Professional Police

OTTAWA POLICE ASSOCIATION

Protecting People

Group benefits plan

*retired members and survivors of members



*For police officers who retired ***before*** September 21, 2001 and
for civilian members who retired ***before*** May 30, 2002

Effective date: October 1, 2023
Publication date: September 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 booklet outlines the specific terms of your group benefits plan as well as the coverage levels of each benefit. Be sure to keep this booklet in a safe place for future reference.

The underwriters and administrators of these benefits are as follows:

- your group life insurance is underwritten by the **Canada Life Assurance Company**;
- your group health and dental coverage is sponsored and administered on a self-insured basis by the **Ottawa Police Association**, the plan administrator;
- the adjudication and processing of all your group health and dental claims is handled by **Coughlin & Associates Ltd.**, the claims administrator; and
- your out-of-province/Canada group travel medical emergency insurance is underwritten by **Global Excel** and administered by **AIG Insurance Company of Canada.**

Please note

Before having any dental treatment that will cost over $200, you should obtain a *Pre-determination of dental benefit estimate*. With a pre-determination estimate, both you and your dentist know how much of the proposed treatment will be paid by the OPA and how much of it is your own responsibility. For details on the *Pre-determination of dental benefit estimate,* see page 54 of this booklet.

This booklet summarizes the benefits and provisions of your group plan. It does not constitute the group contracts, nor does it create or confer any contractual or other rights. Every effort has been made to ensure that the information is accurate. However, if there is any question of interpretation, all rights will be governed solely by the group contracts issued or administered by the plan administrator and/or the respective insurance companies of the Ottawa Police Association (OPA).

If you have any questions about your group benefits that are not covered in this booklet, contact Coughlin & Associates Ltd. at: 613-231-2266, fax 613-231-2345 or e-mail at info@coughlin.ca. Or, call the Ottawa Police Association at 613-232-9434.

The provisions of this book are effective May 1, 2015.

Respecting your privacy

Your personal information will be kept on file by Coughlin & Associates Ltd. Only employees or authorized agents responsible for the administration of your benefit plan will have access to it. You have the right to access or update any incorrect information by submitting a request in writing to:

Privacy Officer
Coughlin & Associates Ltd.
Box 3517, Station C
Ottawa, ON K1Y 4H5

Change of address

This booklet has been sent to every member for whom a current address is available. It is important to inform the claims administrator of any address changes and any dependant changes.

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1. Benefits summary

INSURANCE BENEFITS FOR RETIREES

Basic group life insurance

Amount: $20,000.

Optional group life insurance

Available in units of $10,000 to a maximum of $200,000.

Optional spousal life insurance

Available in units of $10,000 to a maximum of $200,000. (Some restrictions apply.)

HEALTH AND DENTAL BENEFITS FOR RETIREES, SURVIVORS AND DEPENDANTS

Extended health care benefit for retirees and survivors

Reimbursement level: 90 per cent of all eligible expenses, except specified paramedical services that are reimbursed at 100 per cent.

Maximum benefit: Some benefits are subject to yearly or lifetime maximums. The plan has a lifetime maximum of $125,000 for all major medical expenses. An additional $1,000 per year is allowed once the lifetime maximum has been attained.

Deductible*: $25 individual.

$50 family.

Prescription drugs

Reimbursement level: 100 per cent of eligible expenses if drugs are purchased through the Coughlin & Associates Ltd. Preferred Provider Network (the maximum

dispensing fee charged by Preferred Provider Network pharmacies is limited to the Ontario Drug Benefit plan maximum); 90 per cent if prescription drugs are purchased through any other source.

Calendar year* deductible:	Subject to the extended health care deductible. **Note:** The Ontario Drug Benefit Plan deductible and co-payment are not eligible for reimbursement.

**Applies to January 1 to December 31.*

Vision care

Maximum benefit: $150 per individual every two calendar years.

Deductible: Nil.

Out-of-province/Canada medical emergency insurance

Coverage period: 180 consecutive days. The maximum per insured person under age 70 is $5 million lifetime maximum and ages 70 to 79 is $2 million lifetime maximum.

