



**The Ottawa  
Hospital** | **L'Hôpital  
d'Ottawa**

# Your health & dental insurance plan

Non-union employees of  
Ottawa Inner City Health Inc.

Effective date: January 15, 2021  
Issue date: February 15, 2021

# To employees of the Ottawa Hospital

We are pleased to provide this booklet outlining the employee benefits available to you and your family from the Ottawa Hospital.

In addition to providing an outline of the coverage and features of your employee benefit plans, this booklet also provides important information on the plan's administrative and claims procedures. Take time to read the booklet carefully and familiarize yourself with it. Please direct any questions you may have to the plan administrator:

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# 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 extended health care, dental care and vision care benefits are underwritten on a self-funded basis by the Ottawa Hospital, the plan sponsor. All risks in respect to these benefits are borne by the Ottawa Hospital.

As sponsor of the plan, the Ottawa Hospital 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.

The Ottawa Hospital, or its trustees or designates, have the right to interpret 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 medical, dental or vision coverage described in this booklet.

*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.

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.

The interpretations or decision of the administrator made with respect to the benefits plan will be final and binding on all parties.

The emergency out-of-country travel benefit is insured by Royal & Sun Alliance Insurance Company of Canada.

**If you have a concern about a claim, please contact the Human Resources department.**

## Change of address

Be sure to inform the Ottawa Hospital of any address change so that all insurance and *Human Resources* department records remain accurate by completing the appropriate forms. It is important to inform the plan administrator in writing, with appropriate signature, of any address changes.

## Protecting your personal information

The administrator of your group benefit plans is Coughlin & Associates Ltd. At Coughlin, we recognize and respect every individual's right to privacy. When personal information is provided to us, we establish a confidential file that is kept in the offices of Coughlin, or the offices of an organization authorized by Coughlin. We use the information to administer the group benefits plan. We limit access to information in your file to Coughlin staff or persons authorized by Coughlin who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law.

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# Benefit summary

Extended health, vision and dental benefits  
for the employee and his/her dependants

## **ELIGIBLE EMPLOYEE**

Participation in the plan is mandatory for permanent full-time employees, unless you have already arranged to have health and dental coverage through your spouse's employee benefits program.

If your employment status changes from part-time to permanent full-time, you will be required to participate in the benefits plan as a full-time employee. You are required to complete an enrolment form within 31 days of the date of your appointment to permanent full-time status.

Please review the *General information* section.

## **EMPLOYEE COVERAGE**

A person who satisfies the definition of an eligible employee at the Ottawa Inner City Health Inc. will be eligible for the coverage specified in the *Benefit summary*.

## **DEPENDANT COVERAGE**

An employee will be eligible for the dependant coverage specified in the *Benefit summary* on the date the following requirements are met:

- he/she becomes eligible for employee coverage; and/or
- he/she acquires one or more eligible dependants.

## **SUPPLEMENTAL HOSPITAL EXPENSE BENEFIT**

This benefit pays the difference between standard ward and semi-private accommodation in public general hospitals.

## **HOSPITAL EXPENSES BENEFIT**

### **In Canada**

This benefit pays the difference between the semi-private room rate and private room accommodation, provided semi-private hospital was requested at enrolment.

### **Maximum**

Number of days is unlimited.

### **Outside Canada**

Semi-private or private hospital room charges when travelling outside Canada. See the *Emergency out-of-country travel insurance* section.

## **EXTENDED HEALTH CARE BENEFIT**

### **Deductible**

#### **Effective January 1, 2019:**

\$22.50 per individual per calendar year

\$35.00 per family per calendar year

### **Co-insurance**

100 per cent of eligible expenses

### **Overall maximum**

Unlimited.

**Note:** Some individual benefits are subject to yearly or lifetime maximums. Eligible drug dispensing fees are limited to the Ontario Drug Benefit plan maximum.

To contain costs, it is recommended that when you choose a pharmacy, you choose one that charges a dispensing fee in accordance with the current Ontario Drug Benefit (ODB) plan maximum. To facilitate your search, the plan administrator offers a preferred provider network (PPN) of more than 580 pharmacies throughout Ontario. These pharmacies limit their dispensing fees to the ODB maximum. To find a PPN pharmacy near you, check the Coughlin & Associates website at [www.coughlin.ca](http://www.coughlin.ca).

Note: The government may change the ODB plan maximum from time to time. Please refer to the plan administrator to confirm the ODB maximum.

Employees must identify themselves as members of the PPN when they present their prescription.

Emergency claims are handled on an individual basis. An emergency situation is one in which it is necessary to purchase a prescription outside regular pharmacy hours in order to treat an unexpected and urgent medical situation. The purchase of maintenance drugs required to treat a known condition does not qualify as an emergency.

The complete list of PPN pharmacies in eastern Ontario can be found on the *My hospital* portal.

### **Outside Canada**

The plan also provides out-of-country coverage for you and your eligible dependants. It covers an extensive list of expenses for emergency services incurred while travelling outside Canada. This benefit is available as long as you are a Canadian resident, covered by the applicable health plan and your extended health care insurance under this plan is in effect.



## **DENTAL CARE BENEFIT**

Eligible expenses are based on the current year's *Dental Association Fee Guide for General Practitioners* of the province where the services were rendered.

### **Deductible**

Nil.

### **Co-insurance**

Basic services:	100 per cent
Dentures:	100 per cent
Major services:	100 per cent
Orthodontic services:	100 per cent

### **Maximum benefit**

Basic services:	Unlimited.
Major services:	\$2,000 per calendar year per insured person.
Orthodontic services:	\$2,000 per lifetime per insured person.

# General information

## PLAN EFFECTIVE DATE

The features described in this plan are effective November 1, 2015.

## ELIGIBLE EMPLOYEES

All active permanent full-time employees residing in Canada are eligible to participate in this plan upon completion of the waiting period.

Employees and their eligible dependants must be registered under their provincial health care plan in order to be covered under this group benefits plan.

