Professional Police

OTTAWA POLICE ASSOCIATION

Protecting People

# Your Group Insurance Plan

## ACTIVE EMPLOYEES
## (POLICE OFFICERS & CIVILIANS)

**Effective date: January 1, 2024**
**Publication date: December 15, 2023**

# Keep this Booklet in a Safe Place

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

This 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.

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

The insurers and administrators of these benefits are as follows:

| Benefit | Insurer / Administrator | Policy Number |
|---|---|---|
| Group life insurance, dependant group life insurance and long-term disability (LTD) insurance | Canada Life | **42219** |
| Critical illness insurance | Canada Life | **42219GCI** |
| Optional life insurance and optional critical illness insurance | Canada Life | **135035** |
| Accidental death & dismemberment (AD&D) insurance | SSQ Insurance Company Inc. | **1JV30** |
| Extended health care and dental care coverage | The Ottawa Police Association<br>Administered by Coughlin & Associates Ltd. | **22014** |
| Out-of-province/Canada medical emergency insurance coverage | AIG Insurance Company of Canada | **CMG 9429228** |

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

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

# Important

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

Ottawa Police Association, the plan sponsor, underwrites certain benefits on a self-insured basis as indicated in the table on the previous page. All risks in respect to these benefits are borne by Ottawa Police Association.

As sponsor of the plan, Ottawa Police Association 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.

Ottawa Police Association, or its trustees or designates, have the right to interpret the self-funded coverage of the plan and decide any and all matters related to it. This includes the right to clarify or remedy any possible uncertainties, omissions or inconsistencies based on applicable laws and the reasonable and customary charges and treatment for the self-funded benefits described in this booklet.

*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 decisions of Ottawa Police Association, its trustees or designates with respect to the self-insured coverage, will be final and binding on all parties.

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

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

## Protecting Your Personal Information

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

# Table of Contents

# Benefits Summary

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

**Eligibility:** Active employees who are a member in good standing and have made contributions to the benefits program. Participation in the program is a condition of employment. There is no waiting period for benefits.

Temporary employees, part-time employees who work less than 20 hours per week, and seasonal employees are not eligible under this plan.

## Summary of Benefits

### 1. Employee Basic Life Insurance

| | |
|---|---|
| Benefit amount: | $130,000. |
| Reduction: | Benefit reduces to $20,000 at retirement. |
| Termination: | Upon death. |

### 2. Dependent Life Insurance

| | |
|---|---|
| Benefit amount: | |
| • Spouse: | $10,000. |
| • Child: | $5,000. Child must be at least 15 days old. |
| Termination: | When you retire. |

### 3. Employee Optional Life Insurance

| | |
|---|---|
| Benefit amount: | You can choose coverage in units of $10,000, subject to approval of evidence of insurability. |
| Maximum amount: | $500,000. If you are covered under this plan as both an employee and a spouse, you are limited to the $500,000 maximum. |
| Termination: | When you reach age 65. |

### 4. Spouse Optional Life Insurance

| | |
|---|---|
| Benefit amount: | You can choose coverage in units of $10,000, subject to approval of evidence of insurability. |
| Maximum amount: | $500,000. If you are covered under this plan as both an employee and a spouse, you are limited to the $500,000 maximum. |
| Termination: | When you reach age 65, or retire, or when your spouse reaches age 65, or is no longer your spouse, whichever occurs first. |

### 5. Basic Accidental Death and Dismemberment (AD&D) Insurance

| | |
|---|---|
| Benefit amount: | $160,000. |
| Termination: | When you reach age 70, or retire, whichever occurs first. |

### 6. Long-Term Disability (LTD) Insurance

| | |
|---|---|
| Benefit amount: | **Police Officers:** 66.67% of your monthly earnings.<br>**Civilians:** 60% of your monthly earnings. |
| Maximum amount: | **Police Officers:** $7,500.<br>**Civilians:** $6,500. |
| Maximum benefit period: | **Police Officers:** To age 60.<br>**Civilians:** To age 65. |
| All-source maximum: | 90% of the first $1,000 of your monthly take-home pay plus 80% of the balance. |
| Elimination period: | **Police Officers eligible on or after October 15, 1995:** 119 days.<br>**Police Officers eligible prior to October 15, 1995:** 182 days.<br>**Civilians:** 17 weeks. |
| Tax status: | **Police Officers:** Benefits are taxable.<br>**Civilians:** Benefits are not taxable. |
| Termination: | **Police Officers:** When you reach age 60, or retire, whichever occurs first.<br>**Civilians:** When you reach age 65, or retire, whichever occurs first. |

Note: If the employer pays a portion of the premiums, the LTD benefit is taxable.

### 7. Basic Critical Illness Insurance

| | |
|---|---|
| Benefit amount: | |
| • Member: | $10,000. |
| • Spouse: | $10,000. |
| • Child: | $5,000. |
| Termination: | When you reach age 65, or retire, whichever occurs first.<br>In addition, coverage will end on the date a critical illness benefit is paid for a covered condition which you and/or your spouse sustain. Only one claim is permitted for each insured person per lifetime. If your spouse has a claim, your coverage must be changed to single coverage because the spouse is no longer eligible for coverage. If you have a claim and your spouse is still eligible, the benefit will remain as a family coverage. |

### 8. Employee Optional Critical Illness Insurance

| | |
|---|---|
| Benefit amount: | You can choose coverage in units of $10,000, subject to evidence of insurability. |
| Maximum amount: | $250,000. If you are covered under this plan as both an employee and a spouse, you are limited to the $250,000 maximum. |
| Termination: | When you reach age 65, or retire, whichever occurs first.<br>In addition, your coverage will end on the date a critical illness benefit is paid for a covered condition which you sustain. |

### 9. Spouse Optional Critical Illness Insurance

| | |
|---|---|
| Benefit amount: | You can choose coverage in units of $10,000, subject to evidence of insurability. |
| Maximum amount: | $250,000. If you are covered under this plan as both an employee and a spouse, you are limited to the $250,000 maximum. |
| Termination: | When you reach age 65, or retire, or when your spouse reaches age 65, whichever occurs first.<br>In addition, your spouse's coverage will end on the date a critical illness benefit is paid for a covered condition which your spouse sustains. |

### 10. Extended Health Care Benefits

| | |
|---|---|
| Deductible: | Nil. |
| Reimbursement level: | 100% of eligible expenses (unless otherwise specified). |
| Maximum benefit: | Lifetime maximum of $125,000 per insured person. |
| Termination: | When you retire. |

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

**Prescription drugs:**

| | |
|---|---|
| • Deductible: | Nil. |
| • Reimbursement level: | 90% of eligible expenses (unless otherwise specified).<br>100% of eligible expenses if medication is purchased at a Preferred Provider Network pharmacy. |
| • Eligible drugs: | Drugs, serums and injectables, only available by prescription, when prescribed by a medical doctor or dentist and dispensed by a pharmacist, dentist or a physician. |
| • Drug card: | Yes. |
| • Dispensing fee cap: | Nil. |
| • Maximums and exclusions: | |
| - Drugs: | Limited to a 3 month supply. |
| - Preventive vaccines prescribed by a physician: | Excluded. |
| - Sclerosing injections for the treatment of varicosities: | Medically necessary treatment outside Ontario (medication only). Medically necessary treatment in Ontario is covered by the provincial plan. |
| - Viscosupplementation: | Reasonable and customary charges. |
| - Smoking cessation aids (products only): | Lifetime maximum of $300 per insured person. |
| - Sexual dysfunction drugs: | Viagra, Levitra, Cialis and Staxyn to a maximum of $500 per insured person per calendar year. |
| - Fertility treatment: | Lifetime maximum of 12 treatment cycles. |
| - Anti-Obesity/Weight loss drugs: | $1,500 per insured person per calendar year. |

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

**Hospital care:**

| | |
|---|---|
| • Reimbursement level: | 100% of eligible expenses (unless otherwise specified). |
| • Coverage: | Cost of a private or semi-private room for each day of hospitalization. |
| • Palliative care: | Covered under the Hospital care coverage as indicated above. |
| • Convalescent and rehabilitation care: | Excluded. |

| | |
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| • Chronic care: | 90% of eligible expenses. Unlimited maximum. |

**Vision care (eyeglasses, contact lenses and laser eye surgery):**

| | |
|---|---|
| • Reimbursement level: | 100% of eligible expenses (unless otherwise specified) including contact lenses (special conditions). |
| • Maximum: | $350 per insured person per 2 calendar years (the eye examinations maximum limitation listed below is included in the $350 maximum). |
| • Laser eye surgery: | Included in the vision care maximum listed above. |
| • Glasses or contact lenses following cataract surgery: | Excluded. |
| • Artificial crystalline lenses, also known as intraocular lenses (IOL) for cataracts: | Reasonable and customary charges. |
| • Eye examinations, including eye refraction: | $75 per insured person per 2 calendar years (included in the $350 maximum listed above). |
| • Visual training: | Visual training and remedial therapy to correct faulty visual skills when there is no provincial plan coverage. |

**Professional and paramedical services:**

| | |
|---|---|
| • Reimbursement level: | 100% of eligible expenses (unless otherwise specified). There is a $12 per visit co-insurance fee for each service. |
| • Maximum per practitioner: | |
| – Chiropractor: | $1,200 per insured person per calendar year. |
| – Massage therapist or orthotherapist: | $1,250 per insured person per calendar year. |
| – Naturopath: | $1,500 per insured person per calendar year. |
| – Psychologist: | Unlimited. |
| – Speech therapist: | $1,500 per insured person per calendar year. |
| – Physiotherapist or athletic therapist: | $1,250 per insured person per calendar year. |

Imaging techniques ordered by a chiropractor or naturopath limited to maximum of $50 per insured person per calendar year for each of these specialists.

**Medical supplies and services:**

| | |
|---|---|
| • Reimbursement level: | 90% of eligible expenses (unless otherwise specified). |
| • Maximum per service and/or supply: | |
| – External breast prosthesis (following mastectomy): | Eligible after provincial plan coverage. |
| – Surgical brassieres: | Purchase of 2 surgical brassieres per insured person per 12 consecutive months. |
| – Private duty nurse: | Unlimited. |
| – Artificial eye: | Reasonable and customary charges. |
| – Stump socks: | Reasonable and customary charges. |
| – Orthopaedic shoes: | Purchase of custom fitted orthopaedic shoes including modifications to orthopaedic footwear up to $150 per insured person per calendar year. |
| – Custom made orthotics or arch support: | Purchase of custom made orthotics up to $300 per insured person per calendar year. |
| – Elastic support stockings: | Purchase of 4 pairs to maximum of $50 per pair per insured person per calendar year. |
| – Conventional wheelchair: | Reasonable and customary charges. |
| – Other therapeutic equipment: | Reasonable and customary charges. |

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| – Hearing aids: | Purchase up to $500 per ear per insured person for any period of 36 consecutive months. A written prescription by a licensed audiologist or physician is required. |
| – Diagnostic services: | Excluded. |
| – Wigs as result of chemotherapy: | Lifetime maximum of $200 per insured person. |
| – Glucometer or reflectance meter, (includes Freestyle Libre flash monitoring system and associated sensors): | Lifetime maximum of $350 per insured person. |
| – Continuous Glucose monitoring system (receiver, transmitter and associated sensors): | Reasonable and customary changes for Type 1 diabetics. |
| – TENS nerve stimulators: | Reasonable and customary charges to maximum of a 6 months rental. |
| – Intra-uterine devices: | Excluded. |
| – Out-of-province/Canada referral treatment: | Excluded. |

**11. Out-of-Province/Canada Medical Emergency Insurance**

| | |
|---|---|
| Deductible: | Nil. |
| Reimbursement level: | 100% of eligible expenses. |
| Maximum amount: | Under age 70: $5,000,000 lifetime maximum per insured person.<br>Ages 70 to 79: $2,000,000 lifetime maximum per insured person. |
| Coverage period: | 180 consecutive days. |
| Termination: | Class I: All eligible members under age 70.<br>Class II: All eligible retired members under age 80.<br>Class III: All eligible active members ages 70 to 79. |

