Your group insurance plan

Ottawa Catholic School Board

All eligible employees

Effective: September 1, 2009

To employees of the Ottawa Catholic School Board

We are pleased to provide you with this booklet outlining the employee benefits available to you and your family from the Ottawa Catholic School Board. In addition to providing an outline of the coverage and features of your employee benefit plans, this booklet also provides important information such as administrative and claims procedures.

Take time to read the booklet carefully and familiarize yourself with it. Please direct any questions you may have to the plan administrator:

COUGHLIN™
employee benefits specialists

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Ottawa, ON K1G 3R1

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Ottawa, ON K1Y 4H5

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The Ottawa Catholic School Board

Ottawa Catholic School Board

POLICY INFORMATION

Benefit	Insurer	Policy number
Life insurance and optional life insurance	Great-West Life Assurance Company	156381
Accidental death and dismemberment	RBC Insurance Co.	6101
Extended health care Dental care	Self-insured by the Ottawa Catholic School Board	9300 9400
Out-of-country travel	ETFS	28546107

When you have a claim, be sure to obtain the necessary forms from *First Clas*s in the *Benefits Conference,* or from Coughlin & Associates Ltd., the plan administrator. The *Benefits Conference* contains a link to Coughlin & Associates Ltd. where forms can be printed from its website. When they are completed and signed, forward them to Coughlin & Associates Ltd.

Samples of medical and dental claim forms appear at the back of the booklet.

It is only reasonable for you to expect prompt settlement of claims when they arise. Feel free to contact Coughlin for assistance or to ensure that that you have completed the form(s) correctly. For your assistance, a table of policy numbers has been included at the beginning of this booklet.

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

IMPORTANT

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

The Ottawa Catholic School Board, the plan sponsor, underwrites the extended health care and dental care benefits on a self-insured basis. All risks in respect to these benefits are borne by the Ottawa Catholic School Board.

As sponsor of the plan, the Ottawa Catholic School Board, or its trustees or designates, may establish rules or regulations for the administration or governance of the benefits plan and any transactions associated with it.

The Ottawa Catholic School Board, or its trustees or designates, have the right to interpret the plan and decide any and all matters related to it. This includes the right to clarify or remedy any possible uncertainties, omissions or inconsistencies based on applicable laws and the reasonable and customary charges and treatment for the medical, dental or vision coverage described in this booklet.

Reasonable and customary means that the treatment provided is accepted by the appropriate Canadian medical profession as being proven scientifically and effective medically and of a form, intensity, frequency and duration essential to the diagnosis and management of the disease or injury.

In respect to these benefits, no payment will be made for expenses that are related to services, treatments or supplies payable by or covered by a government plan.

The interpretations or decisions of the Ottawa Catholic School Board, its trustees or designates, will be final and binding on all parties.

PROTECTING YOUR PERSONAL INFORMATION

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

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1. Benefit summary

GROUP LIFE INSURANCE BENEFIT

When joining the plan, you may elect one of the following coverage levels:

Plan 1 2.5 times your basic annual salary; or

Plan 2 $5,000.

If there is a change in your status, (for example, marriage or birth/adoption of a child) you may change your coverage from one plan to the other, provided you do so within 31 days of the status change. Otherwise, evidence of insurability will be required.

Termination of coverage

Your coverage will end on the first day of the month coinciding with or following the termination of your employment, attainment of age 65, or retirement, if earlier.

OPTIONAL LIFE INSURANCE BENEFIT

You and/or your spouse may purchase optional life insurance in units of $10,000 to a maximum of $500,000.

Evidence of insurability is required.

Coverage terminates at age 65.

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE

Accidental death

Amount: Equal to your principal sum of your group life insurance benefit.

Accidental dismemberment

Amount: A portion or the entire principal sum, depending on the extent of the loss (See *Loss schedule* in the *Accidental death and dismemberment insurance* section.)

Termination of eligibility

Coverage ceases at the earlier of your termination, retirement or attainment of age 65.

EXTENDED HEALTH CARE

Deductible: Nil.

Co-insurance: 100 per cent of eligible expenses

Maximum benefit: Unlimited

Note: Some individual benefits are subject to yearly or lifetime maximums. Eligible drugs dispensing fees are limited to the Ontario Drug Benefit plan maximum (currently, $7 per prescription or refill.)

Coughlin & Associates Ltd., the plan administrator, offers a preferred provider network (PPN) of approximately 270 pharmacies across Ontario where prescription fees are limited to the Ontario Drug Benefit plan maximum. Simply present the drug card provided by Coughlin when you submit your prescription. The participating pharmacies are listed in the Board's *Benefits Conference*.

As well, the card may be used to pay eligible prescription drug expenses in any pharmacy in Canada.

Termination of coverage: Coverage terminates at the earlier of your termination or retirement.

HOSPITAL EXPENSES BENEFIT

In Canada

Basic accommodation at semi-private or private room rate for active treatment.

Maximum: Number of days unlimited.

Termination of coverage: Coverage terminates at the earlier of your termination or retirement.

VISION CARE BENEFIT

Deductible:	Nil
Co-insurance:	100 per cent of eligible expenses
Maximum benefit:	Eyeglasses, contact lenses, laser eye surgery to a maximum of $350 per 24-month period per insured.
Eye exams:	To a maximum of $90 per exam every two calendar years.
Termination of coverage:	Coverage terminates at the earlier of your termination or retirement.