Please review the *Benefit summary* section.

## Waiting period

Three months.

## ELIGIBLE DEPENDANTS

Dependants residing in Canada, including your spouse and/or any unmarried children (including adopted and step-children) who are under 21 years of age, may be covered under this plan. Unmarried children between the ages of 21 and 25 who are full-time students and dependent on you for support may also be eligible for medical and dental coverage. There is no age limit for dental coverage, provided the student and dependency conditions continue to be met.

Mentally or physically disabled children may remain covered past the maximum age when they are incapable of self-sustaining employment and completely dependent on you for support and maintenance.

The disability must be established prior to the child reaching age 21 or while he/she is eligible as a full-time student. Supporting documentation completed by a medical doctor will be required.

By **spouse**, we mean:

- the person to whom you are legally married; or
- the person with whom you have lived in a common-law relationship for a period of not less than one full year and whom you have publicly represented as your spouse. Unless you request in writing to the plan administrator that your common-law spouse be covered under this plan, the person legally married to you will be considered your spouse. Only one spouse will be eligible for coverage under this program. The same spouse must be insured for all eligible benefits.

### **NO MEDICAL EXAMINATION**

If you enrol in this plan when you first become eligible to do so, no medical examination or other evidence of insurability is required.

### **HOW TO JOIN THE PLAN**

To join the benefits plan, please complete and return the enrolment form to the Human Resources department.

### **EFFECTIVE DATE OF COVERAGE**

All coverage is compulsory for permanent full-time employees and becomes effective on the date you become eligible.

If, initially, you select employee-only coverage and later gain a dependant, your dependant can be enrolled in the plan. Advise your employer of your change in status within 31 days of the change.

Once you have dependant coverage in force, all of your eligible dependants will be covered however, an *Employee Change Form* must be completed and submitted to the Human Resources department, when you add additional dependants or when the status of your dependants changes.

If you are not actively at work on the date your coverage would normally become effective, coverage will commence on the date you return to work.

If on the date coverage would normally be effective one of your dependants (other than a new-born infant) is hospitalized, coverage will commence on the day following his/her discharge from hospital. Once you are covered for dependant coverage, additional dependants will be covered from the eligibility date, regardless of hospital confinement.

### COMPARABLE COVERAGE

You may **decline** to be covered for certain benefits under this plan in order to be covered as a dependant under a comparable group benefits program. If that coverage ends due to either the termination of the group contract or because you cease to be eligible, you may acquire the similar health benefits available under this plan, without delay or providing evidence of good health. **However, you must apply for such coverage within 31 days of the termination of that comparable coverage, including a change in your family status.**

*Change in family status* means:

- the loss of insurance coverage from a spouse's\* group insurance plan;
- the gaining of a spouse\* through either marriage or common-law relationship;
- the divorce, separation or annulment of the person with whom you are married or have a common-law relationship; or
- the birth or adoption of a dependant child.

(\* *Spouse* means the person to whom you are legally married or the person with whom you have lived in a common-law relationship and have represented as your spouse for at least one full year.)

Applicants who apply for coverage after 31 days of the termination of comparable coverage will be asked to provide evidence of insurability before becoming eligible for coverage.

By applying through the evidence of insurability process you will have restrictions on your claims.

The amount payable for dental services will be limited to \$100 for each covered person for the first 12 consecutive months of coverage and amount payable for orthodontic services will be limited to \$100 for each covered person for the first 36 consecutive months of coverage.

## **TERMINATION OF INSURANCE**

### **Employee coverage**

Your coverage will automatically terminate on the earliest of the following events:

- you no longer satisfy the definition of employee;
- your employment terminates;
- you enter the armed forces of any country on a full-time basis;
- the policy terminates or coverages for the group, to which you belong terminate;
- you take an approved leave of absence and do not continue to make premium payments;
- age 75 or retirement, unless specified otherwise (coverage will cease on the last day of the month coincident with your 75th birthday or retirement); or
- you no longer contribute towards the cost of your coverage.

### **Dependant coverage**

Dependant coverage will terminate automatically on the earliest of the following events:

- when your coverage ceases;
- you are no longer eligible for dependant coverage; or
- the dependant no longer satisfies the dependant definition.

**Note:** You must advise the Human Resources department of any change in your dependant status. Otherwise, you may be denied benefit payments.

### Conversion privilege

If your plan terminates, you may be able to convert your group benefits plan to an individual plan. You must apply within 31 days of your termination date. Please contact the plan administrator for more information.

### CONTINUATION OF INSURANCE DURING ABSENCE FROM WORK

If you cease to be eligible for coverage, coverage will automatically terminate as specified under *Termination of insurance*. However, the employer may continue to provide coverage if you cease to be actively employed due to any of the following circumstances:

- 1. Illness or injury.** The earliest of the dates specified in the *Termination of insurance* section or you may be covered for a period of up to 30 days from the time the absence commenced. Coverage may continue, provided you pay 100 per cent of the benefits.
- 2. Maternity/Parental leave.** You may be covered for the duration of the leave. Where governing legislation places the decision to continue coverage on any employee who contributes toward the premium, coverage may be continued at the option of the employee, provided contributions continue.
- 3. Pre-paid leave of absence.** Your coverage will continue for 12 months from the date your leave commenced or longer, provided your employer approves the extension and that you pay 100 per cent of the benefits.
- 4. Lay-off/other leaves of absence.** Your coverage will continue until the end of the month in which you were laid off or your leave commenced.

Benefits can only be continued if you contact Human Resources and make arrangements to complete the required form and provide a payment schedule.

If these provisions permit less than the minimum required by governing legislation, the terms of this policy will be extended to agree with the minimum requirements of the law.

If the employer terminates your employment and is required to extend benefits to you for a prescribed period afterwards in accordance with any federal or provincial employment standards legislation, you may continue to be covered for that period. In no event will coverage extend past the date on which the contract terminates.