**12. Dental Care Benefit**

| | |
|---|---|
| Deductible: | $25 per insured person, $50 per family each calendar year. |
| Fee guide: | Based on the current Dental Association fee guide for general practitioners where service is rendered. |
| Reimbursement amount: | |
| • Basic services: | 100% of eligible expenses. |
| – Maximum: | Combined maximum with major services and orthodontic services, to a maximum of $1,500 per insured person per calendar year. |
| • Major services: | 80% of eligible expenses. |
| – Maximum: | Combined maximum with basic services and orthodontic services, to a maximum of $1,500 per insured person per calendar year. |
| • Orthodontic services: | 50% of eligible expenses. |
| – Maximum: | Combined maximum with basic services and major services, to a maximum of $1,500 per insured person per calendar year. |
| Treatment frequency: | |
| • Complete oral examination: | Once every 9 consecutive months. |
| • Recall oral examination: | Once every 9 consecutive months. |
| • Specific oral examination: | Unlimited. |
| • Emergency oral examination: | Unlimited. |

| | |
|---|---|
| • Complete series of periapical films or panoramic radiographs: | Once every 24 consecutive months. |
| • Polishing: | Once every 9 consecutive months. |
| • Bitewing radiographs: | Once every 9 consecutive months. |
| • Scaling: | Reasonable and customary charges. |
| • Root planing: | Reasonable and customary charges. |
| • Fluoride treatment: | Once every 9 consecutive months. |
| • Tooth coloured (composite) filling: | Eligible on all teeth. |
| • Special periodontal appliances, including occlusal guards and bruxism appliances: | Reasonable and customary charges. |
| • Adjustments to periodontal appliance to control bruxism: | One adjustment of up to 2 units of time after the date of insertion. |
| • Pit and fissure sealants: | For missing primary teeth only. |
| • Occlusal equilibration: | Reasonable and customary charges. |
| • Space maintainers: | For missing primary teeth only. |
| • Oral hygiene instruction: | Excluded. |
| • Anaesthetic: | Reasonable and customary charges. |
| • Denture adjustments including minor adjustments: | Reasonable and customary charges. |
| • Denture rebase/reline: | Once every 5 calendar years. |
| • Preformed stainless steel and polycarbonate crowns: | Reasonable and customary charges. |
| • Crowns, inlays & onlays: | Once every 5 years. Excludes porcelain crowns for molar teeth. |
| • Veneers: | Once every 5 years. |
| • Bridges & dentures: | Once every 5 years. |
| • Laboratory fees: | Reasonable and customary fees specified for the dental treatment or service. |
| Termination: | When you retire. |

# Benefits Insured by Canada Life

The wording in this section has been provided by Canada Life. If there are any discrepancies between the group contract and the information in this section, the group contract will take priority.

This booklet describes the principal features of the group benefit plan sponsored by your Association, but **Group Policy Nos. 42219 and 135035** issued by Great West Life are the governing documents. If there are variations between the information in the booklet and the provisions of the policies, the policies will prevail.

This booklet contains important information and should be kept in a safe place known to you and your family.

**The Plan is underwritten by**

**Canada Life**

### Access to Documents

You have the right, upon request, to obtain a copy of the policy, your application and any written statements or other records you have provided to Canada Life as evidence of insurability, subject to certain limitations.

### Legal Actions

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 actions or proceedings governed by the laws of Alberta and British Columbia), The Insurance Act (for actions or proceedings governed by the laws of Manitoba), the *Limitations Act, 2002* (for actions or proceedings governed by the laws of Ontario), or other applicable legislation. For those actions or proceedings governed by the laws of Quebec, the prescriptive period is set out in the Quebec Civil Code.

### Appeals

You have the right to appeal a denial of all or part of the insurance or benefits described in the contract as long as you do so within one year of the initial denial of the insurance or a benefit. An appeal must be in writing and must include your reasons for believing the denial to be incorrect.

### Benefit Limitation for Overpayment

If benefits are paid that were not payable under the policy, you are responsible for repayment within 30 days after Canada Life sends you a notice of the overpayment, or within a longer period if agreed to in writing by Canada Life. If you fail to fulfil this responsibility, no further benefits are payable under the policy until the overpayment is recovered. This does not limit Canada Life's right to use other legal means to recover the overpayment.

### Protecting Your Personal Information

At Canada Life, we recognize and respect the importance of privacy. Personal information about you is kept in a confidential file at the offices of Canada Life or the offices of an organization authorized by Canada Life. Canada Life may use service providers located within or outside Canada. We limit access to personal information in your file to Canada Life staff or persons authorized by Canada Life who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law. Your personal information may be subject to disclosure to those authorized under applicable law within or outside Canada.

We use the personal information to administer the group benefits plan under which you are covered. This includes many tasks, such as:

- determining your eligibility for coverage under the plan
- enrolling you for coverage
- investigating and assessing your claims and providing you with payment
- managing your claims
- verifying and auditing eligibility and claims
- creating and maintaining records concerning our relationship
- underwriting activities, such as determining the cost of the plan, and analyzing the design options of the plan
- preparing regulatory reports, such as tax slips

We may exchange personal information with your health care providers, your plan administrator, any insurance or reinsurance companies, administrators of government benefits or other benefit programs, other organizations, or service providers working with us or the above when relevant and necessary to administer the plan.

As plan member, you are responsible for the claims submitted. We may exchange personal information with you or a person acting on your behalf when relevant and necessary to confirm coverage and to manage the claims submitted.

You may request access or correction of the personal information in your file. A request for access or correction should be made in writing and may be sent to any of Canada Life's offices or to our head office.

For a copy of our Privacy Guidelines, or if you have questions about our personal information policies and practices (including with respect to service providers), write to Canada Life's Chief Compliance Officer or refer to www.greatwestlife.com.

## COMMENCEMENT AND TERMINATION OF COVERAGE

You are eligible to participate in the plan on the date your employment begins.

- You and your dependents will be covered as soon as you become eligible.
- You must be actively at work when coverage takes effect, otherwise the coverage will not be effective until you return to work.

  Increases in your benefits while you are covered by this plan will not become effective unless you are actively at work.
- Temporary and seasonal members, and part-time members who work less than 17.5 hours per week may not join the plan.

Your coverage terminates when your employment ends, you are no longer eligible, or the policy terminates, whichever is earliest.

- Your dependents' coverage terminates when your insurance terminates or your dependent no longer qualifies, whichever is earlier.
- Your coverage may be extended if it would have terminated because you are not actively at work due to disease or injury, temporary lay-off or leave of absence. Your Association will provide you with details.
- When your coverage terminates, you may be entitled to an extension of benefits under the plan. Your Association will provide you with details.

## DEPENDENT COVERAGE

Dependent means:

- Your spouse, legal or common-law.

  A common-law spouse is a person who has been living with you in a conjugal relationship for at least one year.

- Your unmarried children under age 21, or under age 25 if they are full-time students.

  Children under 15 days are not covered for dependent life insurance.

  Children under age 21 are not covered if they are working more than 30 hours a week, unless they are full-time students.

  Children who are incapable of supporting themselves because of physical or mental disorder are covered without age limit if the disorder begins before they turn 21, or while they are students under 25, and the disorder has been continuous since that time.

## BENEFICIARY DESIGNATION

You may make, alter, or revoke a designation of beneficiary as permitted by law. You should review any beneficiary designation made under this policy from time to time to ensure that it reflects your current intentions. You may change the designation by completing a form available from your Association.

## MEMBER BASIC LIFE INSURANCE

On your death, Canada Life will pay your life insurance benefits to your named beneficiary. If you have not named a beneficiary or there is no surviving beneficiary at the time of your death, payment will be made to your estate. Your Association will explain the claim requirements to your beneficiary.

- If you become disabled while insured, Canada Life may waive the premiums on your life insurance after the waiting period, throughout the benefit period.

  The waiting period is the same as the waiting period under the long term disability income benefit.

  A benefit period is the period of time after the waiting period during which you satisfy the disability definition under the long term disability income benefit. A benefit period will not continue past your 65$^{th}$ birthday.

- Your life insurance will terminate if you are age 65 or over and you are not actively at work. However, if you are not actively at work because of disease or injury, your life insurance may be continued on a premium paying basis for up to 6 months following the date you ceased to be actively at work.

- If any or all of your insurance terminates before age 71, you may be eligible to apply for an individual conversion policy without providing proof of your insurability. You must apply and pay the first premium no later than 31 days after your group insurance terminates. See your Association for details.

## DEPENDENT LIFE INSURANCE

If one of your dependents dies, Canada Life will pay you the dependent life insurance benefit. Your Association will explain the claim requirements.

- If you are disabled and the premiums for your member life insurance are waived, your dependent life insurance will also continue without premium payment until your own coverage terminates or your dependents no longer qualify.
- Your dependent life insurance will terminate if you are age 65 or over and you are not actively at work. However, if you are not actively at work because of disease or injury and your member life insurance is continued, your dependent life insurance will be continued on the same basis.
- If your spouse's insurance terminates before age 71, he or she may be eligible for an individual conversion policy without providing proof of insurability. You or your spouse must apply and pay the first premium no later than 31 days after the group insurance terminates. See your Association for details.

## OPTIONAL LIFE INSURANCE

Optional Life Insurance allows you to choose additional coverage for yourself and your spouse. Check the **Benefit Summary** for the amount of Optional Life Insurance available. When you apply for Optional Life Insurance, you must provide proof of insurability, and the application must be approved by Canada Life. If you or your spouse dies within two years after applying for Optional Life Insurance, Canada Life has the right to verify any medical information you or your spouse provided. If any inconsistencies are discovered, the claim will be denied and any premiums paid will be refunded.

On your death, Canada Life will pay your life insurance to your named beneficiary. If you have not named a beneficiary or there is no surviving beneficiary at the time of your death, payment will be made to your estate. Your Association will explain the claim requirements. If your spouse dies you will be paid the amount for which he or she was insured.

- If your or your spouse's optional life insurance terminates, you or your spouse may be eligible to apply for an individual conversion policy without providing proof of insurability. You must apply and pay the first premium no later than 31 days after your group insurance terminates. See your Association for details.
- Your optional life insurance will not continue past the end of the day before the date you reach age 65. Your spouse's coverage will not continue past the end of the day before the date you or your spouse reaches age 65, whichever comes first.

### Limitation

No benefit is paid for suicide within the first two years of initial or increased optional life coverage. In such a situation, Canada Life refunds the premiums that have been received.

## LONG TERM DISABILITY INSURANCE

Long Term Disability Insurance provides you with regular income to replace salary or wages lost because of a lengthy disability due to accident or sickness.

**Police Officers:** Benefits begin after the waiting period is over and continue until you are no longer disabled **as defined by the policy** or you reach age 60, whichever comes first. Check the **Benefit Summary** for the benefit amount and elimination period.

**Civilians:** Benefits begin after the waiting period is over and continue until you are no longer disabled **as defined by the policy** or you reach age 65, whichever comes first. Check the **Benefit Summary** for the benefit amount and elimination period.

- If disability is not continuous, the days you are disabled can be accumulated to satisfy the waiting period as long as no interruption is longer than 2 weeks and the disabilities arise from the same disease or injury.

- LTD benefits will be paid for the first two years following commencement of payments if you are unable to perform your **regular** work. After two years, LTD benefits will continue as long as your disability prevents you from performing **any** work for which you are or can become reasonably suited by your education, training or experience.

  Other restrictions may apply. Please contact the Association.

- Successive absences from work are considered to be in the same period of disability unless separated by (1) six months of active full-time work while insured or (2) one full month of work while insured and due to wholly different causes. Work performed under a rehabilitation program will not be considered in determining successive periods of disability.

- **Police Officers:** Your LTD insurance will not continue past the end of the day before the date you reach age 60.
- **Civilians:** Your LTD insurance will not continue past the end of the day on the last day of the month in which you reach age 65.

**Other Income**

**Police Officers:** Your LTD benefit is reduced if the total of it and the other income you are entitled to receive while you are disabled exceeds 90% of the first $1,000 of your monthly earnings plus 80% of the balance before you became disabled. If it does, your benefit is reduced by the excess amount. Other income includes:

**Civilians:** Your LTD benefit is reduced if the total of it and the other income you are entitled to receive while you are disabled exceeds 90% of the first $1,000 of your monthly take-home pay plus 80% of the balance before you became disabled. If it does, your benefit is reduced by the excess amount. Other income includes:

- disability benefits you or another member of your family is entitled to on the basis of your disability under the Canada or Quebec Pension Plan that are paid directly to you, except for increases that take effect after the benefit period starts

- retirement benefits under the Canada or Quebec Pension Plan, except for increases that take effect after the benefit period starts

- benefits under any Workers' Compensation Act or similar law

- loss of income benefits available through legislation, except for Employment Insurance benefits, which you and any other member of your family are entitled to on the basis of your disability, including automobile insurance benefits where permitted by law

- disability benefits under a plan of insurance available through membership in an association
- employment income, disability benefits, or retirement benefits related to any employment except an approved rehabilitation plan or program (termination pay and severance benefits are included as employment income under this provision)

**Police Officers:** Earnings received from an approved rehabilitation plan or program are not used to reduce your LTD benefit unless those earnings, together with your income from this plan and the other income listed above, including any increases in Canada or Quebec Pension Plan benefits that take effect after the benefit period starts, would exceed your indexed monthly earnings before you became disabled. If it does, your benefit is reduced by the excess amount.

