Extended health care

(Administered by Coughlin & Associates Ltd.)

Plan administrator

This benefit is administered by Coughlin & Associates Ltd.

General description of the coverage

In this section, *you* means the employee and all dependants covered for extended health care benefits through Coughlin & Associates Ltd.

Extended health care coverage pays for reasonable and customary eligible services or supplies for you that are medically necessary for the treatment of an illness.

To qualify for this coverage you must be entitled to benefits under a provincial medicare plan or federal government plan that provides similar benefits.

An expense must be claimed for the benefit year in which the expense is incurred. You incur an expense on the date the service is received or the supplies are purchased or rented.

The benefit year is from January 1 to December 31.

Subrogation

If an insured person suffers personal injury or loss for which he has a right to bring action for damages against a third party, Coughlin & Associates Ltd. shall be subrogated to the insured person's rights to recover damages to the extent that it may be obligated to pay benefits to the insured person. In such case, Coughlin & Associates Ltd. will require the insured person to complete a subrogation reimbursement agreement. Coughlin & Associates Ltd. has the right to suspend payment of benefits until the completed agreement is received.

Upon judgement or settlement for damages, the insured person shall reimburse Coughlin & Associates Ltd. for benefits paid or payable.

Deductible

There is no deductible.

Prescription drugs

For the following drugs, sera, vaccines and medicines dispensed by a

licensed physician or dentist or by a licensed pharmacist on the written prescription of a licensed physician or dentist limited to a reasonable and customary total of a three-month supply (certain eligible medications may require the prior authorization of the administrator):

(a) medicines, including oral contraceptives, legally requiring a prescription and identified in the Monographs section of the then current Compendium of Pharmaceuticals and Specialties as narcotics, controlled medicines, or medicines requiring a prescription;

(b) life-sustaining medicines not legally requiring a prescription, described below and identified in the Therapeutic Guide section of the then current Compendium of Pharmaceuticals and Specialties:

anti-anginal agents	anti-cholinergic preparations
anti-parkinsonism agents	anti-arrhythmic agents
bronchodilators	glaucoma therapy
anti-hyperlipidemic agents	insulin preparations
hyperthyroidism therapy	oral fibrinolytic agents
parassymathomimetic agents	potassium replacement therapy
tuberculosis therapy	topical enzymatic debriding agents

(c) fertility medicines limited to a lifetime maximum of nine treatment cycles;

(d) smoking cessation products/programs accompanied by a doctor's statement will be reimbursed at 50 per cent with a $250 lifetime maximum;

(e) Viagra®/Cialis®/Levitra®, limited to $500 every calendar year;

(f) Compound mixtures when at least one ingredient is a prescription medication and eligible under the plan.

Excluding in all cases the following drugs:

- food and dietary supplements;

- cosmetic or hygienic products;
- experimental medicines; and
- medicines not considered by Health Canada, the Canadian Medical Association or by the medical association of the province of residence of the covered person to be therapeutically useful.

Drugs and medicines are reimbursed at 90 per cent.

The Golder Associates drug card

Golder staff may pay for their prescription drugs at any retail pharmacy in Canada directly through their drug plan using the pay direct drug card from ESI Canada and Coughlin & Associates Ltd.

The card can be used by you as well as your spouse and eligible dependants. It cannot be used for dental, vision or other health care claims. (Continue to submit claims for those services to Coughlin & Associates Ltd. in the normal fashion.)

The card can be used at any pharmacy in Canada.

If you have *single* coverage in the Golder employee benefits plan, you will receive one Golder pay direct drug card. If you selected *family* coverage, you will receive two cards; one for you and one for your spouse. Note: Only the name of the covered Golder employee appears on the card.

Hospital expenses in your province

We will cover 100 per cent of the costs for hospital care described below in the province where you live.

We will cover out-patient services in a hospital and the difference between the cost of a ward and a semi-private hospital room.

We will also cover the cost of room and board in a convalescent hospital if this care has been ordered by a doctor as long as:

- it follows at least five consecutive days of in-patient hospitalization;
- it begins within 14 days of release from the hospital; and
- it is primarily for rehabilitation.

The maximum amount payable is $20 per day up to a maximum of 180 days for treatment of an illness due to the same or related causes.

For purposes of this plan, a *convalescent hospital* is a facility licensed to provide convalescent care and treatment for sick or injured patients on an in-patient basis. Nursing and medical 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 or a facility for treating alcohol or drug abuse.

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.

Expenses out of your province

ETFS (Global Excel) will cover emergency medical services while you are outside the province where you live. They will also cover referred services. Please refer to the *Out-of province/Canada group travel medical emergency insurance* section.

Medical services and equipment

We will cover 100 per cent of reasonable and customary costs (unless specified otherwise) for the medical services listed below when ordered by a doctor (the services of a licensed optometrist, ophthalmologist, paramedics or dentist do not require a doctor’s order).

- out-of-hospital private duty nurse services recommended as being medically necessary by a physician. Services must be for nursing care, and not for custodial care. The private duty nurse must be a registered nurse in the province where you live and who does not normally live with you. Only 75 per cent of the charge for such service is payable limited to $5,000 per calendar year for each covered person.

- for services of the following, if licensed by a licensing and registration authority, in the province where the service is

rendered. (Reimbursement is based on the dates the services were rendered. If you choose to enter into a block payment or annual payment arrangement for services, reimbursements will only be made at the end of the contract period. Please submit all receipts and a copy of the contract):

- chiropractor;
- osteopath;
- naturopath;
- podiatrist;
- physiotherapist;
- speech therapist;
- masseur;
- acupuncture

limited to $40 per visit; and

- psychologist.

limited to $1,200 per calendar year for the covered person. The services of a certified or registered counsellor or social worker may be considered in lieu of a registered psychologist if a medical doctor's referral is submitted indicating that there is no registered psychologist working within a reasonable distance of the member's home and/or work. The referral must indicate the distance of the nearest registered psychologist.

All receipts must clearly indicate the names of those attending the sessions.

Charges for services by a member of the *College of Physicians and Surgeons* are paid by the provincial health insurance plan.

- For X-rays by a licensed chiropractor, limited to $45 per calendar year for the covered person.

- For surgery performed by a licensed podiatrist, limited to $200 per calendar year for the covered person.

- For visual motor therapy by a licensed optometrist limited to $10 per half-hour.
- For eye examinations by a licensed physician or a licensed optometrist, limited to $75 per examination every 12 consecutive months.
- For services of a dentist for the excision of a cyst or tumour.
- For services of a dentist only if the treatment is both required as a direct result of an accidental injury to sound natural teeth from an external blow, excluding biting accidents, and the treatment is performed within the 12 month period immediately following the accident.

A **sound** tooth is any tooth that did not require restorative treatment immediately before the accident.