#### **CO-ORDINATION OF BENEFITS (COB) AND ORDER OF BENEFIT DETERMINATION**

If you or your dependants are eligible to receive a payment under this contract and a similar payment under another benefits plan, the payment of benefits to you will follow this order:

- if the other plan does not have a COB provision, the benefits of the other plan will be paid first;
- if the other plan contains a COB provision, its benefits will be co-ordinated with those under this agreement so that priority will be given to the plan under which the person is eligible to receive benefits as follows:
  - o other than as a dependant;
  - o as a dependant child of the parent with the earlier month and day of birth in the calendar year;
  - o as a dependant child 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:**

- 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 the child.

**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 the employee is an active, part-time employee;
- 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.

### **Second payer**

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

### **Subrogation**

The plan administrator reserves the right to recover payments or benefits provided to any person or corporation.

### **Change in information**

To ensure the accuracy of the information contained in your file and that you receive all related correspondence, it is important that you contact the Human Resources department as soon as a change in your status occurs (i.e. the addition of a new dependant, a change of address).



# Extended health care

## PAYMENT OF BENEFITS

If, while insured, you or your dependants incur any of the eligible expenses for medically necessary services or supplies in the treatment of an illness or injury, the plan will pay a benefit subject to the *Extended health care and dental care limitations*. After the application of the annual deductible, the amount payable will be determined based on the percentage shown in the *Benefit summary*. A benefit is not payable for an eligible expense used to satisfy the deductible, nor is it payable if the maximum benefit has already been paid.

## DEDUCTIBLE

The individual or family deductible shown in the *Benefit summary* is applied each calendar year.

## SUPPLEMENTAL HEALTH BENEFIT (SEMI-PRIVATE)

This benefit pays the difference between standard ward and semi-private accommodation in public general hospitals.

No benefits are payable for accommodation in psychiatric hospitals or nursing homes.

No benefits are applied if they are payable by any other insurer.

There is no deductible.

## HOSPITAL EXPENSE BENEFIT

### In Canada

The plan covers charges of an approved public general hospital for:

- the difference between semi-private room rate and private room rate, provided semi-private hospital was not waived at enrolment;

- medical and surgical treatment incurred by a person on an out-patient basis (excluding physicians' and special nurses' fees) and/or
- convalescent care at an approved treatment facility to a maximum of \$10 per day for 120 days in any calendar year.

## Outside Canada

Semi-private room and board in excess of ward accommodation.

Extended health benefits include out-of-Canada coverage. *See Out-of-Canada travel benefits* section for details.

**Note:** Reimbursement for eligible services will be made only after your provincial government health plan provides payment towards the cost of the services received.

## ELIGIBLE EXPENSES

The following is a list of the items currently eligible for payment under your benefit plan. Eligible expenses must be reasonable, customary, and recommended by a physician.

Please review the *Benefit summary* section.

### A. Nursing care expenses

On recommendation of an attending physician, out-of-hospital private duty nursing care by a registered nurse or RPN currently registered with the appropriate local authority. The nurse must neither be a relative by blood or marriage nor an employee and must not ordinarily reside in your home. Fees for services provided by the nurse may not exceed an annual maximum of 90 eight-hour shifts to a maximum of \$222 per day, or \$20,000 per year. Subject to approval by the plan administrator.

Charges for the following services are not eligible:

- services provided for custodial care, homemaking duties or supervision;

- services performed by a nursing practitioner who is an immediate family member or lives with the patient;
- services performed while the patient is confined in a hospital, nursing home or similar institution; and
- services that can be performed by a person of lesser qualification, a relative, friend or member of the patient's household.

The physician must complete a nursing care request form. Prior approval by Coughlin & Associates Ltd. is required.

## **B. Drugs and medication**

Drugs, serums, vaccines and injectables, only available by prescription, when prescribed by a medical doctor, a nurse practitioner within the terms and regulations governing that profession, or dentist, and dispensed by a pharmacist, to a maximum three months supply at one time. Charges for Viagra®/Cialis®/Levitra® will be covered to an annual maximum of \$1,000 per calendar year, and six to eight pills per month; oral contraceptives to a maximum one year supply; smoking cessation products including gum or patch to a maximum of \$250 per insured person per lifetime; and fertility drugs.

Reimbursement of brand name drugs is limited to the lowest-priced equivalent (usually the generic, where applicable).

Benefits are not payable for vitamins, unless they are injected, vitamin preparations, food supplements, and drugs *not approved for sale in Canada*.

Note: Eligible expenses for dispensing fees by a licensed pharmacist are limited to the Ontario Drug Benefit plan maximum.

### **Pay-direct drug card**

You can pay for your prescription drugs at any retail pharmacy in Canada directly through your drug plan using the pay-direct drug card from Express Scripts Canada (ESC) and Coughlin & Associates Ltd.

With the pay-direct drug card, your prescription drug claims will be processed on-the-spot. There are no forms to complete, no payment required outside of the deductible. Simply present the card to your pharmacist when you purchase prescription drugs. Your claim payment will be processed immediately.

The card can be used by you as well as your spouse and eligible dependants. The pay-direct drug card is designed to cover only prescription drug costs.

Present the pay-direct drug card to your pharmacist when you purchase prescription drugs. The prescription data will be submitted electronically to ESC and your drug claim will be assessed in seconds while you wait. When your claim is approved, the pharmacist will return the card to you.

The card can be used at any pharmacy in Canada.

### **C. Ambulance services**

- 1 That portion of the cost of air ambulance services to the nearest hospital capable of providing the type of care essential for the patient that is not normally paid by the provincial health insurance plans.
- 2 Licensed ground ambulance to the nearest hospital, capable of providing the type of care essential for the patient that is not normally paid by the provincial health care plan, including service to and from points of arrival and departure, is considered eligible when medically required.

### **D. Medical supplies, aids and appliances**

Appliances and medical expenses required for normal activities of daily living (not solely for sports-related activities).