**Civilians:** Earnings received from an approved rehabilitation plan or program are not used to reduce your LTD benefit unless those earnings, together with your income from this plan and the other income listed

above, including any increases in Canada or Quebec Pension Plan benefits that take effect after the benefit period starts, would exceed your indexed monthly take-home pay before you became disabled. If it does, your benefit is reduced by the excess amount.

**Rehabilitation Benefits**

Rehabilitation involves a work related activity or training strategy that is designed to help you return to gainful employment and a more productive lifestyle. A plan or program will be approved if it is appropriate for the expected duration of your disability and it facilitates your earliest possible return to work.

**Limitations**

No benefits are paid for:

- Disability arising from a disease or injury for which you received medical care before your insurance started. This limitation does not apply if your disability starts after you have been continuously insured for 1 year, or you have not had medical care for the disease or injury for a continuous period of 90 days ending on or after the date your insurance took effect.

- Any period in which you do not participate or cooperate in a prescribed plan of medical treatment appropriate for your condition.

  Depending on the severity of the condition, you may be required to be under the care of a specialist.

  If substance abuse contributes to your disability, the treatment program must include participation in a recognized substance withdrawal program.

- The scheduled duration of a lay-off or leave of absence.

  This does not apply to any portion of a period of maternity leave during which you are disabled due to pregnancy.

- Any 12-month period in which you do not live in Canada for at least 6 months.

- Any period of confinement in a prison or similar institution.

- Disability arising from war, insurrection, or voluntary participation in a riot.

**Conversion Privilege**

If you change jobs, you may apply for an individual LTD policy (one of the standard conversion policies offered by Canada Life), without taking a medical examination. You must apply within one month of the date you start your new job, however, and you must start your new job within six months of the date you leave your present one.

## CRITICAL ILLNESS INSURANCE

If you or your dependent is diagnosed with one of the illnesses defined below while insured, Canada Life will pay you the basic critical illness insurance benefit. Check the **Benefit Summary** for the amount. The benefit is payable after a waiting period of 30 days following the date of diagnosis or at the end of the waiting period, if any, specified for the condition below, whichever is longer. In addition to this benefit, provided it is $10,000 or more, Canada Life will make a $500 donation in your name to a registered charitable organization of your choice.

Optional critical illness insurance allows you to choose additional coverage for yourself and your spouse. Check the **Benefit Summary** for the amount of optional insurance available. If you apply for optional

insurance, you may be required to provide proof of insurability satisfactory to Canada Life. If you elect optional insurance, the amount of the critical illness benefit is the sum of the basic and optional amounts.

Only one critical illness benefit is payable in a person's lifetime. Once a benefit has been paid, no further critical illness insurance is available for that person.

Your critical illness insurance and your dependent basic coverage will not continue past the end of the day before the date you reach age 65. Your spouse's optional critical illness coverage will not continue past the end of the day before the date you or your spouse reaches age 65, whichever is earlier.

**Covered Illnesses**

Any of the following conditions is considered a critical illness if it meets the defined criteria and has been diagnosed by a physician practicing medicine in Canada or the United States who is recognized by the physician's medical licensing body as a specialist in the field of medicine relating to the applicable critical illness. The diagnosis must be supported by objective medical evidence.

- **"heart attack"** – means the death of heart muscle due to obstruction of blood flow, that results in the rise and fall of biochemical cardiac markers to levels considered diagnostic of myocardial infarction, with at least one of the following:

  - heart attack symptoms;
  - new electrocardiogram (ECG) changes consistent with a heart attack; or
  - development of new Q waves during or immediately following an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty.

  No benefits will be paid under this condition for:

  - elevated biochemical cardiac markers after an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty, in the absence of new Q waves; or
  - ECG changes suggesting a prior myocardial infarction, which do not meet the Heart Attack definition as described above.

- **"stroke"** – means an acute cerebrovascular event caused by intra-cranial thrombosis or haemorrhage, or embolism from an extra-cranial source, with:

  - acute onset of new neurological symptoms, and
  - new objective neurological deficits on clinical examination,

  persisting for more than 30 days following the date of the condition. These new symptoms and deficits must be corroborated by diagnostic imaging testing.

  No benefits will be paid under this condition for:

  - transient ischaemic attacks; or
  - intracerebral vascular events due to trauma.

  For greater certainty, lacunar infarcts which do not have the neurological symptoms and deficits set out above, persisting for more than 30 days, do not satisfy the definition of stroke.

- **"coronary artery bypass surgery"** – means the undergoing of heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass graft(s). The surgery must be determined to be medically necessary by a specialist.

  No benefits will be paid under this condition for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

- **"cancer (life-threatening)"** – means a tumour, which must be characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue.

  Types of cancer include carcinoma, melanoma, leukemia, lymphoma, and sarcoma.

  No benefits will be paid under this condition for the following:

  - lesions described as benign, pre-malignant, uncertain, borderline, non-invasive, carcinoma in-situ (Tis), or tumors classified as Ta;
  - malignant melanoma skin cancer that is less than or equal to 1.0 mm in thickness, unless it is ulcerated or is accompanied by lymph node or distant metastasis;
  - any non-melanoma skin cancer, without lymph node or distant metastasis;
  - prostate cancer classified as T1a or T1b, without lymph node or distant metastasis;
  - papillary thyroid cancer or follicular thyroid cancer, or both, that is less than or equal to 2.0 cm in greatest diameter and classified as T1, without lymph node or distant metastasis;
  - chronic lymphocytic leukemia classified less than Rai stage 1; or
  - malignant gastrointestinal stromal tumours (GIST) and malignant carcinoid tumours, classified less than AJCC Stage 2.

  For purposes of the policy, the terms Tis, Ta, T1a, T1b, T1 and AJCC Stage 2 are to be applied as defined in the American Joint Committee on Cancer (AJCC) cancer staging manual, 7th Edition, 2010.

  For purposes of the policy, the term Rai staging is to be applied as explained in KR Rai, A Sawitsky, EP Cronkite, AD Chanana, RN Levy and BS Pasternack: Clinical staging of chronic lymphocytic leukemia. Blood 46:219, 1975.

  Cancer exclusion period

  No benefits will be paid under this condition if, within the first 90 days following the later of the person's effective date of insurance or, for an increase, the effective date of the increase, the person has any of the following:

  - signs, symptoms or investigations that lead to a diagnosis of cancer (covered or excluded under the policy), regardless of when the diagnosis is made; or
  - a diagnosis of cancer (covered or excluded under the policy).

  Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to Canada Life within six months of the date of the diagnosis. If this information is not provided within this period, Canada Life has the right to deny any claim for cancer or any critical illness caused by any cancer or its treatment.
- **"kidney failure"** – means chronic irreversible failure of both kidneys to function, as a result of which regular haemodialysis, peritoneal dialysis or renal transplantation is initiated.

- **"blindness"** – means the total and irreversible loss of vision in both eyes, evidenced by:

  - the corrected visual acuity being 20/200 or less in both eyes; or
  - the field of vision being less than 20 degrees in both eyes.

- **"major organ transplant**" – means irreversible failure of the heart, both lungs, liver, both kidneys, or bone marrow, and transplantation must be medically necessary. To qualify under major organ transplant, the person must undergo a transplantation procedure as the recipient of a heart, lung, liver, kidney or bone marrow, and limited to these entities.

- **"dementia, including Alzheimer's disease"** – means dementia, which must be characterized by a progressive deterioration of memory and at least one of the following areas of cognitive function:

- aphasia (a disorder of speech);
- apraxia (difficulty performing familiar tasks);
- agnosia (difficulty recognizing objects); or
- disturbance in executive functioning (e.g. inability to think abstractly and to plan, initiate, sequence, monitor, and stop complex behaviour), which is affecting daily life.

The person must exhibit:

- dementia of at least moderate severity, which must be evidenced by a Mini Mental State Exam of 20/30 or less, or equivalent score on another generally medically accepted test or tests of cognitive function; and
- evidence of progressive deterioration in cognitive and daily functioning either by serial cognitive tests or by history over at least a six-month period.

No benefits will be paid under this condition for affective or schizophrenic disorders, or delirium.

For purposes of the policy, reference to the Mini Mental State Exam is to Folstein MF, Folstein SE, McHugh PR, J Psychiatr Res. 1975;12(3):189.

- **"Parkinson's Disease and Specified Atypical Parkinsonian Disorders"** – Parkinson's Disease means primary Parkinson's Disease, a permanent neurologic condition which must be characterized by bradykinesia (slowness of movement) and at least one of:

  - muscular rigidity; or
  - rest tremor.

  The person must exhibit objective signs of progressive deterioration in function for at least one year, for which the treating neurologist has recommended dopaminergic medication or other generally medically accepted equivalent treatment for Parkinson's Disease.

  Specified Atypical Parkinsonian Disorders mean progressive supranuclear palsy, corticobasal degeneration, or multiple system atrophy.

  No benefits will be paid under this condition for any other type of parkinsonism.

  Parkinson's Disease and Specified Atypical Parkinsonian Disorders exclusion period

  No benefits will be paid under this condition if, within the first year following the later of the person's effective date of insurance or, for an increase, the effective date of the increase, the person has any of the following:
  - signs, symptoms or investigations that lead to a diagnosis of Parkinson's Disease, a Specified Atypical Parkinsonian Disorder or any other type of parkinsonism, regardless of when the diagnosis is made; or
  - a diagnosis of Parkinson's Disease, a Specified Atypical Parkinsonian Disorder or any other type of parkinsonism.

  Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to Canada Life within six months of the date of the diagnosis. If this information is not provided within this period, Canada Life has the right to deny any claim for Parkinson's Disease or Specified Atypical Parkinsonian Disorders or, any critical illness caused by Parkinson's Disease or Specified Atypical Parkinsonian Disorders or its treatment.

- **"paralysis"** – means total loss of muscle function of two or more limbs as a result of injury or disease to the nerve supply of those limbs, for a period of at least 90 days following the precipitating event.

- **"multiple sclerosis"** – means at least one of the following:

  - two or more separate clinical attacks, confirmed by magnetic resonance imaging (MRI) of the nervous system, showing multiple lesions of demyelination;
  - well-defined neurological abnormalities lasting more than six months, confirmed by MRI imaging of the nervous system, showing multiple lesions of demyelination; or
  - a single attack, confirmed by repeated MRI imaging of the nervous system, which shows multiple lesions of demyelination which have developed at intervals at least one month apart.

- **"deafness"** – means the total and irreversible loss of hearing in both ears, with an auditory threshold of 90 decibels or greater within the speech threshold of 500 to 3000 hertz.

- **"loss of speech"** – means the total and irreversible loss of the ability to speak as a result of physical injury or disease for a period of at least 180 days.

  No benefits will be paid under this condition for all psychiatric related causes.

- **"coma"** – means a state of unconsciousness with no reaction to external stimuli or response to internal needs for a continuous period of at least 96 hours, and for which period the Glasgow coma score must be four or less.

  No benefits will be paid under this condition for a medically induced coma.

- **"severe burns"** – means third degree burns over at least 20% of the body surface.

- **"aortic surgery"** – means the undergoing of surgery for disease of the aorta requiring excision and surgical replacement of any part of the diseased aorta with a graft. Aorta means the thoracic and abdominal aorta but not its branches. The surgery must be determined to be medically necessary by a specialist.

  No benefits will be paid under this condition for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

- **"benign brain tumour"** – means a non-malignant tumour located in the cranial vault and limited to the brain, meninges, cranial nerves or pituitary gland. The tumour must require surgery or radiation treatment or cause irreversible objective neurological deficits.
  No benefits will be paid under this condition for pituitary adenomas less than 10 mm.

  Benign brain tumour exclusion period

  No benefits will be paid under this condition if, within the first 90 days following the later of the person's effective date of insurance or, for an increase, the effective date of the increase, the person has any of the following:

  - signs, symptoms or investigations that lead to a diagnosis of benign brain tumour (covered or excluded under the policy), regardless of when the diagnosis is made; or
  - a diagnosis of benign brain tumour (covered or excluded under the policy).

  Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to Canada Life within six months of the date of the diagnosis. If this information is not provided within this period, Canada Life has the right to deny any claim for benign brain tumour or any critical illness caused by any benign brain tumour or its treatment.

- **"heart valve replacement or repair"** – means the undergoing of surgery to replace any heart valve with either a natural or mechanical valve or to repair heart valve defects or abnormalities. The surgery must be determined to be medically necessary by a specialist.