OUT-OF-COUNTRY EMERGENCY MEDICAL INSURANCE

Emergency medical treatment and hospitalization for up to 60 days, to a maximum of $5 million.

Termination of coverage: Coverage terminates at the earlier of your termination, retirement or attainment of age 70.

DENTAL CARE BENEFIT

Eligible expenses based on the current general practitioners' dental association fee schedule in the province in which services are rendered.

Deductible:	Nil
Co-insurance:	Routine services: 100 per cent, calendar year maximum unlimited.
Dentures:	50 per cent to a maximum $2,000 per calendar year per insured.
Crowns and bridgework:	50 per cent to a maximum $2,000 per calendar year per insured.
Orthodontic services:	50 per cent to a maximum $2,500 per lifetime per insured.
Termination of coverage:	Coverage terminates at the earlier of your termination or retirement.

2. General information

PLAN EFFECTIVE DATE

The features described in this plan are effective September 1, 2009.

ELIGIBILITY

All permanent, full-time employees residing in Canada are eligible to participate in this plan immediately upon employment. Participation in the plan is mandatory, unless you have already arranged to have health and dental coverage through your spouse's employee benefits program.

EMPLOYEE COVERAGE

A person who satisfies the definition of employee as determined by the Ottawa Catholic School Board will be eligible for coverage.

DEPENDANT COVERAGE

An employee will be eligible for the dependant coverage on the date the following requirements are met:

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

ELIGIBLE DEPENDANTS

Dependants residing in Canada, including your spouse and/or any unmarried children (including adopted, foster and step-children) who are under 21 years of age, may be covered under this plan. Unmarried children who are full-time students and dependent on you for support may also be covered.

Mentally or physically handicapped children may remain covered past the maximum age when they are incapable of self-sustaining employment and completely are dependent on you for support and maintenance. This must be established prior to the child reaching age 21. (Supporting documentation completed by a physician will be required.)

NO MEDICAL EXAMINATION

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

EFFECTIVE DATE OF COVERAGE

All coverage is compulsory and becomes effective on the first day of the month you are hired.

You may elect not to be covered for extended health and/or dental benefits under this plan in order to be covered as a dependant under a comparable group benefits program. If that coverage ends because that group contract terminates or because you cease to be eligible, you may enrol in this plan without providing evidence of insurability, provided you apply within 31 days of the termination of that comparable coverage.

If you initially select employee-only coverage and later acquire a dependant, your dependant will be enrolled in the plan. Advise your employer within 31 days of the birth, marriage, or loss of coverage under your spouse's plan. Otherwise, evidence of insurability will be required. Once you have dependant coverage in force, all of your eligible dependants will be covered. There is no need to re-apply.

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

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

All coverage changes including dependant changes, changing from single to dependant, dependant to single, adding or removing dependants etc. must be made through the Human Resources office of the Ottawa Catholic School Board.

TERMINATION OF INSURANCE

Employee coverage

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

1. you no longer satisfy the definition of employee;
2. your classification is terminated;
3. your employment with the Board terminates;
4. you enter the armed forces of any country on a full-time basis;
5. the policy terminates or coverages for the group, division or classification to which you belong terminate;
6. you take an approved leave of absence and do not continue to make premium payments;
7. when you retire;
8. for life, AD&D, and optional life coverages, the first day of the month following your attainment of age 65; or
9. you no longer contribute towards the cost of your coverage.

DEPENDANT COVERAGE

An employee's dependant coverage will terminate automatically on the earliest of the following events:

- the employee's coverage ceases;
- the employee is no longer eligible for dependant coverage; or
- the dependant no longer satisfies the dependant definition.

If the employee dies while covered under this policy, the health and dental coverage for his/her dependants will continue for a period of three months after the employee's death, provided he/she was enrolled in the extended health and/or dental plan at the time of death.

Note: You must advise your employer within 31 days of any change in your dependant status or you may be denied benefits payments.

CONTINUATION OF INSURANCE

If in accordance with the Board policy or applicable collective agreements, an employee ceases to be eligible, coverage will automatically terminate. However, the employer may continue coverage under the circumstances specified below.

If an employee ceases to be actively employed due to:

1. **a maternity leave**; the employee may be covered for the duration of the leave (where governing legislation places the decision to continue coverage on any employee who contributes toward the premium, coverage may be continued at the option of the employee); or

2. **a lay-off, a leave of absence (other than for maternity) or vacation**; he/she may be covered in accordance with Board policy or applicable collective agreements. In cases of approved leave of absence, coverage will continue for 24 months from the date the leave commenced or longer, provided the Board and the insurer approve the extension.

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

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

CO-ORDINATION OF BENEFITS

Benefits provided under this agreement and made available to a person insured under another pre-paid health service contract, insurance policy or plan, shall be co-ordinated and the amount payable pro-rated and limited to the extent that the total coverage does not exceed 100 per cent of all the eligible expenses.

The administrator may obtain from or release to any person or corporation any information considered necessary to implement this provision and facilitate the payment of benefits under this agreement (subject to consent of the covered employee, where required by law).