The following benefits are not acceptable as eligible expenses when ordinarily paid by any government agency or if not authorized in writing by the attending physician. If reimbursement is available under a provincial program, this plan will only consider the balance

after the provincial plan has considered its portion. In no event will payment be made for rental charges that exceed the purchase price of any item.

**It is strongly recommended that an estimate be submitted, along with all supporting medical documentation, prior to incurring any costs.**

Any approved equipment will be reimbursed based on the date for which the item is paid in full.

1. Cost of crutches, canes, walkers, braces made of rigid or semi-rigid material, apnea monitors, aerochambers, surgical bandages or dressings, glass fibre casts, splints (excluding dental splints), trusses, and standard-type artificial limbs or eyes.
2. The rental of a standard-type wheelchair, hospital type bed and respirator/ventilator including hospital bed/wheelchair repairs, when reasonable and customary. (Electric wheelchairs and electric hospital beds are excluded, unless required by medical necessity and recommended by an attending specialist.). In lieu of rental, the plan may, at its discretion, substitute charges for the purchase of such articles where applicable rental charges would exceed the purchase price.
3. Diabetic supplies including glucometers (excluding batteries).
4. Colostomy and ileostomy supplies, where a surgical stoma exists. Includes catheters and urinary kits. A physician's prescription is required.
5. Support hose, maximum of six pairs per calendar year with physician's prescription showing brand name and compression ratio.
6. Custom-made orthopaedic shoes or the actual cost of modifications or adjustments to stock item footwear, two pairs are eligible annually to a maximum \$225 per pair with doctor's prescription. A doctor's referral indicating the condition being treated is required.

7. Custom-moulded orthotics limited to two pair per calendar year to a maximum of \$225 per pair. A doctor's referral indicating the condition being treated is required.
8. Wigs for patients who have undergone special treatment, such as chemotherapy. One wig per lifetime to a maximum of \$1,500. A doctor's referral indicating the condition being treated is required.
9. Cataract eyewear including prosthetic lenses and frames, once only per person who lacks an organic lens or after cataract surgery.
10. Hearing aids, or repairs to existing hearing aids plus initial batteries, to a maximum of \$500 per 36 consecutive months. Hearing aid evaluation tests, ear examinations and replacement batteries are not eligible.
11. Rental of oxygen equipment and related supplies for the administration of oxygen. A doctor's referral indicating the condition being treated is required.
12. Charges for blood transfusions, plasma and radiology (radium therapy).
13. External breast prosthesis (following mastectomies) and a maximum of six mastectomy bras per calendar year.

## **E. Paramedical practitioners**

Medically necessary services of the following licensed, certified or registered (in the province where treatment is given) paramedical practitioners when operating within their recognized fields of expertise, to the levels specified. (Where applicable, no payment can be made until the provincial plans have paid their yearly maximum). All receipts must clearly indicate the names of those attending the sessions.

Reimbursement is based on the dates the services were rendered. If you choose to enter into a block payment or annual payment plan for services, reimbursement will be made upon submission of receipts for services rendered.

1. Psychologist to an aggregate maximum payment of \$500 per insured person per calendar year.
2. Speech therapist up to \$500 per calendar year per insured person, with doctor's or dentist's referral.
3. Physiotherapist to a maximum of \$400 per insured person per calendar year. The physiotherapist cannot be a member of the insured's immediate family or related to the insured by blood or marriage.
4. Registered massage therapist to a maximum of \$400 per insured person per calendar year.
5. Chiropractor to a maximum of \$400 per insured person per calendar year.
6. Osteopath to a maximum of \$300 per person per calendar year.

#### **F. Dental expenses due to accidental injury**

Charges for services of a dentist when treatment results directly from an accidental injury to sound natural teeth from an external blow and not by an object wittingly or unwittingly placed in the mouth. Treatment must begin within 90 days of the accident and be completed within one year. Expenses for such treatments are limited only to those incurred to repair the damage caused directly by the accident. Coverage will be based on the current Ontario Dental Association Fee Guide for General Practitioners.

Please review the *Pre-determination of benefits* and *Alternate benefits provision* sections.

**Note:** 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.

## **G. Vision care**

### **1. Eye glasses or contact lenses**

Reimbursement of eligible eyewear is based on the date the item is paid for in full.

Eligible eyewear is when corrective lenses are required.

The plan will cover 100 per cent of eligible expenses for prescription eyeglasses, prescription sunglasses or prescription contact lenses on the written prescription of a licensed physician or a licensed, certified or registered optometrist or ophthalmologist.

The maximum coverage for all eligible expenses, including glasses (lenses and frames), contact lenses or their repair is \$400 per 24 consecutive months per insured person.

Laser eye surgery is eligible under the vision care benefit for a one-time reimbursement up to the plan maximum.

The plan does not cover the costs of industrial safety glasses or non-prescription eye wear.

### **2. Eye examinations by an optometrist or ophthalmologist**

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

Maximum benefit: \$125 per 24 consecutive months per insured person.



# Emergency out-of-country travel insurance

## SCHEDULE OF BENEFITS

This booklet contains further clauses which may limit coverage. Please read all the benefit description pages carefully. Please note that all dollar amounts are expressed in Canadian currency.

<b>Policyholder name:</b>	<b>The Ottawa Hospital</b>
<b>Policy number:</b>	1060107
<b>Overall maximum per insured person:</b>	\$5 million Canadian per coverage period.
<b>Description of classes:</b>	Class A – All eligible active non-union employees under age 70. Class C – All eligible active non-union employees ages 70-74 inclusively.
<b>Work hours required:</b>	Class A – 37.5 hours per week. Class C – 37.5 hours per week.
<b>Eligibility period:</b>	Class A – as per extended health care benefit plan. Class C – as per extended health care benefit plan.
<b>Termination age:</b>	Class A: age 70 or earlier retirement. Class C: age 75 or earlier retirement.
<b>Common-law spouse co-habitation period:</b>	Continuous co-habitation: Last 12 months
<b>Age limits for dependant children:</b>	Under age 21, or under age 25 if a full-time student at a recognized educational institution:

**Pre-existing condition****stability period:**

Class A: sudden and unforeseen  
(exclusion # 2 does not apply.)

