Care and Dental Care	Self-funded Administered by Coughlin & Associates Ltd.	**25012**	n/a
Out-of-province/Canada Travel Medical Emergency Insurance	AIG Insurance Company of Canada	**CMG 9429163**	Appendix A

If you have questions about your group benefits that are not covered in this booklet, please contact Coughlin & Associates Ltd., your plan administrator, at 613-231-2266, or toll-free 1-888-613-1234, or fax 613-231-2345, or email at info@coughlin.ca or contact the PSAC Human Resources office.

If there are any discrepancies between the group contract and the employee benefits booklet, your coverage will be determined by the terms and conditions of the group contract.

Important

This document contains important information about your employee benefits coverage and should be kept in a safe place. It supersedes and replaces all previous communications material and is the plan document in respect to the benefits described herein.

The Public Service Alliance of Canada (PSAC), the plan sponsor, underwrites certain benefits on a self-insured basis as indicated in the table on the previous page. All risks in respect to these benefits are borne by PSAC.

As sponsor of the plan, the PSAC or its trustees or designates may establish rules or regulations for the administration or governance of the benefits plan and any transactions associated with it. They also have the right to interpret the self-funded coverage of the plan and decide any and all matters related to it. This includes the right to clarify or remedy any possible uncertainties, omissions or inconsistencies based on applicable laws and the reasonable and customary charges and treatment for the self-funded benefits described in this booklet.

The interpretations or decisions of the PSAC, its trustees or designates with respect to the self-insured coverage, will be final and binding on all parties.

Protecting Your Personal Information

The administrator of your group benefits plan is Coughlin & Associates Ltd. (“Coughlin”). Coughlin recognizes and respects every individual’s right to privacy. We are committed to keeping personal information private, confidential, accurate and secure. When personal information is provided to us, we establish a confidential file that is kept in our office, or the office of an organization authorized by us. Personal information is kept in a secure environment. We limit access to personal information in your file to Coughlin staff or persons authorized by Coughlin who require access to perform their duties, to persons to whom you have granted access, and to persons authorized by law. We use the personal information to administer the group benefits plan. You may exercise certain rights of access to the personal information in your file, and where appropriate, to have inaccurate information corrected by sending a written request to Coughlin. For information on our Privacy Policy, visit our website at www.coughlin.ca, or send a written request to our Privacy Officer by mail or by email at privacy@coughlin.ca.

Errors or Omissions

Every effort has been made to ensure that this booklet is accurate and complete. Should error, omission or dispute occur, the terms of the policies issued to the plan sponsor will prevail. Clerical errors made by the plan administrator will not invalidate benefits otherwise in force or continue benefits otherwise terminated.

Any fraud or willfully false statement in making a claim may invalidate your claim. You are not entitled to the claimed benefit. Sometimes, an overpayment situation may occur through no fault of yours. This means you received a greater benefit payment than you were entitled to receive. If you receive a benefit to which you are not entitled, you must immediately repay that amount to the plan sponsor, to Coughlin & Associates Ltd., which administers your group benefit plan on behalf of the plan sponsor, or to the insurer. If you receive benefits to which you are not entitled and do not repay them, any one or more of the following may occur:

a) any benefit payments to which you are entitled may be withheld to recover the amount you owe; and
b) criminal or other legal action may be brought against you.

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Benefits Summary

The following is a summary of your benefits plan. For further details on each benefit, please refer to the appropriate section of this booklet.

Eligibility: Please refer to the *Eligibility* section to determine your eligibility and when coverage begins

Extended Health Care Benefits

APPLIES TO PLAN A AND PLAN C

Deductible:	$10 per insured person, $20 per family each calendar year, to be taken from the drug card.
Reimbursement level:	100% of eligible expenses (unless otherwise specified).
Maximum benefit:	$10,000 per insured person per calendar year.
Termination:	When you reach age 65. Employees who retire from positions located in Newfoundland and Labrador, or in New Brunswick will be entitled to their health care spending account until age 75 as long as they remain residents of that province, and provided they continue not to have access to any other public or private drug plan (from another employer, for example).

NOTE: Some individual benefits are subject to monthly, yearly or lifetime maximums.

Prescription drugs:

• Deductible:	As indicated above under Extended Health Care Benefits.
• Reimbursement level:	100% of eligible expenses (unless otherwise specified).
• Maximum benefit:	$10,000 per insured person per calendar year. Combined maximum applies to drugs, diabetic supplies, allergy serums, injections and smoking cessation products.
• Eligible drugs:	Drugs, serums, vaccines and injectables, only available by prescription with a valid drug identification number (DIN), when prescribed by a licensed health care practitioner or dentist dispensed by a pharmacist, dentist or a physician.
• Drug card:	Yes.
• Dispensing fee cap:	$9.95 in all provinces and territories excluding: Manitoba: maximum $10.73. Nunavut: maximum $10.27.
• Maximums and exclusions:	
- Drugs:	Limited to a 3-month supply for prescription drugs or medicines and a 1-year supply for oral contraceptives.
- Sclerosing injections for the treatment of varicosities:	Cost of medication only.
- Viscosupplementation:	Excluded.
- Smoking cessation aids:	Nicotine patches/inhaler: $525 per insured person per calendar year. Nicorette gum: $600 per insured person per calendar year.
- Sexual dysfunction drugs:	Unlimited.
- Fertility drugs:	Excluded.

Prior authorization may be required by the plan administrator for certain medications.

Hospital care:

• Reimbursement level:	100% of eligible expenses (unless otherwise specified).

• Coverage:	Cost of a private or semi-private room for each day of hospitalization.
• Palliative care:	Covered under the hospital care coverage as indicated above.

Professional and paramedical services:

• Reimbursement level:	100% of eligible expenses (unless otherwise specified).
• Maximum per practitioner:	
− Acupuncturist or naturopath:	Combined maximum of 20 visits per insured person per calendar year. Combined maximum of one X-ray per insured person per calendar year.
− Chiropodist:	Maximum of 20 visits per insured person per calendar year. Maximum of one X-ray per insured person per calendar year. Maximum one surgery per insured person per calendar year.
− Chiropractor:	Maximum of 20 visits per insured person per calendar year. Maximum of one X-ray per insured person per calendar year.
− Massage therapist:	$900 per insured person per calendar year.
− Osteopath:	Maximum of 20 visits per insured person per calendar year. Maximum of one X-ray per insured person per calendar year.
− Podiatrist:	Maximum of 20 visits per insured person per calendar year. Maximum of one X-ray per insured person per calendar year.
− Physiotherapist:	Unlimited.
− Psychologist, or registered social service/worker:	$2,500 per insured person per calendar year.
− Speech therapist:	$250 per insured person per calendar year.

Medical supplies and services:

• Reimbursement level:	100% of eligible expenses (unless otherwise specified).
• Maximum per service and/or supply:	
− External breast prosthesis (following mastectomy):	Reasonable and customary charges.
− Surgical brassieres:	Reasonable and customary charges.
− Private duty nurse:	$5,000 per insured person each calendar year for services of a registered nurse, registered nurse assistant or licensed practical nurse in home only. Physician's referral required.
− Artificial eye:	Includes reimbursement for polishing or rebuilding of the artificial eye per insured person up to reasonable and customary charges.
− Artificial appendages:	Reasonable and customary charges. Replacements eligible after 60 months.
− Stump socks:	Reasonable and customary charges.
− Orthopaedic footwear:	$75 per insured person every calendar year. Prescription required.
− Custom made orthotics or arch support:	50%. $200 per insured person every 2 calendar years. Prescription required.
− Elastic support stockings:	Reasonable and customary charges. Physician's referral required indicating compression of at least 30mm.
− Therapeutic and mobility equipment:	Reasonable and customary charges. Purchase or rental, including repairs/parts. Referral required.
− Hearing aids:	Including aids, repairs and replacement parts. Excludes batteries and cochlear implants. Prescribed by an audiologist.
− Wigs as result of medical condition:	$300 per insured person lifetime maximum. Physician's referral required.
− Glucometer or reflectance meter, (includes Freestyle Libre flash	Reasonable and customary charges.

monitoring system and associated sensors):	
– Obus forms	Reasonable and customary charges. Prescription required.
– Diagnostic services:	Reasonable and customary charges.