Termination of coverage: On the date you reach age 80.

For detailed information on coverage, see the section entitled *Out-of-province/ Canada medical emergency insurance* (Appendix A).

Dental care coverage

Reimbursement amount:

Basic services:	100 per cent.
Major services:	80 per cent.
Orthodontic services:	50 per cent.
Accidental dental:	100 per cent.

Maximum benefit: A combined $1,500 per person per calendar year for all services except accidental dental. No limit is applied to accidental dental coverage.

Calendar year deductible:

- for dental accident coverage: None
- for all other expenses:
  - -individual $25
  - -family $50

Fee guide: Current year's fee guide for general practitioners for the province in which the dental service is rendered.

2. General information

ELIGIBILITY

You, and your eligible dependents, are eligible for benefits, provided you are a retired member in good standing of the Ottawa Police Association or a survivor of a deceased member and have made contributions to the benefits program. To qualify, you must be entitled to pension benefits and have been insured under this benefits plan on the day you retired or became a survivor.

To be eligible for coverage under this program, you must:

- be an insurable member or a survivor of an insured member;
- be in an eligible class;
- satisfy the eligibility conditions; and
- satisfy the effective date of insurance provisions.

You must apply for coverage no later than 31 days after you are eligible to participate.

Changes in insurance benefits

When a change in coverage occurs, your new benefits will become effective on the date of the change.

If health care benefits increase while either you or your dependant are confined in a hospital, the new benefits will become effective on the date of release from the hospital.

Payments for services or supplies received before the date of the increase in benefits will be based on the plan benefits in effect prior to the change.

Calendar year

The benefit year covers the period from January 1 to December 31.

Definition of dependant

Your group benefit plan also provides coverage for a retiree's spouse and a retiree's or survivor's dependants.

By **spouse**, we mean:

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

By **dependant**, we mean:

- an unmarried natural or adopted child under the age of 21 years who is not employed on a regular full-time basis for more than 30 hours per week, unless he/she is a full-time student;
- an unmarried child aged 21 to 25 attending an accredited educational institution on a full-time basis; or
- an unmarried child over the age of 21 who is dependent on you by reason of mental or physical disability, provided he/she has been disabled since before age 21. An unmarried and unemployed dependant child who becomes disabled while attending an accredited educational institution on a full-time basis can also be covered as a dependant.

Termination of coverage

Your coverage will terminate on the earliest of the following dates:

- the date this benefit program terminates;
- the date you cease to be in an eligible class;
- the date you cease to be an insurable member; or
- the due date of the first premium to which you have not made the required contribution.

Dependant coverage terminates on the earliest of the following dates:

- the date your coverage terminates;
- the date you cease to be in a class eligible for dependant coverage;
- the date he/she no longer qualifies as an insurable dependant; or
- the date any required spousal contributions are no longer made.

Coverage for survivors after a member's death

If you die while your dependants are insured under this benefit, the extended health care and dental care benefits will continue for your dependants, with premium payment, until the earliest of:

- the date your dependant no longer meets the dependant definition; or
- the date the group policy terminates.

Co-ordination of benefits

If you or your dependants are also covered under another pre-paid health insurance program or contract, the payment of your benefits will be co-ordinated so that the total benefit you will receive will not exceed 100 per cent of allowable expenses.

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

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 co-ordinated with those under this agreement so that priority will be given to the plan under which the person is eligible to receive benefits as follows:
    - other than as a dependant;
    - as a dependant child of the parent with the earlier month and day of birth in the calendar year;
    - as a dependant child of the parent whose first name begins with the earlier letter in the alphabet, if both parents have the same birthday.

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

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

In cases of separation or divorce:

- the plan of the parent with custody of the child;
- the plan of the spouse of the parent with custody of the child;

- the plan of the parent not having custody of the child;
- the plan of the spouse of the parent not having custody of the child.

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.

3. Group life insurance benefits (underwritten by Canada Life)

1. BASIC LIFE INSURANCE BENEFITS FOR RETIREES

If you die while insured, your beneficiary will receive the amount of your group life insurance proceeds outlined in the *Benefit summary*.