  No benefits will be paid under this condition for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures

- **"loss of independent existence"** – means the total inability to perform, by oneself, at least two of the following six activities of daily living for a continuous period of at least 90 days with no reasonable chance of recovery.

  Activities of daily living are:

  - bathing – the ability to wash oneself in a bathtub, shower or by sponge bath, with or without the aid of assistive devices;
  - dressing – the ability to put on and remove necessary clothing, braces, artificial limbs, or other surgical appliances with or without the aid of assistive devices;
  - toileting – the ability to get on and off the toilet and maintain personal hygiene with or without the aid of assistive devices;
  - bladder and bowel continence – the ability to manage bowel and bladder function with or without protective undergarments or surgical appliances so that a reasonable level of hygiene is maintained;
  - transferring – the ability to move in and out of a bed, chair or wheelchair, with or without the aid of assistive devices; and
  - feeding – the ability to consume food or drink that already has been prepared and made available, with or without the use of assistive devices

- **"loss of limbs"** – means the complete severance of two or more limbs at or above the wrist or ankle joint as the result of an accident or medically required amputation.

- **"motor neuron disease"** – means one of the following: amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease), primary lateral sclerosis, progressive spinal muscular atrophy, progressive bulbar palsy, or pseudo bulbar palsy, and limited to these conditions.

- **"occupational HIV infection"** – means infection with Human Immunodeficiency Virus (HIV) resulting from accidental injury during the course of the person's normal occupation, which exposed the person to HIV contaminated body fluids. The accidental injury leading to the infection must have occurred following the later of the person's effective date of insurance or, for an increase, the effective date of the increase.
  Payment under this condition requires satisfaction of all the following:

  - the accidental injury must be reported to Canada within 14 days of the accidental injury;
  - a serum HIV test must be taken within 14 days of the accidental injury and the result must be negative;
  - a serum HIV test must be taken between 90 days and 180 days after the accidental injury and the result must be positive;
  - all HIV tests must be performed by a duly licensed laboratory in Canada or the United States; and
  - the accidental injury must have been reported, investigated and documented in accordance with current Canadian or United States workplace guidelines.

  No benefits will be paid under this condition if:

  - the person has elected not to take any available licensed vaccine offering protection against HIV; or
  - a licensed cure for HIV infection has become available prior to the accidental injury.

For greater certainty, non-accidental injury including, but not limited to, sexual transmission or intravenous (IV) drug use does not satisfy the definition of Occupational HIV Infection.

- **"bacterial meningitis"** – means meningitis, confirmed by cerebrospinal fluid showing growth of pathogenic bacteria in culture, resulting in neurological deficit documented for at least 90 days from the date of diagnosis.
  No benefits will be paid under this condition for viral meningitis.

- **"aplastic anaemia"** – means chronic persistent bone marrow failure, confirmed by biopsy, which results in anaemia, neutropenia and thrombocytopenia requiring blood product transfusion, and treatment with at least one of the following:

  - marrow stimulating agents;
  - immunosuppressive agents; or
  - bone marrow transplantation.

**Limitations**

No benefits are paid for a critical illness resulting directly or indirectly from or associated with any of the following:

- intentionally self-inflicted injury, or attempt at suicide, while sane or insane
- war, insurrection or voluntary participation in a riot
- participation in a criminal offence or provoking an assault
- use of any drug, poisonous substance, intoxicant, or narcotic, unless prescribed for the person by a licensed physician and taken in accordance with directions given by the licensed physician
- operating a motorized vehicle while the blood alcohol level is higher than 80 milligrams of alcohol per 100 millilitres of blood.

No benefits are paid if death or irreversible cessation of all functions of the brain occurs during the benefit payment waiting period.

## COORDINATION OF BENEFITS

- If you or a dependent is entitled to benefits for the same expenses under another group or government plan or as both a member and dependent under this plan or as a dependent of both parents under this plan, benefits will be co-ordinated so that the total benefits from all plans will not exceed expenses.
- You and your spouse should first submit your own claims through your own group plan. Claims for dependent children should be submitted to the plan of the parent who has the earlier birth date in the calendar year (the year of birth is not considered). If you are separated or divorced, the plan which will pay benefits for your children will be determined in the following order:

  1. the plan of the parent with custody of the child;
  2. the plan of the spouse of the parent with custody of the child;
  3. the plan of the parent without custody of the child;
  4. the plan of the spouse of the parent without custody of the child

  You may submit a claim to the plan of the other spouse for any amount which is not paid by the first plan.

- If any claims are eligible for reimbursement from any government or automobile insurance plan, claims should first be submitted to that plan. The balance of the claim may be submitted to this plan as described above.

# Benefits Insured by SSQ Insurance Company Inc.

The wording in this section has been provided by SSQ Insurance Company Inc. If there are any discrepancies between the group contract and the information in this section, the group contract will take priority.

SSQ INSURANCE COMPANY INC.
**BASIC ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE**

for Employees of OTTAWA POLICE ASSOCIATION

EFFECTIVE DATE: **September 01, 2017**
POLICY N$^{O}$ **1JV30**

This Booklet/Certificate is an important document.
Please keep it in a safe place.

This booklet is an outline of SSQ Insurance Company Inc.'s Accidental Death and Dismemberment insurance program offered to Employees of the Policyholder. It is designed to help you learn more about the coverage offered under this insurance program. This booklet should be kept for future reference.

The Accidental Death and Dismemberment #1JV30 group insurance program's Master Application, endorsements and attached papers, if any, and the entire contract of insurance, all referred to hereafter as the "Policy", set forth the terms and conditions of the insurance program. All rights and obligations are determined in accordance with the Policy, not this booklet. For exact provisions of coverage offered, please contact your Human Resources department.

SSQ Financial Group
*Values in the right place*

**INTRODUCTION**

**What is Accidental Death and Dismemberment insurance?**

Accidental Death and Dismemberment insurance offers the financial protection needed in case of an accident to help alleviate financial setbacks for you and your loved ones. Accidental Death and Dismemberment coverage provides payment in the event of an accident resulting in death or serious injury. The amount that is paid will depend upon the type of injury.

**Who needs Accidental Death and Dismemberment insurance?**

Everyone should plan for their financial security because accidents happen. According to Statistics Canada (2006), unintentional injury is the 5th leading cause of death in Canada. Nowadays, few people set money aside for emergency needs, so this coverage provides you with protection when it is most needed. Not only does Accidental Death and Dismemberment coverage help lighten the financial burden you or your family may experience due to an accident, but most importantly, it will provide you with a peace of mind.

**Why should you consider Accidental Death and Dismemberment insurance?**

Because no one is immune to accidents, Accidental Death and Dismemberment insurance is perceived as a valuable addition to any group insurance plan. Accidents happen and their impact may be devastating to you and your loved ones. Recovery from an accident may take a while and may cost you more than you'd expect. That is why it is beneficial to make Accidental Death and Dismemberment insurance a part of your group insurance plan, as it provides necessary resources when they are most needed.

**What are the advantages of your coverage?**

With our group Accidental Death and Dismemberment insurance, you benefit from:

- Comprehensive coverage
- Extensive list of benefits
- 24-hour, year round and worldwide coverage
- Efficient claims service

**Definitions – for a better comprehension of this booklet**

Wherever used in this booklet:

“Accident” means a sudden and unexpected mishap or event in which an Insured Person is involved and which directly results in an Injury to the Insured Person.

"Accommodation" means lodging at a hotel, motel, inn, bed and breakfast or other like establishment as well as food reasonably required during the lodging, provided however that no indemnity will be paid for lodging at a private residence or for food not consumed as meals by the person seeking reimbursement of expenses.

"Brain Damage" means irreversible physical damage to the brain causing complete incapacity of performing all the substantial and material functions and activities normal to everyday life.

"Day-Care Centre" means a facility, which is run according to the law, including laws and regulations applicable to day-care facilities, and which provides care and supervision for children in a group setting on a regular basis. A Day-Care Centre will not include a hospital, the child's home or school if the only care at such school is provided during normal school hours while the Dependent Child is attending school from grades one (1) through twelve (12).

"Dependent Child" means a natural child, adopted child, stepchild or child with who is in a parent-child relationship with you. The child must be dependant upon you for maintenance and support and:

(a) under 21 years of age; or
(b) under 26 years of age and in attendance at an Institution for Higher Learning on a full-time basis; or
(c) no matter his age on the date of the claim, have been struck with a Functional Disability while satisfying the criteria under paragraphs (1) or (2) above. Proof of existence of this Functional Disability, including the determination by a Physician that the disability exists and when it occurred, must be presented to the Insurer within 31 days after the child reaches the age at which he would otherwise no longer qualify as a Dependent Child under paragraph (1) or (2) above. Thereafter, the Insurer may periodically require that other proof be submitted establishing to its satisfaction that the Functional Disability still exists and that the child otherwise meets the definition of Dependent Child, failing which, the Insurer may determine that the child no longer qualifies as a Dependent Child under the Policy.

“Employee” means an active, full-time and permanent employee of the Policyholder. The employee of the Policyholder must be under the age of seventy (70) and reside in Canada. The Employee is designated by the terms “you” and “your” for the purposes of this booklet.

"Fare" means the regular fare charged for:

(a) an economy class seat on a regular flight by a domestic or international scheduled air carrier;
(b) a coach seat on a passenger train;
(c) a regular seat on a passenger bus;
(d) an economy class accommodation on a boat.

Each of those carriers must hold a current and valid certificate issued by Transport Canada or, if subject to regulation in another country by a similar governmental authority having jurisdiction in that country.

"Functional Disability" means an irreversible and serious limitation of a person's physical or mental capacity or of their skills that prevents the person from living independently.

"Hemiplegia" means the permanent Paralysis and functional loss of use of upper and lower limbs on the same side of the body.

"Hospital" means an institution licensed as a hospital within the jurisdiction in which it operates. To qualify under this definition, a hospital must be an active treatment hospital open at all times for the care and treatment of sick and injured persons, have a staff of one (1) or more Physicians available at all times, provide twenty-four (24) hour nursing service by graduate registered nurses and have organized facilities for diagnostics and surgery. A facility which is primarily a clinic, rest home, nursing home, convalescent hospital or similar establishment is not a Hospital. For the purposes of this definition, a Hospital will include a facility or part of a facility used for rehabilitative care.

"Immediate Family Member" means a person at least eighteen (18) years of age, who is the son, daughter, father, mother, brother, sister, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, sister-in-law, uncle, aunt, nephew, niece, grandson, granddaughter, grandfather, grandmother (all of the above include natural, adopted or step relationships) or the spouse of an Insured Person.

"Injury" means bodily injury caused by an Accident occurring while the Policy is in force as to the Insured Person whose loss is the basis of claim and resulting directly and independently of all other causes in loss covered under the Policy, twenty-four (24) hours a day, anywhere in the world but in no event shall Injury mean Sickness or Disease howsoever caused unless caused by an Accident.

"Institution for Higher Learning" means and is limited to universities, colleges, CEGEPs and professional or vocational schools.

"Insurer", "We", "Us" means SSQ Insurance Company Inc.

"Insured Person" means you, before the date of coverage termination.

"Intoxicated" and "Under the Influence of Drugs" means that the driver has a blood alcohol content and/or is impaired due to the use of alcohol, narcotics or other drugs such that he could be subject to proceedings under provincial, state or federal law, even if he has not been subject to such proceedings.

"Loss of Life" means the death of the Insured Person.

"Loss" means:
(a) as used with reference to a hand or foot, the complete and irrecoverable severance through or above the wrist or ankle joint, but below the elbow or knee joint;
(b) as used with reference to an arm or leg, the complete and irrecoverable severance through or above the elbow or knee joint;
(c) as used with reference to a thumb, the complete and irrecoverable severance of one (1) entire phalanx of the thumb;
(d) as used with reference to a finger, the complete and irrecoverable severance of two (2) entire phalanges of the finger;
(e) as used with reference to toes, the complete and irrecoverable severance of one (1) entire phalanx of the big toe and irrecoverable severance of all phalanges of the other toes;
(f) as used with reference to an eye, the irrecoverable loss of the entire sight thereof, and determined by a Physician to be irrecoverable;
(g) as used with reference to speech, the complete and irrecoverable loss of the ability to utter intelligible sounds, and determined by a Physician to be irrecoverable;
(h) as used with reference to hearing, the complete and irrecoverable loss of hearing, and determined by a Physician to be irrecoverable.

“Loss of Use” means a total incapacity to use part of the body, which has been continuous for twelve (12) consecutive months and was determined by a Physician to be permanent at the end of such period.