Prior authorization of any anticipated expenses for medical supplies and services should be obtained from the plan administrator, Coughlin & Associates Ltd. Supporting documents should be submitted for review to ensure eligibility based on the plan parameters.

Contact Coughlin & Associates regarding required documentation for prior authorization.

Vision Care

APPLIES TO PLAN A, PLAN C AND PLAN D

• Reimbursement level:	100% of eligible expenses (unless otherwise specified) including contact lenses (special conditions).
• Benefit coverage period:	Benefit coverage period begins the date of the first claim and restarts every 24 months thereafter.
• Maximum:	$450 per insured person per 24 consecutive months. Includes prescription glasses, contact lenses and special contact lenses and plano sunglasses to treat ophthalmic diseases/conditions and laser eye surgery.
• Laser eye surgery:	Included in the maximum listed above on an ongoing basis to the full cost of the surgery per insured person combined with any other vision care expenses.
• Glasses or contact lenses following cataract surgery:	One pair, up to maximum of $450 per insured person per period of 24 consecutive months.
• Eye examinations:	Members: Up to 2 exams every calendar year, combined eye exam and contact lens examination/assessment. Must be performed by an optometrist, optician or ophthalmologist. Dependants (spouse and children): One exam every 24 consecutive months, combined eye exam and contact lens examination/ assessment. Must be performed by an optometrist, optician or ophthalmologist.
• Termination:	When you reach age 65. Employees who retire from positions located in Newfoundland and Labrador, or in New Brunswick will be entitled to their health care spending account until age 75 as long as they remain residents of that province, and provided they continue to have access to any other public or private drug plan (from another employer, for example).

Dental Care

APPLIES TO PLAN B, PLAN C AND PLAN D

Deductible:	Nil.
Fee guide:	Based on current Dental Association fee guide for general practitioners, where service is rendered.
Reimbursement amount:	
• Basic services:	100% of eligible expenses.
– Maximum:	Unlimited.
• Major services:	50% of eligible expenses.
– Maximum:	Maximum $5,000 per insured person per calendar year.
• Orthodontic services:	Excluded.
Treatment frequency:	
• Complete oral examination:	Once every 36 consecutive months.
• Recall oral examination:	Twice every 12 consecutive months.
• Specific oral examination:	Twice every 12 consecutive months.
• Complete series of periapical films or panoramic radiographs:	Once every 36 consecutive months.
• Polishing:	Twice every 12 consecutive months.
• Bitewing radiographs:	Twice every 12 consecutive months.
• Scaling:	Reasonable and customary charges.
• Root planing:	Reasonable and customary charges.
• Fluoride treatment:	Twice every 12 consecutive months.
• Tooth coloured (composite) filling:	Eligible on all teeth.
• Pit and fissure sealants:	Unlimited.
• Space maintainers:	For missing primary teeth only.
• Oral hygiene instruction:	Twice every 12 consecutive months.
• Anaesthetic:	Eligible in relation to dental surgery only.
• Denture cleaning:	Twice every 12 consecutive months.
• Denture adjustments:	Once only, 3 months after initial installation.
• Denture rebase/reline:	Once every 36 consecutive months.
• Preformed stainless steel and polycarbonate crowns:	For children under age 16.
• Crowns, inlays & onlays:	Once every 5 years.
• Bridges & dentures:	Once every 5 years.
• Implants	Unlimited.
• Laboratory fees:	Limited to 60% of the fees specified for the dental treatment or service.
Termination:	Age 65.

Out of Province/Canada Trave Medical Emergency Insurance

REFER TO APPENDIX A – AIG INSURANCE COMPANY OF CANADA

Deductible:	Nil.
Reimbursement amount:	100%.
Maximum amount:	$5,000,000 lifetime maximum.
Coverage period:	60 consecutive days per trip.
Termination:	Age 65.

General Information

Change in Information

To ensure you receive all correspondence and that the correct information is stored in your file, contact your employer or the plan administrator as soon as a change occurs (i.e. new dependant or beneficiary, address changes, change in marital status).

Coordination of Benefits (COB)

When payment for benefits provided under this plan is available to a person under any other pre-paid health service contract, insurance policy or plan, benefits shall be co-ordinated and the amount payable under this agreement shall be pro-rated and limited to the extent that the total amount available under all coverages does not exceed 100% of the eligible expenses.

The plan administrator may obtain from or release to any person or corporation, any information considered necessary to implement this provision and facilitate the payment of benefits under this plan, subject to consent of the covered member, if so required by law.

In co-ordination of benefits situations where Coughlin is secondary payer, the original Explanation of Benefits from the primary insurer and copies of the relevant receipts or dental claim form must be submitted.

Order of Benefits Determination

If you or your dependants are eligible to receive a benefit under this plan and the same or similar benefit under any other plan, benefit payment shall be decided in the following manner:

- if another plan does not contain a co-ordination of benefits provision, the benefits of that plan will be paid first prior to the application of benefits under this plan;
- if another plan contains a co-ordination of benefits provision, its benefits will be co-ordinated with the benefits under this plan as follows:

  Priority shall be attributed to the plan under which the person is eligible to receive the benefits in the following order:
  (i) the benefits payable under a plan which insures the individual other than as a dependant will be determined before the benefits of a plan which insures the individual as a dependant;
  (ii) the benefits payable under a plan that insures the individual as a dependant of a covered person with the earlier month and day of birth in the calendar year; or
  (iii) the benefits payable under a plan that insures the individual as a dependant of the parent whose first name begins with the earlier letter in the alphabet, if both parents have the same birthday;

- in cases of separation or divorce:
  (i) the plan of the parent with custody of the child;
  (ii) the plan of the spouse-partner of the parent with custody of the child;
  (iii) the plan of the parent not having custody of the child; or
  (iv) the plan of the spouse-partner of the parent not having custody of the child,

- if the person is covered under another plan, priority will go to:
  (i) the plan where the employee is an active, full-time employee;
  (ii) the plan where the employee is an active, part-time employee; or
  (iii) the plan where the employee is a retiree.

If priority cannot be established according to the above, the benefits shall be paid under both plans in a ratio proportionate to the amounts that would have been paid under each plan had there been coverage under just that plan.

General Limitations

Your health insurance does not cover services and supplies in the following situations:

- services or portion thereof provided under Workers' Compensation or similar program;
- services received for confinement which is primarily for chronic or custodial care;
- services received in a government hospital unless you are required to pay for such services;
- services to which the patient is entitled without charge, or for which there would be no charge if there were no coverage;
- services or portion thereof provided under any government sponsored hospital or medical care program;
- aesthetic surgery (cosmetic surgery for beautification purposes);
- services furnished without charge or paid for directly or indirectly by any government or for which a government prohibits payment of benefits;
- services received from a dental or medical department maintained by the employer, a mutual benefit association, labour union, trustee or similar type of group;
- service, including part-time or temporary service, in the armed forces of any country;
- services required due to war (declared or undeclared), insurrection, or participation in a riot;
- services required due to any intentional self-inflicted injury or disease, while sane or insane.

Eligibility

The CULE retiree benefits plan is a voluntary plan where retiring PSAC employees may purchase single, couple or family benefits coverage at their retirement date.

Retirees have 30 days from the date of retirement to select one of the five benefit plan models, Plans A, B, C, D or E. If the retiree opts not to join the plan at retirement date, his/her decision will be considered irrevocable.