ORDER OF BENEFIT DETERMINATION

If a person is eligible to receive a benefit under this agreement and the same or a similar benefit under any other plan, benefit payments will be decided in the following manner:

1. if another plan does not contain a co-ordination of benefits provision, benefits of that plan will be payable prior to those outlined in this agreement;

2. if another plan contains a co-ordination of benefits provision, the benefits of that plan shall be co-ordinated with the benefits under this plan as follows:

   Priority shall be given to the plan under which the person is eligible to receive the benefits in the following order:

   A. other than as a dependant; or

   B. as a dependant of a covered person with the earlier month and day of birth in the calendar year.

If priority cannot be established in the above manner, the benefits shall be pro-rated among the plans in proportion to the amounts that would have been paid under each plan had there been coverage only by that plan.

SUBROGATION

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

BENEFICIARY

Upon enrolment in the plan, you must designate the beneficiary to whom the death benefits will be payable. Subject to any legal restrictions, the employee may change his or her beneficiary by completing a new enrolment form.

CHANGE IN INFORMATION

To ensure the accuracy of the information contained in your file and that you receive all related correspondence, it is important that you contact the Board's Human Resources department within 31 days of a change in your status (i.e. new dependant, beneficiary, address).

TERMINATION OF COVERAGE

In respect to the life, AD&D and optional life benefits, coverage terminates at the earlier of your termination or retirement or at age 65.

3. Life insurance

If you die while covered under this benefit, the principal sum (shown in the *Benefit summary*) in effect on the date of your death will be paid to your beneficiary or estate when the insurer receives the written proof of death. If you chose $5,000 of coverage, you may change that coverage to 2.5 times your basic annual salary within 31 days of marriage and/or birth/adoption of a child with written notice to the Board's Human Resources department.

EXTENDED DEATH BENEFIT DURING TOTAL DISABILITY

If you are under the age of 65 and become totally disabled while covered under this benefit, the insurer will maintain the coverage without payment of premiums while you are totally disabled, subject to the terms outlined in the remainder of this section. (Receipt of satisfactory proof of total disability is also required.)

Within one year after commencement of total disability, notice that total disability has continued without interruption for at least six months must be given to Great-West Life. Satisfactory proof of total disability must be provided within three months of the date of notice and once each year thereafter when and as required by Great-West Life.

The coverage maintained is that for which you would be covered as of the expiration date of the elimination period, (i.e. the expiration of sick leave.) If, for any reason, the coverage would normally reduce, the amount of coverage will be reduced accordingly.

Upon your death, the amount of coverage will be paid, provided satisfactory proof is submitted that the total disability continued to the date of death.

If you die before age 65 and within a year after the date of commencement of total disability, but before any proof has been given, then notice that the total disability continued to the date of death must be given to Great-West Life within one year after death. The proof must be provided within three months of the date the notice is received by Great-West Life.

If an individual life insurance policy has been issued in accordance with the section entitled *Conversion privilege,* payment will be made only when the individual policy is surrendered without claim.

This extension protection will immediately terminate if you:

- cease to be totally disabled;
- reach age 65;
- fail to furnish any required proof that the total disability has continued; or
- fail to submit to a medical exam by physicians named by Great-West Life when and as often as Great-West Life requires.

If the extension protection ends after you have given proof of total disability and you have not returned to active work with the employer, you have the same rights and benefits as described in the *Conversion privilege* section.

DEFINITION

When used for this coverage total disability means:

1. during the elimination period and the first 24 months, disability will be based on the specific duties you regularly performed for the Board before the disability started. You will be considered disabled if, due to illness or injury, you are unable to perform the significant duties pertaining to your specific assignment;
2. if illness or injury prevents you from performing a duty, it will also be considered to prevent you from performing:
   A. other functions required to complete that duty; and
   B. other functions that can only be performed after that duty is completed;
3. after the initial assessment period, you are considered disabled if illness or injury prevents you from being gainfully employed.

Gainful employment means work:

- you are medically able to perform;
- for which you have at least the minimum qualifications;
- that provides at least 60 per cent of your monthly pre-disability earnings; and
- that exists either in the province or territory where you worked when the disability started or where you currently live.

Note: The availability of work will not be considered in assessing the disability.

EXTENSION OF BENEFIT

A death benefit is payable if you die within 31 days after ceasing to be covered under this benefit. The amount of the benefit is equal to the amount of life insurance coverage you were entitled to convert. This is described in the *Conversion privilege* section below.

CONVERSION PRIVILEGE

If you cease to be covered under this benefit prior to attaining age 65, you may convert your coverage to an individual life insurance policy without evidence of insurability. The policy will be issued in accordance with the applicable laws or guidelines in effect in your province of residence. The amount converted must be at least equal to the minimum amount for which Great-West Life will issue an individual policy for the plan of insurance chosen.

You must apply for the individual policy and pay the first premium within 31 days of ending this coverage. Your individual policy will become effective 31 days after the coverage is terminated.

If you convert all or part of your life coverage, you will not be eligible for further coverage under this group plan, unless the individual policy is cancelled.

TO WHOM PAYABLE

Any benefits payable on your death will be paid to your beneficiary or your estate, as specified by you.

Proof of claim

Written proof of a claim must be given to Great-West Life. Contact Coughlin & Associates Ltd. to make arrangements.