A **natural** tooth is any tooth that has not been artificially replaced.

- For ambulance service to the nearest hospital where treatment is available.
- For an artificial eye, arm, hand, leg, foot, breast and orthopaedic brace, including repairs and adjustments, or replacement if repair is not possible, or to accommodate a growing child.
- For stump socks limited to six pair per calendar year for the covered person.
- For a hearing aid up to a maximum of $2,000 per person every three calendar years (excluding batteries).
- For eye glasses or contact lenses following a cataract operation, limited to $100 for each eye once only.
- For oxygen and its administration.
- For rental of a standard wheelchair, crutches or hospital bed recommended and approved by a licensed physician.

- For the following items if recommended and approved by a licensed physician:
  - compression stockings limited to two pair per calendar year for the covered person;
  - traction appliance;
  - spinal and abdominal medical support;
  - varco traction kit, belt and similar appliance;
  - braces (must be constructed with rigid or semi-rigid material);
  - cervical collar;
  - ileostomy or colostomy kit;
  - urinary supplies, excluding diapers and liners. (Note: ostomy and urinary supplies are payable after incurred expenses exceed the provincial health plan grant.)
  - mastectomy bras limited to four per calendar year;
  - wigs/hair pieces required for permanent hair loss as a result of any injury or disease or for temporary hair loss as a result of medical treatment for any disease, subject to a lifetime maximum of $700 per covered individual.

- for custom built orthopaedic shoes, the charge, reduced by the cost ($50) of ordinary shoes, and orthopaedic modifications to shoes, provided such shoes and modifications are recommended and approved by a licensed physician or by a licensed podiatrist.

- orthotics (custom made inserts or arch supports) - all such claims must be accompanied by a medical statement indicating the foot condition being treated. Reimbursement will also be limited to $300 for all such claims, per calendar year.

- additional services and supplies at the discretion of the policy holder limited to the cost of the device or item which will adequately meet the covered person's fundamental medical needs.

If reimbursement is available under a provincial plan, this plan will only consider the balance after the provincial plan has considered its portion. It is recommended that an estimate with all supporting documentation be submitted prior to incurring any costs. Any approved equipment will be reimbursed based on the date the item is paid in full.

Vision care

Vision care expenses will be reimbursed to a maximum of $350 per insured per 24 consecutive months.

The $350 can be used to cover the costs of prescription glasses or, alternatively, prescription contact lenses. Plus, employees electing to have laser eye surgery can apply the $350 allowance against their laser surgery expenses and, at future 24-month periods, claim an additional $350 until the full cost of laser surgery is recovered, provided coverage is in effect.

Reimbursement of eligible eye wear is based on the date the items are paid in full.

Eye exams by a licensed physician or licensed optometrist will be reimbursed to a maximum of $75 per insured person per 12 consecutive months.

Eye exams are reimbursed based on the date of the eye exam. Fees in addition to the standard eye exams are not eligible for reimbursement.

When coverage ends

Extended health care coverage ends when your other benefits terminate as described under the “General Information” section at the beginning of the booklet. However, at retirement, your coverage will continue under the Retiree Plan.

What is not covered

We will not pay for the following costs:

- for any covered expense incurred during a period of hospital confinement which began before the covered person became insured under the policy;

This limitation will not apply to a child who became insured at birth.

- for a periodic health check-up or examination;
- for travel for health;
- for cosmetic surgery;
- for dental services, except as a covered expense for:
- the excision of a cyst or tumor, and
- only if the treatment is both required as a direct result of an accidental injury to sound natural teeth from an external blow, excluding biting accidents, and the treatment is performed within the 12 month period immediately following the accident;
- for injury or disease for which a covered person is entitled to payment under any Workers' Compensation or similar coverage;
- for an expense for which a covered person is not required to pay, or for which the covered person is entitled to reimbursement under any non-contractual arrangement or under the health plan of the province in which the covered person resides, whether or not the covered person is insured under that plan;
- for a charge which is not permitted to be insured;
- for an injury or disease resulting from war or hostilities of any kind;
- for any deterrent or user fee, other than a chronic care co-payment fee for a covered person under 65 years of age, charged by a hospital;
- for appliances or devices which have been lost, mislaid or stolen;
- for services or supplies not required for activities of daily living.

Co-ordination of benefits

Some plan members may also have medical and/or dental coverage through a spouse's benefit plan. In such cases, coverage under the two plans shall be co-ordinated and the amount payable pro-rated and limited to the extent that the total coverage does not exceed 100 per cent of all eligible expenses.

The first item to deal with is the order of benefit determination. In other words, whose plan pays first.

The insured must first claim from the plan provided by the plan sponsor where he/she is employed. For example, a Golder employee must first claim from the Golder plan, while his/her spouse must claim from his/her plan. Dependants must claim first under the plan of the covered parent with the earlier birthday in the calendar year. For example, if the Golder employee was born in June and his/her spouse was born in July, then the dependants must first claim under the Golder plan.

For the co-ordination of benefits provision, the insured must first claim from his/her own plan and then send copies of the claimed items, as well as the original explanation of benefits that accompanies their first claims payment cheque to the second administrator, keeping copies for personal records. The claim will then be processed a second time and any amounts not reimbursed by the first plan will be considered by the second plan. In no case will the combination of both plans provide reimbursement that exceeds 100 per cent of expenses.

If the person is covered under another plan, priority will go to:

- the plan where the employee is an active, full-time employee;
- the plan where is employee is an active, part-time employee;
- the plan where the employee is a retiree.

In the case of separation or divorce:

- the plan of the parent with custody of the child;
- the plan of the spouse-partner of the parent with custody of the child;
- the plan of the parent not having custody of the child;
- the plan of the spouse-partner of the parent not having custody of

he child.

In summary, claims must be filed with the plan provider according to the order of benefit determination. Subsequently, copies of the claims items and the first plan's reimbursement and explanation of benefits must then be filed with the second plan. Following this procedure will ensure that all claims are adjudicated properly.

If priority cannot be established, the benefit shall be pro-rated among the plans in proportion to the amounts that would have been paid under each plan had there been coverage only by that plan.

When and how to make a claim

To make a claim, complete the claim form that is available from Coughlin & Associates Ltd. or your employer.

In order for you to receive benefits, we must receive the claim no later than 90 days after the earlier of:

- the end of the benefit year during which you incur the expenses, or
- the end of your extended health care coverage.

Out-of-province/Canada group travel medical emergency insurance

Plan administrator

This benefit is administered by Global Excel Management Inc.