Once a retiree joins the plan, he/she may terminate or reduce coverage at any time with 31 days notice. However, he/she may not re-join the plan at a future date, nor can he/she add a spouse at a future date unless proof is supplied that the spouse had alternate coverage elsewhere and that the coverage is now being terminated. The opting-in provision also covers members who were originally covered under spousal plans that later terminated, provided they meet the plan’s eligibility criteria.

Coverage will be provided from the date of retirement until the earlier of the date the retired CULE member attains age 65 or elects to terminate his/her membership in the plan.

Contact the PSAC Human Resources department and obtain, complete and sign an enrolment form for your selected level of coverage. Return it to PSAC Human Resources

Definitions

Spouse:

- an individual to whom the employee is legally married; or
- a common-law partner, with whom you have co-habited for a period of at least 12 months and who is publicly presented as your spouse/partner.

Members must state the name of the person to be considered a spouse for the purposes of the policy. Only one spouse will be covered under the policy at any time and must be a resident of Canada

Dependant child:

- an unmarried person who is a natural, adopted, or stepchild;
- a child of a common-law spouse, who resides with you and is dependent on you for support; and
  (i) younger than 21 years of age and not employed on a regular full-time basis; or
  (ii) up to 25 years of age, or 26 years of age in Quebec, in full-time attendance at an accredited institute of learning, and dependent on you for support; or
  (iii) 21 years or older and incapable of self-sustaining employment due to a mental or physical handicap. The child's coverage will be continued under the policy, provided the child's handicap has existed continuously from a time when he/she was otherwise insured as a dependant under this policy. Supporting documentation by a physician will be required.
- an unmarried child you or your insured spouse have been appointed guardian for all purposes by a court of competent jurisdiction.

Dependant coverage is not available to children who work more than 30 hours per week and are not full-time students or who are not residents of Canada.

To avoid delays or processing problems, contact the plan administrator when any change in dependant status occurs.

Active employee or employee actively at work: an employee who performs all the usual customary duties of the occupation.

Fees and charges: considered under this plan means charges for services whose nature and severity are in accordance with the fee practices and tariffs of the official fee schedule for the profession, or if there is no official fee schedule, representative fee practices and tariffs of the profession in the area.

Inactive / unemployed: an employee who is temporarily absent from work due to disability, temporary lay-off, authorized leave of absence.

Insured person: employee, spouse and dependant child with coverage.

Reasonable and customary: means that the treatment provided is accepted by the appropriate Canadian medical profession as being proven scientifically and effective medically and of a form, intensity, frequency and duration essential to the diagnosis and management of the disease or injury.

Revocable / Irrevocable beneficiary: *Revocable beneficiary* is the person that you name to receive the benefits of an insurance policy can be changed. *Irrevocable beneficiary* is the person that you name to receive the benefits of an insurance policy that cannot be changed without the irrevocable beneficiary's written consent.

Enrolment

To apply for coverage, contact the PSAC Human Resources department and obtain, complete and sign an enrolment form for your extended health/drug, vision care, dental and out-of-province/Canada emergency travel insurance. Return it to PSAC Human Resources. If you acquire your first dependant after becoming insured, you should apply for dependant's benefits within 31 days.

Termination of Insurance

Unless otherwise specified in this booklet, insurance coverage for yourself and your dependants cease the earlier of:

- the date your membership in the CULE retiree benefits plan ends;
- the benefit plan terminates;
- the date you reach age 65.

Contract Holder

PSAC is the contract holder or the party under contract with the provider of administrative services of your employee benefit program.

Contract holder does not refer to you, the employee.

Plan Administrator

The plan administrator is Coughlin & Associates Ltd. Please refer to the *How to Claim Benefits* section for contact information.

Benefit Plan Details

Plan Structure

The plan structure provides for five benefit plan options that will be available to eligible CULE retirees and their dependants. The five plan models are as follows:

- Plan A: Extended Health Care, Vision Care and Out of Country coverage
- Plan B: Dental Care
- Plan C: Extended Health Care, Vision Care, Out of Country and Dental care
- Plan D: Vision Care, Out of Country and Dental care
- Plan E: Health Care Spending Account

For specific maximums and details, please see the Benefit Summary section of this booklet.
To be eligible for coverage CULE members must select their preferred coverage plan within 31 days of their retirement date. Applications for coverage that are received after the 31-day period will not be accepted.

Extended Health Care Benefit

Plan members must be covered under their provincial health care plan to be eligible for this benefit.

If you and/or your eligible dependants incur any eligible expenses for medically necessary services or supplies, the benefit plan will pay a benefit subject to limitations and exclusions. The benefit payable will be based on the amount shown in the Benefit Summary following the payment of the annual deductible, if applicable. All covered services and supplies must be considered reasonable and acceptable by the Canadian medical profession and proven to be effective and in a form, intensity, frequency and duration essential to the diagnosis and treatment of the illness or injury. Certain drugs may require prior authorization from the plan administrator.

Prescription Drug Card

You can pay for your prescription drugs directly through your drug plan using the all-in-one card.
Your all-in-one card provides your pharmacist with immediate confirmation of covered drug expenses. This means your prescription drug claims will be processed immediately. There are no forms to complete. Simply present the drug card to your pharmacist when purchasing prescription drugs. Payment for your claim will be processed immediately.
The drug card can be used by you as well as your spouse and eligible dependants. It is designed to cover prescription drug costs only and can be used at any pharmacy in Canada.

Covered Expenses

The plan will pay for the following services and supplies providing they are not covered by the provincial health care plan to the limits specified in the Benefit Summary.

Prescription Drugs and Medication

- Diabetic supplies such as diabetic needles, syringes, alcohol swabs, and test strips.
- Certain eligible medications may require the prior authorization of the plan administrator.
- Compound mixtures, when at least one ingredient is a prescription requiring medication.
- Drugs, sera, vaccines and injectables only available when prescribed by a licensed health care practitioner or dentist.
- Charges for nicotine replacement products or smoking cessation therapies.
- Oral contraceptives.
- Drugs and supplies available without a prescription and required as a result of a colostomy or ileostomy and/or the treatment of cystic fibrosis, diabetes and Parkinson's or heart disease

Hospital Care

The plan will cover the costs for care in the province where you live, up to the cost of accommodation listed in the Benefits Summary.

A hospital is a facility licensed to provide care and treatment for sick or injured patients, primarily while they are acutely ill. It must have facilities for diagnostic treatment and major surgery. Nursing care must be available 24 hours a day. It does not include a nursing home, rest home, home for the aged or chronically ill, sanatorium, convalescent hospital or a facility for treating alcohol or drug abuse or beds set aside for any of these purposes in a hospital.

Palliative care establishment means any establishment in Canada designated as such by law that provides, under the supervision of a physician, care and treatment to patients, mainly during the terminal phase of their illness, and that provides nursing care 24 hours a day by a registered nurse and maintains daily records of each patient under the care of a physician. An active treatment hospital designated as such by law, extended care facility, rest home, convalescent or rehabilitation centre, home for the aged or

the chronically ill, home for the mentally ill, sanatorium, convalescent hospital, or institution for the care and treatment of alcoholism or drug addiction is not considered a palliative care establishment.

Paramedical Services

Medically necessary services, including X-rays, of licensed, certified or registered (in the province where treatment is given) paramedical practitioners up to reasonable and customary fees per visit when operating within their recognized fields of expertise to the maximums specified in the Benefits Summary. Reimbursement is based on the dates the services were rendered. All receipts must clearly indicate the names of those attending the sessions.

Medical Services and Supplies

The plan will cover the costs after provincial plan coverage (if applicable) for the medical services listed below when ordered by a doctor, up to the maximums indicated in the Benefits Summary. If no maximum is indicated, reimbursement will be based on the reasonable and customary costs in the locality where the services and supplies were provided. Reimbursement of eligible items is based on the date the items are paid in full. It is strongly recommended that prior authorization, accompanied by supporting documents, be submitted prior to incurring expenses for medical equipment with substantial cost implications.