Disability claim

Written notice must be provided no later than one year after the date of commencement of total disability. Written proof must be given no later than three months after the date on which Great-West Life receives the notice. Contact Coughlin & Associates Ltd. to make arrangements.

LIVING BENEFITS

Definitions

In this section, the following phrases have these meanings:

1. *Living benefits* means the amount of life insurance coverage that you may place under this option. The living benefit is a one-time lump sum payment equal to 50 per cent of your total amount of life insurance coverage in effect on the date the insurer receives proof that you are terminally ill.

   The maximum benefit is $50,000. The living benefits may be reduced if, within six months after receiving such proof, a reduction on account of age would have been applied to your life insurance coverage. In that case, the living benefit would amount to 50 per cent of your life coverage in-force after applying the reduction, subject to the living benefits maximum.

2. *Terminally* ill means your life expectancy is 12 months or less.

OPTION

If you become terminally ill while insured under this plan or while your coverage is being maintained under the *Extended death benefit* during total disability provision, you may elect to exercise the living benefits option. The election is subject to the following provisions:

Payment of living benefits

If you elect this option, Great-West Life will pay the living benefits in one sum when it receives proof that you are terminally ill.

To whom payable

Under this option, the benefit is payable to you.

AMOUNT PAYABLE ON YOUR DEATH

Great-West Life will pay to your beneficiary the proceeds of the life insurance coverage, less the total of the living benefits option you received. In addition, when you apply for living benefits, it will also pay interest calculated from the date of the living benefits payment to the date of your death, using the annual interest rate provided by Great-West Life.

CONDITIONS

Your right to be paid under this option is subject to these terms:

1. You must elect this option in writing in a form satisfactory to Great-West Life.
2. You must furnish satisfactory proof to Great-West Life that your life expectancy is 12 months or less, including certification by a physician.
3. Since the living benefits will be made available to you on a voluntary basis only, it is subject to the following terms:

   A. if you are required by law to use this option to meet the claims of creditors, whether in bankruptcy or otherwise, you are not eligible for this option;

B. if you are required by a government agency to use this option in order to apply for, get or keep a government benefit or entitlement, you are not eligible for this option; and

C. the deduction of the living benefits and its accrued interest take priority over any other demand or claim for the insurance proceeds payable on your death.

EFFECT ON COVERAGE

When you elect this option, the total amount of life insurance benefit payable on your death, including any amount under the *Extended death benefit during total disability* provision, will be reduced by the living benefits. Also, any amount you could otherwise have converted to an individual policy will also be reduced by the living benefits.

4. Accidental death and dismemberment (AD&D) insurance

This benefit provides a lump sum cash benefit in the event of your accidental death or dismemberment.

LOSS SCHEDULE

If such injuries shall result in any one of the following specific losses within one year from the date of accident, RBC Insurance will pay the loss outlined below. However, no more than the aggregate of the principal sum will be paid for injuries resulting from the same accident.

For loss of:	Percentage of principal sum
• Life	100%
• Both hands or both feet	100%
• Sight of both eyes	100%
• One hand and one foot	100%
• One hand or foot and sight of one eye	100%
• Speech and hearing in both ears	100%
• One leg or one arm	75%
• Either hand or foot	66⅔%
• Sight of one eye	66⅔%
• Speech or hearing in both ears	66⅔%
• Thumb and index finger of the same hand	33⅓%
• Four fingers of the same hand	33⅓%

• All toes of one foot	12½%
• Hearing in one ear	16⅔%
• Quadriplegia (total & irreversible paralysis of all four limbs)	200%
• Paraplegia (total & irreversible paralysis of both lower limbs)	200%
• Hemiplegia (total & irreversible paralysis of one arm and one leg on the same side of the body)	200%

Loss of use of:

• Both hands or arms	100%
• One arm or one leg	75%
• One hand or one foot	66⅔%

With the exception of quadriplegia, hemiplegia and paraplegia, the maximum payable for any one accident will not exceed the principal sum of the AD& D benefit.

The benefit is payable only if death or loss occurs within 365 days of the accident.

Loss shall mean the following:

- with regard to hands and feet, actual severance through or above wrist or ankle joint;
- with regard to eyes, entire and irrecoverable loss of sight;
- with regard to leg or arm, actual severance through or above knee or elbow joint;
- with regard to thumb and fingers, actual severance through or above metacarpophalangeal joints;

- with regard to toes, actual severance through or above metatarsophalangeal joints;
- with regard to speech and hearing, entire and irrecoverable loss; and
- with regard to paralysis (quadriplegia, paraplegia, hemiplegia), loss of use must be complete and irreversible.

Loss of use of an arm, hand, leg or foot must be total and irreversible and must be continuous for 12 months after which the benefit for loss of use is payable, provided such nerve damage is determined to be permanent.

EXPOSURE OR DISAPPEARANCE

If loss results from unavoidable exposure to the elements, the relevant amount will be payable under the terms of the policy.

If your body has not been found within one year after the date of the disappearance, sinking or wrecking of the vehicle in which you were an occupant at the time of the accident, it will be presumed that you had suffered loss of life resulting from bodily injury caused by an accident at the time of the event.