Benefit summary

Hospital accommodation	Reasonable and customary costs
Physician charges	Reasonable and customary costs
Diagnostic services	Reasonable and customary costs
Paramedical services	$250 per profession
Prescription drugs	30-day supply per prescription
Ambulance services	Reasonable and customary costs
Medical appliances	Reasonable and customary costs
Private duty nurse	Up to $5,000
Emergency air transportation	Reasonable and customary costs
Transportation to bedside	Economy round-trip airfare plus up to $150 per day to $3,000

Return of travelling companion	One-way airfare
Treatment of dental accidents	Up to $2,000
Meals and accommodation	Up to $150 per day, to $3,000 per trip
Vehicle return	Up to $5,000
Return of deceased	Up to $5,000
Incidental expenses	Up to $250

Important notice. Please read carefully

Travel insurance is designed to cover losses arising from sudden and unforeseeable circumstances occurring while you are travelling temporarily outside your province or territory of residence. It is important that you read and understand your plan before you travel. In the event of any discrepancy between the provisions of a booklet or other document you hold and the provisions of the policy, the provisions of the policy shall govern. The insurer has contracted Global Excel Management Inc. (called *Global Excel*") to provide medical assistance and claims services under the policy.

In the event of an emergency, call Global Excel immediately

The emergency telephone numbers are listed on the back of the medical assistance card provided.

Global Excel must be contacted before you seek medical treatment. If your condition renders you unable to do so, then someone else must contact Global Excel immediately for you. Do not assume that someone will contact Global Excel on your behalf. It remains your responsibility to ensure that Global Excel has been contacted prior to receiving medical treatment or as soon as reasonably possible.

If you incur any expenses without prior approval by Global Excel, such

expenses will be covered, except where the policy expressly requires the prior approval or authorization of Global Excel, on the basis of the reasonable and customary costs that would have been payable for such expenses by the insurer in accordance with the terms and conditions of the policy. Such expenses may be higher than this amount. Therefore, you will be responsible for paying any difference between the amount you incur and the reasonable and customary costs reimbursed by the insurer.

Individual coverage - eligibility, effective date and termination

Participant coverage

To be covered under the policy as a participant, you must meet the following eligibility requirements:

1. be covered under the government health insurance plan of your province or territory of residence;

2. be covered under the basic group extended health care plan of the policyholder;

3. be younger than the termination age specified in the *Schedule of benefits*;

4. have your place of employment in Canada;

5. have your permanent residence in Canada; and

6. a) if you are covered as an employee of the policyholder, you must also:

    1. work the minimum number of hours per week specified in the Schedule of benefits; and

    2. have satisfied the eligibility period specified in the *Schedule of benefits*; or

        if you are covered as a member of the policyholder who is other than an employer, you must also:

1. be a member in good standing of the policyholder; and

2. be on the monthly list of members entitled to coverage provided to the insurer by the policyholder.

Participant coverage will become effective on the later of:

1. the date the policy becomes effective; or

2. the date the participant's coverage becomes effective under the basic group extended health care plan of the policyholder.

Coverage for disabled employees or employees who are not actively at work on the date their coverage would normally become effective will become effective on the date the employee resumes active work.

Participant coverage will terminate immediately upon the earlier of:

1. the date you cease to meet the above eligibility requirements for participant coverage;

2. the date the premium is due if the policyholder does not remit your premium to the insurer, except where this is the result of clerical error; or

3. the date the policy is terminated.

Dependant coverage

To be covered under the policy as a dependant, you must meet the following eligibility requirements:

1. be covered under the government health insurance plan of your province or territory of residence;

2. be covered as a dependant under the basic group extended health care plan of the policyholder; and

3. meet the definition of dependant in the policy.

Dependant coverage, if any, will become effective on the later of:

1. the date the policy becomes effective; or

2. the date the dependant's coverage becomes effective under the basic group extended health care plan of the policyholder, but in no event prior to date the participant's insurance becomes effective.

Dependant coverage will terminate immediately upon the first to occur of:

1. the date the dependant ceases to meet the above eligibility requirements for dependant coverage;

2. the date the participant's coverage terminates, except if termination is due to the death of the participant, in which case your coverage will continue until the earlier of the expiry of two years or the date you cease to meet the definition of dependant or reach the termination age specified in the *Schedule of benefits* or remarry or die, provided the policyholder continues to make the required premium payments; or

3. the date the policy is terminated.

Benefits

The policy covers expenses that are:

- incurred outside the province or territory of residence of the insured person;

- medically necessary;

- reasonable and customary costs;

- incurred as a result of an emergency due to sudden and unforeseen sickness and/or injury occurring during the coverage period;

- in excess of those covered by the government health insurance plan or other insurance under which you may have coverage; and

- legally insurable; subject to the overall maximum per insured person specified in the *Schedule of benefits*. In the event of an emergency, the following benefits are payable under the policy. However, certain expenses, as specified below, are covered only if you obtain the prior approval of Global Excel.

1. **Hospital accommodation:** Room and board costs up to the semi-private room rate charged by the hospital. If medically necessary, expenses for treatment in an intensive or coronary care unit are also covered. If coverage terminates for any reason during your hospital stay, benefits continue until discharge, to a maximum of one year. In no case will expenses for in-patient stays be covered for a period greater than 365 days per insured person.

2. **Physician charges:** Charges for treatment by a physician.

3. **Diagnostic services:** Laboratory tests and X-rays prescribed by the attending physician and that are part of the emergency treatment. The policy does not cover magnetic resonance imaging (MRI), cardiac catheterization, computerized axial tomography (CAT) scans, sonograms or ultrasounds and biopsies unless Global Excel authorizes such services in advance.

4. **Paramedical services:** The services (including X-rays) of a licensed chiropractor, physiotherapist, podiatrist or osteopath, to the maximum specified in the *Benefit summary* section of the *Schedule of benefits*, per insured person, per profession listed above, when approved in advance by Global Excel.

5. **Prescriptions:** Drugs, including injectable drugs, and sera that can only be obtained upon medical prescription, that are prescribed by a physician and that are supplied by a licensed pharmacist when medically necessary for emergency treatment, except when needed to stabilize a chronic condition or a medical condition that you had before your trip. This benefit is limited to a 30-day supply per prescription, unless you are hospitalized.

6. **Ambulance services:** When reasonable and medically necessary,

licensed ground ambulance service to the nearest medical facility.

7. **Medical appliances:** When approved in advance by Global Excel, minor appliances such as crutches, casts, splints, canes, slings, trusses, braces, walkers and/or the temporary rental of a wheelchair when prescribed by the attending physician, obtained outside your province or territory of residence and medically necessary.

8. **Private duty nurse:** The professional services of a registered private nurse, when medically necessary and while hospitalized, to the maximum specified in the *Benefit summary* section of the *Schedule of benefits*, per insured person, when approved in advance by Global Excel.

9. **Emergency air transportation:** When approved and arranged in advance by Global Excel:

    a. air ambulance to the nearest appropriate medical facility or to a Canadian hospital for immediate emergency treatment;

    b. transport on a licensed airline with an attendant (where required) to return you to your province or territory of residence for immediate emergency treatment.