"Motorized Vehicle" means a passenger car, van, jeep-type automobile, sports utility vehicle (SUV), any truck-type automobile, truck, ambulance, or any type of motorized vehicle used by municipal, provincial or federal police forces.

“Paralysis” means the loss of ability to move all or part of the body.

“Paraplegia” means the permanent Paralysis and functional loss of use of both lower limbs of the body.
“Physician” means an individual who is legally licensed to practice medicine and provide treatment within the scope of his licence by:
(a) a recognized medical licensing organization in the jurisdiction where the treatment is rendered, provided he is a member in good standing of such licensing body, or
(b) a governmental agency having jurisdiction over such licensing where the treatment was rendered.
The Physician must not ordinarily reside in the Insured Person's residence. The Physician must not be an Insured Person, an Immediate Family Member or business associate of an Insured Person.

“Policy” means Policy #1JV30 as well as the attached Master Application, any endorsements and attached papers.

“Policyholder” means OTTAWA POLICE ASSOCIATION.

“Principal Sum” means the amount indicated in Item 3 of the Master Application as being applicable to the Insured Person and stated on the Insured Person's most recently signed individual enrollment card on file with the Policyholder, if any.

“Quadriplegia” means the permanent Paralysis and functional loss of use of both upper and lower limbs of the body.

"Regular Care and Attendance" means observation and treatment to the extent necessary under existing and recognized standards of medical practice.

"Seat Belt" means a belt that forms a restraint system in a Motorized Vehicle.
For the purposes of this definition, a Seat Belt includes infant and child restraint systems used in Motorized Vehicles and the restraining belts which are part of a stretcher used in the transportation of sick or injured persons by ambulance.

“Sickness or Disease” means the alteration of a person’s state of health resulting from internal or external cause(s), creating objectively verifiable symptoms and/or signs, and revealing itself by the impairment of physiological or mental functions.

“Specific Loss” means Loss of Life, Loss, Loss of Use, Quadriplegia, Paraplegia or Hemiplegia, all as defined in this section of this booklet.

"Spouse" means an individual under the age of seventy (70):
- to whom you are legally married or in a civil union with; or
- with whom you have continuously cohabited in a conjugal relationship for a minimum of one (1) year immediately before the date of the event insured against.

However, when the individual is the biological or adoptive mother or father of at least one of your children and is cohabitating with you, the individual shall be deemed a Spouse from the date of birth or adoption of that child, if that date precedes the end of the period of one year of cohabitation.
Only one (1) individual will qualify as your Spouse. If you are legally married or in a civil union but are also cohabiting with an individual as described under Item (b) above, you may elect in writing, which one of the individuals will qualify as a Spouse under the Policy. This election must be filed with the Policyholder. The

Insurer will not be bound by an election not filed before the occurrence of the event insured against. If an election is not filed, the Spouse will be the individual to whom you are legally married or in a civil union with.

"Transportation" means conveyance from one place to another by private or public Motorized Vehicle, bus, train, boat, ferry, airplane or helicopter.

Throughout this booklet, the male pronoun will be construed as the feminine when the person is a female.

# DETAILS OF THE PROGRAM

**Eligibility**

The Accidental Death and Dismemberment insurance program is available to Employees of the Policyholder residing in Canada and who are participating in the Policyholder's Basic Group Life Insurance Program.

As an active, full-time and permanent Employee of OTTAWA POLICE ASSOCIATION, you are eligible under the Accidental Death and Dismemberment insurance program if you are under the age of seventy (70). If you are absent from active work for any reason other than bona fide vacation or maternity/parental leave, you will only become eligible upon return to active work.

## Coverage Amounts

**Mandatory program**

The Accidental Death and Dismemberment insurance program is a mandatory group coverage for you.

The amount of the Principal Sum applicable is $160,000.

**Effective Date of Individual Coverage**

Your individual coverage will take effect:
- on effective date of the Policy, if you meet the criteria described under the "Eligibility" section of this booklet on or prior to the effective date of the Policy;
- on the date the Employee returns to active full-time work if such Employee is absent from full-time work for any reason other than bona fide vacation or a maternity / parental leave on the Effective Date of the Policy;
- on the date insurance under the Policyholder's Basic Group Life Insurance program becomes effective with respect to an Employee who becomes insured under such program.

**Individual Coverage Termination**

Your coverage terminates on the earliest of the following dates:
- the date the Policy is terminated;
- the premium due date if the Policyholder fails to pay the required premium, except as the result of an inadvertent error;
- the premium due date coincident with or following the date you reach seventy (70) years of age;
- the premium due date coincident with or following the date you cease to be an active Employee of the Policyholder on account of leave of absence, lay-off, maternity/parental leave, disability, resignation, dismissal, pension or retirement, except as provided under the following sections of this booklet:
  - Waiver of Premium
  - Continuation of Coverage During Approved Leaves
  - Extension of Coverage

This insurance program may be cancelled by the Policyholder by mailing to the Insurer written notice stating the date on which such cancellation will be effective. The program may also be cancelled by the Insurer by mailing to the Policyholder at the address shown in the Policy, written notice stating when, not less than thirty (30) days prior to the anniversary date of the policy, the date on which such cancellation will be effective. The mailing of such notice as aforesaid will be sufficient proof of notice and the effective date of cancellation stated in the notice will become the end of the Policy period. Delivery of such written notice either by the Policyholder or by the Insurer will be equivalent to mailing.

## PROGRAM BENEFITS

**Specific Loss Accident Indemnity**

When, within three hundred and sixty-five (365) days after the date of an Accident, an Insured Person suffers an Injury from such Accident which results in a Specific Loss listed below, the Insurer will pay an indemnity as indicated below:

**Loss of**

| | |
|---|---|
| Life | The Principal Sum |
| The entire sight of both eyes | The Principal Sum |
| Speech and hearing in both ears | The Principal Sum |
| One hand and the entire sight of one eye | The Principal Sum |
| One foot and the entire sight of one eye | The Principal Sum |
| The entire sight of one eye | Three-Fourths of the Principal Sum |
| Speech | Three-Fourths of the Principal Sum |
| Hearing in both ears | Three-Fourths of the Principal Sum |
| Hearing in one ear | Two-Fifths of the Principal Sum |
| All toes of one foot | One-Third of the Principal Sum |

**Loss or Loss of Use of**

| | |
|---|---|
| Both hands | The Principal Sum |
| Both feet | The Principal Sum |
| One hand and one foot | The Principal Sum |
| One arm | Four-Fifths of the Principal Sum |
| One leg | Four-Fifths of the Principal Sum |
| One hand | Three-Fourths of the Principal Sum |
| One foot | Three-Fourths of the Principal Sum |
| The thumb and index finger or at least four fingers of one hand | Two-Fifths of the Principal Sum |

**Paralysis of**

| | |
|---|---|
| Both upper and lower limbs (Quadriplegia) | Two Times the Principal Sum |
| Both lower limbs (Paraplegia) | Two Times the Principal Sum |
| The upper and lower limbs of one side of body (Hemiplegia) | Two Times the Principal Sum |

However, in the case of Quadriplegia, Paraplegia and Hemiplegia, if the Insured Person dies within ninety (90) days after the date of the Accident, the indemnity payable by the Insurer will be limited to the Principal Sum.

Indemnity provided under this section for all Specific Losses sustained by an Insured Person as the result of any one (1) Accident will not exceed the following:
(a) the Principal Sum, with the exception of Quadriplegia, Paraplegia and Hemiplegia; or
(b) with respect to Quadriplegia, Paraplegia and Hemiplegia, two times the Principal Sum, provided that the Insured Person lives longer than ninety (90) days after the date of the Accident.

Under this section, in no event will the Insurer pay more than two times the Principal Sum as the result of the same Accident, regardless of the combination of losses suffered.

**Covered Accidental Death and Dismemberment Benefits**

**Surgical Reattachment Benefit**

If an Injury sustained by an Insured Person results in the complete severance of the Insured Person's limb or appendage or part of either a limb or appendage, and if such severed limb, appendage or part is then surgically reattached to that Insured Person within three hundred and sixty-five (365) days after the date of the Accident resulting in such Injury, then the Insurer will pay an indemnity to such Insured Person as follows:
(1) Whether or not the Insured Person regains use of the severed limb, appendage or part, the Insurer will pay an indemnity equal to 50% of the indemnity that would have been payable under the section of this booklet entitled "Specific Loss Accident Indemnity" for the Loss of such limb, appendage or part, if the surgical reattachment had not been performed.
(2) If, after the reattachment of the severed limb, appendage or part and within three hundred and sixty-five (365) days after the date of the Accident resulting in such Injury, the Insured Person suffers a total, irrecoverable and permanent Loss of Use of such reattached limb, appendage or part, the Insurer will pay an indemnity as provided under the section of this booklet entitled "Specific Loss Accident Indemnity" for Loss of Use of such limb, appendage or part, less any amount(s) paid or payable under the Surgical Reattachment Benefit section shown under item (1) above.
(3) If, after the reattachment of the severed limb, appendage or part and within three hundred and sixty-five (365) days after the date of the Accident resulting in such Injury, such reattachment fails and the limb, appendage or part must be amputated, the Insurer will pay an indemnity as provided under the section of this booklet entitled "Specific Loss Accident Indemnity" for the Loss of such limb, appendage or part less any amount(s) paid or payable under this Surgical Reattachment Benefit section, under items (1) and (2).

Indemnity payable under this section and the section of this booklet entitled "Specific Loss Accident Indemnity" for any one (1) Insured Person as the result of any one (1) Accident will not exceed the Principal Sum.

**Repatriation Benefit**

In the event an Insured Person suffers a Loss of Life resulting from Injury more than fifty (50) kilometres from that Insured Person's normal place of residence and indemnity for such loss becomes payable under the section of this booklet entitled "Specific Loss Accident Indemnity", the Insurer will pay the reasonable and necessary expenses actually incurred for the transportation of the body of the deceased Insured Person to a resting place (including but not limited to a funeral home or the place of interment) in proximity to the normal place of residence of the deceased Insured Person, including charges for the preparation of the body for such transportation, not to exceed, in the aggregate, the amount of twenty-five thousand dollars ($25,000) for all such expenses paid under this section as a result of one (1) Accident.

The indemnity payable under this section will be payable to the person who actually incurred the expenses.

The amount payable under this section will be co-ordinated with any amount which is paid or payable for a same or similar benefit provided under any other policies issued to the Policyholder by the Insurer.

**Education Benefit**

In the event you suffer a Loss of Life resulting from an Injury and indemnity for such loss becomes payable under the section of this booklet entitled "Specific Loss Accident Indemnity", the Insurer will pay the reasonable and necessary tuition fees for any Dependent Child who, on the date of or within the following three hundred and sixty-five (365) days of the Insured Person's death, is enrolled or enrolls as a full-time student in any Institution for Higher Learning, up to the lesser of the following amounts:

(a) five percent (5%) of such deceased Insured Person's Principal Sum; or
(b) five thousand dollars ($5,000),

for each year (up to five (5) consecutive years) per Dependent Child during which such Dependent Child remains enrolled as a full-time student in an Institution for Higher Learning.

The total maximum payable under this section will not exceed five thousand dollars ($5,000) per year per Dependent Child.

The indemnity will be paid each year upon receipt of proof satisfactory to the Insurer that the Dependent Child is enrolled as a full-time student in an Institution for Higher Learning. Payment will not be made for expenses incurred prior to the Loss of Life of such Insured Person, nor for room, board, books or other living, travelling or clothing expenses.

The indemnity payable under this section will be payable to the person who actually incurred the expenses.

The amount payable under this section will be co-ordinated with any amount which is paid or payable for a same or similar benefit provided under any other policies issued to the Policyholder by the Insurer.

**Day-Care Benefit**

In the event you suffer a Loss of Life resulting from an Injury and indemnity for such loss becomes payable under the section of this booklet entitled "Specific Loss Accident Indemnity", the Insurer will pay the reasonable and necessary expenses actually incurred for Day-Care Centre attendance for any Dependent Child under thirteen (13) years of age at the date of the Insured Person's death and who on the date of or within the following three hundred and sixty-five (365) days after such Insured Person's death, is enrolled or enrolls in a Day-Care Centre, to the lesser of the following amounts:

(a) five percent (5%) of such deceased Insured Person's Principal Sum; or
(b) five thousand dollars ($5,000),

for each year (up to five (5) consecutive years) per Dependent Child during which such Dependent Child remains enrolled in a Day-Care Centre.

The total maximum payable under this section will not exceed five thousand dollars ($5,000) per year per Dependent Child.

The indemnity will be paid each year upon receipt of satisfactory proof that the Dependent Child is enrolled in a Day-Care Centre, but payment will not be made for expenses incurred prior to the Loss of Life of such Insured Person, nor for room, board or other ordinary living, travelling or clothing expenses.