If any or all of your life insurance coverage terminates, you may apply to convert your coverage to an individual policy, provided you apply within 31 days after the termination of the insurance. During this 31-day period, your life insurance plan will remain in force free of charge.

2. OPTIONAL LIFE INSURANCE COVERAGE FOR RETIREES AND RETIREES' SPOUSES

A retiree and his or her spouse may each purchase up to $200,000 of additional life insurance in multiples of $10,000.

Evidence of insurability is required.

If you die while insured, the amount will be paid to the person you name as beneficiary. If your spouse dies, the amount will be paid directly to you.

If you become disabled, you may continue your life insurance protection by paying premiums directly to Canada Life until age 65, at which time, you may be eligible to convert your coverage to an individual insurance policy from Canada Life.

If either you or your spouse dies by suicide within two years of the effective date of the policy, coverage will be limited to the amount of premiums paid during that time.

Your optional life insurance coverage terminates when you attain age 65. Your spouse's coverage terminates on the earlier of your 65th birthday, or when he/she

reaches age 65. You may apply to convert your coverage to an individual policy, provided you apply within 31 days after the termination of the insurance.

Application forms are available from the Ottawa Police Association or Coughlin & Associates Ltd.

Conversion

If you or your dependant leave the group, your life insurance coverage can be converted to an individual plan, provided you do so within 31 days of termination.

4. Extended health care
(claims administered by Coughlin & Associates Ltd.)

Extended health care benefits can help you and your family meet some of the costs of medical expenses not covered by your provincial health care plan. You will be reimbursed all reasonable and customary expenses, subject to the maximums and limitations outlined in this chapter and in the chapter entitled *Benefits summary*, provided treatment is recommended by a licensed attending physician or dentist.

Reimbursement for services provided outside Ontario will be made in Canadian funds. The plan will not pay an amount that is greater than it would normally pay for charges when they are incurred outside your province of residence.

APPLIANCES AND MEDICAL EXPENSES ON THE WRITTEN PRESCRIPTION OF A PHYSICIAN

1. Ambulance services

Ambulance services, including air ambulance services, are covered if they are provided by a licensed ambulance company.

Coverage is limited to $100 per trip for air ambulance and $45 per trip for ground ambulance.

Transportation must be to the nearest centre where essential treatment is available. If transportation is to a further centre, the claims administrator will allow alternative benefits based on coverage for transportation to the nearest centre where essential treatment is available.

2. Nursing home services

This benefits program covers the government-authorized co-payment for accommodation in a nursing home or clinic provided:

- confinement begins when the covered person is insured under this program;

- it represents acute, convalescent, or palliative care and does not include custodial care;
- it immediately follows three or more days of confinement in a hospital as a registered bed-patient; and
- confinement/care is recommended by a physician or surgeon.

The maximum amount payable is the lesser of the difference between the actual charges and benefits under the government hospital plan and $31.25 per day.

A nursing home/clinic is an institution that offers in-patient accommodation, has a staff of one or more physicians available at all times and continuously provides 24-hour medical care by or under the supervision of professional nurses. Facilities established primarily as residences for senior citizens or which provide personal rather than medical care are not included.

3. Home health agency services

The program covers the costs of visiting nursing services from a home health agency on a part-time basis provided:

- visits are made by a qualified graduate nurse;
- services are for members who are ill at home and not in a hospital;
- services are for members, not dependants;
- you have an acute illness. (Nursing service is not provided indefinitely. In cases of long, continued illness, the nurse will make sufficient visits to teach a member of your family how to provide the necessary care); and
- the nurse does not give massage treatments, anaesthetics or assist at operations.

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

Your out-of-province/Canada group travel medical emergency insurance is underwritten by Global Excel and administered by AIG Insurance Company of Canada.

Out-of-province/Canada coverage is available for trip durations of 30 consecutive days or less. Members should make their own insurance arrangements for trips lasting longer than 30 days.

Coverage terminates on the date you reach age 80.

Detailed information is outlined in the section entitled *Out-of-province/Canada medical emergency insurance* (Appendix A).