10. **Transportation to bedside:** When approved in advance by Global Excel, a single round-trip economy airfare from Canada plus up to the amounts specified in the *Benefit summary* section of *Schedule of benefits* for the cost of meals and commercial accommodation for one of the following: spouse, parent, child, brother, sister or business partner, to:

    a. be with you if you are travelling alone and have been hospitalized as the result of an emergency. To be payable, this benefit requires that you eventually be hospitalized as an in-patient for at least three consecutive days outside your province or territory of residence and that the attending physician provide written certification that the situation was serious enough to warrant the visit; or

b. identify the deceased insured person prior to the release of the body, where necessary. The insurer will only reimburse covered expenses evidenced by original receipts.

11. **Return of travelling companion:** If you are returned to your province or territory of residence under the *Emergency air transportation* or *Return of deceased* benefit, the insurer will reimburse the cost of a single one-way economy airfare for a travelling companion to return to Canada, when approved in advance by Global Excel.

12. **Treatment of dental accidents:** To the maximum specified in the *Benefit summary* section of the *Schedule of benefits* per insured person for emergency dental treatment to repair natural, vital and sound teeth or permanently attached artificial teeth provided the injury was caused by an external, accidental blow to the mouth or face. You must consult a physician or dentist immediately following the injury. Treatment must begin during the coverage period and be completed prior to returning to your province or territory of residence. An accident report is required from a physician or dentist for claims purposes.

13. **Meals and accommodation:** To the maximum specified in the *Benefit summary* section of the *Schedule of benefits* per participant, for the cost of commercial accommodation and meals for the participant and/or any of his/her dependants when their trip is extended beyond the last day of the scheduled trip due to the sickness and/or injury suffered by an insured person. Global Excel must authorize this benefit in advance. The fact that you are unable to travel must be certified by the attending physician and supported with original receipts from commercial organizations.

14. **Vehicle return:** To the maximum specified in the *Benefit summary* section of the *Schedule of benefits* if neither you, nor someone travelling with you, are able to operate your vehicle, whether owned or rented, during your trip due to sickness and/or injury. Arrangements and payment will be made for the return of

the vehicle to your home in your province or territory of residence or the nearest appropriate rental agency. Benefits will only be payable for a single person to return the vehicle when approved and/or arranged in advance by Global Excel. This benefit does not cover wages lost by the person driving your vehicle. The insurer will only reimburse covered expenses evidenced by original receipts.

15. **Return of deceased:** To the maximum specified in the *Benefit summary* section of the *Schedule of benefits* towards the cost of preparation and transportation of the deceased insured person to their province or territory of residence in the event of death due to sickness and/or injury. In the case of cremation and/or burial at the place of death of the insured person, this benefit is limited to $2,500. The cost of the casket or urn is not covered.

16. **Incidental expenses:** To the maximum specified in the *Benefit summary* section of the *Schedule of benefits* for your out-of-pocket expenses such as telephone charges, television rental and parking while you are hospitalized for an emergency and the expenses are incurred as a direct result of such hospitalization. The insurer will only reimburse covered expenses evidenced by original receipts.

Exclusions

The policy does not cover losses or expenses related in whole or in part, directly or indirectly, to any of the following:

1. Treatment or services normally covered or reimbursable under a government health insurance plan or under other insurance you might have.

2. Any condition that existed prior to departure unless such pre-existing medical condition has been stable (i.e. no change in symptoms, no hospitalization, no change in condition, no new prescription drugs or prescribed change in treatment or medication) immediately prior to departure for the pre-existing condition stability period specified in the *Schedule of benefits*.

3. Any trip booked or commenced contrary to medical advice or after you are diagnosed with terminal illness.

4. Any medical condition for which, prior to departure, medical evidence suggests a reasonable expectation that treatment or hospitalization could be required while travelling.

5. Treatment, surgery, medication, services or supplies that are not required for the immediate relief of acute pain and suffering or that you elect to have provided outside your province or territory of residence when medical evidence indicates that you could return to your province or territory of residence to receive such treatment. The delay to receive treatment in your province or territory of residence has no bearing on the application of this exclusion.

6. Treatment or surgery during a trip when the trip is undertaken for the purpose of securing or with the intent of receiving medical or hospital services, whether or not such trip is taken on the advice of a physician.

7. Cardiac catheterization, angioplasty, and/or cardiovascular surgery including any associated diagnostic test(s) or charges unless approved by Global Excel prior to being performed, except in extreme circumstances where such surgery is performed on an emergency basis immediately upon admission to hospital.

8. Magnetic resonance imaging (MRI), computerized axial tomography (CAT) scans, sonograms or ultrasounds and biopsies unless Global Excel authorizes such services in advance.

9. Hospitalization or services rendered in connection with general health examinations for "check-up" purposes, treatment of an ongoing condition, regular care of a chronic condition, home health care, investigative testing, rehabilitation or ongoing care or treatment in connection with drugs, alcohol or any other substance abuse or non-compliance with any prescribed medical therapy or treatment and medical treatment of an acute sickness and/or injury after the initial emergency has ended (as determined by the

medical director of Global Excel).

10. A disorder, disease, condition or symptom that is emotional, psychological or mental in nature unless hospitalized.

11. Emergency air transportation and/or car rental unless approved and arranged in advance by Global Excel.

12. Treatment not performed by or under the supervision of a physician or licensed dentist.

13. Treatment or hospitalization of mother or child as a result of pregnancy, miscarriage, childbirth or complications of any of these conditions occurring in the four weeks before or after the expected delivery date.

14. War, invasion, act of a foreign enemy, declared or undeclared hostilities, civil war, rebellion, revolution or military power.

15. Terrorism or by any activity or decision of a government agency or any other entity to prevent, respond to or terminate terrorism except for ensuing loss or damage which results directly from fire or explosion. Such loss or damage is excluded regardless of any other cause or event that contributes concurrently or in any sequence to the loss or damage.

16. Committing or attempting to commit an illegal act or a criminal act.

17. Suicide (including any attempt thereat) or self-inflicted injury, whether or not you are sane.

18. Service in the armed forces.

19. Participation in any sport as a professional athlete (for which you are remunerated), or in motorized or mechanically assisted racing or speed contests (defined as an organized activity of a competitive nature in which speed is a determining factor in the outcome of the event).

20. Loss or damage to eyeglasses, sunglasses, contact lenses, or prosthetic teeth, limbs or devices and resulting prescription thereof.

21. The replacement of an existing prescription whether by reason of loss, unless otherwise specified elsewhere in the policy, 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 or which are not required as a result of an emergency.

22. Upgrading charges and cancellation penalties for airline tickets, unless approved in advance by Global Excel.

23. The cost of any airline ticket covered under the policy where your ticket may be exchanged or used for the same purpose.