The indemnity payable under this section will be payable to the person who actually incurred the expenses.

The amount payable under this section will be co-ordinated with any amount which is paid or payable for a same or similar benefit provided under any other policies issued to the Policyholder by the Insurer.

If none of the Insured Person's Dependent Children satisfy the above requirements or the requirements as shown under the section entitled "Education Benefit", the Insurer will pay to your beneficiary the lesser of the following amounts:
(a) five percent (5%) of the deceased Insured Person's Principal Sum; or
(b) two thousand and five hundred dollars ($2,500),
under only one (1) of the policies issued by the Insurer.

**Rehabilitation Benefit**

In the event you suffer a Specific Loss resulting from an Injury and indemnity for such loss becomes payable under the section of this booklet entitled "Specific Loss Accident Indemnity" and such Injury requires that you participate in a rehabilitation program in order to be qualified to engage in an occupation in which you would not have engaged except for such Injury, the Insurer will pay the reasonable and necessary expenses that you actually incurred for such program within three (3) years after the date of such loss. Payment will not be made for room, board or other ordinary living, travelling or clothing expenses.

Payment by the Insurer for the total of all expenses that you incurred under this section will not exceed fifteen thousand dollars ($15,000) as the result of any one (1) Accident.

The amount payable under this section will be co-ordinated with any amount which is paid or payable for a same or similar benefit provided under any other policies issued to the Policyholder by the Insurer.

**Workplace Modification and Accommodation Benefit**

In the event you suffer a Specific Loss resulting from an Injury and indemnity for such loss becomes payable under the section of this booklet entitled "Specific Loss Accident Indemnity" and you require special adaptive equipment and/or workplace modification in order to reasonably accommodate your return to active work with OTTAWA POLICE ASSOCIATION, the Insurer will pay the reasonable and necessary expenses actually incurred by OTTAWA POLICE ASSOCIATION for such equipment and/or modification provided:
(1) OTTAWA POLICE ASSOCIATION agrees in writing to provide the special adaptive equipment and/or make modifications to the workplace for the purpose of making it accessible and adaptable to your needs; and
(2) OTTAWA POLICE ASSOCIATION acknowledges in writing that the performance of the essential duties of your job would be compromised in the absence of such modification or accommodation; and
(3) The proposed special adaptive equipment and/or workplace modification have prior written approval by the Insurer.

The Insurer has the right to have you examined by a professional of its choice to evaluate the appropriateness of the proposed modifications and/or equipment.

The indemnity under this section will be paid to OTTAWA POLICE ASSOCIATION once you have returned to active work with OTTAWA POLICE ASSOCIATION and the Insurer has been provided with written proof of the expenses incurred. The benefit is not payable if OTTAWA POLICE ASSOCIATION does not incur any cost in providing the special adaptive equipment and/or the workplace modification.

Payment by the Insurer for the total of all expenses incurred by OTTAWA POLICE ASSOCIATION under this section will not exceed five thousand dollars ($5,000) as a result of any one (1) Accident.

The amount payable under this section will be co-ordinated with any amount which is paid or payable for a same or similar benefit provided under any other policies issued to the Policyholder by the Insurer.

**Occupational Training Benefit**

In the event you suffer a Loss of Life resulting from an Injury and indemnity for such loss becomes payable under the section of this booklet entitled "Specific Loss Accident Indemnity", the Insurer will pay the reasonable and necessary expenses actually incurred within the following three (3) years after the date of such loss by your Spouse who engages in a formal occupational training program in order to become specifically qualified for active employment in an occupation for which he would not otherwise have sufficient qualifications. Payment will not be made for room, board or other ordinary living, travelling or clothing expenses.

Payment by the Insurer for the total of all expenses incurred by your Spouse under this section will not exceed fifteen thousand dollars ($15,000).

The indemnity payable under this section will be payable to the person who actually incurred the expenses.

The amount payable under this section will be co-ordinated with any amount which is paid or payable for a same or similar benefit provided under any other policies issued to the Policyholder by the Insurer.

**Family Transportation Benefit**

In the event an Insured Person suffers a Specific Loss resulting from an Injury and indemnity for such loss becomes payable under the section of this booklet entitled "Specific Loss Accident Indemnity" and such Insured Person is under the Regular Care and Attendance of a Physician, the Insurer will pay the reasonable and necessary expenses actually incurred by one (1) Immediate Family Member or family representative for Transportation to the bedside of such Insured Person by the most direct route from the normal place of residence of the Immediate Family Member or family representative, Accommodation in the vicinity, and return to the normal place of residence of such Immediate Family Member or family representative by the most direct route if the Insured Person had been travelling unaccompanied by an Immediate Family Member. Payment will not be made for other ordinary living, travelling or clothing expenses.

The Insurer will not pay any indemnity under this section unless such Insured Person is confined as an inpatient in a Hospital located more than fifty (50) kilometres from his normal place of residence.

Reimbursement of Transportation expenses under this section is limited to the cost of a single return trip to the bedside of the Insured Person while in Hospital. More than one form of conveyance may be used for the Transportation if necessary, but the indemnity paid will be limited to the Fare or Fares reasonably required for a single return trip. If Transportation occurs in a Motorized Vehicle other than one operated under a license for the conveyance of passengers, then reimbursement of Transportation expenses will be limited to a maximum of thirty-five cents ($0.35) per kilometre travelled for such return trip.

The total maximum amount payable under this section by the Insurer will not exceed fifteen thousand dollars (15 000$) as a result of any one (1) Accident.

The indemnity payable under this section will be payable to the person who actually incurred the expenses.

The amount payable under this section will be co-ordinated with any amount which is paid or payable for a same or similar benefit provided under any other policies issued to the Policyholder by the Insurer.

**Identification Benefit**

In the event an Insured Person suffers a Loss of Life resulting from an Injury and indemnity for such loss becomes payable under the section of this booklet entitled "Specific Loss Accident Indemnity" and the police or similar governmental authority requires identification of the Insured Person’s body, the Insurer will pay the reasonable and necessary expenses actually incurred by one (1) Immediate Family Member or family representative for Transportation to the location of the Insured Person’s body by the most direct route

from the normal place of residence of the Immediate Family Member or family representative, Accommodation in the vicinity, and return to the normal place of residence of such Immediate Family Member or family representative by the most direct route, if, at the time of death, the Insured Person had been travelling unaccompanied by an Immediate Family Member. Payment will not be made for other ordinary living, travelling or clothing expenses.

The Insurer will not pay any indemnity under this section unless the Insured Person's body is located more than fifty (50) kilometres from the Insured Person's normal place of residence.

Reimbursement of Transportation expenses under this section is limited to the cost of a single return trip to identify the deceased Insured Person. More than one form of conveyance may be used for the Transportation if necessary, but the indemnity paid will be limited to the Fare or Fares reasonably required for a single return trip. If Transportation occurs in a Motorized Vehicle other than one operated under a license for the conveyance of passengers, then reimbursement of Transportation expenses will be limited to a maximum of thirty-five cents ($0.35) per kilometre travelled for such return trip.

The total maximum amount payable under this section by the Insurer will not exceed twenty-five thousand dollars (25 000$) as a result of any one (1) Accident.

The indemnity payable under this section will be payable to the person who actually incurred the expenses.

The amount payable under this section will be co-ordinated with any amount which is paid or payable for a same or similar benefit provided under any other policies issued to the Policyholder by the Insurer.

**Seat Belt Benefit**

In the event an Insured Person suffers a Specific Loss resulting from an Injury and indemnity for such loss becomes payable under the section of this booklet entitled "Specific Loss Accident Indemnity", the Insurer will pay an additional indemnity equal to ten percent (10%) of the applicable indemnity payable under the section of this booklet entitled "Specific Loss Accident Indemnity", subject to a maximum of fifty thousand dollars ($50,000), if at the time of the Accident causing such Injury, the Insured Person was driving or riding in a Motorized Vehicle and wearing a properly fastened Seat Belt.
At the time of the Accident, the driver of the Motorized Vehicle must hold a current and valid driver's license of a rating authorizing him to operate such Motorized Vehicle and neither be Intoxicated nor Under the Influence of Drugs.

Proof of Seat Belt use to the satisfaction of the Insurer must be provided as part of the written proof of loss.

**Home Alteration and/or Vehicle Modification Benefit**

In the event an Insured Person suffers a Specific Loss listed below resulting from an Injury:
(1) Loss of both feet or legs; or
(2) Loss of Use of both feet or legs; or
(3) Quadriplegia, Paraplegia or Hemiplegia,
and indemnity for such loss becomes payable under the section of this booklet entitled "Specific Loss Accident Indemnity" and such Insured Person requires the use of a wheelchair, as result of such loss, in order to be ambulatory, the Insurer will pay the reasonable and necessary expenses actually incurred by the Insured Person within three (3) years following the date of Loss for home alteration and/or vehicle modification as provided under this section.

To be covered under this section, the alteration or modification must enable the Insured Person to access his residence and/or his vehicle in a wheelchair and must be approved, where required by law, by licensing authorities.

The total maximum amount payable under this section by the Insurer will not exceed fifteen thousand dollars ($15,000) as a result of any one (1) Accident.

The amount payable under this section will be co-ordinated with any amount which is paid or payable for a same or similar benefit provided under any other policies issued to the Policyholder by the Insurer.

**Aircraft Coverage**

Insurance provided under the Policy includes coverage for loss when such loss results from Injury sustained while and as a result of the Insured Person:

(a) riding as a passenger, and not as a pilot, operator or member of the crew, in or on any aircraft (other than an aircraft owned by OTTAWA POLICE SERVICE or a temporary substitute or replacement thereof as indicated below) having a current and valid certificate of airworthiness and being piloted by a person who then holds a current and valid pilot's license of a rating authorizing him to pilot such aircraft.

(b) riding as a passenger, and not as a pilot, operator or member of the crew, in or on any aircraft operated by the Canadian Armed Forces or by a similar military service of any duly constituted governmental authority of any other recognized country.

(c) riding as a passenger, pilot, operator or member of the crew in or on:

| | |
|---|---|
| Make and Model of Aircraft: | Cessna U206G -1981 |
| Registration: | CGMJF |
| **Number of Seats** | |
| Pilot or Crew: | 1 |
| Passenger: | 2 |

or any other aircraft of like design and capacity as the aircraft owned by OTTAWA POLICE SERVICE or chartered or leased as temporary substitute or replacement aircraft, providing each such aircraft has a current and valid certificate of airworthiness and is being operated at the time with the consent of OTTAWA POLICE SERVICE, and is piloted by a pilot who then holds a current and valid pilot’s license of a rating authorizing him to pilot such aircraft

(d) boarding or alighting from or being struck by any aircraft.

The Policy excludes Injury sustained while and as a result of riding in or on any aircraft owned, operated or leased by or on behalf of OTTAWA POLICE SERVICE, other than as stated under (c) above.

**Exposure and Disappearance Coverage**

In the event an Insured Person undergoes unavoidable exposure to natural elements and, as a direct result, suffers a Specific Loss for which indemnity would have been payable under the section of this booklet entitled "Specific Loss Accident Indemnity" if it had been caused by an Accident, the Insurer will pay the amount specified for the same loss as in the section of this booklet entitled "Specific Loss Accident Indemnity".

In the event an Insured Person is not found within one (1) year following the date of the disappearance or sinking or wrecking of the conveyance in which he was riding at the time of such disappearance or sinking or wrecking and under such circumstances as would otherwise be covered under the section of this booklet entitled "Specific Loss Accident Indemnity", it will be presumed the Insured Person suffered a Loss of Life resulting from an Injury at the time of such disappearance, sinking or wrecking.

**Brain Damage Benefit**

In the event an Insured Person suffers Brain Damage as a result of an Injury, the Insurer will pay the Principal Sum, less any other amount paid or payable under the section of this booklet entitled "Specific Loss Accident Indemnity" as the result of the same Accident, provided:

(a) The Insured Person incurs Brain Damage within one hundred and twenty (120) days from the date of the Accident; and

(b) The Insured Person is hospitalized as a result of Brain Damage at least seven (7) of the first one hundred and twenty (120) days of the Injury; and

(c) A Physician determines and the Insurer is satisfied that the Insured Person has evidence of Brain Damage for at least six (6) consecutive months.

**Extension of Coverage**

Your individual coverage will be continued for a period of up to twelve (12) months if your employment has been terminated by OTTAWA POLICE SERVICE provided such continuation of coverage is required by any applicable provincial or federal employment law or by a severance package agreement that you received from OTTAWA POLICE SERVICE and payment of premium is continued.