- Hearing aids, or repairs to existing hearing aids to the limits outlined in the Benefit Summary.
- Custom-made orthopaedic shoes or modifications to orthopaedic shoes.
- Custom-made orthotic inserts for shoes.
- Private duty nursing services when medically necessary. Services must be for nursing care, and not for custodial care. The private duty nurse must be a nurse or nursing assistant who is licensed, certified or registered in the province where you live and who does not normally live with you. The services of a registered nurse are eligible only when someone with lesser qualifications cannot perform the duties.
- External breast prosthesis (following mastectomies) and surgical brassieres.
- Elastic support stockings to the limits outlined in the Benefit Summary.
- Wigs for patients who have undergone chemotherapy treatment or have a medical condition, to the limits outlined in the Benefit Summary.
- Transportation in a licensed ground or air ambulance, if medically necessary, that takes you to and from the nearest hospital that is able to provide the necessary medical services.
- Rental or at the administrator's discretion, purchase of durable equipment including but not limited to standard-type wheelchair, wheelchair repairs, hospital bed (with or without mattresses), hospital bed rails, respirator/ventilator, oxygen and its administration, apnea monitors. In lieu of rental, the plan may, at its discretion, substitute charges for the purchase of such articles where applicable rental charges will be applied to the purchase price.
- Rental or at the administrator's discretion, purchase of braces, trusses, casts, canes, crutches, walkers, splints (excluding dental splints), cervical collars, standard-type artificial limb or eye. Braces must be constructed with rigid or semi-rigid material, required for normal activities of daily living, and not solely for sports-related activities, with the written prescription of a physician.
- Obus® back forms.

- Purchase of colostomy and ileostomy supplies (where surgical stoma exists), payable after incurred expenses exceed the provincial health plan.

- Laboratory tests performed by a commercial laboratory for the diagnosis of an illness.

- Medical services and supplies including bandages, surgical dressings, blood transfusions, plasma, radium and radioactive isotope treatments when authorized by the patient's attending physician.

- Certain diagnostic laboratory services and X-rays, except for those provided by a doctor in the course of treatment and not normally covered by the provincial health care plan.

- The costs of treatment for the repair or replacement of natural teeth, which require treatment as a result of accidental blow to the mouth. Damage must be caused by a direct blow to the mouth, not from an object wittingly or unwittingly placed in the mouth. The accident must have occurred after the effective date of the plan. Treatment must be completed within 12 months of the date of the accident. Reimbursement will be based on the current Dental Association fee guide for general practitioners, in the province of residence in effect at the time of the treatment.

- *Gender re-assignment (GRS):* Coverage is provided for a number of medical services associated with GRS procedures. All requests for coverage should be submitted in advance for consideration by the plan administrator and its medical consultants. The covered person will be responsible to provide supportive documentation that addresses the following eligibility criteria:
    - the covered person must be a permanent resident of Canada, eligible for government health care in their province or territory of residence;
    - must be under the care of a physician;
    - must be on hormonal therapy and submit proof of such;
    - must have lived in the new role (male or female) for at least two years;
    - must be assessed by a psychiatrist specializing in gender dysphoria to establish medical and emotional stability;
    - must present a letter of referral from the psychiatrist recommending the surgery, as well as a letter of consultation from a second psychiatrist also recommending the surgery.

  Covered services include, but are not limited to, vaginalplasty, penile prosthesis implant, mastectomy, penectomy, orchidectomy, oophorectomy, tracheal shaving, hair epilation (face and neck) hysterectomy and augmentation mammoplasty only if there is amastia (absence of the mammae) following hormonal treatment. As well, drugs and other supplies and services that would be covered by this plan under any other medical circumstance will be reimbursed subject to relevant benefit entitlement and limitation provisions.

  Reimbursement of reasonable and customary charges for GRS will be based on the most beneficial published provincial or territorial health plan at the incurred date of service and made in accordance with all other provisions (i.e. deductible, maximum amounts, etc.) governing this plan.

  Coverage does not include:
    - phalloplasty (as it is still considered experimental), hair epilation (other than face and neck), vocal cord surgery, semen or ovum preservation, facial and nasal surgeries.
    - services or supplies required as a result of complications resulting from GRS-related procedures.
    - services or supplies allowed under the covered person’s provincial or territorial health plan.
    - any other supply or service that would not be allowed by this plan under any other medical circumstance.

Out-of-Canada Referral Treatment

Eligible expenses incurred outside the province of residence of the insured person as a result of a referral include the following provisions:

1) This service or treatment must not be available in Canada or in the normal province of residence of the insured person;
2) The insured person must provide the insurer with a letter of referral from a physician in his normal province of residence, indicating that he is being referred to another physician;
3) The insurer must give prior written approval;
4) The provincial health and/or hospital insurance plans must pay a portion of the eligible expenses.

The maximum amount payable by the insurer under this provision is limited to the percentage specified in the Benefits Summary.

Expenses Not Covered

- Services covered by any provincial government plan or any workers' compensation board.
- Any care, services or supplies that are not medically necessary, as determined by the plan administrator.
- Services or supplies to the extent that their costs exceed the reasonable and customary rates in the locality where the services or supplies are provided.
- Care, services or supplies utilized as treatment of lifestyle choices, as determined by the plan administrator.
- Services or supplies that are primarily for cosmetic purposes.
- Drugs or medicines, services or supplies that have been self-prescribed, or prescribed by or for family members.
- Drugs, injectables, supplies or appliances that are experimental or that are not approved by Health Canada.
- Vitamins unless they are injected, vitamin preparations, food supplements, and drugs not approved for sale in Canada.
- Lancets, insulin infusion pumps and supplies.
- Charges incurred as a result of conditions arising from war, whether or not war was declared, from participation in any civil commotion, insurrection or riot, or while serving in the armed forces.
- Vision care expenses for magnifying glasses or safety glasses of any kind.
- Additional, duplicate or replacement appliances or devices, except where the replacement is required because the existing appliance can no longer be made serviceable due to normal wear and tear, or as the result of a pathological change, unless prior approval in writing is obtained from the plan administrator.
- Charges incurred as a result of self-inflicted injury or while committing, or attempting to commit, a criminal offence.
- All fees charged by medical practitioners for the completion of medical forms or other documentation, or charges incurred for failing to keep a scheduled appointment or for the transfer of medical files.
- Services or supplies purchased outside Canada except as provided under the out-of-country care provision.
- The plan will not pay for the following, even when prescribed:
    - the cost of giving injections, serums and vaccines
    - medicines obtained from a doctor or dentist
    - treatments for weight loss, including drugs, proteins and food or dietary supplements
    - hair growth stimulants
    - contact lens care products and eye lubricant
    - dietary supplement, diet foods, vitamins, vitamin supplements, minerals other than hematinics, and anorexiants
    - food and food products including infant formula, infant foods, salt and sugar substitutes
    - skin and hair care products, including protectives, soaps, cleansers, emollients, lubricants, suntan lotions and deodorants
    - personal hygiene products, contraceptive preparations and devices
    - dental and oral hygiene products, including toothpastes, mouthwashes, and prophylaxis treatments

  - lozenges and cough suppressants or antacids, anti-flatulents and absorbents
  - medications for pets
  - laxatives, anti-diarrheals and hemorrhoidals
  - drugs listed as excluded in the Benefits Summary
- In respect to these benefits, no payment will be made for expenses that are related to services, treatments or supplies payable by or covered by a government plan.

Vision Care

Reimbursement of eligible eye wear is based on the date the items are paid in full. A written prescription by a licensed or registered optometrist or ophthalmologist is required. Reimbursement for eye exams is based on the date of the eye exam.

Eligible deductibles, reimbursements and maximums to the limits specified in the Benefit Summary.

