Your Group Insurance Plan

LONG-TERM TEMPORARY EMPLOYEES (LTTE)

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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
Extended health care and dental care coverage	The Ottawa Police Association Administered by Coughlin & Associates Ltd.	**22014**
Out-of-province/Canada travel 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.

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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 temporary employees who work 35 hours a week and have completed twenty-four months of continuous full-time service provided the member is in good standing and has made contributions to the benefits program.

Summary of Benefits

1. Extended Health Care Benefits

Deductible:	Nil.
Reimbursement level:	100% of all 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). 100% of eligible expenses if medication is purchased at a Preferred Provider Network pharmacy.
• Eligible drugs:	Drugs, serums and injectables, only available by prescription with a valid drug identification number (DIN), when prescribed by a licensed health care practitioner 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.

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.
• 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.
− 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 charges 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.

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

3. 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 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 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.

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
    - treatments for weight loss, including drugs, proteins and food or dietary supplements
    - 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 surgical 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

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 Heath 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 date9s) 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 dates 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 one-screen instructions and provide your group and certificate numbers, both which can be found on your all-in-one benefits cards.

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 and Coughlin is the secondary payer, please include the original explanation of benefits from the primary insurer, along with photocopies of the original receipts.

Claim 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 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

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

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.