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

COUGHLIN
employee benefits specialists
Coughlin & Associates Ltd. is a People Corporation company

October 2023

ATTN: Ottawa Inner City Health Employees

RE: Addendum – Effective October 1, 2023

The addendums below have been added to your existing group benefit policy. This section supersedes any inconsistent provisions in the policy, except to the extent that such provisions are expressly amended hereby.

Instructions on how to claim using the Adjudicare platform will follow the addendum section. Should you have any questions or concerns please do not hesitate to reach out to Coughlin and Associates, contact information will also be provided following the addendum.

- Elimination of the annual deductible ($22.50 for single and $35.00 for family coverage per calendar year) - Effective January 1, 2024
- Extended Health, Semi-private Hospital and Dental Care benefits are extended to the member's spouse and dependents for one year following the member's death if the member was enrolled in Family coverage - Effective October 1, 2023
- Elimination of the 3-month waiting period for new hires or any new enrollments currently serving the waiting period for enrollment in Extended Health, Semi-private Hospital and Dental Care coverage - Effective October 1, 2023
- Mental Health coverage will be increasing to $3,000 per person per calendar year - Effective October 1, 2023
- The combined maximum for physiotherapy, chiropractic and massage therapy services will be increasing to $1,500 per person per calendar year - Effective October 1, 2023
- Extended health care and dental benefits, including semi-private hospital coverage, will continue for full-time employees until their 80th birthday, subject to the employee being otherwise entitled to benefits under the collective agreement – Effective September 1, 2022 ***Please note that this is only applicable to Non-Union Active Members and Non-Union Members on Leave**
- Life Insurance and Accidental Death and Dismemberment will continue for full-time employees until their 80th birthday, subject to the employee being otherwise entitled to benefits under the collective agreement – Effective Sept 1, 2022 ***Please note that this is only applicable to Non- Union Active Members and Non-Union Members on leave**
- Out of country travel coverage has been transferred form RSA to AIG, please refer to travel portion of the booklet below for further details effective June 1, 2022
- Accidental Death and Dismemberment coverage has been transferred from ACE to CHUBB, please refer to the AD&D portion of the booklet below for further details
- Retirees are not eligible for out of country coverage
- Continuous glucose monitoring (including transmitter and associated sensors) is now covered to a maximum of $4,000 per insured per calendar year effective April 1, 2021

Sincerely,
Coughlin & Associates Ltd.

How to Claim Benefits

Life Insurance Claim

In the event of a death, your beneficiary should immediately contact your employer who will provide the necessary information.

Claims for Life benefits must be made as soon as reasonably possible.

Reimbursement Details Regarding Extended Health Care and Dental Care Claims

To be eligible for reimbursement, Coughlin & Associates Ltd. must receive proof of claim within 24 months of the date of purchase or service. You have 90 days following the termination of your coverage to submit claims for reimbursement.

Interest shall not be payable on any reimbursement under this plan. All expenses incurred and paid by the participants shall be deemed to have been incurred and paid in Canadian dollars and reimbursement shall be in Canadian dollars.

Reimbursement

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

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

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

Member Portal - Electronic Claims

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

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

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

Pre-Authorized Deposit (PAD)

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

To enrol in the PAD program:

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

Point-of-Service Claims Submission

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

Pharmacy:
BIN/Carrier ID #34
Group Number# 58527
Certificate number - printed on your card

Dental:
BIN/Carrier ID #000034
Group Number# 58527
Certificate number - printed on your card

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

Submitting Paper Claims

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

Please note that all claim receipts will be retained by Coughlin & Associates Ltd .. It is therefore recommended that you retain photocopies of receipts for your records.

Dental Care Claims

Coughlin & Associates Ltd. offers electronic submission of dental claims via Electronic Data Interchange (EDI). This fast and secure method of claiming allows your claim to be sent directly from your dental office to our claims department for adjudication.

Our EDI service uses the secure data networks of Telus, the dedicated claims processing network sponsored by the Canadian Dental Association. With Telus, you can be assured that the information contained in your dental claim will be transmitted to Coughlin & Associates Ltd. quickly, safely and confidentially right from your dentist's office.

To make use of EDI for dental claim submissions, please present your all-in-one benefit card to your dental provider. You may also contact Coughlin & Associates Ltd. to receive the necessary information.

People Advantage Preferred Provider Network

People Advantage is our exclusive preferred provider network that offers cost savings on prescription drugs, eye wear, and other valuable perks. We make saving on prescription drug costs easy. You and your dependents will benefit from our partnerships with select pharmacies through reduced dispensing fees, *reduced markups* and other value-adds. A full list of partners can be accessed with the instructions below.

Sign In Instructions

1. Sign into your Coughlin Member Portal, either on Desktop or through the Coughlin Mobile App

2. If on Desktop, select the Health Solutions tab from along the top of the screen and from there select "People Advantage Preferred Provider Network" tile.

3. If on the mobile app, select "My Profile" located in the bottom right-hand corner of the screen. From there you will be able to select "Health Solutions" and find the "People Advantage Preferred Provider Network" tile.

Claims Appeal Process

In the event a claim is denied and the employee is not in agreement, an appeal may be submitted in writing by the employee to Coughlin & Associates Ltd., identifying the basis of the appeal and including supporting medical information justifying the expense as medically necessary.

These appeals will be reviewed in conjunction with our medical/dental consultants and the decision will be communicated in writing to the employee.

Contact Us

Claims Department :

Tel. : 613 231-8540

Toll-Free : 1 877 768-3378

Email : ottclaims@coughlin.ca

All Other Inquiries

Tel. : 613 231-2266

Toll-Free : 1 888 613-1234

Fax. : 613 231-2345

Email : info@coughlin.ca

Website : www.coughlin.ca

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

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

Business Hours : Monday to Friday: 8 :30am – 4 :30pm

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:

Coughlin & Associates Ltd.
466 Tremblay Road
Ottawa, ON K1G 3R1

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

Telephone:
613-231-2266

For claims service telephone:
613-231-8540

Fax:
613-231-2345

E-mail:
info@coughlin.ca

Web site:
www.coughlin.ca

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.

Table of contents

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.

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:
    - other than as a dependant;
    - as a dependant child of the parent with the earlier month and day of birth in the calendar year;
    - 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, psychotherapist and social worker to a combined maximum of $800 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.

Policyholder name:	**The Ottawa Hospital**
Policy number:	1060107
Overall maximum per *insured person:*	$5 million Canadian per coverage period.
Description of classes:	Class A – All eligible active non-union employees under age 70. Class C – All eligible active non-union employees ages 70-74 inclusively.
Work hours required:	Class A – 37.5 hours per week. Class C – 37.5 hours per week.
Eligibility period:	Class A – as per extended health care benefit plan. Class C – as per extended health care benefit plan.
Termination age:	Class A: age 70 or earlier retirement. Class C: age 75 or earlier retirement.
Common-law spouse co-habitation period:	Continuous co-habitation: Last 12 months
Age limits for dependant children:	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.

36 01 NOT ECA 0819 000

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.

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

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

24. Crowns and root canals.

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

26. 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. Dependants beyond the termination age may be covered, provided that the participant has not yet reached the termination age.

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

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

"Vehicle" means any automobile, station wagon, mini-van, sports utility vehicle (for on-road use), motorcycle, pick-up truck or a

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

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

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, 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.*

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 abcessor 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

Prosthodontic 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).

Prosthodontic 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

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

- replacement is necessitated by the extraction of additional natural teeth;
- the existing prosthesis 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 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 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

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.
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
Website: 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
Website: 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

Sun Life Financial

your group benefits

The Ottawa Hospital

Ottawa Inner City Health Inc.

Contract Number 56253 and AB10215001
Effective July 1, 2020

The Basic Accidental Death & Dismemberment Insurance benefit is insured by ACE INA Insurance

Table of Contents

General Information

The information contained in this section applies only to benefits insured by Sun Life Assurance Company of Canada.

About this booklet

The information in this employee benefits booklet is important to you. It provides the information you need about the group benefits available through your employer's group contract with Sun Life Assurance Company of Canada (*Sun Life*), a member of the Sun Life Financial group of companies.

Your group benefits may be modified after the effective date of this booklet. You will receive written notification of changes to your group plan. The notification will supplement your group benefits booklet and should be kept in a safe place together with this booklet.

If you have any questions about the information in this employee benefits booklet, or you need additional information about your group benefits, please contact your employer.

Eligibility

To be eligible for group benefits, you must be a resident of Canada and meet the following conditions:

- you are a permanent full-time employee.
- you are actively working for your employer at least 37.5 hours a week.
- you have completed the waiting period.

The waiting period for your group plan is 3 months of continuous employment.

We consider you to be actively working if you are performing all the usual and customary duties of your job with your employer for the scheduled number of hours for that day. This includes scheduled non-working days and any period of continuous paid vacation of up to 3

months if you were actively working on the last scheduled working day. We do not consider you to be actively at work if you are receiving disability benefits or are participating in a partial disability or rehabilitation program.

Your dependents become eligible for coverage on the date you become eligible or the date they first become your dependent, whichever is later. You must apply for coverage for yourself in order for your dependents to be eligible.