24. Crowns and root canals.

25. Treatment or services received in the province where you attend school or work on a full-time basis or in your home country, if you are a foreign student studying in Canada or a non-resident working in Canada.

General provisions and limitations

1. **Notice to Global Excel:** In the event of a sickness and/or injury likely to give rise to an emergency, you must give immediate notice to Global Excel. Failure to do so may limit the benefits payable under the policy. If you incur any expenses without prior approval by Global Excel, such expenses will be covered, except where the policy expressly requires the prior approval or authorization of Global Excel, on the basis of the reasonable and customary costs that would have been payable for such expenses by the insurer in accordance with the terms and conditions of the policy. Such expenses may be higher than this amount, therefore you will be responsible for paying any difference between the amount you incur and the reasonable and customary costs reimbursed by the insurer.

2. **Transfer or medical repatriation:** During an emergency (whether prior to admission or during a covered hospitalization), the insurer reserves the right to:

   a. transfer you to one of Global Excel's preferred health care providers; and/or

   b. return you to your province or territory of residence for the medical treatment of your sickness and/or injury where this poses no danger to your life or health. If you choose to decline the transfer or return when declared medically stable by the medical director of Global Excel, the insurer will be released from any liability for expenses incurred for such sickness and/or injury after the proposed date of transfer or return. Global Excel will make every provision for your medical condition when choosing and arranging the mode of your transfer or return and, in the case of a transfer, when choosing the hospital.

3. **Limitation of benefits:** Once you are deemed medically stable to return to Canada (with or without medical escort) either in the opinion of the medical director of Global Excel or by virtue of discharge from a medical facility, your emergency will be deemed to have ended, whereupon any further consultation, treatment, recurrence or complication related to the emergency will no longer be eligible for coverage under the policy.

4. **Misrepresentation and non-disclosure:** Your entire coverage under the policy shall be voidable if the insurer determines, whether before or after loss, that you or the policyholder have concealed, misrepresented or failed to disclose any material fact or circumstance concerning the policy or your interest therein, or if you or the policyholder refuse to disclose information or to permit the use of such information, pertaining to any of the insured persons under the policy. Consequently and following a loss, no claim shall be payable by the insurer and you shall be solely responsible for all expenses relating to your claim, including medical repatriation costs.

5. **Subrogation:** If you suffer a loss covered under the policy, the insurer is granted the right from you to take action to enforce all your rights, powers, privileges, and remedies, to the extent of benefits paid under the policy, against any person, legal person or entity which caused such loss. Additionally, if "no fault" benefits or other collateral sources of payment of medical expenses are available to you, regardless of fault, the insurer is granted the right to make demand for, and recover, those benefits. If the insurer institutes an action it may do so at its own expense, in your name, and you will attend at the place of loss to assist in the action, in addition to providing the insurer all information, co-operation and assistance it may reasonably require. If you institute a demand or action for a covered loss, you shall immediately notify the insurer so that the insurer may safeguard its rights.

   Notwithstanding any provisions in the policy to the contrary, the insurer's rights under this paragraph shall be governed by the laws of the state, province, or district where the loss occurs, or where benefits under the policy are paid.

   You shall take no action after a loss that will impair the rights of the insurer set forth in this paragraph and shall do all such things as are necessary to secure such rights.

6. **Arbitration:** Notwithstanding any clause in the policy, the parties hereto undertake to submit to an arbitration procedure, to the exclusion of the courts, any present or future dispute relating to a claim.

   The arbitration proceedings shall be governed by the arbitration law in force in the Canadian province or territory of residence of the participant. The parties agree that any action will be referred to arbitration.

7. **Applicable law:** The policy is governed by the law of the Canadian province or territory of residence of the participant. Any legal proceeding by the insured person, his heirs or assigns shall

be brought in the courts of the Canadian province or territory of residence of the participant.

8. **Other insurance:** If, at the time of loss, you have insurance from another source, or if there is any other party responsible for benefits provided under the policy, the insurer will pay covered expenses only in excess of those covered by that other insurer or other responsible party, including credit cards, private or public health plans, private or provincial auto plans, or any other insurance, whether collectable or not, which provides the insured person with some or all of the benefits and coverage provided under the policy. If, however, that other insurance is also "excess only", the insurer will co-ordinate payment of all eligible claims with that other insurer. All co-ordination follows the Canadian Life and Health Insurance Association guidelines. In no case, will the insurer seek to recover against employment related plans if the lifetime maximum for all in country and out-of-country benefits is $50,000 or less.

9. **Co-ordination and order of benefits:** If a person has coverage under another plan that does not provide for co-ordination of benefits, that plan will be considered primary carrier and will be responsible for making the initial payment. If the other plan does provide for co-ordination of benefits, the order of benefit will be as follows:

   Participant and dependant spouse

   The plan insuring the participant or the participant's dependant spouse as an employee/member pays benefits before the plan insuring the participant or the participant's spouse as a dependant.

   Dependant child

   If the dependant child is insured as a dependant under the participant's and the spouse's plans, benefits will first be payable under the plan of the parent whose birthday comes first in the calendar year. The balance of eligible expenses can then be

submitted to the plan of the other parent.

If both parents have the same birthday (month/day), the claims for children must be submitted to the plan in the alphabetical order of the parents' first names. When a person is insured under other group or individual policies or government plans, the benefits payable from all sources cannot exceed 100 per cent of expenses incurred.

10. **Rights of examination:** To be entitled to payment of benefits provided under the policy, the participant, on his own behalf and on behalf of his dependants hereby authorizes any physician, health professional, hospital, institution and any other organization to forward to the insurer or its representatives, all information, reports or documents that they may require.

    The participant authorizes the insurer to communicate directly with any physician, health professional, hospital, institution or other organization to obtain any information required for the assessment of claims and relieves the persons concerned of all legal responsibility which could arise from the disclosure of such information.

    In the event of death, the insurer will require that a death certificate be filed with the claim. Furthermore, the insurer has the right to request an autopsy and review any autopsy report, if not prohibited by law.

11. **Limitation of actions:** An action or proceeding against the insurer for the recovery of a claim under the policy shall not be commenced more than one year (two years in the Northwest Territories, and three years in the province of Quebec) after the date the insurance money became payable or would have become payable if it had been a valid claim.

12. **Availability and quality of care:** Neither the insurer nor Global Excel shall be responsible for the availability or quality of any medical treatment (including the results thereof) or transportation

at the vacation destination, or your failure to obtain medical treatment during the coverage period.

13. **Evidence of age:** The insurer reserves the right to request proof of age of any insured person.

14. **Assignment:** Benefits under the policy may not be assigned

15. **When money payable:** All money payable under the policy shall be paid by the insurer within 60 days after it has received proof of claim.