This extension of coverage will terminate at 12:01 a.m., Standard Time, on the first (1st) day of the month following either the completion of the twelve (12) month period or the date you return to work in any capacity, whichever is earlier.

Extensions of coverage for periods in excess of twelve (12) months may be granted, provided written request is submitted by the Policyholder to the Insurer.

The coverage which is provided as a result of extension under this section will be subject to the terms and provisions of the Policy which were in effect as of the date of termination of employment, including any provision providing for reductions in amounts of insurance.

Notwithstanding anything contained to the contrary in the Policy, in no event will indemnities payable for any event insured against which occurs while coverage is being continued under this clause exceed the amount that would have been payable to you at the date of termination of employment.

**Continuation of Coverage during Approved Leaves**

If, under the Policyholder's Basic Group Life Insurance policy, an Insured Employee's life insurance is continued during any approved leave of absence, temporary lay-off, maternity/parental leave or disability leave, coverage under this policy will also be continued for an Insured Employee, provided payment of premium is continued.

The coverage which is provided as a result of continuation under this section will be subject to the terms and provisions of the Policy that were in effect as of the date of commencement of the leave, including any provision providing for reductions in amounts of insurance.

Notwithstanding anything contained to the contrary in the Policy, in no event will indemnities payable for any event insured against which occurs while individual coverage is being continued under this section exceed the amount that would have been payable to you at the date of commencement of your leave.

**Waiver of Premium**

When, under the Policyholder's basic group life insurance policy, your life insurance coverage is extended under a waiver of premium provision as the result of total disability resulting from a Sickness or Disease, from a Sickness or Disease related to pregnancy, from an Injury or from an Accident, coverage under the Policy will also be extended and waiver of premium granted.

Premiums will continue to be waived until the earliest of the following dates:
(a) the date the Policy is terminated; or
(b) the date you reach **sixty-five (65) years of age**; or
(c) the date the you cease to be totally disabled; or
(d) the date you fail to provide proof satisfactory to the Insurer of the continuance of total disability within ninety (90) days of request of such proof or refuse to submit to a medical examination requested by the Insurer.

The coverage which is continued under this section is subject to the terms and provisions of the Policy which are in effect on the date prior to the commencement of total disability, including any provision providing for reductions in amounts of insurance or any indemnity.

Notwithstanding anything contained to the contrary in the Policy, in no event will indemnities payable for any event insured against which occurs while coverage is being continued under this section exceed the amount that would have been payable, if any, to the Insured Person at the date prior to your commencement of total disability.

The Insurer has the right to request proof of total disability or the continuation thereof from time to time, as the Insurer may reasonably require. Failure to provide proof satisfactory to the Insurer may result in termination of this "Waiver of Premium" section.

**Conversion to an Individual Insurance Contract**

In the event your coverage is terminated because:
(a) you cease to be an active Employee of OTTAWA POLICE SERVICE on account of resignation, dismissal, retirement or failure to return to work for the Policyholder following a period of total disability; or
(b) you cease to be an eligible person under the Policy; or
(c) the period of extension of your coverage as provided in the "Extension of Coverage" section ends,
if you have not reached the age of seventy (70), you may make a written application to the Insurer within thirty-one (31) days of said termination to obtain an individual accident policy. On reception of such application, the Insurer will, without evidence of insurability, issue an individual accident policy to the applicant.

However, conversion will not be possible if the Policy is terminated at the time of the application

The benefits provided will be set out in a Specific Loss Accident Indemnity schedule available from the Insurer at the time of conversion, and the amount of insurance that may be converted will not exceed the lesser of:
(a) the amount of insurance then in effect on the date of termination; or
(b) a total aggregate amount of two hundred and fifty thousand dollars ($250,000) for all such conversions.

Premiums for such an individual accident policy being issued in compliance with the aforementioned condition will be calculated at the Insurer’s rates then in force for your attained age at the date of conversion. Premiums will be payable annually in advance and the accident policy will be issued on an annually renewable basis.

**Indemnity Payment and Beneficiaries**

Indemnity payable in the event of your Loss of Life will be paid to the beneficiary or beneficiaries designated in writing by you on your basic group life insurance application on file with the Policyholder or basic group life insurance carrier, as the case may be, on your most recently signed enrollment card or beneficiary designation card on file with the Policyholder, or, if there is no such beneficiary designation, such indemnity will be paid to your estate. All other indemnities payable will be paid to you, with the exception of indemnities payable under the following sections of this booklet, for which, indemnity will be paid to the person who actually incurred the expenses giving rise to the indemnity:
- Repatriation Benefit
- Education Benefit
- Day-Care Benefit
- Workplace Modification and Accommodation Benefit
- Occupational Training Benefit
- Family Transportation Benefit
- Identification Benefit
- Home Alteration and/or Vehicle Modification Benefit

**Exclusions**

No benefit will be paid for any loss, fatal or non-fatal, caused or contributed to by:

- self-inflicted injuries, suicide or attempted suicide, whether the Insured Person was sane or insane;
- war whether declared or undeclared, and whether or not the Insured Person was actually participating therein;
- civil commotion, riot, insurrection, armed conflict if the Insured Person was participating therein, except if such participation occurs while performing the normal and regular duties which pertain to "His Occupation"
  "His Occupation" means each and every occupation or employment as a member of the police force of OTTAWA POLICE SERVICE that the Insured Person was engaged in for wage or profit on the date of the accident.
- the Insured Person's service, whether as a combatant or non-combatant, in the armed forces of any country;
- the Insured Person riding as a passenger or otherwise in any vehicle or device for aerial navigation, other than as provided in the section of this booklet entitled "Aircraft Coverage";
- medical treatment or surgery on the Insured Person, except if the medical treatment or surgery was needed because of an Accident.

**Proof of Loss**

Written proof of loss must be furnished to the Insurer within ninety (90) days after the date of Accident resulting in such loss. Failure to furnish such proof within such time will not invalidate any claim if it is shown not to have been reasonably possible to furnish such proof during such time and that such proof was furnished as soon as was reasonably possible, but in no event later than one (1) year after the date of the Accident.

**Physical Examination and Autopsy**

The Insurer will have the right and opportunity to examine, at its own expense, the person of the Insured Person whose loss is the basis of claim under the Policy, where and so often as it may reasonably require while it determines the validity of a claim hereunder, and in the case of death, the right and opportunity to require an autopsy where it is not forbidden by law.

**Payment of Claims**

All indemnities provided in the Policy for loss will be paid after customary proof of loss satisfactory to the Insurer has been given in accordance with the requirements of the Policy. With respect to Insured Persons of the Policyholder for whom premium is paid in Canadian funds, all moneys payable under the Policy are payable in the lawful money of Canada. With respect to Insured Persons of a Policyholder who pay the premium in U.S. funds, all moneys payable under the Policy are payable in the lawful money of the United States of America.

**Legal Actions**

Legal action will not be taken to recover indemnities under the Policy until sixty (60) days after proof of loss has been submitted to the Insurer in accordance with the requirements of the Policy. Thereafter, the claimant must take any legal action based on the Policy within a one (1) year period [three (3) years in the province of Quebec] following submission of a proof of loss to the Insurer.

# Benefits Administered by Coughlin & Associates Ltd.

## Definitions

By spouse/partner, we mean:

- the person to whom you are legally married;
- the person with whom you have lived in a common-law relationship for 12 consecutive months and whom you have publicly represented as your spouse/partner; or
- a former spouse (including divorced or ex-common law spouse) when mandated by court order.

Only one spouse will be eligible for coverage under this program. The same spouse must be insured for all eligible benefits.

By dependant child, we mean:

- an unmarried natural, adopted, or step child who is entirely dependent on you for maintenance and support and who is:
    - under 21 years of age who is not employed on a regular full-time basis for more than 30 hours per week; or
    - between 21 years of age and under 25 years of age and attending an accredited educational institution on a full-time basis; or
    - unmarried child who is incapable of supporting themselves due to a physical or mental disorder and who depends on you for maintenance and financial support, provided the child has been disabled before the limiting age and the disorder has been continuous since that time. Supporting documentation completed by a medical doctor will be required.

## Effective Date of Dependant Coverage

Coverage for dependants will go into effect on the latest of the following dates:

- the date your spouse/partner/dependant becomes eligible for coverage;
- the same day you apply for spousal/dependant coverage, provided the application is made within 31 days of the date you first become eligible for coverage. If you do not apply for dependant coverage within the 31-day period, evidence of insurability will be required.

All coverage changes (dependant changes, changing from single to family or family to single, adding or removing dependants, etc.) must be made through your human resources office or the plan administrator.

## Comparable Coverage and Late Applicants

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 similar 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 addition of a spouse through either marriage or a 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 dependent child.

Applicants who apply for coverage after 31 days of the termination of comparable coverage will be asked to provide evidence of insurability. This means that in order to qualify for benefit coverage, the late applicant must fulfil certain medical standards, as set by the administrator, so as to not pose significant financial risk

to the plan sponsor. Your application will be reviewed and coverage may be approved or declined based on the information provided.

All coverage changes (dependant change, changing from single to family coverage, or family to single, adding or removing dependants, etc.) must be made through your employer or the plan administrator.
All fees charged by medical practitioners for the completion of medical forms or other documentation are the responsibility of the applicant.

## Coverage Following the Termination of Extended Health and Dental Care Benefits

If your extended health and/or dental care coverage terminates due to any reason, including termination of your employment or retirement, you and your dependants may be eligible for similar coverage under an individual policy, without providing evidence of insurability. You must apply for such coverage within 60 days of the termination of your coverage under this policy. Other coverage options may also be available.

Please contact the plan administrator for further information.

## Coordination of Benefits (COB) Guidelines

If you or your dependants are also covered under another health insurance program or contract, the payment of your benefits will be coordinated so that the total benefit you will receive will not exceed 100% of allowable expenses.

Subject to the consent of the covered person, the plan administrator may release to any person or corporation any data necessary to implement this provision.

## Order of Benefits 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 coordinated 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 dependent child of the parent with the earlier month and day of birth in the calendar year;
    - as a dependent 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.

# Extended Health Care Benefit

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

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 limitations. The amount payable will be determined based on the percentage and maximums shown in the *Benefits Summary.*

For benefits where no maximum is indicated, reimbursement will be limited to the reasonable and customary cost of that product or service.

Reasonable and customary treatment 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 deemed necessary and relevant for the diagnosis and management of the illness or injury, subject to the limits specified in the *Benefits Summary.*

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

*Calendar year* means the period from January 1st to December 31st inclusively.

## Prescription Drug Card

You can pay for your prescription drugs directly through your drug plan using the all-in-one card.

Your al-in-one card provides your pharmacist with immediate confirmation of covered drug expenses. This means your prescription drug claims will be processed immediately. There are no forms to complete. Simply present the drug car to your pharmacist when purchasing prescription drugs. Payment for your claim will be processed immediately.

The drug card can be used by you as well as your spouse and eligible dependants. It is designed to cover prescription drug costs only and can be used at any pharmacy in Canada.

## Prescription Drugs

Drugs, serums, compound mixtures and injectables, including oral contraceptives, only available by prescription, when prescribed by a medical doctor within the terms and regulations governing that profession, or dentist.

Sclerosing injections used in the treatment of varicosities, when this treatment is primarily for therapeutic and not cosmetic purposes, up to the maximum specified in the *Benefits Summary.*

Diabetic supplies such as diabetic needles, syringes, alcohol swabs, test strips, lancets and glucometers (excluding batteries).

Viscosupplementation devices are eligible up the limitation listed in the *Benefits Summary.*

Certain eligible medications may require the prior authorization of the plan administrator.

Compound mixtures, when at least one ingredient is a prescription requiring medication, are eligible under the plan.

## Hospital Care

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

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

A chronic care hospital is a licensed hospital that provides chronic care for patients who are chronically ill, whose chronic care needs cannot be provided at home. The patient requires a range of therapeutic services, medical management and/or skilled nursing care not available elsewhere. It does not include a nursing home, rest home, home for the aged, sanatorium, convalescent hospital or a facility for treating alcohol or drug abuse. If the plan member is confined in a chronic hospital or chronic care unit of a public general hospital, reimbursement will be made up to the maximum indicated in the *Benefits Summary.*

*Palliative care establishment* means any establishment in Canada designated as such by law that provides, under the supervision of a physician, care and treatment to patients, mainly during the terminal phase of their illness, and that provides nursing care 24 hours a day by a registered nurse and maintains daily records of each patient under the care of a physician. An active treatment hospital designated as such by law, extended care facility, rest home, convalescent or rehabilitation centre, home for the aged or the chronically ill, home for the mentally ill, sanatorium, convalescent hospital, or institution for the care and treatment of alcoholism or drug addiction is not considered a palliative care establishment.