Who qualifies as your dependent

Your dependent must be your spouse and a resident of Canada or the United States.

Your spouse by marriage or under any other formal union recognized by law, or your partner of the opposite sex or of the same sex who is publicly represented as your spouse, is an eligible dependent. You can only cover one spouse at a time.

Enrolment

You have to enrol to receive coverage. To enrol, you must request coverage in writing by supplying the appropriate enrolment information to your employer. For a dependent to receive coverage, you must request dependent coverage.

Proof of good health will be required when you request Optional Life coverage and any increase in that coverage. Coverage will not take effect before Sun Life approves the proof of good health.

When coverage begins

Your coverage begins on the date you become eligible for coverage.

If you are not actively working on the date coverage would normally begin, your coverage will not begin until you return to active work.

A dependent's coverage begins on the later of the following dates:

- the date your coverage begins.
- the date the dependent becomes eligible for coverage.
- the date Sun Life approves the dependent's proof of good health, if required.

However, for a dependent who is hospitalized, coverage will begin when the dependent is discharged from hospital and is actively pursuing normal activities.

If you are not actively working on the date your spouse's Optional Life coverage would normally begin, then that coverage will not begin until you return to active work with your employer.

If there are additional conditions for a particular benefit, these conditions will appear in the appropriate benefit section later in this booklet.

Changes affecting your coverage

From time to time, there may be circumstances that change your coverage.

For example, your employment status may change, or your employer may change the group contract. Any resulting change in the coverage will take effect on the date of the change in circumstances.

The following exceptions apply if the result of the change is an increase in coverage:

- if proof of good health is required, the change cannot take effect before Sun Life approves the proof of good health.
- if you are not actively working when the change occurs or when Sun Life approves proof of good health, the change cannot take effect before you return to active work.
- if a dependent is hospitalized on the date when the change occurs, the change in the dependent's coverage cannot take effect before the dependent is discharged and is actively pursuing normal activities.

Updating your records

To ensure that coverage is kept up-to-date, it is important that you report any of the following changes to your employer:

- change of dependents.
- change of name.

- change of beneficiary.

Accessing your records

For insured benefits, you may obtain copies of the following documents by contacting Coughlin & Associates Ltd.:

- your enrolment form or application for insurance.
- any written statements or other record, not otherwise part of the application, that you provided to Sun Life as evidence of insurability.

For insured benefits, on reasonable notice, you may also request a copy of the contract.

The first copy will be provided at no cost to you but a fee may be charged for subsequent copies.

Requests for a copy of the contract should be directed to one of the following sources:

- our website at www.mysunlife.ca.
- our Customer Care centre by calling toll-free at 1-800-361-6212.

When coverage ends

As an employee, your coverage will end on the earlier of the following dates:

- the date your employment ends or you retire.
- the date you are no longer actively working.
- the end of the period for which premiums have been paid to Sun Life for your coverage.
- the date the group contract ends.

A dependent's coverage terminates on the earlier of the following dates:

- the date your coverage ends.
- the date the dependent is no longer an eligible dependent.

- the end of the period for which premiums have been paid for dependent coverage.

The termination of coverage may vary from benefit to benefit. For information about the termination of a specific benefit, please refer to the appropriate section of this employee benefits booklet.

Replacement coverage

The group contract will be interpreted and administered according to all applicable legislation and the guidelines of the Canadian Life and Health Insurance Association concerning the continuation of insurance following contract termination and the replacement of group insurance.

Sun Life will not be responsible for paying benefits if an insurer under a previous group contract is responsible for paying similar benefits.

If such legislation or guidelines require that Sun Life resume paying certain benefits because of a recurrence of an employee's total disability, Sun Life will resume payment at the same amount and for the remainder of the maximum benefit period.

Making claims

Sun Life is dedicated to processing your claims promptly and efficiently. You should contact your employer to get the proper form to make a claim.

There are time limits for making claims. These limits are discussed in the appropriate sections of this employee benefits booklet. If you fail to abide by these time limits, you may not be entitled to some or all benefit payments.

All claims must be made in writing on forms approved by Sun Life.

For the assessment of a claim, Sun Life may require medical records or reports, proof of payment, itemized bills, or other information Sun Life considers necessary. Proof of claim is at your expense.

Legal actions

Limitation period for Ontario:

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless

commenced within the time set out in the *Limitations Act, 2002*.

Limitation period for any other province:

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the *Insurance Act* or other applicable legislation of your province or territory.

Proof of disability

From time to time, Sun Life can require that you provide us with proof of your total disability. If you do not provide this information within 90 days of the request, you will not be entitled to benefits.

Medical examination

We can require you to have a medical examination if you make a claim for benefits. We will pay for the cost of the examination. If you fail or refuse to have this examination, we will not pay any benefit.

Recovering overpayments

We have the right to recover all overpayments of benefits either by deducting from other benefits or by any other available legal means.

Definitions

Here is a list of definitions of some terms that appear in this employee benefits booklet. Other definitions appear in the benefit sections.

Appropriate treatment

Appropriate treatment is defined as any treatment that is performed and prescribed by a doctor or, when Sun Life believes it is necessary, by a medical specialist. It must be the usual and reasonable treatment for the condition and must be provided as frequently as is usually required by the condition. It must not be limited solely to examinations or testing.

Basic earnings

Basic earnings are the salary you receive from your employer excluding any bonus, overtime or incentive pay.

Doctor

A doctor is a physician or surgeon who is licensed to practice medicine where that practice is located.

Eligible Permanent Full-time employees – Non-union

All employees other than Auxiliary employees.

Illness

An illness is a bodily injury, disease, mental infirmity or sickness. Any surgery needed to donate a body part to another person which causes

total disability is an illness.

Retirement date If you are totally disabled, your retirement date is your 65th birthday, unless you have actually retired before then.

We, our and us We, our and us mean Sun Life Assurance Company of Canada.

Basic and Optional Life Coverage

Insurer

This benefit is insured by Sun Life Assurance Company of Canada.

General description of the coverage

Your Life coverage provides a benefit for your beneficiary if you die while covered. Your spouse's Life coverage provides a benefit if your spouse dies while covered.

Basic Life coverage for you

Amount

Your Life benefit is 2 times your annual basic earnings, rounded to the next higher $1,000. The maximum amount of coverage is $1,000,000.

Reduction

Your benefit will reduce to $10,000 when you reach age 65.

Coverage ends

Your coverage will end when you retire or reach age 70, whichever is earlier. Coverage may also end on an earlier date, as specified in *General Information*.

Optional Life coverage for you

Amount

You can choose coverage in units of $10,000. The maximum amount of coverage is $500,000.

Proof of good health

Required on all optional amounts of coverage.

Coverage ends

Your coverage will end when you retire or reach age 65, whichever is earlier. Coverage may also end on an earlier date, as specified in *General Information*.

Optional Life coverage for your spouse

Amount

You can choose Optional Life coverage for your spouse in units of $10,000 up to a maximum of $500,000.

Proof of good health

Required on all optional amounts of coverage.

Coverage ends

Optional coverage for your spouse will end when you retire or reach age 65, or when your spouse reaches age 65, whichever is earlier. Coverage may also end on an earlier date, as specified in *General Information*.

Who we will pay

If you die while covered, Sun Life will pay the full amount of your benefit to your last named beneficiary on file with Sun Life.

If you have not named a beneficiary, the benefit amount will be paid to your estate. Anyone can be your beneficiary. You can change your beneficiary at any time, unless a law prevents you from doing so or you indicate that the beneficiary is not to be changed.

For your spouse's optional coverage, Sun Life will pay the full amount of the benefit to the last named beneficiary on file with Sun Life. If you have not named a beneficiary, the benefit amount will be paid to you.

A minor cannot personally receive a death benefit under the plan until reaching the age of majority. If you reside outside Québec and are designating a minor as your beneficiary, you may wish to designate someone to receive the death benefits during the time your beneficiary is a minor. If you reside outside Québec and have not designated a trustee, current legislation may require Sun Life to pay the death benefit to the court or to a guardian or public trustee. If you reside in Québec, the death benefit will be paid to the parent(s)/legal guardian of the minor on the minor’s behalf. Alternatively, you may wish to designate the estate as beneficiary and provide a trustee with directions in your will. You are encouraged to consult a legal advisor.

Suicide

If you or your spouse have any optional coverage that has been in effect for less than 2 years, we will not pay benefits if death is by suicide, regardless of whether you or your spouse have a mental illness or intend or understand the consequences of your actions. However, we will refund all applicable Life coverage premiums that have been paid.

Coverage during total disability

If you become totally disabled before you retire or reach age 65, whichever is earlier, Life coverage may continue without the payment of premiums as long as you are totally disabled. This continued coverage is subject to the terms of the contract which were in effect on the date you became totally disabled, including reductions and terminations.

Sun Life must receive proof of your total disability within 12 months of the date the disability begins. After that, we can require ongoing proof that you are still totally disabled.

If proof of total disability is approved after an individual insurance policy becomes effective as a result of converting the group Life coverage, the group Life coverage will be reduced by the amount of the individual insurance policy, unless the individual insurance policy is exchanged for a refund of premiums.