5. Prescription drugs

The plan will cover the cost of the following drugs to the maximums specified in the *Benefits summary*, when prescribed by a licensed physician and are dispensed by a licensed pharmacist:

- oral contraceptives, as well as the Norplant® implant. (The Norplant® implant is eligible once every five years, other prescribed contraceptives are not eligible during the first 36 months from insertion);
- drugs that must be injected and syringes for self-administered injections of covered drugs (Synvisc® is an eligible item).
- anti-convulsants;
- glaucoma therapy drugs;
- anti-anginal agents, anti-arrhythmic agents, cardiotonics, vasodilators, vasopressors, potassium replacements;
- bronchodilators, mucolytics, parasympathomimetics, tuberculosis therapy drugs;
- anti-parkinsonians, anticholinergic/antispasmodic agents;

- hyperthyroidism drugs;
- smoking cessation products to a lifetime maximum of $300 per person;
- compound mixtures when at least one ingredient is a prescription-requiring medication and eligible under the plan; and
- drugs used in the treatment of infertility to a lifetime maximum of 12 treatment cycles.

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

Coverage for drugs covered under any government drug plan are limited to the amount you may be required to pay for yourself or your family. The Ontario Drug Benefit (ODB) deductible and co-payment fee for patients over age 65 are not eligible.

Benefits not covered

1. Any drug that does not have a drug identification number as defined by the Food and Drugs Act, Canada.
2. Proprietary or patent medicines registered under the Food and Drugs Act, Canada;
3. Homeopathic preparations, dietary supplements, therapeutic nutrients, infant foods (formula) and sugar or salt substitutes, unless federal or provincial legislation requires a prescription for their sale.
4. Vaccines used to prevent disease.
5. Erectile dysfunction drugs taken orally (e.g. Viagra®, Cialis®, Levitra®.)
6. Drugs that are used for cosmetic purposes.
7. Expenses for drugs that are used for a condition not recommended by the manufacturer.

Prescription Drug Card

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

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

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

6. Medical supplies

The plan will pay for the rental, or at the claims administrator's discretion, the purchase, of the following medical supplies and equipment when prescribed by a licensed physician. The prescription must include the medical diagnosis and the duration of treatment:

1. **Breathing equipment** including:

    - oxygen and the equipment needed for its administration;
    - intermittent positive pressure breathing machines;
    - continuous positive airway pressure machines;
    - apnea monitors for respiratory dysrhythmias;
    - mist tents and nebulizers;
    - chest percussors, drainage boards, and sputum stands;
    - suction pumps; and
    - tracheostoma tubes.

2. **Orthopedic equipment** including:

    - braces (excluding orthodontic braces) when constructed of rigid or semi-rigid material, required for normal activities of daily living (not solely for sports-related activities) and cervical collars,
    - custom-fitted orthopedic shoes, including modifications to orthopedic footwear, to a maximum of $150 per calendar year on the written prescription of a physician, indicating the diagnosis;
    - custom-made foot orthotics to a maximum of $300 per member per calendar year on the written prescription of a physician, indicating the diagnosis;
    - casts;
    - splints, including shoes attached to a splint (intra-oral splints are not covered); and
    - non-union bone stimulators.

3. **Prosthetic equipment** including:

    - artificial eyes, including rebuilding and polishing of artificial eyes;
    - standard artificial limbs, including repairs, stump socks and shoulder harnesses;
    - cleft palate obturators;
    - external breast prosthesis; and
    - surgical brassieres, two every 12 consecutive months.

4. **Mobility aids** including canes, walkers, crutches, parapodiums, wheelchairs and their repair and rechargeable batteries for wheelchairs. Special wheelchair features required primarily for participation in sports are not covered.

5. **One hearing aid per ear** every 36 consecutive months to a maximum of $500 per ear, including batteries, tubing and ear moulds, if provided at the time of purchase, when prescribed by an ear, nose and throat specialist. Hearing tests are not eligible.