WAIVER OF PREMIUM

When total disability from an accident or illness continues for a period of six consecutive months, premiums shall be waived for any continuous period of such disability for as long as the insured employee is the disabled up to age 65, termination of employment or termination of the policy, whichever occurs first.

REPATRIATION

If as the result of a covered accident, you die at 100 kilometres or more from your residence, the plan will pay up to $10,000 for your preparation and transportation to your city of residence.

REHABILITATION BENEFIT

When injuries result in a payment being made under the specific loss benefit, an additional amount will be paid as follows:

The reasonable and necessary expenses actually incurred for special training of the insured to a limit of $10,000, provided:

- the training is required due to the injury and is necessary for the insured to qualify to engage in an occupation in which he/she would not have been engaged except for the injury;
- expenses are incurred within two years from the date of the accident; and
- no payment is made for ordinary living, travelling or clothing expenses.

EDUCATION BENEFIT

If you sustain an injury that results in loss of your life within 365 days of the date of accident, an education benefit will be paid to an eligible dependant child.

An dependant child will be eligible for the education benefit if:

- at the time of the accident, he/she is enrolled as a full-time student in any institution of higher learning beyond the 12th grade level; or
- he/she is in the 12th grade level and within 365 days of the accident, enrols as a full-time student in an institution of higher learning.

Payment will be equal to the lesser of:

- three per cent of the insured employee's principal sum per year; or
- $5,000 per year.

The education benefit will be paid each year for four consecutive years if the covered dependant child remains enrolled as a full-time student.

The first payment will be made:

- when the policy's benefit for loss of life becomes payable; and
- on the date the insurer receives written proof that the dependant child is attending an institution of higher learning as a full-time student.

Future payments will be made for each following school year on the date the insurer receives written proof that the dependant child is attending an institution of higher learning as a full-time student.

If at the time of loss of life, the insured employee has dependant children not eligible to receive the *Education benefit,* RBC will pay an additional $1,500 to the beneficiary.

Institution of higher learning includes any university, CEGEP, trade school or college, as defined where you live.

SPOUSAL RETRAINING BENEFIT

When an injury to the insured employee results in a payment being made for loss of life, limb or sight, an additional benefit amount will be paid for the expenses actually incurred by your spouse within three years from the date of the accident for an approved and mutually agreed upon formal occupational training to qualify him/her to gain active employment in an occupation for which he/she would otherwise not have had sufficient qualifications. The maximum payable available is $10,000.

FAMILY TRANSPORTATION BENEFIT

If while on a trip covered by this policy, you are confined as an in-patient in a hospital for injuries and under the regular care and attendance of a legally qualified physician or surgeon other than yourself and require the personal attendance of a member of the immediate family as recommended by the attending physician or surgeon, the insurance company will pay for the expense incurred for transportation to you by the most direct route by a licensed common carrier to a maximum of $3,500.

Member of the immediate family means the spouse, parents, grandparents, children over age 18, brother or sister of the insured.

Hospital means an institution licensed as a hospital, open at all times for the care and treatment of injured persons, with organized facilities for diagnosis, major surgery and with 24-hour nursing services. It must not include a facility or part of a facility primarily used for the aged, the treatment of drug addiction or alcoholism, rehabilitative care, custodial or educational care, or a rest home, nursing home or convalescent hospital.

Regular care and attendance means observation and treatment to the extent necessary under existing standards of medical practice for the condition causing the confinement.

HOME ALTERATION AND VEHICLE MODIFICATION

If you receive a principal sum payment for injury or illness and are subsequently required to use a wheelchair, then upon presentation of proof of payment, this benefit will pay:

- the one-time cost of alterations to your residence to make it wheelchair accessible and habitable; and
- the one-time cost of modifications necessary to your motor vehicle to make it accessible or driveable.

Benefit payments herein will not be paid unless:

- home alterations are made by a person or persons qualified to do so and recommended by a recognized organization providing support and assistance to wheelchair users; and
- vehicle modifications are carried out by a person or persons with experience in such matters and modifications are approved by the provincial vehicle licensing authorities.

The combined maximum payable under both items above cannot exceed $10,000.

BENEFICIARY

The beneficiary for the *Accidental loss of life* benefit shall be as designated under the current group life insurance policy and on file with the plan administrator. All other benefits shall be payable to the insured employee.

EXCLUSIONS

This policy does not cover losses caused by or resulting from any one or more of the following:

1. intentionally self-inflicted injuries, suicide or any attempt thereof, while sane or insane;

2. declared or undeclared war or any act thereof;

3. accident occurring while the insured is serving on full-time active duty in the armed forces of any country or international authority (any premium paid to be returned by the company and pro-rated for the period while on full-time active duty);

4. travel or flight in any vehicle or device for aerial navigation, including boarding or alighting therefrom,

   A. while being used for any test or experimental purpose; or

   B. while the insured is operating, learning to operate or serving as a member of the crew thereof; or

   C. while it is being operated by or for or under the direction of any military authority, other than a transport type aircraft operated by the Armed Forces Air Transport Group of Canada or the similar air transport service of any other country; or

   D. while on any such aircraft or device that is owned or leased by or on behalf of the policyholder or any subsidiary or affiliate of such policyholder.