Total disability must continue for:

- an uninterrupted period of 6 months, or
- the elimination period for Long-Term Disability if you are entitled to Long-Term Disability payments, whichever is shorter.

This coverage will continue without payment of premiums, from the date the Long-Term disability claim is approved, until the date you cease to be totally disabled or the date you fail to give Sun Life proof of your continued total disability, whichever is earlier.

Spouse Optional Life coverage will also continue without payment of premiums, as long as your Life coverage is continued without payment of premiums, but not after the Spouse Optional Life benefit is terminated.

For the purposes of your Life coverage, you will be considered totally disabled if you are prevented by illness from performing any occupation you are or may become reasonably qualified for by education, training or experience. However, if you are totally disabled under the Long-Term Disability benefit, you are also considered to be totally disabled under the Life benefit.

Living Benefits Loan Program

If you are terminally ill with a life expectancy of 24 months or less, you may apply for a commercial loan under the Sun Life Living Benefits Loan Program. Under this program, you may receive an advance of up to 50% of your Basic Life coverage, to a maximum of $100,000.

If you are within 5 years of a scheduled reduction of your Basic Life coverage, the advance you may receive cannot exceed 50% of the lowest reduced amount of your Basic Life coverage. If you are within 5 years of the termination of your Basic Life coverage, you may not apply for a commercial loan under the Sun Life Living Benefits Loan Program. This program is subject to other restrictions. Please contact your employer for details.

Converting Life coverage

If your Life coverage ends or reduces for any reason other than your request, you may apply to convert the group Life coverage to an individual Life policy with Sun Life without providing proof of good health.

If your spouse's Life coverage ends for any reason other than your request, your spouse may apply to convert the group Life coverage to an individual Life policy with Sun Life without providing proof of good health.

The request must be made within 31 days of the reduction or end of the Life coverage.

There are a number of rules and conditions in the group contract that apply to converting this coverage, including the maximum amount that can be converted. Please contact your employer for details.

When and how to make a claim

Claims for Life benefits must be made as soon as reasonably possible. Claim forms are available from your employer.

Long-Term Disability

Insurer

This benefit is insured by Sun Life Assurance Company of Canada.

General description of the coverage

Long-Term Disability coverage provides a benefit to you if you are totally disabled. You qualify for this benefit if you provide proof of claim acceptable to Sun Life that:

- you became totally disabled while covered, and
- you have been following appropriate treatment for the disability since its onset.

For your Long-Term Disability coverage,

- during the elimination period and the following 24 months (this period is known as the **own occupation period**), you will be considered totally disabled while you are continuously unable due to an illness to do the essential duties of your own occupation, and
- afterwards, you will be considered totally disabled if you are continuously unable due to an illness to do any occupation for which you are or may become reasonably qualified by education, training or experience.

If you have 35 or more years of employment with your employer, you will be considered totally disabled while you are prevented by illness from performing the essential duties of your own occupation.

If you must hold a government permit or licence to perform your own occupation and your permit or licence is withdrawn or not renewed solely for medical reasons, we will consider you totally disabled for up to 12 months after the end of the elimination period. You cannot be working other than in a Sun Life approved partial disability or rehabilitation program.

Benefits are paid at the end of each month and are based on your coverage on the date you became totally disabled.

If you are totally disabled for part of any month, we will pay 1/30 of the monthly benefit for each day you are totally disabled.

When disability payments begin

Your Long-Term Disability payments begin after you have been totally disabled for an uninterrupted period of 120 days or after the last day benefits are payable under any short-term disability, loss of income or other salary continuation plan, whichever is later.

This period, which must be completed before disability benefits become payable, is the **elimination period**.

If you become totally disabled during a lay-off or approved leave and your coverage continues during this time, you will be eligible for benefit payments following your recall or scheduled return to full-time work with your employer. You must have been totally disabled for an uninterrupted period of 120 days and still be totally disabled on the date you are recalled or scheduled to return to full-time work with your employer.

What we will pay

Here is how we calculate your Long-Term Disability payments. All references to income in this disability provision are to the gross amounts before any deductions.

Step 1: We take a percentage of your monthly basic earnings based on your years of employment with your employer up to a maximum of $10,000 as follows:

- 66.67% if you have less than 20 years of employment.
- 70% if you have between 20 and 30 years of employment.
- 75% if you have more than 30 years of employment.

Step 2: We subtract any income provided to you:

- for the same or a subsequent disability under any government-sponsored plan, including amounts payable on behalf of a dependent, but excluding employment insurance benefits and automatic cost-of-living increases under any government-

sponsored plan that occur after benefits begin.

- for any disability under any Workers' Compensation Act or similar law, excluding automatic cost-of-living increases that occur after benefits begin.
- from any occupation, other than Partial Disability or Rehabilitation benefits.
- under the Québec Parental Insurance Plan.
- under the Hospitals of Ontario Pension Disability Benefit Plan.

The result from Step 2 is the amount you will normally receive.

If this amount plus the above sources of income and all the additional sources of income listed below exceeds 85% of your pre-disability basic earnings, we will reduce your Long-Term Disability payment by the excess. If your benefit is non-taxable, the maximum will be 80% of your pre-disability basic earnings after income tax.

Additional sources of income provided to you:

- from any employer by reason of the same or subsequent disability.
- under a motor vehicle insurance plan which provides disability benefits to the extent that the law does not prohibit such a deduction.
- under a group plan, including any coverage resulting from your membership in an association of any kind.
- under any retirement or pension plan of the employer.
- under any Criminal Injuries Compensation Act or similar law, where allowed by law.

If you are eligible for any of the income amounts above and do not apply for them, we will still consider them part of your income. We can estimate those benefits and use those amounts when we calculate your

payments.

If you receive any of the income amounts above in a lump sum, we will determine the equivalent compensation this represents on a monthly basis using generally accepted accounting principles.

We will not take into account any benefits that began before your disability began. However, increases in those benefits as a result of your disability will be taken into account.

We have the right to adjust your benefit payments when necessary.

Maternity / parental leave of absence

Maternity leave agreed to with your employer will begin on the date you and your employer have agreed will be the start of your leave or the date the child is born, whichever is earlier. The leave will end on the date you and your employer have agreed that you will return to active, full-time work or the actual date you return to active, full-time work, whichever is earlier.

Parental leave is the period of time that you and your employer have agreed on.

Sun Life will determine any portions of a maternity or parental leave which are voluntary and any portions which are health-related. The health-related portion of the leave is the period in which a woman can establish, through appropriate medical documentation, that she is unable to work for health reasons related to childbirth or recovery from childbirth.

Long-Term Disability benefits will only be payable for health-related portions of the leave where necessary in order to comply with requirements such as employment standards, human rights and employment insurance, after you have been disabled for an uninterrupted period of 120 days, provided your coverage has been continued.

However, if your employer has a Supplemental Unemployment Benefit (SUB) plan as defined in the Employment Insurance regulations covering the health-related portion of the maternity or parental leave, Sun Life will not pay any benefits under this plan during any period

benefits are payable to you under your employer's SUB plan.

Partial disability program

You may be required to participate in a partial disability program approved by Sun Life in writing.

After you are eligible for Long-Term Disability payments, you may be considered for a partial disability program in which you return to your own occupation for a reduced number of hours per week.

During your partial disability program, you can receive a salary from your employer for the hours worked. However, your Long-Term Disability payments will be reduced by the percentage of your normal work week that you are now working for your employer.

During your partial disability program your total income from all sources cannot exceed 100% of your pre-disability basic earnings, indexed for inflation (less provincial and federal income taxes if your benefit is non-taxable). If this is the case, your Long-Term Disability payments will be further reduced by the excess.

Your participation in a partial disability program will be limited to the own occupation period.

Rehabilitation program

You may be required to participate in a rehabilitation program approved by Sun Life in writing.

It may include the involvement of our rehabilitation specialist, part-time work, working in another occupation or vocational training to help you become capable of full-time employment.

Sun Life is under no obligation to approve or continue a rehabilitation program for an employee. We will consider such factors as financial considerations and our opinion on the merits of rehabilitation.

During your rehabilitation program, you may receive your Long-Term Disability payments plus income from other sources. However, if during any month your total income is more than 100% of your pre-disability basic earnings, indexed for inflation (less provincial and federal income taxes if your benefit is non-taxable), your Long-Term Disability payments will be reduced by the excess.

You should consider participating in a rehabilitation program as soon as possible after becoming totally disabled. If you enter a rehabilitation program during the elimination period, it will not be considered an interruption of the elimination period.

Interrupted periods of disability during elimination period

Interrupted periods of total disability due to the same or related causes occurring before the elimination period has been completed are treated as one period of disability and are accumulated to complete the elimination period as long as this benefit is in force and all of the following conditions are met:

- the initial period of total disability lasts for at least 30 days without interruption.
- afterwards, there is no interruption of more than 30 days.
- each period of total disability is completed within 12 months after the start of the elimination period, or as approved by Sun Life in advance in cases where the elimination period is 365 days or more.

The difference between your normal number of scheduled hours and the number of hours actually worked is credited towards the elimination period.