6. Diabetic supplies including:

- insulin and insulin syringes;
- Novolin pens, or similar insulin injection devices using a needle;
- test strips;
- bloodletting devices, including platforms and lancets;
- Glucometer or reflectance meter, (includes Freestyle Libre flash monitoring system and associated sensors) to a lifetime maximum of $350 per person;
- insulin infusion sets, not including infusion pumps;
- Continuous Glucose monitoring system (receiver, transmitter and associated sensors) reasonable and customary charges for Type 1 diabetics.

7. Other medical supplies including:

- hospital beds, bed rails, trapeze bars, head halters, and traction apparatus (air-fluidized and electric hospital beds are not covered);
- colostomy and ileostomy supplies after the provincial government grant has been exhausted, if applicable;
- catheters and catheterization supplies;
- rental of transcutaneous nerve stimulators for the control of chronic pain (nerve stimulation, not muscle stimulation), up to a maximum period of six months;
- custom-made pressure supports for lymphedema;
- custom-made graduated compression hose, to a maximum of four pairs in a calendar year on the written prescription of a physician indicating the diagnosis;
- custom-made burn garments;
- wigs for cancer patients undergoing chemotherapy to a lifetime maximum of $200 per person;

- surgically implanted intraocular lenses; and
- trusses.

7. Paramedical services (reimbursed at 100 per cent, unless specified)

Services of the following licensed certified or registered (in the province when treatment is given) paramedical practitioners up to reasonable and customary fees per visit when operating within their recognized fields of expertise to the levels specified. All receipts must clearly indicate the names of those attending the sessions. Reimbursement is based on the dates the services were rendered. If you choose to enter into a block payment or annual payment plan for services, reimbursement will be made at the end of the contract period, upon submission of all receipts and a copy of the contract.

1. **Chiropractor** to a maximum $500 per insured per calendar year and 90 per cent of the cost of X-rays to a maximum of $50.
2. **Massage therapist** to a maximum $500 per retired member per calendar year.
3. **Naturopath** to a maximum $500 per retired member per calendar year and 90 per cent of the cost of X-rays to a maximum of $50.
4. **Physiotherapist or a certified athletic therapist**, to a maximum $500 per retired member per calendar year.
5. **Psychologist** to a maximum $500 per retired member per calendar year.
6. **Speech therapist** to a maximum $500 per retired member per calendar year.
7. **Osteopath**, when referred by a physician, to a maximum of $500 per retired member per calendar year.
8. **Home nursing care (reimbursed at 90 per cent)** payable from the beginning of the first day of care for a licensed practical nurse and registered nursing assistant. No maximum is applied for benefits provided by a registered nurse. Coverage is limited to the minimum number of hours and level of skill needed to provide each essential nursing service.

All paramedical services rendered by a family member related by blood or marriage are not eligible.

Services must be approved in advanced by the plan administrator. To apply for a pre-care assessment, contact the claims administrator for a *Request for Nursing Care* form and ask the attending physician to complete it. This benefit does not cover chronic care.

8. Vision care

The plan covers the cost of eye examinations, including refraction, to a maximum of $12.50 every two calendar years, provided they are performed by a licensed ophthalmologist or optometrist and coverage is not available under the insured person's provincial government plan. Eye exams are reimbursed based on the date of the eye exam. Fees that are in addition to the standard eye exam are not eligible for reimbursement.

It also covers the cost of glasses and contact lenses when prescribed by licensed ophthalmologist, optometrist, or optician to a maximum $150 every two calendar years. Reimbursement of eligible eye wear is based on the date when items are paid in full.

Plus, it will pay an additional benefit of $200 every four calendar years (less any payments for glasses and contact lenses during that period) for contact lenses when they are prescribed for severe corneal astigmatism, severe corneal scarring, keratoconus, or aphakia and vision in the better eye cannot be corrected to the 20/40 level by glasses.

Visual training and remedial therapy performed by a licensed ophthalmologist or optometrist are covered when such services are not covered in whole or in part by the person's provincial government plan.

The vision care plan also covers the cost of lenses and frames prescribed by a licensed ophthalmologist for treatment of strabismus or hyperopia, for dependant children under age 11.

It will cover a portion of the cost of laser eye surgery in lieu of lenses, frames or contact lenses, to the plan maximum per two year period. At two year intervals, the plan administrator may consider reimbursing the remaining balance in the same fashion upon receipt of a claim submission.