Class C: Six months.

**Coverage period:**

60 days per trip.

**BENEFIT SUMMARY****Refer to Section II for benefit details.**

Hospital accommodation	Reasonable & customary costs
Physician charges	Reasonable & customary costs
Diagnostic services	Reasonable & customary costs
Paramedical services	\$250 per profession
Prescription drugs	30-day supply per prescription
Ambulance services	Reasonable & customary costs
Medical appliances	Reasonable & customary costs
Private duty nurse	Up to \$5,000
Emergency air transportation	Reasonable & 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

## NOTICE

This Notice is attached to and forms part of your Group Travel Insurance Benefit Booklet, underwritten by Royal & Sun Alliance Insurance Company of Canada.

It is hereby understood and agreed that, as of **January 15, 2021**, the terms and conditions of your Group Travel Insurance Benefit Booklet are amended as follows:

**The following wording replaces any existing Exclusion(s) wording in your Benefit Booklet related to medical conditions or losses you suffer or contract in a specific country, region or area while a travel advisory is issued by the Canadian Government:**

Any sickness, injury, or medical condition you suffer or contract, or any loss you incur in a specific country, region or area while a travel advisory of "Avoid non-essential travel" or "Avoid all travel" is in effect for that specific country, region or area and the travel advisory was issued by the Government of Canada before your departure date, even if the trip is undertaken for essential reasons. This exclusion only applies to medical conditions or losses which are related, directly or indirectly, to the reason for which the travel advisory was issued.

If the travel advisory is issued after your departure date, your coverage under this insurance in that specific country, region or area will be restricted to a period of 10 days from the date the travel advisory was issued, or to a period that is necessary for you to safely evacuate the country, region or area, after which coverage will be limited to medical conditions or losses which are unrelated to the reason for which the travel advisory was issued, while the travel advisory remains in effect.

For Emergency Medical Travel Insurance benefits, this exclusion does not apply to medical conditions or losses which are related to Coronavirus disease 2019 (COVID-19), even while a travel advisory related to COVID-19 is in effect.

This Notice is intended to provide information regarding changes to your insurance coverage. For more complete details regarding your coverage, including terms, conditions, limitations and exclusions, please refer to your Benefit Booklet. Please keep this Notice with your Benefit Booklet.

These insurance products are underwritten by Royal & Sun Alliance Insurance Company of Canada.

You may contact the insurer at **1-888-877-1710** in Canada and the U.S. or visit [www.rsagroup.ca](http://www.rsagroup.ca).

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## **GROUP OUT-OF-PROVINCE/CANADA TRAVEL MEDICAL EMERGENCY INSURANCE**

### **Important notice – Please read carefully**

Travel insurance is designed to cover losses arising from sudden and unforeseeable circumstances occurring while *you* are temporarily travelling 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.

## **SECTION I: 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:
  - i. work the minimum number of hours per week specified in the *Schedule of benefits*; and
  - ii. have satisfied the eligibility period specified in the *Schedule of benefits*; or
- b. if you are covered as a member of the policyholder who is other than an employer, you must also:
  - i. be a member in good standing of the policyholder; and
  - ii. 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 first to occur 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; or
- 3 the date the policy is terminated.

## SECTION II: 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 such services are authorized in advance by Global Excel.
- 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 which 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 benefit* or the *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. This benefit must be authorized in advance by Global Excel. 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.

### SECTION III: 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 such services are authorized in advance by Global Excel.
- 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 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.

- 2 Upgrading charges and cancellation penalties for airline tickets, unless approved in advance by Global Excel.
- 3 The cost of any airline ticket covered under the policy where your ticket may be exchanged or used for the same purpose.
- 4 Crowns and root canals.
- 5 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.
- 6 Medication, drugs or toxic substance abuse or overdose (whether or not you are sane); alcohol abuse, alcoholism or an accident while being impaired by drugs or alcohol or having an alcohol concentration that exceeds 80 milligrams per 100 millilitres of blood.

#### **SECTION IV: 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 the insurer 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.

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:** This insurance is a second payer plan. For any loss or damage insured by, or for any claim payable under any other liability, group or individual basic or extended health insurance plan, or contracts including any private or provincial or territorial auto insurance plan providing hospital, medical,



or therapeutic coverage, or any other insurance in force concurrently herewith, amounts payable hereunder are limited to those covered benefits incurred outside the province of residence that are in excess of the amounts for which an insured person is insured under such other coverage.

All co-ordination with employee related plans follows Canadian Life and Health Insurance Association Inc. 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. If the lifetime maximum for all in-country and out-of-country benefits is over \$50,000, the insurer will co-ordinate benefits only above this amount.

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 hereby 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 hereby 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, 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.

#### **SECTION V: 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.

## **SECTION VI: 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.

## **SECTION VII: 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; which continuously provides nursing services by graduate registered nurses; which 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; which 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, step-daughter, step-father, step-mother, 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 co-habitation 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. Dependents 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.

## **SECTION VIII: CLAIMS**

### **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 thirty days from the date the claim arises under the policy;
- b. within ninety 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. Where the claimant has not received the forms within that time, he/she 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 date(s) 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: RSA INSURANCE**

For privacy information, please see [www.rsagroup.ca](http://www.rsagroup.ca), or call 1-800-716-4339.

RSA Travel Insurance recognized and respects every individual's right to privacy. When you apply for benefits, we establish a confidential file of your personal information. We use 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.

We limit 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. We 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.

#### **IDENTIFICATION OF INSURER**

This insurance is underwritten by Royal & Sun Alliance Insurance Company of Canada.