If the Long-Term Disability benefit terminates, any balance of the elimination period must subsequently be completed by uninterrupted total disability.

Interrupted periods of disability after payments begin

If you had a total disability for which we paid Long-Term Disability benefits and total disability occurs again due to the same or related causes, we will consider it a continuation of your previous disability if it occurs within 6 months of the end of your previous disability. You must be covered when total disability reoccurs.

These benefits will be based on your coverage as it existed on the original date of total disability.

If you recover damages from another person

We have the right to part of any money you recover through legal action or settlement from another person, organization or company who caused your disability.

If you decide to take legal action, you must comply with the applicable terms of the group contract concerning legal action.

If you recover money, you must pay us 75% of your net recovery or the total disability income benefits paid or payable to you under this plan, whichever is less. Your net recovery does not include your legal costs. Seventy-five percent of your net recovery must be held in trust for us.

We have the right to withhold or discontinue disability income payments if you refuse or fail to comply with any of these terms.

Your responsibilities

During your total disability, you must make reasonable efforts to:

- recover from your disability, including participating in any reasonable treatment or rehabilitation program and accepting any reasonable offer of modified duties from your employer.
- return to your own occupation during the first 24 months that benefits are payable.
- obtain training in order to qualify for another occupation if it becomes apparent that you will not be able to return to your own occupation within the first 24 months that benefits are payable.
- try to obtain work in another occupation after the first 24 months that benefits are payable.
- obtain benefits that may be available from other sources.

If you do not, Sun Life may hold back or discontinue benefits.

When payments end

Your Long-Term Disability payments end on the earlier of the following dates:

- the date you are no longer totally disabled.
- the last day of the month in which you reach age 65.

- the last day of the month in which you retire with a pension.
- the last day of the month in which you die.

When coverage ends

Long-Term Disability coverage will end on the day you reach age 65 less the elimination period of 120 days or the day you retire, whichever is earlier. Coverage may also end on an earlier date, as specified in *General Information*.

Payments after coverage ends

If the Long-Term Disability benefit terminates while you are totally disabled, you are entitled to continue receiving payments, as long as your total disability is uninterrupted, as if the benefit were still in effect.

What is not covered

We will not pay benefits for any period:

- you are not receiving appropriate treatment.
- that you do any work for wage or profit except as approved by Sun Life.
- you are not participating in an approved partial disability or rehabilitation program, if required by Sun Life.
- you are on a leave of absence, strike or lay-off except as stated under *Maternity / parental leave of absence* or except where specifically agreed to by Sun Life.
- you are absent from Canada longer than 4 months due to any reason, unless Sun Life agrees in writing in advance to pay benefits during the period.
- you are serving a prison sentence or are confined in a similar institution.

We will not pay benefits for total disability resulting from:

- the hostile action of any armed forces, insurrection or participation in a riot or civil commotion.

- intentionally self-inflicted injuries.
- participation in a criminal offence.

When and how to make a claim

To make a claim, complete the Notice of Claim for Group Long-Term Disability Benefits that is available from your employer.

We must receive notice of claim on the earlier of the following dates:

- 60 days after the total disability begins.
- within 30 days of the termination of this Long-Term Disability benefit.

Part of the application process will include filling out claim forms that give us as many details about the claim as possible. You, the attending doctor and your employer will all have to complete claim forms.

In order to receive benefits, we must receive these forms no later than 90 days after the end of the elimination period.

We will assess the claim and send you or your employer a letter outlining our decision.

From time to time, Sun Life can require that you provide us with proof of your total disability. If you do not provide this information within 90 days of this request, you will not be entitled to benefits.

BASIC ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE PLAN FOR THE EMPLOYEES OF THE OTTAWA HOSPITAL

Insurer ***This benefit is insured by ACE INA Insurance.***

POLICY NUMBER: AB10215001

BASIC ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE PLAN

COVERAGE
The plan offers you full 24-hour protection against accidents, on or off the job, on business, on vacation, at home, regardless of your health history.

ELIGIBILITY
As stated under your Basic Group Life Insurance Plan.

BENEFIT AMOUNT
You are insured for a benefit amount equal to your Basic Group Life Insurance Plan.

Benefit terminates at age 70 or earlier retirement.

In the event of your death, the benefit amount is payable to the beneficiary you have named under your Group Life Insurance Plan or in the absence of such designation, to your Estate.

SCHEDULE OF LOSSES

Accidental Death & Dismemberment

If such injuries shall result in any one of the following specific losses within 1 year from the date of the accident, ACE INA Life Insurance will pay the percentage of the benefit amount, based on the amount stated under the benefit amount section, however, that not more than one (the largest) of such benefits shall be paid with respect to injuries resulting from one accident.

	Percentage of Benefit Amount
Loss of Life	100%
Loss of Entire Sight of Both Eyes	100%
Loss of One Hand and One Foot	. 100%
Loss of Use of One Hand and One Foot	. 100%
Loss of One Hand and Entire Sight of One Eye	100%
Loss of One Foot and Entire Sight of One Eye	100%
Loss of Speech and Hearing in Both Ears	100%
Brain Death	100%
Loss of Both Arms, Both Hands, Both Legs of Both Feet	200%
Loss of Use of Both Arms, Both Hands, Both Legs or Both Feet	200%
Quadriplegia	200%
Paraplegia	200%
Hemiplegia	200%
Loss of One Arm or One Leg	75%
Loss of Use of One Arm or One Leg	75%
Loss of One Hand or One Foot	66 2/3%
Loss of Use of One Hand or One Foot	66 2/3%
Loss of Entire Sight of One Eye	66 2/3%
Loss of Speech or Hearing in Both Ears	66 2/3%
Loss of Thumb and Index Finger of Same Hand	33 1/3%
Loss of Four Fingers of Same Hand	33 1/3%
Loss of Hearing in One Ear	25%
Loss of All Toes of Same Foot	12.5%

"Loss" shall mean with respect to hand or foot, the actual severance through or above the wrist or ankle joint; with respect to arm or leg, the actual severance through or above the elbow or knee joint; with respect to eye, the total and irrecoverable loss of sight; with respect to speech, the total and irrecoverable loss of speech which does not allow audible communication in any degree; with respect to hearing, the total and irrecoverable loss of hearing which cannot be corrected by any hearing aid or device; with respect to thumb and index finger or four fingers, the actual severance through or above the metacarpophalangeal joints of the same hand (the joints between the fingers and the hand); with regard to toes, the actual severance through or above the metatarsophalangeal joints (the joints between the toes and the foot) of the same foot. If an Insured Person suffers complete severance of a hand, foot, arm or leg as described above, then ACE INA Life Insurance will pay the amount specified in the Schedule of Losses even if the severed limb is surgically reattached, whether successful or not.

"Loss" as used with reference to quadriplegia (paralysis of both upper and lower limbs), paraplegia (paralysis of both lower limbs), and hemiplegia (total paralysis of upper and lower limbs of one side of the body), means the complete and irrecoverable paralysis of such limbs, provided such loss of function is continuous for 365 consecutive days and such loss of function is thereafter determined on evidence satisfactory to ACE INA Life Insurance to be permanent.

"Loss of Use" shall mean the total and irrecoverable loss of function of an arm, hand, foot, leg provided such loss of function is continuous for 12 consecutive months and such loss of function is thereafter determined on evidence satisfactory to ACE INA Life Insurance to be permanent.

“Brain Death” means irreversible unconsciousness with total loss of brain function; and complete absence of electrical activity of the brain, even though the heart is still beating. All benefits that are payable at 200% of the Principal Sum are subject to an all policies combined maximum benefit amount of $2,000,000.

Repatriation Benefit
When injuries result in loss of life of an Insured Person outside 150 kilometers from their city of permanent residence or outside Canada and the loss of life occurs within 365 days from the date of the accident, ACE INA Life Insurance will pay the actual expense incurred for preparing the deceased for burial and shipment of the body to the city of residence of the deceased, but not to exceed $15,000.

Rehabilitation Benefit
When injuries result in a payment being made by ACE INA Life Insurance under any benefit excluding the Loss of Life Benefit, ACE INA Life Insurance will also pay the reasonable and necessary expenses actually incurred up to a limit of $15,000 for special training of an Insured Employee provided:
(a) such training is required because of such injuries and in order for an Insured Employee to become qualified to engage in an occupation in which he or she would not have been engaged except for such injuries;
(b) expenses are to be incurred within 2 years from the date of the accident;
(c) no payment will be made for ordinary living, travelling, or clothing expenses.

Family Transportation Benefit
When injuries result in an Insured Person confinement as an in-patient in a hospital outside 150 kilometers from an Insured Person's city of permanent residence or outside Canada and requires personal attendance of a "Member of the Immediate Family" as recommended by the attending physician, in writing, ACE INA Life Insurance will pay for the expense incurred by the member of the family, for the transportation by the most direct route by a licensed common carrier to an Insured Person, while confined, but not to exceed $15,000.

"Member of the Immediate Family" means spouse, parent or stepparent, child or stepchild, brother or sister, stepbrother or stepsister, brother-in-law or sister-in-law, mother-in-law or father-in-law, and son-in-law or daughter-in-law.