## Vision Care

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

The plan will also cover contact lenses that are prescribed because the regular surface of the lens of the eye (the cornea) is impaired in some way and visual acuity cannot be improved to at least a 20/40 level in the better eye with ordinary eyeglasses.

## Paramedical Services

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

If you choose to enter into a block payment or annual payment plan for services, reimbursement will be made at the end of the contract period, upon submission of all receipts and a copy of the contract.

## Medical Services and Supplies

The plan will cover the costs after provincial plan coverage (if applicable) for the medical services listed below when ordered by a doctor, up to the maximums indicated in the *Benefits Summary.* If no maximum is indicated, reimbursement will be based on the reasonable and customary costs in the locality where the services and supplies were provided. Reimbursement of eligible items is based on the date the items are paid in full.

- Hearing aids, or repairs to existing hearing aids plus initial batteries. Hearing aid evaluation tests, ear examinations and replacement batteries are not eligible.

- Custom-made orthopaedic shoes or modifications to orthopaedic shoes when prescribed by a doctor, podiatrist or chiropodist (must indicate medical diagnosis).

- Custom-made orthotic inserts for shoes, when prescribed by a doctor, podiatrist or chiropodist (must indicate medical diagnosis).

- Private duty nursing services when medically necessary. Services must be for nursing care, and not for custodial care. The private duty nurse must be a nurse or nursing assistant who is licensed, certified or registered in the province where you live and who does not normally live with you. The services of a registered nurse are eligible only when someone with lesser qualifications cannot perform the duties. A pre-care assessment must be provided and prior authorization by the plan administrator is required.

- External breast prosthesis (following mastectomies) and surgical brassieres.

- Elastic support stockings, including compression hose, showing the brand name and compression ratio.

- Wigs for patients who have undergone special treatment, such as chemotherapy. A doctor's referral indicating the condition being treated is required.

- Transcutaneous electric stimulators (TENS) machines. A doctor’s referral indicating the condition being treated is required.

- Continuous Glucose monitoring systems (receiver, transmitter and associated sensors), to the specifications outlined in the ***Benefit Summary.*** Contact the plan administrator, Coughlin & Associates Ltd., regarding prior authorization and required documentation.

- Transportation in a licensed ground or air ambulance, if medically necessary, that takes you to and from the nearest hospital that is able to provide the necessary medical services.

- Rental or at the administrator’s discretion, purchase of durable equipment including but not limited to standard-type wheelchair, wheelchair repairs, hospital bed (with or without mattresses), hospital bed rails, respirator/ventilator, oxygen and its administration, apnea monitors. In lieu of rental, the plan may, at its discretion, substitute charges for the purchase of such articles where applicable rental charges will be applied to the purchase price.

- Rental or at the administrator’s discretion, purchase of braces, trusses, casts, canes, crutches, walkers, splints (excluding dental splints), cervical collars, standard-type artificial limb or eye. Braces must be constructed with rigid or semi-rigid material, required for normal activities of daily living, and not solely for sports-related activities, with the written prescription of a physician.

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

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

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

- The costs of treatment for the repair or replacement of natural teeth, which require treatment as a result of accidental blow to the mouth. Damage must be caused by a direct blow to the mouth, not from an object wittingly or unwittingly placed in the mouth. The accident must have occurred after the effective

date of the plan. Treatment must be completed within 6 months of the date of the accident. Reimbursement will be based on the current Dental Association fee guide for general practitioners, based on the province where services were rendered.

## Expenses Not Covered

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

# Dental Care Benefit

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

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

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

## Pre-determination of Benefits / Treatment Plan

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

## Alternate Benefit Provision

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

This provision cannot be applied on excluded provisions, services or devices.

## Basic Services

### *Examinations*

- Complete oral examination, according to the frequency specified in the *Benefits Summary*
- Recall oral examination, according to the frequency specified in the *Benefits Summary*
- Specific oral examination, according to the frequency specified in the *Benefits Summary*
- Emergency oral examination, according to the frequency specified in the *Benefits Summary*

#### *Diagnostic services*

- Radiographic examination and complete intra-oral film series, according to the frequency specified in the *Benefits Summary*
- Periapical films, according to the frequency specified in the *Benefits Summary*
- Occlusal films
- Posterior bitewing films, according to the frequency specified in the *Benefits Summary*
- Extra-oral films
- Panoramic films, according to the frequency specified in the *Benefits Summary*
- Cephalometric films
- Tracing and interpretation of radiographs from another source

### *Preventive services*

- Polishing, according to the frequency specified in the *Benefits Summary*
- Fluoride treatment, according to the frequency specified in the *Benefits Summary*
- Oral hygiene instruction, according to the frequency specified in the *Benefits Summary*
- Interproximal discing of teeth
- Finishing restorations
- Pit and fissure sealants, according to the frequency specified in the *Benefits Summary*
- Space maintainers, according to the frequency specified in the *Benefits Summary*
- Prophylactic odontotomy/enameloplasty

### *Restorative services*

- Non-bonded amalgam restorations for primary teeth, permanent anterior and bicuspid teeth, permanent molar teeth
- Caries/trauma/pain control
- Pin reinforcement
- Acrylic or composite restorations, according to the frequency specified in the *Benefits Summary*
- Prefabricated post and core
- Stainless steel/plastic full coverage restorations for primary teeth
- Preformed stainless steel and polycarbonate crowns, according to the frequency specified in the *Benefits Summary*

### *Endodontic services*

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

### *Periodontal services*

- Periodontal scaling and root planing
- Gingivectomy
- Flap approach with osteoplasty/osteotomy
- Flap approach with curettage, according to the frequency specified in the *Benefits Summary*
- Distal wedge procedure
- Osseous grafts
- Soft tissue grafts (free connective tissue grafts)
- Vestibuloplasty (oral manifestations / oral mucosal disorders)
- Post-surgical treatment

### *Adjunctive periodontal services*

- Provisional splinting – intra-coronal, extra-coronal per unit of time
- Occlusal equilibration, according to the frequency specified in the *Benefits Summary*
- Special periodontal appliances, including occlusal guards and bruxism appliances, according to the frequency specified in the *Benefits Summary*
- Maintenance, adjustments and repairs to periodontal appliances, according to the frequency specified in the *Benefits Summary*

### *Surgical services*

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

### *Anaesthesia*

- In relation to covered procedures, according to the frequency specified in the *Benefits Summary*

### *Professional visits*

- Periodontal services post-operative visits, according to the frequency specified in the *Benefits Summary*

### *Adjunctive general services*

- Drugs (injections)

### *Repairs and rebasing*

- Denture adjustments including minor adjustments, according to the frequency specified in the *Benefits Summary*
- Denture repairs and additions
- Denture re-basing and/or re-lining
- Denture, tissue conditioning
- Resetting of teeth

# Major Services

### *Major restorative treatment*

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

- Replacement is necessitated by the extraction of additional natural teeth
- The existing prosthesis cannot be made serviceable and is in accordance with the frequency specified in the *Benefits Summary*
- The existing prosthesis is temporary and is replaced with a permanent one within 12 months

### *Prior extraction clause*

Prosthodontic services for a fixed or removable prosthesis are covered when they are required to replace a natural tooth or teeth extracted after the effective date of coverage and the appliance is installed after the person has been covered for a minimum of one year.

### *Dental implants*

Note: Dental implants and related services are covered, however, the alternate benefit provision will apply.

### *Crowns, inlays and onlays*

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

### *Other restorative services*

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

### *Prosthodontic services, fixed*

- Fixed prosthetic evaluation for cases of extensive or complicated restorative dentistry

### *Prosthodontic services, removable*

- Complete dentures
- Partial dentures
- Denture remakes
- Immediate complete or partial dentures
- Transitional complete or partial dentures

Transitional complete and partial dentures: An existing transitional prosthesis must be replaced with a permanent one within 12 months.

### *Pontics*

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

### *Retainers, crowns*

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

## Orthodontic Services

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. 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, and not on the amount or date of the payment, even if treatment is prepaid. The maximum reimbursement for the initial orthodontic payment is 35% of the total cost of the orthodontic treatment.

- Services for diagnostic purposes
- Preventive orthodontic treatment
- Comprehensive orthodontic treatment
- Appliances to control harmful oral habits

## Expenses Not Covered

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

# How to Claim Benefits

## Life Insurance Claim

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

Claims should be submitted as soon as possible, but no later than 3 months after the end of the benefit payment waiting period or 3 months after the plan terminates, whichever is earlier.

## Accidental Death and Dismemberment (AD&D) Insurance Claim

You must notify OTTAWA POLICE ASSOCIATION of your claim, either in writing or verbally, as soon as you suffer the Injury on which the claim is based, as such notice must be given in writing to the Insurer within thirty (30) days after the date of the Accident resulting in such Injury. In the event that you are unable to give such notice, your beneficiary or beneficiaries or the person entitled to an indemnity under your coverage, may notify OTTAWA POLICE ASSOCIATION on your behalf.

The Insurer, upon receipt of the above-mentioned notice, will send claim forms to OTTAWA POLICE ASSOCIATION. These claim forms constitute the written proof of loss and must be completed and returned to the Insurer within ninety (90) days after the date of Accident resulting in such loss.

Failure to give such notice within the time provided in the Policy will not invalidate any claim if it is shown not to have been reasonably possible to give such notice during such time and that such notice was given as soon as was reasonably possible, but in no event later than one (1) year after the date of the Accident.

**Claim Forms**
The Insurer, upon receipt of such notice, agrees to furnish to the claimant such forms as are usually furnished by it for filing proof of loss. If such forms are not so furnished within fifteen (15) days after the Insurer's receipt of such notice, the claimant will be deemed to have complied with the requirements of the Policy as to proof of such loss upon submitting, within the time fixed in the Policy for filing proofs of loss, written proof covering the occurrence, character and extent of the loss for which claim is made.

For more information, contact the Ottawa Police Association at 613-232-9434, or Coughlin & Associates Ltd. at 613-231-2266.

## Long-Term Disability Insurance Claim

In the event of a disability claim, immediately contact your employer who will provide the necessary information.

To submit claims online, go to www.greatwestlife.com.

To submit paper claims, obtain a Member Claim Submission Guide (form M4307B) and follow the guide's instructions.

You can get this form from your Association, or online from the Great West Life corporate website. To access the form online, go to www.greatwestlife.com.

Please ensure that your claim is submitted to Canada Life as soon as possible, but no later than 6 months after the end of the waiting period.

## Critical Illness Insurance Claim

In the event of a claim, immediately contact the Ottawa Police Association who will provide the necessary information.

Claims should be submitted as soon as possible, but no later than 3 months after the end of the benefit payment waiting period or 3 months after the plan terminates, whichever is earlier.

## Out-of-Province/Canada Medical Emergency Insurance Claim

In the event of a claim, immediately contact your carrier who will provide the necessary information.

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

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

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

## Extended Health Care and Dental Care Claims

To be eligible for reimbursement, Coughlin & Associates Ltd. must receive proof of claim within 12 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

1. 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.

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

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

## Pre-Authorized Deposit (PAD)

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

To enrol in the PAD program:

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

## Point-of-Service Claims Submission

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

**Pharmacy:**
BIN/Carrier ID #34
Group Number # 61176
Certificate number – printed on your card

**Dental:**
BIN/Carrier ID #000034
Group Number # 61176
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 from the primary insurer, along with photocopies of the original receipts.

Claim forms may be obtained on the Coughlin & Associates Ltd. website at www.coughlin.ca.

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

## Dental Care Claims

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

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

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

When your dental care claim is submitted electronically, it will be processed within two to four business days.

## Claims Appeals Process

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

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

## Contact Us

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

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

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

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

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

# APPENDIX A –

## Out-of-Province/Canada Medical Emergency Insurance

UNDERWRITTEN BY **AIG Insurance Company of Canada**

Contact Coughlin & Associates Ltd., your benefits administrator for any and all questions related to this benefit.

# EMERGENCY OUT OF PROVINCE MEDICAL

For all in benefit Members of

**Ottawa Police Association**

Professional Police

OTTAWA POLICE ASSOCIATION

Protecting People

POLICY NUMBER
CMG 9429228

February 2023

## 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 Police Association and their eligible dependents whose names are on file with the Policyholder and as shown below are insured under this Plan.

Class I: All eligible Members under age 70.
Class II: All eligible retired Members under age 80.
Class III: All eligible active Members ages 70 to 79.

## 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 180 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:**

Under age 70 - $5,000,000.00 lifetime maximum
Ages 70 to 79 - $2,000,000.00 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 9429228.

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 9429228**

**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 9429228**

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