5. Extended health care

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 *General health and dental limitations*. The amount payable will be determined based on the limits outlined below. A benefit is not payable for an eligible expense used to satisfy any, nor if the maximum benefit has already been paid.

Reasonable and customary charges means charges for services and supplies usually furnished for cases of the nature and severity of the case being treated in accordance with representative fees and prices in the area.

ELIGIBLE EXPENSES

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

1. HOSPITAL EXPENSE BENEFIT

In Canada

Charges of an approved public general hospital for the following:

1. Private room or semi-private room and board in excess of ward accommodation.

2. Medical and surgical treatment incurred by a person on an out-patient basis (excluding physicians' and special nurses' fees).

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

2. DRUGS AND MEDICATION

Drugs, serums, vaccines and injectables that either legally require a prescription or are only available by prescription and when prescribed by a physician or dentist and dispensed by a pharmacist, physician or dentist to a maximum of three months supply at one time.

Prescribed smoke cessation products will be covered to a maximum of $200 per lifetime or three months supply, whichever comes first, including the costs of attendance at special clinics.

As well, drugs and supplies available without a prescription and required as a result of a colostomy or ileostomy* and/or for the treatment of cystic fibrosis, diabetes and Parkinson's or heart disease. (Diaphragms, IUDs and breast pumps are not covered.)
(*Payable after incurred expenses exceed the provincial health plan grant.)

Charges for Viagra®/Levitra®/Cialis® will be covered to a maximum of $500 per year, provided there is co-medical attestation of an impotence problem.

Note: Eligible expenses for dispensing fees by a licensed pharmacist are limited to the Ontario Drug Benefit plan maximum (currently, $7 per prescription or refill.) Coughlin & Associates Ltd. maintains a preferred provider network of pharmacies that will not charge more than the Ontario Drug Benefit plan maximum.

Certain eligible medications may require prior authorization of the administrator.

3. PARAMEDICAL PRACTITIONERS

Services of the following licensed, certified or registered (in the province where treatment is given) paramedical practitioners when operating within their recognized fields of expertise, to the levels specified, up to the reasonable and customary fees per visit. (Where applicable, no payment can be made until the provincial plans have paid their yearly maximum).

1. Psychologist and therapist under the direct supervision of a psychologist, to an aggregate maximum payment of $1,500 per person per calendar year. All receipts must clearly indicate the names of those attending the sessions.

2. Speech therapist, podiatrist, osteopath, naturopath (naturopath consultations only – no supplements), massage therapist, chiropractor and physiotherapist: for each such practitioner, payments up to a total of $350 per person per calendar year, provided no amount is paid by any government plan.

Reimbursement is based on the dates the services were rendered. If you choose to enter into a block or annual payment plan for services, reimbursement will only be made at the end of the contract period by submitting all receipts and a copy of the contract.

Please note that each paramedical practitioner's name and registration number must appear on all receipts.

4. NURSING CARE EXPENSES

On recommendation of an attending physician, out-of-hospital private duty nursing care by a graduate registered nurse currently registered with the appropriate local authority. The nurse must not be a relative by blood or marriage, nor an employee, and must not ordinarily reside in your home. Expenses may not exceed $10,000 per lifetime per insured (excluding in-hospital nursing care).

If a graduate registered nurse is not available when needed, medically required nursing services of a registered nursing assistant or licensed practical nurse will be eligible.

Note: These services must be pre-approved by the plan administrator before commencement of any nursing care services.

5. PRESCRIBED MEDICAL SUPPLIES, AIDS AND APPLIANCES

1. Cost of crutches, glass fibre casts, splints (excluding dental splints), cryocuffs, trusses, and artificial limbs or eye, external breast prosthesis (following mastectomies), a maximum of two mastectomy bras per calendar year. Braces, when constructed with rigid or semi-rigid material, will be considered, if required for normal everyday activity and not solely for sports related activities.

2. The rental of a wheelchair, hospital type bed and respirator/ventilator (electric wheelchairs and electric hospital beds are excluded unless required by medical necessity and recommended by an attending specialist.) Replacement appliances, including those that are not serviceable, are eligible once every five consecutive years. 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. The rental or purchase of a quadriflex machine or transcutaneous nerve stimulator (TNS) machine is not covered.

3. Diabetic supplies including glucometers (except batteries); glucometers are limited to once every five consecutive calendar years.

4. Support hose, maximum of six pairs per calendar year with physician's prescription showing brand name and compression ratio.

5. Custom made orthopaedic shoes which are attached to and form part of a brace are payable at 100 per cent limited to two pairs annually. If the shoes are not part of a brace, two pairs are eligible annually up to 50 per cent of the cost of the shoes or the cost of the adjustment, if greater. (Orthopaedic shoes to accommodate custom moulded arch supports are not covered). A referral from a physician, podiatrist or chiropodist indicating the medical diagnosis is required.

6. Custom-moulded arch supports to a maximum of $500 per person per calendar year. A referral from a physician, podiatrist or chiropodist indicating the medical diagnosis is required.

7. Wigs for patients who have undergone special treatment, such as chemotherapy, or have lost their hair due to illness. There is no maximum.
8. Cataract eyewear including prosthetic lenses and frames, once only per person who lacks an organic lens after cataract surgery.
9. Hearing aids to a maximum of $1,200 per ear once every 48 calendar months.
10. Colostomy or ileostomy and incontinence related supplies are payable when the provincial health care maximum has been exhausted.
11. Charges for radiology, blood transfusions and oxygen including the equipment necessary for administering oxygen. MRIs in private clinics are not covered.