Spousal Occupational Training Benefit

When injuries result in a payment being made by ACE INA Life Insurance under the Loss of Life Benefit, ACE INA Life Insurance will pay in addition the expenses actually incurred, within 365 days from the date of the accident, by the spouse of an Insured Employee for a formal occupation training program for the purpose of specifically qualifying such spouse to gain active employment in an occupation for which the spouse would otherwise not have sufficient qualifications. The maximum payable hereunder is $15,000.

Home Alteration and Vehicle Modification Benefit

In the event an Insured Person sustain an injury which results in a payment being made under the Schedule of Losses, excluding the Loss of Life Benefit, and such injury subsequently requires the use of a wheelchair to be ambulatory, ACE INA Life Insurance will pay the reasonable and necessary expenses actually incurred within 365 days from the date of the accident for:

1. the one-time cost of alterations to an Insured Person's principal residence to make it wheelchair accessible and habitable; and
2. the one-time cost of modifications necessary to a motor vehicle utilized by an Insured Person to make the vehicle accessible or driveable for an Insured Person.

Benefit payments herein will not be paid unless:
(i) home alterations are made by a person or persons experienced in such alterations and recommended by a recognized organization, providing support and assistance to wheelchair users; and
(ii) vehicle modifications are carried out by a person or persons with experience in such matters and modifications are approved by the Provincial vehicle licensing authorities.

The maximum payable under both items 1 and 2 shall be 10% of an Insured Person's Principal Sum amount to a maximum of $50,000.

Day Care Benefit

If an Insured Person suffers a loss of life in a covered accident while the policy is in force, ACE INA Life Insurance will pay, in addition to all other benefits payable under the policy a Day Care Benefit equal to the reasonable and necessary expenses actually incurred, subject to the lesser of 5% of an Insured Person's Principal Sum amount or a maximum of $5,000 per year, on behalf of any dependent child who is enrolled in a legally licensed day care centre on the date of the accident or who enrolls in a legally licensed day care centre within 365 days following the date of the accident.

The "Day Care Benefit" will be paid each year for 4 consecutive years, but only upon receipt of satisfactory proof that a child is enrolled in a legally licensed day care centre.

"Dependent Child" means the Employee's eligible unmarried natural, legitimate, illegitimate, adopted, step child or common law child who is principally dependent on the Employee or the Employee's Spouse for financial support.

Special Education Benefit

If an Insured Person suffers a loss of life in a covered accident while the policy is in force, ACE INA Life Insurance will pay, in addition to all other benefits payable under the policy, a Special Education Benefit up to 5% of an Insured Person's Principal Sum amount, (subject to a maximum of $5,000 per year), on behalf of any dependent child who, on the date of the accident, is enrolled as a full-time student in any post-secondary institution of higher learning or was at the 12th grade level and subsequently enrolls as a full-time student in any post-secondary institution of higher learning within 365 days following the date of the accident.

The "Special Education Benefit" is payable annually for a maximum of 4 consecutive annual payments but only if the dependent child continues his or her education as a full-time student in an institution of higher learning.

Bereavement Benefit
When injuries covered by the policy result in loss of life of an Insured Person within 365 days from the date of the accident, ACE INA Life Insurance will pay the reasonable and necessary expenses actually incurred by the spouse and dependent children of an Insured Person for up to 6 sessions of grief counseling, by a "Professional Counsellor", subject to a maximum of $1,000.

"Professional Counsellor" means a therapist or counsellor who is licensed, registered or certified to provide such treatment.

In-Hospital Confinement Monthly Income Benefit
In the event an Insured Person sustains an injury which results in a payment being made under the Schedule of Losses, excluding the Loss of Life Benefit, and an Insured Person is hospital confined as an in-patient and is under the care of a legally qualified and registered physician or surgeon other than himself or herself, ACE INA Life Insurance will pay for each full month, 1% of an Insured Person's Principal Sum amount, subject to a maximum amount of $2,500, or 1/30 of such monthly benefit for each day of partial month, retroactive to the 1st full day of such confinement but not to exceed 365 days in the aggregate for each period of hospital confinement.

"Hospital" as used herein means a legally constituted establishment which meets all of the following requirements: (1) operates primarily for the reception, care and treatment of sick, ailing or injured persons as inpatients; (2) provides 24 hour a day nursing service by registered or graduate nurses; (3) has a staff of one or more licensed physicians available at all times; (4) provides organized facilities for diagnosis and surgical facilities; and (5) is not primarily a clinic, nursing home or convalescent home or similar establishment nor, other than incidentally, a place for alcoholics or drug addicts.

"In-Patient" means a person admitted to a hospital as a resident or bed-patient and who is provided at least one day's room and board by the hospital.

Cosmetic Disfigurement Benefit

If an Insured Person suffers a third degree burn in a non-occupational accident, ACE INA Life Insurance will pay a percentage of the Principal Sum amount depending on the area of the body which was burned according to the following table:

Body Part	(A) Area Classification	(B) Maximum allowable	(C) Maximum % of Principal Sum Payable
Face, Neck, Head	11	9%	99%
Hand & Forearm	5	4.5%	22.5%
Either Upper Arm	3	4.5%	13.5%
Torso (Front or Back)	2	18%	36%
Either Thigh	1	9%	9%
Either Lower Leg (below knee)	3	9%	27%

The maximum % of Principal Sum Payable (C) is determined by multiplying the Area Classification (A) by the Maximum Allowable % for Area Burned (B). In the event of a 50% surface burn, the Maximum Allowable % for Area Burned (B) is reduced by 50%. This table only represents the maximum % of the Principal Sum payable for any one accident. If an Insured Person suffers burns in more than 1 area as a result of any one accident, benefits will not exceed a maximum of $25,000.

Continuance of Coverage

If an Insured Employee is: (1) laid off on a temporary basis; (2) temporarily absent from work due to short-term disability; (3) on leave of absence; or (4) on maternity leave, coverage shall be extended for 12 months, subject to the payment of premiums. If an Insured Employee assumes other occupational duties during the leave or lay-off period, no benefits shall be payable for a loss occurring during the performance of such other occupation.

Seat Belt Benefit
In the event an Insured Person sustains an injury which results in a payment being made under the Schedule of Losses, an Insured Person Principal Sum amount will be increased by 10% to a maximum of $25,000 if, at the time of the accident, an Insured Person was driving or riding in a vehicle and wearing a properly fastened seat belt. Due proof of seat belt use must be provided as part of the written proof of loss.

"Vehicle" means a private passenger car, station wagon, van, or jeep-type automobile.
"Seat Belt" means those belts that form a restraint system.

Identification Benefit
In the event accidental loss of life is sustained by an Insured Person not less than 150 kilometers from an Insured Person's normal place of residence and identification of the body by a "Member of the Immediate Family" has been requested by the police or a similar governmental authority, ACE INA Life Insurance will reimburse the reasonable expenses actually incurred by such member for:
a) transportation by the most direct route to the city or town where the body is located; and
b) hotel accommodation in such city or town, subject to a maximum duration of 3 days.

The reimbursement of such expenses incurred is subject to the accidental Loss of Life Benefit being subsequently payable in accordance with the terms of the policy following the identification of the body as an Insured Person. The maximum amount payable will not exceed $15,000 for all such expenses.

Payment will not be made for board or other ordinary living, travelling or clothing expenses, and transportation must occur in a vehicle or device operated under a license for the conveyance of passengers for hire.

"Member of the Immediate Family" means spouse, parent or stepparent, child or stepchild, brother or sister, stepbrother or stepsister, brother-in-law or sister-in-law, mother-in-law or father-in-law, and son-in-law or daughter-in-law.

HIV Benefit

If you should sustain an accidental bodily injury in the performance of your duties as required by your employer, which results in the acquiring and testing positive for the Human Immunodeficiency Virus within one year from the date of the accident, ACE INA Life Insurance Insurance will pay a benefit equal to 10% of your Benefit amount subject to a maximum of $10,000 provided the following criterion are met:

1. An accident report must be completed specifying the circumstances of the bodily injury and remitted to your employer, within 48 hours of the occurrence.
2. You must submit to a blood test for the Human Immunodeficiency Virus within 48 hours of the accident. The results of this test must then be forwarded to your employer, to be kept on file.

If the initial test is negative and you subsequently test positive for the Human Immunodeficiency Virus within one year of the accident, the applicable benefit payment will be made by ACE INA Life Insurance.

Critical Illness Benefit

If, while coverage is in effect but only after coverage has been in effect for a period of ninety days, you are then diagnosed with any one of the covered illnesses listed below and you satisfies the following conditions:

(A) have been hospitalized as an in-patient continuously for at least 48 hours, and
(B) survive for a period of thirty days thereafter, and
(C) you are under age 65.

ACE INA Life Insurance will pay 10% of the principal sum to a maximum of $10,000.

Covered Illnesses

Encephalitis	Parkinson's Disease	Tuberculosis
Meningitis	Acute poliomyelitis	Typhoid fever
Necrotizing fascitis	Acute rheumatic fever	Yersinia pestis

ACE INA Life Insurance shall only be obligated to pay the critical illness benefit once notwithstanding that an Insured Person may be diagnosed with more than one of the covered illnesses.