Covered expenses

- reimbursement for prescription eyeglasses or contact lenses to the limits specified in the Benefit Summary; or
- reimbursement for laser eye surgery covered on an on-going basis to the limits specified in the Benefit Summary. Surgery performed while insured can be claimed every 24 months (as long as the person is still a covered employee or dependant) until the full cost of the surgery has been reimbursed. The total amount payable for all laser surgery and corrective eye wear may not exceed the plan maximum per 24-month period;
- reimbursement for plano sunglasses prescribed by a physician for the treatment of ophthalmic diseases or conditions to the limits specified in the Benefit Summary.

Commencement of your benefit period is based on the initial date you receive vision care benefits. Contact the plan administrator to confirm your eligibility prior to using any vision care benefits.

Expenses not covered

- vision examinations, except if identified as an eligible expense in the Benefit Summary;
- special or unusual procedures such as, but not limited to, orthoptics, vision training, subnormal vision aids and aniseikonic lenses;
- replacement of lenses or frames that are lost, broken or stolen, unless at the time of such replacement, you are otherwise eligible to the limits specified in the Benefit Summary;
- vision benefits that are not dispensed by an optometrist, an optician, or an ophthalmologist;
- charges for eyeglass accessories (i.e., cases).

Dental Care

If, while insured, you or your dependants incur any of the eligible expenses for dental services, the plan will pay a benefit subject to the dental care limitations. The amount payable will be determined based on the percentage shown in the Benefits Summary.

Benefits are based on the Dental Association fee guide for general practitioners, denturists or specialist indicated in the Benefits Summary.

Reimbursement of lab fees will be limited to the reasonable and customary charge for such services in the area where the services are provided.

Pre-determination of Benefits / Treatment Plan

Where a course of treatment is expected to cost $500 or more or will involve major dental services, it is recommended that the insured person obtain a written estimate outlining the procedures and itemized charges, including X-rays, from the attending dentist. The estimate should be submitted to the plan administrator prior to commencement of the treatment. The plan administrator will review the estimate and advise the insured person on the amount of benefit payable.

Basic Services

Examinations

- Complete oral examination
- Recall oral examination
- Specific oral examination
- Emergency oral examination

Diagnostic services

- Radiographic examination and complete intra-oral film series
- Periapical films
- Occlusal films
- Posterior bitewing films
- Extra-oral films
- Panoramic films
- Cephalometric films
- Tracing and interpretation of radiographs from another source

Preventive services

- Polishing, according
- Fluoride treatment
- Oral hygiene instruction
- Interproximal discing of teeth
- Finishing restorations
- Pit and fissure sealants
- Space maintainers
- Prophylactic odontotomy/enameloplasty

Restorative services

- Non-bonded amalgam restorations for primary teeth, permanent anterior and bicuspid teeth, permanent molar teeth
- Caries/trauma/pain control

- Pin reinforcement
- Acrylic or composite restorations, according to the frequency specified in the *Benefits Summary*
- Prefabricated post and core
- Stainless steel/plastic full coverage restorations for primary teeth
- Preformed stainless steel and polycarbonate crowns

Endodontic services

- Pulpotomy
- Root canal therapy
- Apexification
- Periapical services (apicoectomy / apical curettage, retrofilling)
- Root amputation
- Surgery: endodontic exploratory
- Perforations/restorative defect, pulp chamber repair, root repair, non-surgical and surgical
- Isolation of endodontic tooth/teeth
- Hemisection
- Chemical bleaching of endodontically treated tooth/teeth
- Intentional removal, apical filling and re-implantation
- Emergency procedures
- Replantation (excluding root canal therapy and surgery)
- Re-positioning of traumatically displaced tooth/teeth

Periodontal services

- Periodontal scaling and root planing
- Gingivectomy
- Flap approach with osteoplasty/osteotomy
- Flap approach with curettage
- Distal wedge procedure
- Osseous grafts
- Soft tissue grafts (free connective tissue grafts)
- Vestibuloplasty (oral manifestations / oral mucosal disorders)
- Post-surgical treatment

Adjunctive periodontal services

- Provisional splinting – intra-coronal, extra-coronal per unit of time
- Occlusal equilibration
- Special periodontal appliances, including occlusal guards and bruxism appliances
- Maintenance, adjustments and repairs to periodontal appliances.

Surgical services

- Removal of erupted tooth (uncomplicated)
- Removal of each additional tooth in the same surgical site
- Removal of erupted tooth (complicated)
- Removal of impacted tooth
- Removal of residual roots
- Surgical exposure of tooth
- Surgical repositioning of tooth
- Alveoloplasty
- Gingivoplasty and/or stomatoplasty
- Excision, removal of bone
- Surgical excision (cysts and neoplasms)
- Surgical incision

- Frenectomy
- Miscellaneous surgical services

Anaesthesia
- In relation to covered procedures

Professional visits
- Periodontal services post-operative visits

Adjunctive general services
- Drugs (injections)

Repairs and rebasing
- Denture adjustments including minor adjustments
- Denture repairs and additions
- Denture re-basing and/or re-lining
- Denture, tissue conditioning
- Resetting of teeth

Major Services

Major restorative treatment
Prosthodontic services for the replacement of an existing fixed or removable prosthesis will be considered if one of the following circumstances occurs:

- Replacement is necessitated by the extraction of additional natural teeth
- The existing prosthesis cannot be made
- The existing prosthesis is temporary and is replaced with a permanent one within 12 months

Dental implants
Dental implants and related services

Crowns, inlays and onlays
- Acrylic, processed
- Acrylic, processed to metal
- Acrylic or plastic, transitional, direct (chairside)
- Acrylic or plastic, transitional, indirect
- Porcelain
- Porcelain fused to metal base
- Cast metal post and core as a separate procedure
- Cast metal post and core concurrent with impression for crown
- Pre-formed stainless steel (permanent anterior tooth, permanent posterior tooth)
- Pre-formed plastic (permanent tooth)
- Metal inlay restorations, including temporization
- Metal inlay, three surfaces
- Onlay, per tooth
- Retentive pins in inlays and crowns
- Porcelain inlay/onlay, including temporization

Other restorative services
- Prefabricated metal post and core
- Pin reinforced amalgam post and core

- Pin reinforced composite post and core
- Crown made to an existing partial denture clasp (additional to crown)

Prosthodontic services, fixed
- Fixed prosthetic evaluation for cases of extensive or complicated restorative dentistry

Prosthodontic services, removable
- Complete dentures
- Partial dentures
- Denture remakes
- Immediate complete or partial dentures
- Transitional complete or partial dentures

Pontics
- Metal cast pontic
- Porcelain fused to metal pontic
- Porcelain pontic, aluminous
- Acrylic processed to metal pontic
- Acrylic pontic processed, transitional during healing
- Acrylic pontic transitional, acid etched to adjacent teeth
- Retainers, inlays and onlays
- Metal inlay
- Metal onlay
- Metal onlay, acid etch bonded

Retainers, crowns
- Acrylic crown, processed, indirect, transitional during healing
- Acrylic crown, direct, transitional during healing
- Acrylic processed to metal crown
- Porcelain crown, aluminous
- Porcelain fused to metal crown
- Metal three-quarter cast crown
- Metal full cast crown
- Retentive pins in abutments

Expenses Not Covered

- Services, treatments or supplies, eligible under this plan and payable under any government plan, including any no-fault motor vehicle insurance plan.
- Expenses incurred as a result of intentionally self-inflicted injuries.
- Charges resulting from committing or attempting to commit a criminal offence.
- Dental care, services or supplies that are primarily for cosmetic purposes.
- Expenses incurred for correction of temporomandibular joint dysfunction (TMJ).
- Conditions arising from war, (whether declared or not), participation in any civil commotion, insurrection or riot, or while serving in the armed forces.
- Any dental procedure not included in the list of eligible dental services.
- Charges for procedures in excess of those stated in the fee guide as stated in the *Benefits Summary*
- Services completed after termination of coverage.
- Personal Protective Equipment (PPE).
- All fees charged by medical practitioners for the completion of medical forms or other documentation, or charges incurred for failing to keep a scheduled appointment or for the transfer of medical files.
- Services or supplies purchased outside Canada except as provided under the out-of-country care provision.