No benefits will be paid for services and supplies required as a condition of employment.

Expenses NOT covered

1. Expenses for which benefits are payable under the Workplace Safety & Insurance Board Act or legislation or by any government agency.

2. Expenses that private insurers are not permitted to cover by law.

3. Services or supplies the insured person is entitled to without charge by law or for which a charge is made only because the person has insurance coverage.

4. The portion of the expense for services or supplies payable by the government health plan in the person's home province, whether or not the person is actually covered by that plan.

5. Expenses for services or supplies rendered or prescribed by a person who is ordinarily a resident in the covered person's home or who is related to him/her by blood or marriage.

6. Services or supplies that do not represent reasonable treatment.

7. Services or supplies for:

    - cosmetic treatment;

    - recreation or sports;

    - the diagnosis or treatment of infertility, except as may be provided under the prescription drug provision; or

    - contraception, other than oral contraceptives.

8. Services or supplies associated with covered items, unless specifically listed as a covered expense.

9. Extra medical supplies that function as spares or alternatives;

10. Services or supplies received outside Canada except as provided under the out-of-country care provision.

11. Services or supplies received out-of-province in Canada, unless:
    - the person is covered by the government health plan in his/her home province; and
    - the claims administrator would have paid benefits for the same services or supplies if they had been received in the person's home province.
12. Expenses arising from war, insurrection, or voluntary participation in a riot.
13. Sunglasses and safety glasses.
14. Cryocuffs.
15. Breast pump.

5. Dental care coverage

Your dental care benefits are designed to help you meet the costs of certain dental expenses incurred by you and/or the insured members of your family.

Any dental treatment received must be recommended and performed by a qualified dentist or denturist.

Fee guide

Your reimbursement for covered dental expenses will be based on the current year's fee schedule for general practitioners for the province in which the dental service was rendered.

1. Basic coverage

The plan pays 100 per cent of the following eligible expenses:

Diagnostic services

- one oral examination every nine months (these include complete oral examination, oral pathology, periodontal, surgical, prosthodontic, endodontic and orthodontic examinations, limited oral examinations);
- specific and emergency examinations;
- consultations required by the attending dentist;
- complete series of intra-oral radiographs, once every 24 months;
- intra-oral radiographs (excluding bitewing radiographs);
- intra-oral bitewing radiographs, once every nine months;
- sialography;
- panoramic radiographs, once every 24 months;

- diagnostic X-ray in relation to dental surgery;
- cephalometric radiographs;
- hand and wrist radiographs;
- radiopaque dyes used to demonstrate lesions;
- interpretation of radiographs or models from another source;
- microbiological, histological, cytological, and pulp vitality tests; and
- laboratory reports.

No benefits will be paid for duplicate radiographs under this provision.

Preventive services

- up to one unit of polishing once every nine months;
- scaling;
- topical application of fluoride, once every nine months;
- pit and fissure sealants on bicuspids and permanent molars, once every five years;
- space maintainers for primary teeth only; (Acid etched pontic type space maintainers are covered only when provided for missing central and lateral teeth);
- maintenance of space maintainers;
- appliances for the control of harmful habits, including related observations, adjustments, repairs, alterations, and removal; and
- finishing restorations.

No benefits will be paid for:

- custom fluoride appliances;
- oral hygiene instruction and plaque control; and/or
- nutritional counselling.

Minor restorative services

- caries, trauma, and pain control;
- non-bonded amalgam and tooth-coloured fillings;
- retentive pins and prefabricated posts for fillings; and
- prefabricated metal crowns.

Endodontic services

- treatment of the pulp chamber;
- root canal therapy;
- apexification; and
- periapical services.

Periodontal services

Covered periodontal services include but are not limited to:

- root planing;
- periodontal surgery;
- occlusal adjustment and equilibration; and
- periodontal appliances, including adjustments, re-lines, and repairs.

No benefits will be paid for:

- topical application of anti-microbial agents; and
- subgingival periodontal irrigation.