Exposure and Disappearance
Loss resulting from unavoidable exposure to the elements shall be covered to the extent of the benefits afforded an Insured Person. If the body of an Insured Person has not been found within 1 year of disappearance, stranding, sinking or wrecking of the conveyance in which an Insured Person was riding at the time of the accident, it shall be presumed, subject to all other conditions of the policy, that an Insured Person suffered a loss of life resulting from bodily injuries sustained in the accident covered under the policy.

Conversion Privilege
On the date of termination of employment or during the 31-day period following termination of employment, an Insured Person may convert his or her insurance to an individual ACCIDENTAL DEATH and DISMEMBERMENT only insurance policy of ACE INA Life Insurance. The individual policy will be effective either as of the date that the application is received by ACE INA Life Insurance or on the date that coverage under the group policy ceases, whichever occurs later. The premium will be the same, as a person would ordinarily pay when applying for an individual policy at that time. Application for an individual policy may be made at any office of ACE INA Life Insurance. The amount of insurance benefit converted shall not exceed that amount issued during employment up to an all policies combined maximum of $200,000. The individual policy will cover ACCIDENTAL DEATH and DISMEMBERMENT only.

Benefits payable under this section will be limited to only one (1) policy in the event the benefits are contained in two (2) or more policies issued to the Policyholder by ACE INA Life Insurance (not applicable to the Schedule of Losses, Exposure and Disappearance and Conversion).

Waiver of Premium

If you are under age 65 and become totally disabled* while you are insured under this plan and satisfactory evidence of your total disability is provided to ACE INA Life Insurance on an annual basis, payment of premium will be waived until the earlier of the following occurs:

a) you return to active employment with your employer;
b) you attain age 65;
c) the master policy underwritten by ACE INA Life Insurance is terminated.

Once you return to active employment with your employer, your coverage will continue only upon the commencement of premium payments.

*You will be considered totally disabled if you are unable to engage in any business or occupation and perform in any work for compensation or profit and has existed continuously for a period of at least 12 months or is in accordance with the waiver of premium requirements under the Policyholder's Group Life Insurance Policy.

Exclusions

The plan does not cover any loss, which is the result of:

1. intentionally self-inflicted injuries, suicide or any attempt thereat, while sane or insane;
2. declared or undeclared war or any act thereof;
3. travel or flying in an aircraft owned or leased by the Policyholder, an Insured Person or a member of an Insured Person's household, or aircraft being used for any test or experimental purpose, firefighting, power line inspection, pipeline inspection, aerial photography or exploration;
4. losses occurring while an Insured Person is serving on full-time active duty in the Armed Forces of any country or international authority (any premium paid to be returned by ACE INA Life Insurance pro-rata for any such period of full-time active duty);
5. travel or flight in any vehicle or device for aerial navigation; except to the extent such travel or flight is provided in the "Hazards Insured Against" section of the Accidental Death & Dismemberment portion of the policy.

How to Claim

Note: In the event of a claim, notice of claim must be given to ACE INA Life Insurance within 30 days from the date of the accident and subsequent proof of claim must be submitted to ACE INA Life Insurance within 90 days from the date of the accident. A claim form can be obtained from the benefits administrator.

This brochure has been prepared in connection with a group plan underwritten by ACE INA Life Insurance. For ease of reference it contains a brief description only and does not mention every provision of the contract issued. Please remember that rights and obligations are determined in accordance with the contract and not this brochure. For the exact provisions applicable, please consult your Employer.

Underwritten by: **ACE INA Life Insurance**

Respecting your privacy

Respecting your privacy is a priority for the Sun Life Financial group of companies. We keep in confidence personal information about you and the products and services you have with us to provide you with investment, retirement and insurance products and services to help you meet your lifetime financial objectives. To meet these objectives, we collect, use and disclose your personal information for purposes that include: underwriting; administration; claims adjudication; protecting against fraud, errors or misrepresentations; meeting legal, regulatory or contractual requirements; and we may tell you about other related products and services that we believe meet your changing needs. The only people who have access to your personal information are our employees, distribution partners such as advisors, and third-party service providers, along with our reinsurers. We will also provide access to anyone else you authorize. Sometimes, unless we are otherwise prohibited, these people may be in countries outside Canada, so your personal information may be subject to the laws of those countries. You can ask for the information in our files about you and, if necessary, ask us in writing to correct it. To find out more about our privacy practices, visit *www.sunlife.ca/privacy*.

You have a choice

We will occasionally inform you of other financial products and services that we believe meet your changing needs. If you do not wish to receive these offers, let us know by calling 1-877-SUN-LIFE (1-877-786-5433).

This group plan arranged by:
Coughlin & Associates Ltd.
Tel. No.: (613) 231-2266
Fax No.: (613) 231-2345
WEBMASTER@coughlin.ca

CHUBB

Basic Accidental Death & Dismemberment Insurance

For the employees of: The Ottawa Hospital

Policy Number:
AB10215001

Underwritten by:
Chubb Life Insurance Company of Canada

Effective Date:
January 01, 2019

This brochure has been prepared in connection with a group plan underwritten by Chubb Life Insurance Company of Canada ("Chubb Life"). For ease of reference it contains a brief description only and does not mention every provision of the contract issued. Please remember that rights and obligations are determined in accordance with the contract and not this brochure. For the exact provisions applicable, please consult your Employer.

COVERAGE

The plan offers you full 24-hour protection against accidents, on or off the job, on business, on vacation, at home, regardless of your health history.

ELIGIBILITY

As stated under your Basic Group Life Insurance Plan.

BENEFIT AMOUNT

You are insured for a benefit amount equal to your Basic Group Life Insurance Plan.

In the event of your death, the benefit amount is payable to the beneficiary you have named under your Group Life Insurance Plan or in the absence of such designation, to your Estate.

SCHEDULE OF LOSSES

Accidental Death & Dismemberment

If such injuries shall result in any one of the following specific losses within one year from the date of the accident, Chubb Life will pay the percentage of the benefit amount, based on the amount stated under the benefit amount section, however, that not more than one (the largest) of such benefits shall be paid with respect to injuries resulting from one accident.

	Percentage of Benefit Amount
Loss of Life	100%
Loss of Use of One Hand and One Foot	100%
Loss of Entire Sight of Both Eyes	100%
Loss of One Hand and One Foot	100%
Loss of One Hand and Entire Sight of One Eye	100%
Loss of One Foot and Entire Sight of One Eye	100%
Loss of Speech and Hearing in Both Ears	100%
Brain Death	100%
Loss of Both Arms, Both hands, Both Legs of Both Feet	200%
Loss of Use of Both Arms, Both Hands, Both Legs or Both Feet	200%
Quadriplegia	200%
Paraplegia	200%
Hemiplegia	200%
Loss of One Arm or One Leg	75%
Loss of Use of One Arm or One Leg	75%
Loss of One Hand or One Foot	66 2/3%
Loss of Entire Sight of One Eye	66 2/3%
Loss of Use of One Hand or One Foot	66 2/3%
Loss of Speech or Hearing in Both Ears	66 2/3%

Loss of Thumb and Index Finger of Same Hand 33 1/3%
Loss of Four Fingers of Same Hand 33 1/3%
Loss of Hearing in One Ear..... 25%
Loss of All Toes of Same Foot..... 12 1/2%

"Loss" shall mean with respect to hand or foot, the actual severance through or above the wrist or ankle joint; with respect to arm or leg, the actual severance through or above the elbow or knee joint; with respect to eye, the total and irrecoverable loss of sight; with respect to speech, the total and irrecoverable loss of speech which does not allow audible communication in any degree; with respect to hearing, the total and irrecoverable loss of hearing which cannot be corrected by any hearing aid or device; with respect to thumb and index finger, the actual severance through or above the first phalange; with respect to fingers, the actual severance through or above the first phalange of all four fingers of the same hand; with regard to toes, the actual severance of both phalanges of all toes of the same foot. If an Insured Person suffers complete severance of a hand, foot, arm or leg as described above, then Chubb Life Insurance will pay the amount specified in the Schedule of Losses even if the severed limb is surgically reattached, whether successful or not.

"Loss" as used with reference to quadriplegia (paralysis of both upper and lower limbs), paraplegia (paralysis of both lower limbs), and hemiplegia (total paralysis of upper and lower limbs of one side of the body), means the complete and irrecoverable paralysis of such limbs,

"Loss of Use" shall mean the total and irrecoverable loss of function of an arm, hand, foot, leg or thumb and index finger of the same hand provided such loss of function is continuous for twelve consecutive months and such loss of function is thereafter determined on evidence satisfactory to Chubb Life Insurance to be permanent.

"Brain Death" means irreversible unconsciousness with total loss of brain function; and complete absence of electrical activity of the brain, even though the heart is still beating.

All benefits that are payable at 200% of the principal Sum are subject to an all policies combined maximum benefit amount of $2,000,000

Repatriation Benefit

When injuries covered by this plan result in a loss of life outside 150 kilometers from your city of permanent residence or outside Canada and the loss of life occurs within 365 days from the date of the accident, Chubb Life will pay the actual expense incurred for preparing the deceased for burial and shipment of the body to the city of residence of the deceased, but not to exceed $15,000.