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

<sup>TM</sup>“RSA” and the RSA logo are trademarks owned by RSA Insurance Group plc, licensed for use by Royal & Sun Alliance Insurance Company of Canada.

<sup>TM</sup> Viator is a trademark of RSA Travel Insurance Inc.

# Dental care

## PAYMENT OF BENEFITS

Benefits are based on the current year's *Dental Association Fee Guide for General Practitioners* of the province where the services were rendered. Charges must be for reasonable and necessary dental care or denture therapy or supplies provided or ordered by a dentist or physician.

### Eligible expenses

Coverage is available in the following areas:

1. **Basic** services are unlimited.
2. **Major restorative** services are reimbursed at 100 per cent to a maximum of \$2,000 each per insured person per calendar year.

Dental implants are covered however, the *Alternate benefit provision* will apply.

3. **Orthodontic** services are reimbursed at 100 per cent to a lifetime maximum of \$2,000 per insured person.

## BASIC SERVICES

Only those treatments listed below are eligible:

### Examinations

- complete oral examination (once every 36 months);
- recall oral examination (once every nine months);
- emergency examination; and
- specific oral area examination.

### Diagnostic services

- radiographic examination and complete intra-oral film series (once every 36 months);
- periapical films;
- occlusal films;
- posterior bitewing films (once every nine months);

- extra-oral films;
- sinus examination;
- sialography;
- use of radiopaque dyes to demonstrate lesions;
- panoramic films (once every three years);
- cephalometric films;
- tracing and interpretation of radiographs from another source;
- tomography;
- TMJ X-rays; and
- hand and wrist (as diagnostic aid for dental treatment).

### **Tests and laboratory examinations**

- microbiological cultures for determination of pathologic agents;
- dental caries susceptibility test;
- biopsy, soft-hard tissue; and
- cytological examination.

### **Case presentation/consultation/other dentists**

- consultation with patient: two units every 12 months.
- consultations with a member of the profession.

### **Preventive services**

- light scaling and/or polishing (once every nine months);
- fluoride treatment;
- oral hygiene instruction (once every nine months);
- interproximal discing of teeth;
- oral hygiene re-instruction (once every nine months); and
- pit and fissure sealants for children up to age 18.

### **Restorative services**

- non-bonded amalgam restorations for primary teeth, permanent anterior and bicuspid teeth, permanent molar teeth;
- caries/trauma/pain control;

- tooth-colored restorations, primary and permanent teeth (including acid and non-acid etching);
- pin reinforcement;
- acrylic or composite restorations;
- prefabricated post and core; and
- stainless steel/plastic full coverage restorations for primary teeth.

### **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; and
- re-insertion of dentogenic media.

### **Periodontal services**

- application of displacement dressing;
- management of acute infections and other oral lesions;
- de-sensitization of tooth surface;
- periodontal scaling and root planing (combined maximum of eight units of time per calendar year);
- gingival curettage;
- gingivoplasty;
- gingivectomy;
- flap approach with osteoplasty/otectomy;

- 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; and
- periodontal abscess or pericoronitis.

### **Adjunctive periodontal services**

- provisional splinting – intra-coronal, extra-coronal per unit of time;
- occlusal equilibration (eight units of time every 12 months);
- special periodontal appliances, including occlusal guards and bruxism appliances;
- maintenance, adjustments and repairs to periodontal appliances; and
- removal of fixed periodontal splints.

### **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;
- transplantation of tooth;
- surgical repositioning of tooth;
- gingival fibre incision;
- enucleation of an unerupted tooth and follicle;
- alveoplasty;
- gingivoplasty and/or stomatoplasty;
- excision, removal of bone;
- reduction of bone, tuberosity;
- surgical excision (cysts and neoplasms);
- surgical incision;



- fractures;
- frenectomy; and
- miscellaneous surgical services.

### **Anaesthesia**

- in relation to covered procedures.

### **Professional visits**

#### **Adjunctive general services**

- drugs (injections.)

#### **Denture repairs, re-basing and re-lining**

- denture adjustments (complete or partial dentures);
- minor adjustments (after three months from insertion);
- denture repairs and additions;
- denture re-basing and/or re-lining;
- denture, tissue conditioning; and
- resetting of teeth.

### **DENTURES**

#### **Prosthetic services, removable**

- complete dentures (once every five years);
- partial dentures (once every five years); and
- denture remakes.

### **MAJOR RESTORATIVE SERVICES**

- diagnostic casts (unmounted) as per the formulary codes;
- 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; and
- porcelain inlay/onlay, including temporization.

### **Crowns**

- acrylic, processed (not for molar teeth);
- acrylic, processed to metal (not for molar teeth);
- acrylic or plastic, transitional, direct(chairside);
- acrylic or plastic, transitional, indirect;
- porcelain (not for molar tooth);
- porcelain fused to metal base (not for molar tooth);
- metal full cast;
- metal three-quarter cast;
- metal transition, direct (chairside);
- cast metal post and core as a separate procedure; and
- cast metal post and core concurrent with impression for crown.

### **Other restorative services**

- pre-fabricated metal post and core;
- pre-fabricated metal post and cast core;
- pin reinforced amalgam post and core;
- pin reinforced composite post and core; and
- crown made to an existing partial denture clasp (additional to crown).

### **Prosthetic services, fixed**

- fixed prosthetic evaluation for cases of extensive or complicated restorative dentistry.

### **Pontics**

- metal cast pontic;
- slotted facing;
- porcelain fused to metal pontic (not for molar teeth);
- porcelain pontic, aluminous (not for molar teeth);
- acrylic processed to metal pontic (not for molar teeth);
- acrylic pontic processed, transitional during healing;

- acrylic pontic transitional, acid etched to adjacent teeth;
- reverse pin pontic;
- retainers, inlays and onlays;
- metal inlay;
- metal onlay; and
- 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 (not for molar teeth);
- porcelain crown, aluminous (not for molar teeth);
- porcelain fused to metal crown (not for molar teeth);
- metal three-quarter cast crown;
- metal full cast crown;
- intra-oral indexing for soldering purposes; and
- retentive pins in abutments.