How to Claim Benefits

Out-of-Province/Canada Group Travel Medical Emergency Insurance Claim

In the event of a claim, immediately contact your carrier who will provide the necessary information.
Your benefit plan provides for direct payment to providers in order to reduce your out-of-pocket expenses. Whenever possible the carrier will arrange for direct billing with providers, and you may choose to assign benefits to the provider of the service (hospital, clinic, physician). To facilitate direct billing be sure to present your medical assistance card to the provider.

Claims you pay out-of-pocket must be submitted directly with all original receipts and a completed claim form including the following information:

1. Your name and complete address;
2. Canadian provincial or territorial Government Health Insurance Plan number with its expiry date or version code (if applicable);
3. Claimant's date of birth, name and, if applicable, relationship to you;
4. Proof of the departure date(s) and return date(s);
5. All original prescription drug receipts (not cash register receipts), and/or itemized bills from the medical provider(s) stating the date(s) of the service(s) provided, the diagnosis, all dates and types of treatment, and the name of the medical facility and/or physician.

Reimbursement Details Regarding Extended Health Care and Dental Care Claims

To be eligible for reimbursement, Coughlin & Associates Ltd. must receive proof of claim within 24 months of the date of purchase or service. You have 90 days following the termination of your coverage to submit claims for reimbursement.
Interest is not payable on any reimbursement under this plan. All expenses incurred and paid by the participants will be deemed to have been incurred and paid in Canadian dollars and reimbursement shall be in Canadian dollars.

Reimbursement

Reimbursement will be made for expenses incurred and paid by a participant for any of the eligible services, substances and appliances set out in and in accordance with, the provisions set forth in the plan group agreement, provided such expenses:

a. are incurred and paid for services, substances and appliances prescribed by, and given under the direction of a physician, subject to the conditions of this agreement; and
b. are in the opinion of the plan administrator reasonable and customary in the area in which they are rendered or supplied.

Reimbursement will not be made for of any eligible expense unless the benefit premiums were paid when due for the months in which the service, substance or appliance was rendered or supplied.

Member Portal – Electronic Claims

Coughlin & Associates Ltd. offers employees and plan members the option to submit claims for prescription drugs, health and dental online. To access this service, please register at Coughlin's plan member portal members.coughlin.ca or download the mobile app from the App Store or Google Play. Once you are on the portal or have accessed the app:

- Click *Register Account*
- Follow the on-screen instructions and provide your group and certificate numbers, both of which can be found on your all-in-one benefits card.

Once registered, Click Submit a Claim to get started with online claiming.

Pre-Authorized Deposit (PAD)

Pre-authorized deposit is the fastest way for employees and plan members to receive claim reimbursements. Claim reimbursement deposits can be made into your bank account following the approval of your claim and eliminate both the wait for cheques to arrive by mail and the trip to the bank.
To enrol in the PAD program:

- Login to Coughlin's plan member portal
- Click on your profile and select *Direct Deposit.*

Point-of-Service Claims Submission

Claims may also be submitted direct via a point-of-service claims system at approved healthcare providers. Present your all-in-one benefit card to your provider, which will provide them with the following, required information:

Pharmacy :	**Dental:**
BIN/Carrier ID #34	BIN/Carrier ID #000034
Group Number # 59270	Group Number # 59270
Certificate number – printed on your card	Certificate number – printed on your card

Please note that health and dental claims must be submitted within the time limits specified by your benefit plan.

Submitting Paper Claims

To submit claims by paper/mail, please complete the appropriate claim form and send it, along with any applicable receipts, to Coughlin & Associates Ltd. at the mailing address found below. If your claim includes a coordination of benefits and Coughlin is the secondary payer, please include the original explanation of benefits from the primary insurer, along with photocopies of the original receipts.
Claim forms may be obtained on the Coughlin & Associates Ltd. website, at www.coughlin.ca.
Please note that all claim receipts will be retained by Coughlin & Associates Ltd.. It is therefore recommended that you retain photocopies of receipts for your records.

Dental Care Claims

Coughlin & Associates Ltd. offers electronic submission of dental claims via Electronic Data Interchange. This fast and secure method of claiming allows your claim to be sent directly from your dental office to our claims department for adjudication.
Our EDI service uses the secure data networks of Telus, the dedicated claims processing network sponsored by the Canadian Dental Association. With Telus, you can be assured that the information contained in your dental claim will be transmitted to Coughlin & Associates Ltd. quickly, safely and confidentially right from your dentist's office.
To make use of EDI for dental claim submissions, please present your all-in-one benefit card to your dental provider. You may also contact Coughlin & Associates Ltd. to receive the necessary information.

Claims Appeals Process

In the event a claim is denied and the employee is not in agreement, an appeal may be submitted in writing by the employee to Coughlin & Associates Ltd., identifying the basis of the appeal and including supporting medical information justifying the expense as medically necessary.
These appeals will be reviewed in conjunction with our medical/dental consultants and the decision will be communicated in writing to the employee.

Contact Us

Claims department:
Tel: 613-231-8540
Toll-free 1-877-768-3378
Email: ottclaims@coughlin.ca

All other inquiries:
Tel: 613-231-2266
Toll-free 1-888-613-1234
Fax: 613-231-2345
Email: info@coughlin.ca
Website: www.coughlin.ca

Mailing address:
P.O. Box 3517, Station C
Ottawa, ON K1Y 4H5

Street address:
466 Tremblay Road
Ottawa, ON K1G 3R1

Business hours:
Monday to Friday: 8:30 a.m. to 4:30 p.m. EST

APPENDIX A –
Out-of-Province/Canada Travel Medical Emergency Insurance

Underwritten by **AIG Insurance Company of Canada**

The benefit summary provides coverage highlights for these benefits.
Contact **Coughlin & Associates Ltd.**, your benefits administrator for any and all questions related to this benefit.

Provided by
Global Excel Management Inc.

PUBLIC SERVICE ALLIANCE OF CANADA (PSAC) AND CANADIAN UNION OF LABOUR EMPLOYEES (CULE)

INSURANCE IDENTIFICATION

CMG 9429163

In the event of a medical emergency, you must contact Global Excel immediately:

From Canada and the U.S. call:	**1-877-207-5018**
or collect from anywhere else call:	**1-819-566-3940**

WORLDWIDE COVERAGE

EMERGENCY OUT OF PROVINCE MEDICAL

For all in benefit Members of

Public Service Alliance of Canada (PSAC)
and Canadian Union of Labour Employees (CULE)

Public Service Alliance of Canada
Alliance de la Fonction publique du Canada

POLICY NUMBER
CMG 9429163

November 2022

EMERGENCY OUT-OF-PROVINCE MEDICAL COVERAGE

Each Canadian province provides a provincial medical plan with comprehensive benefits for hospital confinement, the service of medical doctors and other health practitioners, ambulance services, etc. In many cases, the benefits provided by these plans will pay all, or almost all, of the expenses you incur in your home province. (Note: In this Plan, "province" also refers to a "territory" of Canada, where applicable; "you" and "your" includes the Insured Members and their eligible dependents.)

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

This Plan provides extensive coverage for many services rendered outside your province of residence. It is important to note that such expenses are covered provided that they were unexpected and of an emergency nature.

ELIGIBILITY

All Insured Members and Retirees under the Public Service Alliance of Canada (PSAC) and Canadian Union of Labour Employees (CULE) and their eligible dependents whose names are on file with the Policyholder are insured under this Plan.

Class I: All eligible active Employees under age 75.
Class II: All eligible active Employees over age 70 and under age 85.
Class III: All eligible retired Employees under age 75.