The preceding benefits are not acceptable as eligible expenses when ordinarily paid by any government agency or if not authorized in writing by the attending physician.

In no event will payment be made for rental charges that exceed the purchase price of any item.

6. AMBULANCE SERVICES

1. That portion of the cost of air ambulance services to the nearest hospital capable of providing the type of care essential for the patient that is not normally paid by the provincial health insurance plans, subject to one round trip per calendar year.
2. Licensed ground ambulance to the nearest hospital including service to and from points of arrival and departure are considered eligible.

7. DENTAL EXPENSES DUE TO ACCIDENTAL INJURY

Charges for services of a dentist when treatment results directly from an accidental injury to sound natural teeth from an external blow and not by an object wittingly or unwittingly placed in the mouth.

If the accident occurred after the effective date of the plan and treatment is rendered either within six months of the accident or before this agreement expires, whichever comes first, and provided that payment for such service is not available to the participant from any government agency or other commercial carrier, then such expenses will be covered. Expenses for such treatments are limited only to those incurred to repair the damage caused directly by the accident. The procedure must be the one least expensive to provide a professionally-adequate result.

Note: A sound tooth is any tooth that did not require restorative treatment immediately before the accident. A natural tooth is any tooth that has not been artificially replaced.

8. NURSING HOME

Room, board and normal nursing care provided in a licensed nursing home or clinic (for convalescent or chronic care, but excluding custodial care), up to maximum of $20 per day for 120 days.

9. VISION CARE

The plan will cover 100 per cent of eligible expenses without any deductible if you or your dependants incur charges for prescription eyeglasses or prescription contact lenses on the written prescription of a licensed physician or a licensed, certified or registered optometrist or ophthalmologist.

The maximum coverage for all eligible expenses, including glasses, contact lenses, laser surgery and examinations, is $350 per 24-month period.

Note: The plan may pay for both eyeglasses and contact lenses for the same person within the 24-month period subject to the applicable maximum dollar limit. When a claim is submitted, reimbursement is made by reviewing all claims made within the preceding 24-month period and calculated by deducting any amounts reimbursed during that period from the eligible maximum. For example, a claim submitted in June 2009 would be reviewed to June 2007 and any amounts paid in that period would be deducted from your claims reimbursement.

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

Eye exams are reimbursed based on the date of the eye exam to a maximum of $90 per exam every 24 consecutive months. Fees in addition to those of the standard eye exam are not eligible.

10. OUT-OF-PROVINCE BUT WITHIN CANADA

Expenses incurred out-of-province but within Canada are covered as if benefits would have been payable had they been incurred in your home province provided:

- for an emergency or unexpected illness, the insured person is temporarily out-of-province for business, vacation or further education; or
- the required medical treatment is not readily available in the province of residence and the person is forced to seek such treatment elsewhere.

11. OUT-OF-PROVINCE/COUNTRY TRAVEL MEDICAL EMERGENCY INSURANCE

Travel insurance is designed to cover losses arising from sudden and unforeseeable circumstances occurring while you are temporarily travelling outside your province or territory of residence. It is important that you read and understand your plan before you travel. In the event of any discrepancy between the provisions of a booklet or other document you hold and the provisions of the policy, the provisions of the policy shall govern. The insurer has contracted Global Excel Management Inc. (called "*Global Excel*") to provide medical assistance and claims services under the policy.

In the event of an emergency, you must call Global Excel immediately. The emergency telephone numbers are listed on the back of the Medical Assistance Card provided.

Global Excel must be contacted before you seek medical treatment. If your condition renders you unable to do so, then someone else must contact Global Excel immediately for you. Do not assume that someone will contact Global Excel on your behalf. It remains your responsibility to ensure that Global Excel has been contacted prior to receiving medical treatment or as soon as reasonably possible.

If you incur any expenses without prior approval by Global Excel, such expenses will be covered, except where the policy expressly requires the prior approval or authorization of Global Excel, on the basis of the reasonable and customary costs that would have been payable for such expenses by the insurer in accordance with the terms and conditions of the policy. Such expenses may be higher than this amount, therefore you will be responsible for paying any difference between the amount you incur and the reasonable and customary costs reimbursed by the insurer.

Participant coverage

To be covered under the policy as a participant, you must meet the following eligibility requirements:

1. be covered under the government health insurance plan of your province or territory of residence;
2. be covered under the basic group extended health care plan of the policyholder;
3. be actively employed and younger than age 70;
4. have your place of employment in Canada;
5. have your permanent residence in Canada; and
6. if you are covered as a member of the policyholder who is other than an employer, you must also:

   i) be a member in good standing of the policyholder; and

   ii) be on the monthly list of members entitled to coverage provided to the insurer by the policyholder.

Participant coverage will become effective on the later of:

- the date the policy becomes effective; or
- the date the participant's coverage becomes effective under the basic group extended health care plan of the policyholder.

Coverage for disabled employees or employees who are not actively at work on the date their coverage would normally become effective will become effective on the date the employee resumes active work.