### **Adjunctive general services**

- in-office laboratory charges.

### **Major restorative treatment**

Prosthetic 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 is at least five years old and cannot be made serviceable; and
- the existing prosthesis is temporary and is replaced with a permanent one within 12 months.

## **ORTHODONTIC SERVICES**

Orthodontic services are available and are reimbursed at 100 per cent to a maximum of \$2,000 per lifetime per insured person.

Orthodontic services must be for a treatment that has as its primary objective the correction of malocclusion of the teeth.

An orthodontic treatment plan must be submitted prior to initial claim (see pre-determination section below). Orthodontic fees will be eligible for reimbursement on a monthly basis for the duration of the active treatment, as outlined in the orthodontic treatment plan.

Reimbursement for the initial orthodontic fee must not exceed 35 per cent of the total treatment plan. The balance of the orthodontic fees will be eligible for reimbursement on a monthly basis for the duration of the active treatment, outlined in the orthodontic treatment plan. Reimbursement of the monthly fees will be based on the amount or date of payment, if different from the treatment plan.

## **DENTAL CARE BENEFIT PROVISIONS**

### **Pre-determination of benefits**

Where a course of treatment is expected to cost \$300 or more or will involve the use of crowns, inlays, onlays, bridges or dentures, 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.

### **Alternate benefit provision**

Situations may arise where alternate methods of treatment may be available. It is solely for you and your dentist to decide which method will be employed, however, the plan administrator reserves the right to use the least expensive treatment method that would provide a professionally adequate result.

When a treatment plan is not filed with the plan administrator prior to commencement of treatment, the plan administrator reserves the right to pay benefits based on the least expensive alternate procedures that will provide a professionally adequate result.

The alternative benefit provision cannot be applied to excluded expenses.

### **Comparable coverage**

If your comparable dental coverage terminates because that group contract terminates, or because you cease to be eligible for the comparable coverage, you and your dependants may acquire the dental coverage under this plan without restrictions, providing you apply for coverage within 31 days. If you apply after the 31-day period, coverage will commence on the date you apply. However, the amount payable for services other than orthodontic services will be limited to \$100 for the first 12 consecutive months your insurance is in force. For orthodontic services, the amount payable will be limited to \$100 for the first 36 consecutive months the insurance is in force.

Where a range of fees or individual consideration or laboratory charges is included, the plan administrator will determine the amount payable, based on reasonable and customary charges.

The balance of the treatment fees and laboratory charges will remain the insured person's responsibility.

## Definition of terms

*Change in family status* means:

- the loss of insurance coverage from a spouse's group insurance plan;
- the gaining of a spouse\* through either marriage or common-law relationship;
- the divorce, separation or annulment of the person with whom you are married or have a common-law relationship;
- the birth or adoption of a dependant child.

(\* *Spouse* means the person to whom you are legally married or the person with whom you have lived in a common-law relationship and have represented as your spouse for at least one full year.)

Applicants who apply for coverage after 31 days of the termination of comparable coverage or a change in status must complete the evidence of insurability form.

*Dental assistant* means a person duly qualified to perform the service rendered and includes a dental hygienist and any other similarly qualified person.

*Dental expenses* means expenses for dental treatment recommended as necessary by a dentist that are not in excess of the maximum fee specified for general practitioners in the current year's *Dental Association Fee Guide for General Practitioners* in the province where services are rendered. If a specialist performs treatments, the plan will only reimburse up to the levels specified in that fee guide.

For denturists, *dental expenses* mean expenses for dental treatment recommended as necessary by a denturist that are not in excess of the minimum fee specified in the current year's *Denturist Fee Guide*.

*Dental hygienist* means a person who is duly licensed to perform dental hygiene.

***Dental mechanic*** or denturist means a person, including a dental therapist, denturologist and any other similarly qualified person who is duly qualified to perform the service rendered and who practices in the province in which he/she is legally permitted to deal directly with the public.

***Dentist*** means a person duly qualified and legally licensed to practice dentistry, provided that person renders a service within the scope of his/her license.

***Extended health benefits*** mean that portion of the plan that provides for the reimbursement of medical supplies and services.

***Fee schedule*** means the schedule of professional services and fees as determined by the plan administrator.

***Hospital*** means only a legally operated institution for the care and treatment of sick and injured persons. It must have organized facilities for diagnosis and major surgery and 24-hour nursing service and does not include a private or convalescent hospital except where expressly stated herein.

***Optometrist*** means a person duly qualified and legally licensed to practice optometry.

***Percentage*** means that portion of eligible expenses in excess of the calendar year deductible that shall be reimbursed to the employee by the plan.

***Physician*** means a doctor of medicine duly licensed to practice medicine, or any other practitioner recognized by the College of Physicians and Surgeons in the province in which the treatment is rendered.

***Proof*** means written evidence that is sufficient to verify the circumstances of an event or to establish a fact pertinent to a person's coverage or a claim for benefit that is acceptable to the administrator.

*Reasonable and customary charges* 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.