PERIOD OF COVERAGE

You and your dependents are covered while outside your province of residence for such reasons as business or vacation. Expenses incurred by you are not covered in the event that you had left the province for the purpose of obtaining medical treatment, (except as indicated under the Referral Services benefit).

Trips are limited to 60 consecutive days.

EMERGENCY COVERAGE FOR HOSPITAL, MEDICAL AND THERAPEUTIC SERVICES OUTSIDE PROVINCE OF RESIDENCE

When injuries or sickness result in emergency hospitalization, medical or therapeutic services, the Company will pay benefits for the period this contract is in force, not to exceed the maximum benefit amount shown below for the actual expenses incurred outside your province of residence that exceed the amount which is payable with respect to such expenses under any government hospitalization or medical care plan in your province of residence (GHIP), or if you are not covered under any such plan, to the extent that they exceed any amount which would be payable with respect to such expenses under the provincial medical plan if you were covered under any such plan.

Benefit maximum amount reduces as follows:

Under age 70 - $5,000,000.00 lifetime maximum
Age 70 to 74 - $2,000,000.00 lifetime maximum
Age 75 and over - $1,000,000.00 lifetime maximum

HOSPITAL CONFINEMENT

Benefits are payable for confinement as a resident in-patient in a hospital, including semi-private accommodation and charges made by the hospital for services and supplies rendered by such hospital and provided for use during such confinement.

In the event that you are confined to hospital at the end of your trip outside Canada and thus prevented from returning to Canada, insurance will continue for the period of such confinement, but in no event for more than 12 months from the date the first insured expense was incurred.

MEDICAL AND THERAPEUTIC SERVICES:

Benefits are payable for:

a) the services of a legally qualified physician or surgeon (other than an insured person);

b) laboratory tests and X-ray examination by a legally qualified doctor of medicine for the purpose of diagnosis;

c) the services of a registered graduate nurse (other than a relative by blood or marriage), up to a maximum of 50 nursing shifts at the usual and customary fee, but not more than $100 per shift;

d) rental of crutches or hospital type bed, or the cost of splints, canes, slings, trusses, braces or other approved prosthetic appliances;

e) the services of a legally qualified anaesthetist;

f) drugs or medicines that require a legally qualified physician's written prescription;

g) services of a chiropodist, chiropractor, osteopath, physiotherapist or podiatrist (other than a relative) up to a maximum of $300 per practitioner;

h) expenses for accidental injury to natural and sound teeth (capped or crowned teeth are considered whole or sound natural teeth) which requires treatment by a legally qualified dentist or dental surgeon within 30 days from the date of the accident, not to exceed in the aggregate the amount of $2,000 as the result of any one accident;

i) expenses for the relief of dental pain, other than pain caused by an accident, initiated within 48 hours of the onset and completed no later than 90 days after initial treatment, not to exceed $500; and

j) out-patient services provided by a hospital.

AUTOMOBILE RETURN

If you become totally disabled and you are unable to continue your trip or vacation, the Company will pay the actual charges of a commercial agency for the return of your private or rental vehicle used for the trip, to your place of residence or nearest rental agency, up to a maximum of $4,000.

"Totally Disabled" means your complete inability, on medical evidence, to continue your duties or activities and to continue your trip or vacation.

REPATRIATION BENEFIT

When injuries or sickness covered by this Plan result in your loss of life in a province or country other than your place of residence and within 365 days after the date of the incident, the Company will pay the actual expense incurred for preparing your body for burial or cremation and shipment of your body to your place of residence in Canada, the amount not to exceed $15,000.

IDENTIFICATION BENEFIT

If your body requires identification following your loss of life for which a benefit is paid or payable hereunder, the Company will pay to one of your Immediate Family members, the reasonable and necessary expenses actually incurred by such Immediate Family member for:

a) commercial lodging and board while en route and/or during the stay in the city or town where the body is located (not to exceed a maximum duration of 3 consecutive nights); and

b) transportation by the most direct route to such location.

This benefit is payable by the Company only if the body is located outside the Immediate Family member's normal province of residence and the identification of the body is requested by the police or a similar law enforcement agency having authority over such matters.

Payment will not be made for ordinary living, travelling or clothing expenses, other than as specifically stated above. If transportation occurs in a vehicle or device other than one operated under the license for the conveyance of passengers for hire, the reimbursement of transportation expenses will be limited to a maximum of $0.40 per kilometre travelled.

The maximum amount payable for this benefit is $5,000 per Insured Person.

TRIP INTERRUPTION BENEFIT

If your scheduled departure is delayed for at least 12 hours due to sickness or hospitalization as provided by the Plan, or due to sickness or hospitalization of your covered travelling companion, the Company will reimburse you up to a maximum of $500 for the extra cost of your one-way economy/charter air fare via the most cost-effective itinerary to your next scheduled travel destination or original departure point of the same trip.

The Company will also reimburse the additional and unplanned hotel and meal expenses, telephone calls and taxi fares up to a combined maximum of $300 per day to a maximum of 5 days.

In order to claim any of the above outlined expenses, original itemized invoices must be provided at time of claim. The combined maximum amount payable for this benefit is $2.000 per Insured Person per incident.

FAMILY TRANSPORTATION BENEFIT

If you suffer injury or sickness, resulting in being confined to a hospital located outside your province of residence, the Company shall pay the reasonable and necessary expenses actually incurred for the transportation of an Immediate Family member to the hospital.

This benefit is only payable if:

a) confinement to hospital occurs within 365 days of the sickness or the accident causing the injury; and

b) reimbursement of expenses are limited to the cost of one economy class return air fare via the most direct route, or the equivalent amount toward another type of common carrier transportation for such immediate family member.

The maximum amount payable for this benefit for any one sickness, or for all injuries resulting from any one accident, is $15,000 and incidental travel expenses up to a maximum of $200 per day to a maximum of $800 per Insured Person.

RETURN TRANSPORTATION FOR TRAVELLING COMPANION

If you are repatriated to Canada in accordance with the Repatriation Benefit, or return to Canada in accordance with the Ground or Air Transportation benefit, the Company will pay a benefit to you (or your estate) for the extra cost of a one-way economy air fare transportation on a commercial flight or charter via the most cost effective itinerary to transport your Travel Companion to Canada.

The maximum amount payable for this benefit for any one trip is $5,000 per Insured Person for the transport of one Travel Companion.

RETURN AND ESCORT OF DEPENDENT CHILDREN UNDER AGE

If you are repatriated to Canada in accordance with the Repatriation Benefit, or return to Canada in accordance with the Ground or Air Transportation benefit, the Company will pay a benefit to you (or your estate) for the cost of a one-way economy air fare transportation on a commercial flight or charter via the most cost effective itinerary to transport your Dependent Children travelling with you on a trip to their home, plus reasonable overnight hotel accommodation and meal expenses and for the services of an attendant to escort your Dependent Children under age 16, if required.

The maximum amount payable for this benefit for any one trip is $5,000 per repatriated or returned Insured Person.

REFERRAL SERVICES

In the event you are referred to a hospital outside your province of residence as a resident in-patient, the Company will pay benefits for reasonable and customary charges for standard ward accommodation and for charges made by the hospital for services and supplies to the extent that such are medically necessary. Coverage shall also include the reasonable and customary services of a physician or legally qualified surgeon.

Prior to the commencement of any referral treatment, written pre-authorization from your provincial medical plan and the Company must be obtained. The government hospitalization or medical care plan in your province of residence (GHIP) may cover most, or all, of these costs. Any referral requires written recommendation from the physician or legally qualified surgeon stating the reason for the referral, and a letter from GHIP outlining their liability. Failure to comply in obtaining pre-authorization will result in non-payment.

The maximum amount payable for this benefit in any consecutive 12 month period is $50,000 per Insured Person.