16. **Continuance of individual coverage during absence from work:** If a participant is absent from work due to disability, temporary lay-off, authorized leave of absence, strike or any other work stoppage, the insurance will be continued as long as the participant remains covered under the policyholder's basic group extended health care plan.

17. **Examination of the policy:** The policy, including any endorsements, will be kept at the office of the policyholder. You may consult the policy during the regular business hours of the policyholder.

Automatic extension of coverage period

The coverage period per trip will automatically be extended up to 72 hours, provided the participant has not reached the termination age, if:

a. you are hospitalized due to a medical emergency on the last day of coverage. Your coverage will remain in force for as long as you are hospitalized and the 72-hour extension commences upon release from hospital;

b. a late train, boat, bus, plane, or other vehicle in which you are a passenger causes you to miss your scheduled return to your province or territory of residence (including by reason of weather);

c. the vehicle in which you are travelling is involved in a traffic accident or mechanical breakdown that prevents you from returning to your province or territory of residence on or before

your return date;

d. you must delay your scheduled return to your province or territory of residence due to a medical emergency.

All claims incurred after your original scheduled return date must be supported by documented proof of the event resulting in your delayed return.

International assistance service

Global Excel is available to take your calls 24 hours a day, seven days a week.

Emergency call centre — No matter where you travel, professional assistance personnel are ready to take your call. Global Excel can also provide you with Canada Direct instructions and codes so that you only deal with Canadian telephone operators.

Referrals — Global Excel can refer you to the preferred medical providers (hospitals, clinics and physicians) that are closest to where you are staying. With a referral, it is less likely that you will have to pay for services out-of-pocket.

Benefit information — Explanation of your coverage is available to you and to the medical providers who are treating you.

Medical consultants — Global Excel's team of medical professionals, available 24 hours a day, will monitor the services given in the event of a serious emergency. If necessary, Global Excel will help you return to Canada for the care you need.

Urgent message relay — In the event of a medical emergency, Global Excel will contact your travelling companion to keep him/her advised of your medical situation and will help you exchange important messages with your family.

Interpretation service — Global Excel can connect you to a foreign language interpreter when required for emergency services in foreign countries.

Direct billing — Whenever possible, Global Excel will instruct the hospital or clinic to bill the insurer directly.

Claims information — Global Excel will answer any questions you have about the eligibility of your claim, standard verification procedures and the way that the benefits under the policy are administered.

Definitions

"Accident" means a fortuitous, sudden, unforeseen and unintentional event exclusively attributable to an external cause resulting in bodily injury.

"Actively at work" means the employee is physically and mentally capable of doing each and every function of his/her occupation, on the basis of the minimum number of hours worked per week specified in the *Schedule of benefits*. If an employee is not actively at work due to vacation, holidays, a non-scheduled working day, maternity or parental leave, then actively at work means the capability to perform the employee's normal duties at the employee's normal place of employment on the same basis as the employee who is actively at work.

"Coverage period" means the number of consecutive days specified in the *Schedule of benefits* during which you are covered under the policy when you take a trip and which is calculated as of the commencement date of your trip.

"Dependant" means the spouse and the unmarried child of the participant or spouse, who is under the age limit specified in the *Schedule of benefits*, is dependent on the participant for support and is not employed on a full-time basis. A dependant child who is physically or mentally disabled and totally dependent on the participant for support will continue to be eligible provided he/she was covered as a dependant under the policy before attaining such age limit.

"Emergency" means the occurrence of a sickness and/or injury during the coverage period that requires immediate medically necessary treatment for the relief of acute pain or suffering, other than

experimental or alternative treatment, and such treatment cannot be delayed until your return to Canada.

"Global Excel" and **"Global Excel Management Inc."** mean the company appointed by the insurer to provide medical assistance and claims services under the policy.

"Government health insurance plan" means the health care coverage provided by Canadian provincial and territorial governments to their residents.

"Hospital" means an institution which is designated as a hospital by law; which is continuously staffed by one or more physicians at all times; that continuously provides nursing services by graduate registered nurses; that is primarily engaged in providing diagnostic services and medical and surgical treatment of a sickness and/or injury in the acute phase, or active treatment of a chronic condition; that has facilities for diagnosis, major surgery and in-patient care. The term hospital does not include convalescent, nursing, rest or skilled nursing facilities, whether separate from or part of a regular general hospital, nor a facility operated exclusively for the treatment of persons who are mentally ill, aged, or drug or alcohol abusers.

"Immediate family member" means your spouse, son, daughter, father, mother, brother, sister, stepson, stepdaughter, stepfather, stepmother, mother-in-law, father-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandson, granddaughter, grandfather or grandmother.

"Injury" means any unexpected and unforeseen harm to the body that is caused by an accident, that you sustained during the coverage period and that requires emergency treatment that is covered by the policy.

"In-patient" means a patient who occupies a hospital bed for more than 24 hours for medical treatment and for which admission was recommended by a physician when medically necessary .

"Insurer" means Royal & Sun Alliance Insurance Company of Canada.

"Medical assistance card" means the card provided to the participant and on which the following information is shown: name of the policyholder, policy number, coverage period per trip and emergency telephone numbers.

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

a. is appropriate and consistent with the diagnosis according to accepted community standards of medical practice;

b. is not experimental or investigative in nature;

c. cannot be omitted without adversely affecting the condition of the insured person or quality of medical care;

d. cannot be delayed until the insured person returns to his province or territory of residence.

"Ongoing condition" means an acute sickness and/or injury that requires continuing care and/or treatment after the initial emergency has ended as determined by the medical director of Global Excel.

"Participant" means an employee or a member whom the policyholder identifies as being entitled to coverage under the policy and for whom the policyholder has paid the required premium.

"Physician" means a medical practitioner whose legal and professional standing within his or her jurisdiction is equivalent to that of a doctor of medicine (M.D.) licensed in Canada, who is duly licensed in the jurisdiction in which he or she practices, who prescribes drugs and/or performs surgery and who gives medical care within the scope of his or her licensed authority. A physician must be a person other than you or your immediate family member.

"Policy" means the group travel emergency medical insurance contract issued to, and on file with, the policyholder, bearing the policy number specified in the *Schedule of benefits*.

"Policyholder" means the company or organization specified in the *Schedule of benefits* and to which the policy is issued.

"Reasonable and customary costs" means costs that are incurred for approved, covered 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 and/or injury.

"Sickness" means a disease or disorder of the body that 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.

"Spouse" means the person to whom the participant is legally married or with whom he has been residing for the cohabitation period specified in the *Schedule of benefits*.

"Terminal illness" means you have a condition that is cause for the physician to estimate that you have less than six months to live.

"Termination age" means the age specified in the *Schedule of benefits* at which the participant's coverage terminates. Dependants beyond the termination age may be covered provided that the participant has not yet reached the termination age.