## Limitations

No payment will be made for expenses resulting from:

- self-inflicted injuries or illness while sane or insane;
- any injury or illness for which the covered person is entitled to compensation under any Workers' Compensation Act;
- charges levied by a physician or dentist for time spent travelling, broken appointments, transportation costs, room rental charges or for advice given by telephone or other means of telecommunication;
- cosmetic surgery or treatment unless the surgery or treatment is for accidental injuries and commences within 90 days of an accident;
- injury resulting directly or indirectly from insurrection, war, service in the armed forces of any country or participation in a riot;
- services, treatments or supplies payable, or covered only by, a government plan;
- examinations required for the use of a third party;
- travel for health reasons;
- dental treatment received from a dental or medical department maintained by an employer, an association, or a labor union;
- the replacement of an existing appliance which has been lost, mislaid or stolen;
- services and supplies rendered for full mouth reconstruction, for a vertical dimension correction, or for a correction of temporomandibular joint dysfunction;
- any charges for services, treatment or supplies for which there would be no charge except for the existence of coverage;
- drugs, sera, vaccines, injectables and supplies which are not approved by Health and Welfare Canada (Food & Drugs) or are experimental or limited in use, whether or not so approved;
- experimental medical procedures or treatment methods not approved by the provincial medical association or the appropriate medical specialty society;

- any charges for porcelain crowns on molar teeth (this policy will cover metal allowance only);
- charges for treatment by a family member who is treating an employee related to him/her by blood or marriage;
- bonded amalgam restorations; and
- dispensing fees that exceed the current Ontario Drug Benefit (ODB) rate, unless the claim is deemed an *“emergency claim”*.

## Extension of benefits

If one of your covered dependants is hospitalized when your coverage terminates, then benefits will be payable in the same manner as your own, or until your dependant is discharged from the hospital, whichever is earlier.

If you or your dependant are pregnant on the date coverage would normally cease, payment will be made for pregnancy-related eligible expenses.

Extension of major medical benefits will cease when the contract terminates.

In most cases, dental benefits are not payable after the date your coverage terminates, even when a treatment plan has been filed and benefits determined by the plan administrator. However, benefits are payable under the following circumstances:

1. Where an impression for a denture, bridge, crown, inlay or onlay had been taken prior to the date your coverage terminates and the termination of coverage. Related dental expenses incurred within 30 days after the termination of coverage, are eligible.
2. If your coverage terminates due to your death, dental expenses incurred on behalf of your dependants will be eligible for payment provided:
  - the services are rendered within 90 days following your death; and
  - they are part of a series of planned dental services started prior to your death or rendered at definite dental appointments made prior to your death.

## Claims procedures

When you have a claim, be sure to obtain the necessary forms from the Coughlin website at [www.coughlin.ca](http://www.coughlin.ca) or the Human Resources Department. Then, forward them to Coughlin & Associates Ltd, the plan administrator.

It is only reasonable for you to expect prompt settlement of claims when they arise. Check with your plan administrator to ensure that you are using the correct form and that you have completed it correctly.

Sometimes, physicians send claim forms directly to the plan administrator. This frequently delays claims settlement since the employee section must also be completed prior to submission.

### EXTENDED HEALTH CARE

Keep a record of all out-of-pocket expenses incurred by you and your covered dependants. It is important that all original receipts for eligible expenses be submitted with your claim. Clearly indicate the name of the person for whom the expense was incurred. Complete the appropriate claim form and submit it along with these receipts to the plan administrator. Faxes of medical claims cannot be accepted.

- 1 All original receipts should show the name, registration number, address and telephone number of the practitioner.
- 2 All claims for extended health care benefits must be submitted by the end of the calendar year following the year in which the expense was incurred.
- 3 If your coverage terminates for any reason, written proof of claim must be submitted within 90 days of the termination of coverage.

**DENTAL CARE**

Special claim forms have been designed and are available on the Coughlin website at [www.coughlin.ca](http://www.coughlin.ca) or at the Human Resources Department.

Standard dental claim forms are also available from all dentists and are acceptable, provided the employer information and/or policy number is clearly indicated. The insured person as well as the dentist must complete a claim form. A separate claim must be completed for each person receiving treatment.

Payment may be made directly to the dentist, if so desired, by assigning the benefit to the dentist in the appropriate space provided on the claim form. Claims must be submitted by the end of the calendar year following the year in which the expense was incurred.

If your coverage terminates for any reason, written proof of claim must be submitted within 90 days of the termination of coverage.

**OUR ELECTRONIC DATA INTERCHANGE (EDI) SERVICE**

Coughlin & Associates Ltd. can process your dental claim using the 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.

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

- the Coughlin & Associates Ltd. Telus carrier identification number (also known as the BIN number) is **610105 on the Telus network**;
- your unique employee identification number; and
- the policy number of your group benefit plan is **19041**.

The Human Resources department, your pay stub or the plan administrator can provide you with your employee identification number.

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

#### **DIRECT DEPOSIT SERVICE**

With direct deposit, employees no longer have to wait for a claim reimbursement cheque to arrive and then find time to bank it. Instead, when the claim is approved, it will be deposited directly to your bank account. You will then receive an email, or a letter if no e-mail address has been provided, from Coughlin & Associates Ltd. confirming the date and amount of the deposit. The email will include a confidential, password-protected link listing the complete details of your claims payment. The Direct Deposit Authorization Form can be found at [www.coughlin.ca](http://www.coughlin.ca)

**CHECK YOUR CLAIMS ELECTRONICALLY**

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](http://www.coughlin.ca).
- 2 To access the portal, click 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.

The full menu of available services and claims history is listed.

## **DROP OFF YOUR CLAIMS**

Coughlin & Associates offers a convenient drop-off service for your health and dental claims. Employees can submit claim forms and original receipts in person Monday to Friday during regular business hours to the Coughlin head office located at 466 Tremblay Road, Ottawa, Ontario, K1G 3R1.

## **CONTACT US**

### **Questions?**

#### ***Claims Department:***

Tel: 613-231-8540 or toll-free 1-877-768-3378

Email: [ottclaims@coughlin.ca](mailto:ottclaims@coughlin.ca)

Website: [www.coughlin.ca](http://www.coughlin.ca)

#### ***All other inquiries:***

Tel: 613-231-2266 or toll-free 1-888-613-1234

Fax: 613-231-2345

Email: [info@coughlin.ca](mailto:info@coughlin.ca)

Website: [www.coughlin.ca](http://www.coughlin.ca)

#### ***Mailing Address:***

P.O. Box 3517, Station C

Ottawa, ON K1Y 4H5

#### ***Business Hours:***

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