It is understood and agreed that expenses incurred under the Referral Services provision are not due to an emergency. It is further understood and agreed that exclusion h) is not in effect for expenses incurred under the Referral Services provision.

EMERGENCY TRAVEL ASSISTANCE OFFERS THE FOLLOWING FEATURES:

Travel assistance is provided by Global Excel Management Inc. With centres worldwide they will:

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

HOW TO CLAIM

If you require emergency medical care or hospitalization, you or someone acting on your behalf should contact Global Excel Management Inc. immediately. If circumstances prevent you from calling Global Excel Management Inc. right away, you should contact them as soon as you can. Global Excel Management Inc. will help ensure that you receive the medical care you need and, if possible, will make claims payment arrangements directly with the hospital or service provider.

If you contact GLOBAL EXCEL MANAGEMENT INC. right away, your claim may be pre-approved so you can avoid having to pay upfront and claim for reimbursement later.

If you are not able to contact Global Excel Management Inc. before being billed for the charges, or if your medical needs are minor in nature (i.e., costing less than $500), it is your responsibility to pay the bill promptly yourself and then submit a claim as soon as you return from your trip. In any case, your claim should be submitted no later than 90 days after the expense was incurred. Global Excel Management Inc. and the insurance company are not responsible for dealing with any payment reminders or collection notices that you receive from medical providers.

To make a claim for out-of-pocket expenses, contact a Global Excel Management Inc. operator at:

From Canada & U.S., call toll free 1-877-207-5018
Outside Canada & U.S., call collect 1-819-566-3940

Give the operator your name and your Policy Number: CMG 9429163.

The operator will send you a claim form. When you complete the form, provide the patient's name and provincial health plan number and your certificate number. Be sure to attach detailed statements and original receipts showing the services rendered and the charges for each service.

Mail your completed claim form and attachments to:

Global Excel Management Inc.
73 Queen Street
Lennoxville, QC, J1M 1J3

Please make sure you obtain your medical records, statements or detailed receipts at the time of treatment and/or discharge, to submit with your claim. All claims must be submitted to Global Excel Management Inc. as soon as possible, and no later than 90 days after the expense was incurred.

COORDINATION OF BENEFITS

Global Excel Management Inc. will co-ordinate coverages with other policies according to the CLHIA's Coordinating Coverage Guidelines for Out-of- Country/Province Health Care Expenses. The total amount payable from all sources may not exceed the expenses you incurred.

IN AN EMERGENCY, HERE'S WHAT TO DO

Call Global Excel Management Inc. immediately in the event of a serious medical emergency.

Their operators are backed by a team of emergency care professionals - physicians and nurses who work closely with the doctor looking after you, and if necessary, your family or company doctor, to help ensure that you receive the medical care you need.

An operator will ask you the following:

Your name, location and the details or your emergency.
Your Policy Number: CMG 9429163
Service Support Telephone Numbers:

Telephone:
From Canada & U.S., call toll free 1-877-207-5018
Outside Canada & U.S., call collect 1-819-566-3940

GROUND TRANSPORTATION

The use of a licensed ground ambulance to a maximum of $5,000 any one accident or sickness.

AIR TRANSPORTATION

a) If an injury or sickness commencing during the course of your trip results in a medically necessary Air Transportation, the Company will pay benefits for covered expenses up to a maximum of $500,000. An Air Transportation must first be approved by the Company and it must be ordered by a legally licensed physician or surgeon who certifies that the severity of your injury or sickness warrants your Air Transportation and that such is medically necessary.

b) If, due to the geographical area at the onset of your medical emergency an air ambulance is deemed necessary, the Company will pay the cost of a licensed air ambulance for your transport to the nearest hospital or medical facility where appropriate medical treatment can be obtained.

Air Transportation means:

a) your medical condition warrants immediate transportation from the place where you suffered the injury or sickness to the nearest hospital where appropriate medical treatment can be obtained; or

b) after being treated at a local hospital, your medical condition warrants transportation to the place where you reside (provided such residence is located in Canada) to obtain further medical treatment or to recover; or

c) both **a)** and **b)** above.

Covered expenses are only those reasonable and customary expenses, up to the maximum, for transportation, medical services and medical supplies which are medically necessary and incurred in connection with your Air Transportation. All transportation arrangements made for transporting you must be by the most direct and economical route. Expenses for special transportation must be recommended by the attending physician or surgeon or required by the standard regulations of the conveyance transporting you.

Expenses for medical supplies and services must be recommended by the attending physician or surgeon. Air Transportation means any land, water or air conveyance required in connection to transport you during an Air Transportation. Special Transportation includes, but is not limited to, air ambulance, land ambulances, commercial airlines and private motor vehicles.

Charges for use of a local ambulance and/or the use of a scheduled air carrier on physician's advice, up to the cost of a one-way economy air fare for you and $250 for incidental travel expenses; if return by stretcher is required, the cost of such additional economy class seating as is necessary; if a medical attendant is required to accompany you, the Company will pay the fee of such attendant plus one return economy air fare and reasonable incidental travel expenses.

EXCLUSIONS AND LIMITATIONS

Benefits are not payable for:

a) injuries received while you are participating in any maneuvers or training exercises of the armed forces;

b) pregnancy, miscarriage, voluntary termination of pregnancy, childbirth or their complications except that in the case of a pregnancy, complications which occur before the end of the seventh month will be covered if they occur while insured hereunder;

c) sickness or injury where the trip is undertaken for the purpose of securing medical treatment or advice for such sickness or injury;

d) dental surgery or cosmetic surgery unless such surgery is a result of a covered injury;

e) emotional or mental disorders unless you are hospitalized;

f) sickness or injury due to participation in professional sports;

g) treatment or services that contravene any government hospital or medical plan in Canada;

h) expenses incurred on an elective (non-emergency) basis;

i) loss or injury as a result of suicide or any attempt thereat or self-inflicted injuries while sane or insane;

j) an act of declared or undeclared war, civil war, rebellion, revolution; insurrection, military or usurped power or confiscation or nationalization or requisition by or under the order of any government or public or local authority;

k) any services or supplies provided by an Insured Person;

l) any treatment or surgery not required for the immediate relief of acute pain or suffering;

m) any treatment or surgery which reasonably could be delayed until you return to your province of residence; and

n) anticipated medical treatments required on an ongoing basis or for continued stabilization of a medical condition known to you prior to departure.

All expenses must be incurred on a non-elective emergency basis and are in excess of any individual, group or provincial medical plan.

EXTENDED COVERAGE AFTER TERMINATION

In the event of the delayed arrival of your common carrier hospitalization this Plan will automatically be extended at no charge:

1) 24 hours in the event of a delayed common carrier;
2) the period of hospitalization plus 24 hours after you are released from hospital.

TERMINATION OF COVERAGE

Coverage will terminate on the earliest of:

1) the date you cease to meet the eligibility requirements of the Plan;
2) the date any required premium is unpaid; or
3) the date the Master Policy terminates or in accordance with any other terms and conditions stated in the Master Policy.

WHAT TO DO IN A MEDICAL EMERGENCY

You or someone acting on your behalf should call Global Excel Management Inc. immediately, before you get medical assistance. If you can't call right away, contact Global Excel Management Inc. as soon as you are able to do so.

Call:

U.S. & Canada 1-877-207-5018
Outside U.S. & Canada 1-819-566-3940 collect

The operator will ask you for:

Your name, location and the details of your emergency
Your Policy Number: CMG 9429163

The operators are backed by a team of emergency care professionals - physicians and nurses who work closely with the doctor looking after you, and if necessary, your family or company doctor, to help ensure that you receive the medical care you need.

This brochure has been prepared to help you understand your coverage and, as such, does not create or confer any contractual or other rights. The terms and conditions governing the insurance are set out in the group Master Policy issued by AIG Insurance Company of Canada. In the event of any variation between information in this brochure and the provisions of the policy, the latter will prevail.

AIG