"Terrorism" means an ideologically motivated unlawful act or acts, including but not limited to the use of violence or force or threat of violence or force, committed by or on behalf of any group(s), organization(s) or government(s) for the purpose of influencing any government and/or instilling fear in the public or a section of the public.

"Trip" means a journey that you undertake which commences on the date of your departure from your province or territory of residence and ends when you return to your province or territory of residence.

"Vehicle" means any automobile, station wagon, mini-van, sports

utility vehicle (for on-road use), motorcycle, pick-up truck or a mobile home, camper truck or trailer home under 11 meters (36 feet) in length, used exclusively for the transportation of passengers other than for hire, in which the insured person is a passenger or driver during the trip.

"You", **"Your"** and **"insured person"** mean any one of the participant or the participant's dependants covered under the policy.

Claims procedures for your out-of-province/Canada group travel medical emergency insurance

Notice and proof of claim

In the event that Global Excel is not contacted immediately, the insured person, or a beneficiary entitled to make a claim, or the agent of any of them, shall:

a. give written notice of claim by delivery thereof or by sending it by registered mail to Global Excel not later than 30 days from the date the claim arises under the policy;

b. within 90 days from the date a claim arises under the policy, furnish Global Excel such proof of claim as is reasonably possible in the circumstances of the emergency giving rise to the claim and the loss occasioned thereby, the right of the claimant to receive payment, his age and the age of the beneficiary, if relevant; and

c. if required by Global Excel, provide a satisfactory certificate stating the cause for which the claim is made and the duration of the disability, if applicable.

Failure to give notice or proof

Failure to give notice of claim or furnish proof of claim within the prescribed period above does not invalidate the claim if the notice or proof is given or furnished as soon as is reasonably possible, and in no event later than one year from the date of injury or the date a claim arises under the policy on account of sickness if it is shown that it was not reasonably possible to give notice or furnish proof within the time so prescribed.

Insurer to furnish forms for proof of claim

Global Excel, on behalf of the insurer, shall furnish forms for proof of claim within 15 days after receiving notice of claim, but where the claimant has not received the forms within that time he may submit his proof of claim in the form of a written statement of the cause or nature of the emergency giving rise to the claim.

Claims procedures

You are responsible for providing all the documents outlined below and for any charges levied for these documents. To file a claim, you must:

a. include the policy number, the patient's name (married and maiden, if applicable), date of birth, and Canadian provincial or territorial government health insurance plan number with its expiry date or version code (if applicable);

b. submit all original itemized bills from the medical provider(s) stating the patient's name, diagnosis, all dates and type of treatment, and the name of the medical facility and/or physician;

c. provide the original prescription drug receipts (not cash receipts) from the pharmacist, physician or hospital showing the name of the prescribing physician, prescription number, name of preparation, date, quantity and total cost;

d. provide proof of the departure and return date(s);

e. provide written proof of claim within 90 days of the date of receipt of services covered under the policy;

f. provide additional information pertinent to your claim, as may be required by Global Excel after receipt of your claim;

g. sign and return the authorization form, provided by Global Excel, allowing the insurer to recover payment from the Canadian provincial or territorial government health insurance plan. The

insurer will co-ordinate and pay your claim to the participating medical providers and where permitted, co-ordinate claims directly with the Canadian provincial or territorial government health insurance plan on your behalf; and

h. return the unused portion of your air ticket to Global Excel if the *Emergency air transportation benefit* is used.

All amounts in the plan are in Canadian currency unless otherwise indicated. If you have paid a covered expense in a currency other than Canadian currency, you will be reimbursed in Canadian currency at the prevailing rate of exchange on the date that the claim payment is made. This insurance will not pay interest.

Any information not provided may result in a delay in processing your claim.

All pertinent documents should be sent to:

Global Excel Management Inc.

73 Queen St.

Sherbrooke, Québec

J1M 0C9

Tel.: 1-866-870-1898 (toll free) or 819-566-1898 (collect) during business hours (EST).

Protecting your privacy: out-of-province/Canada group travel medical emergency insurance

For privacy information, please see www.rsagroup.ca, or call 1-800-716-4339.

ETFS recognizes and respects every individual's right to privacy. When you apply for benefits, ETFS establishes a confidential file of your personal information. It uses the information to administer the benefit

plan under which you are covered. This includes many tasks, such as:

- determining your eligibility for coverage under the plan;
- assessing your claims and providing you with payment;
- managing your claims;
- verifying and auditing eligibility and claims; and
- underwriting activities, such as determining the cost of the plan and analyzing the design options of the plan.

ETFS limits access to information in your file to staff, to persons authorized by us who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law. ETFS may also exchange information, when necessary to administer the benefit plan, with your health care provider, other insurance and reinsurance companies, and your plan administrator.

Viator™ Out-of-Province/Canada Group Travel Medical Emergency Insurance is underwritten by Royal & Sun Alliance Insurance Company of Canada and administered by Expert Travel Financial Security (E.T.F.S.) Inc. (called "**ETFS**").

In the event of an occurrence likely to result in a claim under this insurance, immediate notice should be given to Global Excel.

Dental care

(Administered by Coughlin & Associates Ltd.)

Plan administrator

This benefit is administered by Coughlin & Associates Ltd.

General description of the coverage

In this section, *you* means the employee and all dependants covered for dental care benefits through Coughlin & Associates Ltd.

Dental care coverage pays for reasonable and customary eligible expenses that you incur for dental procedures provided by a licensed dentist, denturist, dental hygienist and anaesthetist while you are covered by this group plan.

For each dental procedure, we will only cover reasonable expenses. We will not cover more than the fee stated in the dental association fee guide in the province where the employee lives, regardless of where the treatment is received. Payments will be based on the current fee guide for general practitioners, denturists or specialists of your province of residence at the time the treatment is received.

If you receive any temporary dental service, it will be included as part of the final dental procedure used to correct the problem and not as a separate procedure.

Deductible

There is no deductible under your dental plan.

Reimbursement

You will be reimbursed as follows:

Basic services:	100 per cent
Major restorative services:	50 per cent
Orthodontic services:	50 per cent

Calendar year or lifetime maximum

Basic services:	$1,000 calendar year maximum
Major restorative services:	$2,000 calendar year maximum
Orthodontic expenses:	$3,000 lifetime maximum

Pre-determination

Before the work is done, we suggest that you send us an estimate for any major treatment or any procedure that will cost more than $500. You should send us a completed dental claim form that shows the treatment that the dentist is planning and the cost. Both you and the dentist will have to complete parts of the claim form. We will tell you how much of the planned treatment is covered. This way you will know how much of the cost you will be responsible for before the work is done.