Denture maintenance

- denture re-lines for dentures, once every five years;
- denture re-bases for dentures, once every five years;
- resilient liner in re-lined or re-based dentures, once every five years; and
- tissue conditioning following the three-month post insertion care.

Covered oral surgery includes but is not limited to:

- removal of teeth;
- surgical exposure of teeth;
- the following procedures for re-modelling and re-contouring oral tissues:
    - minor alveoloplasty; and
    - gingivoplasty and stomatoplasty;
- surgical incisions;
- surgical excision of tumors, cysts, and granulomas;
- treatment of fractures, including related bone grafts to the jaw; and
- treatment of maxillofacial deformities, including related bone grafts to the jaw and cheiloplasty.

Palatal obturators are also covered under this provision. Cleft palate obturators are not covered.

No benefits will be paid for:

- surgical movement of teeth (this service is covered under *Orthodontic coverage).*

Adjunctive services

- minor remedies for relief of dental pain when provided on an emergency basis;
- therapeutic injections; and,
- anaesthesia required in relation to covered services. The provision of general anaesthetic facilities, equipment, and supplies is covered only when a separate anaesthetist is required.

No benefits will be paid for:

- hypnosis or acupuncture;
- charges made by a dentist for broken appointments; and
- charges made by a dentist for completion of claim forms.

2. Major coverage

Your dental plan will pay 80 per cent of eligible expenses for the following services.

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

Crowns, inlays, onlays and veneers

Crowns, inlays, onlays and veneers are covered when a tooth has extensive structural loss that cannot be adequately restored using other procedures. The following items are covered:

- metal, plastic, porcelain, gold and ceramic crowns (coverage for crowns on molars is limited to the cost of metal crowns. The cost of complicated crowns is limited to the cost of standard crowns);

- onlays (coverage for tooth-coloured onlays on molars is limited to the cost of metal onlays);
- inlay (coverage for tooth-coloured inlays on molars is limited to the cost of metal inlays);
- veneers;
- posts, cores, and pins related to covered crowns;
- copings related to covered crowns;
- repairs to covered tooth-coloured materials; and
- removal and re-cementation of crowns, inlays and onlays.

No benefits will be paid for:

- recontouring existing crowns; and
- staining porcelain.

Dentures and bridgework

The following appliances are covered when they are required to replace one or more teeth necessarily extracted after the effective date of coverage and the appliance is installed after the person has been covered for a minimum of one year:

- standard complete dentures;
- standard cast or acrylic partial dentures; and
- complete overdentures or bridgework when standard complete or partial dentures are not viable treatment options. (Coverage for tooth-coloured retainers and pontics on molars is limited to the cost of metal retainers and pontics).

Replacement appliances are also covered when the existing appliance is at least five years old and cannot be made serviceable.

No benefits will be paid for dentures that have been lost, mislaid or stolen.

Appliance maintenance

Denture repairs, additions and resetting of denture teeth are covered.

Alternate benefit provision

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

The alternate benefits provision cannot be applied to excluded expenses.

3. Orthodontic coverage

The plan will pay 50 per cent of the cost of orthodontics for both children and adults. Children must be six years or older when treatment starts.

Diagnostic services

The following diagnostic services are covered:

- diagnostic photographs; and
- orthodontic diagnostic casts.

Fixed and removable appliances for orthodontic treatment are covered. This includes related charges for observations, adjustments, repairs, alterations, removal and retention. Surgical movement of teeth is also covered.

No benefits will be paid for expenses covered under another group plan's extension of benefits.

Reimbursement for the initial orthodontic fee must not exceed 35 per cent of the total treatment plan. The balance of the orthodontic fees will be eligible for reimbursement on a monthly basis for the duration of the active treatment, outlined

in the orthodontic treatment plan. Reimbursement of the monthly fees will be based on the amount or date of payment, if different from the treatment plan.

4. Dental accident coverage

Your dental plan will cover 100 per cent of the costs of treatment of accidental injury to sound, natural teeth. (A sound tooth is any tooth that did not require restorative treatment immediately before the accident. A natural tooth is any tooth that has not been artificially replaced.)