Rehabilitation Benefit

When injuries result in a payment being made by Chubb Life under any benefit excluding the Loss of Life Benefit, Chubb Life will also pay the reasonable and necessary expenses actually incurred up to a limit of $15,000 for special training provided:

(a) such training is required because of such injuries and in order for you to become qualified to engage in an occupation in which you would not have been engaged except for such injuries;
(b) expenses are to be incurred within two years from the date of the accident;
(c) no payment will be made for ordinary living, travelling, or clothing expenses.

Family Transportation Benefit

When injuries result in your confinement as an in-patient in a hospital outside 150 kilometers from your city of permanent residence or outside Canada and requires personal attendance of a member of your immediate family as recommended by the attending physician, in writing, Chubb Life will pay for the expense incurred by your family member, for the transportation by the most direct route by a licensed common carrier to you, while confined, but not to exceed an amount of $15,000.

"Member of your immediate family" means spouse, parent or stepparent brother or sister, stepbrother or stepsister, brother-in-law or sister-in-law or father-in-law, and son-in-law or daughter-in-law.

Spousal Occupational Training Benefit

When injuries to you result in a payment being made by Chubb Life under the Loss of Life Benefit, Chubb Life will pay in addition, the expenses actually incurred, within 365 days from the date of the accident, by your spouse for a formal occupation training program for the purpose of specifically qualifying your spouse to gain active employment in an occupation for which your spouse would otherwise not have sufficient qualifications. The maximum payable hereunder is $15,000.

Home Alteration and Vehicle Modification Benefit

In the event you sustain an injury which results in a payment being made under the Schedule of Losses, excluding the Loss of Life Benefit, and such injury subsequently requires the use of a wheelchair to be ambulatory, Chubb Life will pay the reasonable and necessary expenses actually incurred within 365 days from the date of the accident for:

1. the one-time cost of alterations to your principal residence to make it wheelchair accessible and habitable; and
2. the one-time cost of modifications necessary to a motor vehicle utilized by you

to make the vehicle accessible or operable for you.
Benefit payments herein will not be paid unless:

(i) home alterations are made by a person or persons experienced in such alterations and recommended by a recognized organization, providing support and assistance to wheelchair users; and
(ii) vehicle modifications are carried out by a person or persons with experience in such matters and modifications are approved by the Provincial vehicle licensing authorities.

The maximum payable under both items 1 and 2 shall be 10% of an Insured Person's Principal Sum amount to a maximum of $50,000.

Day Care Benefit

If you suffer a loss of life in a covered accident while the policy is in force, Chubb Life will pay, in addition to all other benefits payable under the policy a "Day Care Benefit" equal to the reasonable and necessary expenses actually incurred, subject to the lesser of 5% of your benefit amount or a maximum of $5,000 per year, on behalf of your dependent child who is enrolled in a legally licensed day care centre on the date of the accident or who enrolls in a legally licensed day care centre within 365 days following the date of the accident. The "Day Care Benefit" will be paid each year for 4 consecutive years, but only upon receipt of satisfactory proof that your child is enrolled in a legally licensed day care centre.

"Dependent Child" means the Employee's eligible unmarried natural, legitimate, illegitimate, adopted, step child or common law child who is principally dependent on the Employee or the Employee's Spouse for financial support.

Special Education Benefit

If you suffer a loss of life in a covered accident while the policy is in force, Chubb Life will pay, in addition to all other benefits payable under this policy, a "Special Education Benefit" up to 5% of your benefit amount, (subject to a maximum of $5,000 per year), on behalf of any dependent child who, on the date of the accident, is enrolled as a full-time student in any post-secondary institution beyond the 12th grade level, or was at the 12th grade level and subsequently enrolls as a full-time student in an institution of higher learning within 365 days following the date of the accident.

The **"Special Education Benefit"** is payable annually for a maximum of four consecutive annual payments but only if the dependent child continues his/her education as a full-time student in an institution of higher learning.

Bereavement Benefit

When injuries covered by this policy result in loss of life within 365 days from the date of the accident, Chubb Life will pay the reasonable and necessary expenses actually incurred by the spouse and dependent children of the Insured Person for up to 6 sessions of grief counseling, by a Professional Counsellor, subject to a maximum of $1,000.

"Professional Counsellor" means a therapist or counsellor who is licensed, registered or certified to provide such treatment.

In-Hospital Confinement Monthly Income

In the event you sustain an injury which results in a payment being made under the Schedule of Losses excluding the Loss of Life Benefit and you are hospital confined as an in-patient and are under the care of a legally qualified and registered physician or surgeon other than himself, Chubb Life will pay for each full month, one percent of your Principal Sum, subject to a maximum benefit of $2,500, or one-thirtieth of such monthly benefit for each day of partial month, retroactive to the 1st full day of such confinement but not to exceed 365 days in the aggregate for each period of hospital confinement.

"Hospital" as used herein means a legally constituted establishment which meets all of the following requirements: (1) operates primarily for the reception, care and treatment of sick, ailing or injured persons as in-patients; (2) provides 24 hour a day nursing service by registered or graduate nurses; (3) has a staff of one or more licensed physicians available at all times; (4) provides organized facilities for diagnosis and surgical facilities; and (5) is not primarily a clinic, nursing home or convalescent home or similar establishment nor, other than incidentally, a place for alcoholics or drug addicts.

"In-Patient" means a person admitted to a hospital as a resident or bed-patient and who is provided at least one day's room and board by the hospital.

Cosmetic Disfigurement

If, you suffer a third degree burn in a non-occupational accident, Chubb Life will pay a percentage of the Principal Sum depending on the area of the body which was burned according to the following table:

Body Part	(A) Area Classification	(B) Maximum allowable % for Area Burned	(C) Maximum % of Principal Sum Payable
Face, Neck, Head	11	9%	99%
Hand & Forearm	5	4.5%	22.5%
Either Upper Arm	3	4.5%	13.5%
Torso (Front or Back)	2	18%	36%
Either Thigh	1	9%	9%
Either Lower Leg (below knee)	3	9%	27%

The maximum percent of Principal Sum Payable (C) is determined by multiplying the Area Classification (A) by the Maximum Allowable percent for Area Burned (B). In the event of a 50% surface burn, the Maximum Allowable percent for Area Burned (B) is reduced by 50%. This table only represents the maximum percent of the Principal Sum payable for any one accident. If the Insured suffers burns in more than one area as a result of any one accident, benefits will not exceed a maximum of $25,000.

Continuance of Coverage

In the case of a Primary Insured who is (1) laid-off on a temporary basis, (2) temporarily absent from work due to short-term disability, or (3) on leave of absence, coverage shall be extended for a period of 12 months following the beginning of any such event subject to payment of premiums.

In the case of a Primary Insured who is on maternity or parental leave coverage shall be extended for a period of up to 18 months following the beginning of any such event subject to payment of premiums.

If an Insured assumes other occupational duties during the leave or lay-off period, no benefits shall be payable for a loss occurring during the performance of such other occupation.

Seat Belt Benefit

In the event you sustain an injury which results in a payment being made under the Schedule of Losses, your Benefit amount will be increased by 10% to a maximum of $25,000 if, at the time of the accident, you were driving or riding in a vehicle and wearing a properly fastened seat belt. Due proof of seat belt use must be provided as part of the written proof of loss.

"Vehicle" means a private passenger car, station wagon, van, or jeep-type automobile. **"Seat Belt"** means those belts that form a restraint system.

Identification Benefit

In the event accidental Loss of Life is sustained by you not less than150 kilometers from your normal place of residence and identification of the body by a member of the immediate family has been requested by the police or a similar governmental authority, Chubb Life will reimburse the reasonable expenses actually incurred by such member for:

a) transportation by the most direct route to the city or town where the body is located; and
b) hotel accommodation in such city or town, subject to a maximum duration of three days.

The reimbursement of such expenses incurred is subject to the accidental loss of life indemnity being subsequently payable in accordance with the terms of this policy following the identification of the body as the Insured Person. The maximum amount payable will not exceed $15,000 for all such expenses.

Payment will not be made for board or other ordinary living, travelling or clothing expenses, and transportation must occur in a vehicle or device operated under a license for the conveyance of passengers for hire.

"Member of your immediate family" means spouse, parent or stepparent brother or sister, stepbrother or stepsister, brother-in-law or sister-in-law or father-in-law, and son-in-law or daughter-in-law.

HIV Benefit

If you should sustain an accidental bodily injury in the performance of your duties as required by your employer, which results in the acquiring and testing positive for the Human Immunodeficiency Virus within one year from the date of the accident, Chubb Life Insurance will pay a benefit equal to 10% of your Benefit amount subject to a maximum of $10,000 provided the following criterion are met:

1. An accident report must be completed specifying the circumstances of the bodily injury and remitted to your employer, within 48 hours of the occurrence.
2. You must submit to a blood test for the Human Immunodeficiency Virus within 48 hours of the accident. The results of this test must then be forwarded to your employer, to be kept on file.