Note: For orthodontic treatments, a plan must be submitted prior to the initial claim. Reimbursement for the initial orthodontic fee will not exceed 35 per cent of the total treatment cost. The balance of the orthodontic fees will be eligible for reimbursement on a monthly basis for the duration of the active treatment, as outlined in the treatment plan.

Reimbursement of monthly fees will not be based on the amount or date of payment, if different from the treatment plan.

Covered expenses

(1) Basic services:

- routine examinations, once every six months;
- intra-oral X-rays and bite-wing X-rays, limited to once every six months;
- fillings;
- extractions;
- oral surgery;
- polishing, up to one unit, once every six months;
- fluoride treatments, once every six months;
- periodontal treatment of the soft and hard tissue supporting the teeth, including provisional intracoronal splinting and bruxism grinding appliances but excluding any other type of splinting or orthodontic treatments;
- endodontics;
- space maintainers and regainers for missing primary teeth;
- re-basing, re-lining and repair of dentures;
- pit and fissure sealants for children under age 18;
- therapeutic scaling and root planing will be reimbursed to a combined maximum of eight units of time per calendar year.

(2) Major restorative services:
- inlays and onlays;
- crowns;
- fixed bridges;
- dentures, excluding duplicate set and equilibrated dentures;
- bridge repair;
- implantology. (The alternate benefit clause will apply.)

Pre-determination

Where a course of treatment to cost $500 or more, or if you want to know the exact reimbursement of a certain detail procedure, it is recommended that the covered person obtain from the attending dentist a written estimate outlining the procedures and itemized charges, including X-rays, if and when required. The estimate should be submitted to Coughlin & Associates Ltd. prior to commencement of the treatment.

Alternate benefit clause

Situations may arise where alternate methods of treatment may be available. It is solely for the member and his/her dentist to decide which method will be employed. As the basis for determining liability under the benefit plan, the plan administrator reserves the right to use the lease expensive method of treatment that would provide a professionally adequate result.

The alternate benefit clause cannot be applied to excluded expenses.

(3) Orthodontic services:
- orthodontic treatment;
- orthodontic appliances.

When coverage ends

Dental care coverage ends when your other benefits terminate as described under the *"General information"* section at the beginning of the booklet. However, at retirement, your coverage will continue under the retiree plan.

What is not covered

No benefit will be paid:
(1) for a covered expense otherwise payable under this policy;
(2) for an expense incurred for cosmetic purposes;

(3) for replacement fillings more frequent than once per 18-month period, unless necessitated by further damage or decay;
(4) for an expense incurred for the removal of an amalgam restoration and its replacement with an alternate material unless there is evidence of recurrent decay or significant breakdown;
(5) for injury or disease for which a covered person is entitled to payment under any Workers' Compensation or similar coverage;
(6) for an expense for which a covered person is not required to pay, or for which the covered person is entitled to reimbursement under any non-contractual arrangement;
(7) for an expense or injury or disease resulting from war or hostilities of any kind;
(8) for preventive recall services for a covered person more than once per period of six consecutive months;
(9) for an expense incurred for construction of an inlay, onlay or crown unless there is extensive decay, breakdown or fracture of the tooth at the time of construction where an amalgam or similar restorative material can not adequately restore the tooth;
(10) for an expense incurred for replacement of an inlay, onlay, crown of fixed bridge unless there is extensive decay or breakdown which can not be repaired by use of amalgam or similar restorative material;
(11) for an expense incurred for a precision attachment or for dental restorations for the purposes of periodontal splinting, full mouth rehabilitation, altering of the vertical dimension or modifying the occlusion, or for the treatment of TMJ dysfunction;

(12) for appliances which have been lost, stolen or mislaid;
(13) for laboratory charges in excess of reasonable and customary amounts as determined by the plan administrator;
(14) charges for services or supplies where there would have been no charges in the absence of dental insurance.

When and how to make a claim

To make a claim, complete the claim form that is available from Coughlin & Associates Ltd. and your employer. The dentist will have to complete a section of the form.

In order to receive benefits, we must receive a claim no later than 90

days after the earlier of:

- the end of the benefit year during which you incur the expenses, or
- the end of your dental care coverage.

We can require that you give us the dentist's statement of the treatment received, pre-treatment X-rays and any additional information that we consider necessary.

File dental claims electronically

Coughlin & Associates Ltd. can process your dental claim using our electronic data interchange (EDI) claims processing service.

With EDI, ***your dental claim can be sent directly from your dental office*** to our claims department for adjudication.

EDI uses the secure data networks of Telus, the dedicated claims processing network sponsored by the Canadian Dental Association.

With Telus, your dental claim will be transmitted to Coughlin & Associates Ltd. directly from your dentist's office.

To take advantage of Coughlin's EDI service, just tell your dentist that Coughlin & Associates Ltd. is your claims administrator and present him/her with the following security codes:

- the Coughlin & Associates Ltd. Telus carrier identification number (also known as the BIN number), which is **610105 on the Telus network**;
- your unique employee identification number; and
- the policy number of your group benefit plan, **9705**.

An important note: If you do transmit your claim electronically through Telus, your reimbursement will be mailed to you within two to four business days.

Pre-authorized deposit and member

Members and employees of benefit plans administered by Coughlin & Associates Ltd. can have their health and dental claims reimbursements

portal

deposited directly to their bank accounts.

With Coughlin's Pre-Authorized Deposit (PAD) reimbursement program, you can receive their reimbursement within two to five days following the approval of your medical or dental claims. You will not have to wait for the arrival of a cheque and a trip to the bank before depositing your reimbursement.

To enrol in Coughlin's PAD program, log-on to the Coughlin website at www.coughlin.ca and follow the instructions on the home page.

Check your claims electronically

You can also check the status of your claims electronically. But first, you must register with Coughlin & Associates Ltd.'s claims administration system. Just follow these steps.

You can also check the status of your claims electronically. But first, you have to register with Coughlin & Associates Ltd.'s claims administration system. Just follow these steps:

1. Go to www.coughlin.ca.
2. To access the portal, go to the *"Log on"* menu item at the upper right of the Coughlin & Associates Ltd. website.
3. Using the drop down menu located there, select *"Member portal"* link. Then, click the *"Go"* button.
4. First-time users must then click the *Haven't registered yet?* button and complete the registration form. (Note: your temporary password, which is needed to register, should have been provided on previous claim assessments.)
5. A user identification number and password will then be assigned.
6. After that, just click on *Claims history* to review the status of your recent claims.

For more information contact Coughlin & Associates Ltd. at:

Street address:

466 Tremblay Road

Ottawa, Ontario
K1G 3R1

Email: webmaster@coughlin.ca

Telephone: 613-231-2266
Fax: 613-231-2345
Toll-free 1-888-613-1234

Mailing address:

Box 3517, Station C
Ottawa, Ontario
K1Y 4H5