Treatment resulting from accidental injury that does not qualify under this provision and which is rendered within 24 months of the accident will be considered under the other dental coverage provisions on the same basis as treatment of dental defect or disease.

Coverage for diagnostic, restorative, preventive, endodontic, periodontal, surgical, and adjunctive services under this provision is based on basic coverage provisions while crowns, pontics, initial dentures, onlays, and bridgework will be based on major coverage provisions.

No benefits will be paid for:

- treatment performed more than six months after the accident;
- denture repair or replacement;
- orthodontic diagnostic services; and/or
- orthodontic treatment.

The accidental dental benefit has no coverage maximum or deductible.

Pre-determination of dental benefit

If you are facing a dental treatment that will cost $300 or more, you should receive an estimate of how much your dental plan will cover before treatment begins. Ask your dentist to submit a detailed treatment plan, which includes the procedure codes, anticipated dates of treatment and the proposed charges. Then, submit it to the claims administrator for review.

The claims administrator will let you know how much will be reimbursed.

If you change dentists during the course of treatment, a new treatment plan will have to be submitted for review.

Expenses NOT covered

1. Expenses that private insurers are not permitted to cover by law.
2. Services or supplies the insured person is entitled to without charge by law or for which a charge is made only because the person has insurance coverage.
3. Services or supplies that do not represent reasonable treatment.
4. Services or supplies associated with:
    - treatment performed for cosmetic purposes only;
    - congenital defects or developmental malformations, which is not a Class I, II, and III malocclusion;
    - temporomandibular joint disorders; and/or
    - vertical dimension correction.
5. Expenses arising from war, insurrection or voluntary participation in a riot.
6. Services or supplies covered under the *Extended health care* benefit, unless the amount payable for the same expenses is greater under this benefits provision. If it is, benefits will be paid under this *Dental care* provision.
7. Dental treatment not yet approved by the Canadian Dental Association or which is clearly experimental in nature.
8. Expenses for services or supplies rendered or prescribed by a person who is ordinarily a resident in the covered person's home or who is related to the covered person by blood or marriage.

6. How to Claim Benefits

This group benefits plan is designed to protect you and your dependants against the sudden impact of financial losses resulting from death, health care and dental care expenses. When you have a claim, please obtain the necessary forms from the Ottawa Police Association or Coughlin & Associates Ltd., the claims administrator.

Life Insurance/Death claims

Keep this booklet in a safe place where you and your beneficiary may refer to it. In the event of a death, contact the Ottawa Police Association at 613-232-9434 to receive the necessary claim forms and information.

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 providers of the service (hospital, clinic, physician). To facilitate direct billing be sure to present your medical assistance card to the provider.

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

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

Reimbursement Details Regarding Extended Health Care and Dental Care Claims

To be eligible for reimbursement, Coughlin & Associates Ltd. must receive proof of claim within 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 is not payable on any reimbursement under this plan. All expenses incurred and paid by the participants will be deemed to have been incurred and paid in Canadian dollars and reimbursement shall be in Canadian dollars.

Reimbursement

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

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

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

Member Portal – Electronic Claims

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

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

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

Pre-Authorized Deposit (PAD)

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

To enrol in the PAD program:

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

Point-of-Service Claims Submission

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

Pharmacy:	**Dental:**
BIN/Carrier ID #34	BIN/Carrier ID #000034
Group Number # 61176	Group Number # 61176
Certificate number – printed on your card	Certificate number – printed on your card

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

Submitting Paper Claims

To submit claims by paper/mail, please complete the appropriate claim form and send it, along with any applicable receipts, to Coughlin & Associates Ltd. 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 claims

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

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

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

Claims Appeals Process

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

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

Contact Us

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

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

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

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

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

7. Policy numbers

Benefit: Life and LTD
Provider: Canada Life
Policy number: 42219 and 135035

Benefit: Out-of-country claims
Provider: Global Excel on behalf of AIG Insurance Company of Canada
Policy number: CMG 9429228

Benefit: All health and dental claims
Provider: OPA/Coughlin & Associates Ltd.
Policy number: 22014

Printed by members of:
CUPE·SCFP4000

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