If the initial test is negative and you subsequently test positive for the Human Immunodeficiency Virus within one year of the accident, the applicable benefit payment will be made by Chubb Life Insurance.

Critical Illness Benefit

If, while coverage is in effect but only after coverage has been in effect for a period of ninety days, you are then diagnosed with any one of the covered illnesses listed below and you satisfies the following conditions:

(A) have been hospitalized as an in-patient continuously for at least 48 hours, and
(B) survive for a period of thirty days thereafter, and
(C) you are under age 65.

Chubb Life Insurance will pay 10% of the principal sum to a maximum of $10,000.
Covered Illnesses

Encephalitis	Parkinson's Disease	Tuberculosis
Meningitis	Acute poliomyelitis .	Typhoid fever
Necrotizing fascitis	Acute rheumatic fever	Yersinia pestis

Chubb Life Insurance shall only be obligated to pay the critical illness benefit once notwithstanding that an Insured Person may be diagnosed with more than one of the covered illnesses.

EXPOSURE AND DISAPPEARANCE

Loss resulting from unavoidable exposure to the elements shall be covered to the extent of the benefits afforded you. If your body has not been found within one year of disappearance, stranding, sinking or wrecking of the conveyance in which you were riding at the time of the accident, it shall be presumed, subject to all other conditions of this policy, that you suffered a loss of life resulting from bodily injuries sustained in an accident covered under this policy.

CONVERSION PRIVILEGE

On the date of termination of employment or during the 31 day period following termination of employment, you may convert your insurance to an individual ACCIDENTAL DEATH AND DISMEMBERMENT only insurance policy of Chubb Life. The individual policy will be effective either as of the date that the application is received by Chubb Life or on the date that coverage under the group policy ceases, whichever occurs later. The premium will be the same, as a person would ordinarily pay when applying for an individual policy at that time. Application for an individual policy may be made at any office of Chubb Life Insurance. The amount of insurance benefit converted shall not exceed that amount issued during employment all policies combined. The individual policy will cover ACCIDENTAL DEATH and DISMEMBERMENT only.

Benefits payable under this section will be limited to only one (1) policy in the event the benefits are contained in two (2) or more policies issued to the Policyholder by ACE INA Life Insurance (not applicable to the Schedule of Losses, Exposure and Disappearance and Conversion).

WAIVER OF PREMIUM

If you are under age 65 and become totally disabled* while you are insured under this plan and satisfactory evidence of your total disability is provided to Chubb Life on an annual basis, payment of premium will be waived until the earlier of the following occurs:

a) you return to active employment with your employer;
b) you attain age 65;
c) the master policy underwritten by Chubb Life is terminated.

Once you return to active employment with your employer, your coverage will continue only upon the commencement of premium payments.

*You will be considered totally disabled if you are unable to engage in any business or occupation and perform in any work for compensation or profit and your disability has existed continuously for a period of at least 12 months or is in accordance with the waiver of premium requirements under the Policyholder's Group Life Insurance Policy.

EXCLUSIONS

The plan does not cover any loss, which is the result of:

1. intentionally self-inflicted injuries, suicide or any attempt thereat, while sane or insane;
2. war or any act thereof
3. flying in an aircraft owned or leased by your employer, yourself or a member of your household, or aircraft being used for any test or experimental purpose, firefighting, powerline inspection, pipeline inspection, aerial photography or exploration;
4. full-time, active duty in the armed forces.
5. flying as pilot or crew member in any aircraft or device for aerial navigation: Except to the extend such travel or flight is provided in the Hazards Insured Against section of the Accidental Death & Dismemberment portion of the policy.

GENERAL PROVISIONS

Beneficiary

An employee or any spouse has the right to name a beneficiary when he applies for insurance.

It is understood that the beneficiary designation made under the Policyholder's Group Life Insurance Policy shall be recognized as the beneficiary under the policy, unless a further designation has been made that specifically identifies the policy. Failing such designation, all benefits will be paid to the estate of the insured person.

All other indemnities of the policy will be payable to the insured person.
An insured person can change his beneficiary at any time, where permitted by law. The Company assumes no responsibility for the validity of such designation or change of beneficiary.

The beneficiary designation made by the insured person (if any) under the replaced policy has been retained. The insured person should review the existing designation to ensure it reflects his/her current intention.

The policy contains a provision removing or restricting the right of the insured person to designate persons to whom or for whose benefit insurance money is to be payable.

Legal Actions

No action at law or in equity shall be brought to recover on the policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with requirements of the policy. For residents of Alberta and British Columbia: Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the Insurance Act. For residents of Manitoba: Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in The Insurance Act. For residents of Ontario: Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the Limitations Act, 2002. Otherwise, every action must be brought within one year from the date of loss or such longer period as may be required under the law applicable in the insured person's province of residence.

Change of Insurer

An insured person under a former policy may not be excluded from the new policy or be denied benefits solely because of a pre-existing condition limitation that was not applicable or that did not exist in the former policy, or because the person is not at work on the date of coming into force of the new policy.

The insured person and any claimant under the policy has the right, as determined by law applicable in the insured person's province of residence, to obtain a copy of his/her application, any written evidence of insurability (as applicable) and the Policy, on request, subject to certain access limitations.

HOW TO CLAIM

In the event of a claim, claim forms can be obtained from the Plan Administrator.

Notice of claim must be given to Chubb Life within 30 days from the date of the accident, the beginning of the disability or after the survival period, and

subsequent proof of claim must be submitted to Chubb Life within 90 days from the date of the accident or after survival period.

Failure to give notice of claim or furnish proof of claim within the time prescribed in the policy condition will not invalidate the claim if the notice or proof is given or furnished as soon as reasonably possible and if it is shown that it was not reasonably possible to give notice or furnish proof within the time so prescribed. In no event, will Chubb Life accept notice of claim beyond one (1) year.

04/19

Chubb Life is part of the Chubb group of insurance companies, with operations in 54 countries, Chubb provides commercial and personal property and casualty insurance, personal accident and supplemental health insurance, reinsurance and life insurance to a diverse group of clients.

Chubb Limited, the parent company of Chubb Life, is listed on the New York Stock Exchange (NYSE: CB) and is a component of the S&P 500 index.

EMERGENCY OUT OF PROVINCE MEDICAL

For all in benefit Members of

The Ottawa Hospital

The Ottawa Hospital | L'Hôpital d'Ottawa

POLICY NUMBER
CMG 9428862

June 2022

EMERGENCY OUT-OF-PROVINCE MEDICAL COVERAGE

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

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

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

ELIGIBILITY

All in benefit Members under The Ottawa Hospital and their eligible dependents whose names are on file with the Policyholder and as shown below are insured under this Plan.

Class I: PIPSC Union Members under age 75.
Class II: Full-time Non-union Members under age 75.
Class III: Part-time Non-union Members under age 65.

PERIOD OF COVERAGE

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

Trips are limited to 60 consecutive days.

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

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

Benefit maximum amount:

$ 5,000,000.00 lifetime maximum

HOSPITAL CONFINEMENT

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

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

MEDICAL AND THERAPEUTIC SERVICES:

Benefits are payable for:

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

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

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

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

e) the services of a legally qualified anaesthetist;

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

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

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

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

j) out-patient services provided by a hospital.

AUTOMOBILE RETURN

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

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

REPATRIATION BENEFIT

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

IDENTIFICATION BENEFIT

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

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

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

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

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

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

TRIP INTERRUPTION BENEFIT

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

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

In order to claim any of the above outlined expenses, original itemized invoices must be provided at time of claim. The combined maximum amount payable for this benefit is $2,000 per Insured Person per incident.

FAMILY TRANSPORTATION BENEFIT

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

This benefit is only payable if:

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

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

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

RETURN TRANSPORTATION FOR TRAVELLING COMPANION

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

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

RETURN AND ESCORT OF DEPENDENT CHILDREN UNDER AGE

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

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

REFERRAL SERVICES

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

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

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

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

EMERGENCY TRAVEL ASSISTANCE OFFERS THE FOLLOWING FEATURES:

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

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

HOW TO CLAIM

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

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

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

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

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

Give the operator your name and your Policy Number: **CMG 9428862.**

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

Mail your completed claim form and attachments to:

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

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

COORDINATION OF BENEFITS

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

IN AN EMERGENCY, HERE'S WHAT TO DO

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

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

An operator will ask you the following:

Your name, location and the details or your emergency.
Your Policy Number: CMG 9428862

Service Support Telephone Numbers:

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

GROUND TRANSPORTATION

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

AIR TRANSPORTATION

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

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

Air Transportation means:

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

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

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

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

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

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

EXCLUSIONS AND LIMITATIONS

Benefits are not payable for:

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

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

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

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

e) emotional or mental disorders unless you are hospitalized;

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

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

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

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

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

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

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

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

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

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

EXTENDED COVERAGE AFTER TERMINATION

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

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

TERMINATION OF COVERAGE

Coverage will terminate on the earliest of:

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

WHAT TO DO IN A MEDICAL EMERGENCY

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

Call:

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

The operator will ask you for:

Your name, location and the details of your emergency
Your Policy Number: CMG 9428862

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

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

AIG