Participant coverage will terminate immediately upon the first to occur of:

1. the date you cease to meet the above eligibility requirements for participant coverage;
2. the date the premium is due if the policyholder does not remit your premium to the insurer, except where this is the result of clerical error; or
3. the date the policy is terminated.

Dependant coverage

To be covered under the policy as a dependant, you must meet the following eligibility requirements:

1. be covered under the government health insurance plan of your province or territory of residence;
2. be covered as a dependant under the basic group extended health care plan of the policyholder; and
3. meet the definition of *dependant* in the policy.

Dependant coverage, if any, will become effective on the later of:

1. the date the policy becomes effective; or
2. the date the dependant's coverage becomes effective under the basic group extended health care plan of the policyholder, but in no event prior to date the participant's insurance becomes effective.

Dependant coverage will terminate immediately upon the first to occur of:

1. the date you cease to meet the above eligibility requirements for dependant coverage;
2. the date the participant's coverage terminates, except if termination is due to the death of the participant, in which case, your coverage will continue until the earlier of the expiry of two years or the date you cease to meet the definition of dependant or reach the termination age of 70 years old, or remarry or die, provided the policyholder continues to make the required premium payments; or
3. the date the policy is terminated.

Overall maximum per insured

The overall maximum per insured person is $5 million per covered period.

The policy covers expenses that are:

- incurred outside the province or territory of residence of the insured person;
- medically necessary;
- reasonable and customary costs;
- incurred as a result of an emergency due to sudden and unforeseen sickness and/or injury occurring during the coverage period;
- in excess of those covered by the government health insurance plan or other insurance under which you may have coverage;
- legally insurable; and
- subject to the overall maximum per insured person of $5 million per coverage period.

In the event of an emergency, the following benefits are payable under the policy. However, certain expenses, as specified below, are covered only if you obtain the prior approval of Global Excel.

1. **Hospital accommodation:** Reasonable and customary room and board costs up to the semi-private room rate charged by the hospital. If medically necessary, expenses for treatment in an intensive or coronary care unit are also covered. If coverage terminates for any reason during your hospital stay, benefits continue until discharge, to a maximum of one year. In no case will expenses for in-patient stays be covered for a period greater than 365 days per insured person.
2. **Physician charges:** Reasonable and customary charges for treatment by a physician.
3. **Diagnostic services:** Reasonable and customary costs for laboratory tests and X-rays prescribed by the attending physician and that are part of the emergency treatment. The policy does not cover magnetic

resonance imaging (MRI), cardiac catheterization, computerized axial tomography (CAT) scans, sonograms or ultrasounds and biopsies unless Global Excel authorizes such services in advance.

4. **Paramedical services:** The services (including X-rays) of a licensed chiropractor, physiotherapist, podiatrist or osteopath, to the maximum of $250 per insured person, per profession listed above, when approved in advance by Global Excel.

5. **Prescriptions:** Drugs, including injectable drugs, and sera that can only be obtained upon medical prescription, that are prescribed by a physician and that are supplied by a licensed pharmacist when medically necessary for emergency treatment, except when needed to stabilize a chronic condition or a medical condition which you had before your trip. This benefit is limited to a 30-day supply per prescription, unless you are hospitalized.

6. **Ambulance services:** When reasonable and medically necessary, licensed ground ambulance service to the nearest medical facility.

7. **Medical appliances:** When approved in advance by Global Excel, minor appliances such as crutches, casts, splints, canes, slings, trusses, braces, walkers and/or the temporary rental of a wheelchair when prescribed by the attending physician, obtained outside your province or territory of residence and medically necessary.

8. **Private duty nurse:** The professional services of a registered private nurse, when medically necessary and while hospitalized, to a maximum of $5,000 per insured person, when approved in advance by Global Excel.

9. **Emergency air transportation:** Reasonable and customary cost, when approved and arranged in advance by Global Excel:

   a) air ambulance to the nearest appropriate medical facility or to a Canadian hospital for immediate emergency treatment;

   b) transport on a licensed airline with an attendant (where required) to return you to your province or territory of residence for immediate emergency treatment.

10. **Transportation to bedside:** When approved in advance by Global Excel, a single round-trip economy airfare from Canada plus up to $150 per day to a maximum of $3,000 per trip for the cost of meals and commercial accommodation for one of the following: spouse, parent, child, brother, sister or business partner, to:

    a) be with you if you are travelling alone and have been hospitalized as the result of an emergency. To be payable, this benefit requires that you eventually be hospitalized as an in-patient for at least three consecutive days outside your province or territory of residence and that the attending physician provide written certification that the situation was serious enough to warrant the visit; or

    b) identify the deceased insured person prior to the release of the body, where necessary.

    The insurer will only reimburse covered expenses evidenced by original receipts.

11. **Return of travelling companion:** If you are returned to your province or territory of residence under the *Emergency air transportation* benefit or the *Return of deceased* benefit, the insurer will reimburse the cost of a single one-way economy airfare for a travelling companion to return to Canada, when approved in advance by Global Excel.

12. **Treatment of dental accidents:** Up to $2,000 per insured person for emergency dental treatment to repair natural, vital and sound teeth or permanently attached artificial teeth provided the injury was caused by an external, accidental blow to the mouth or face. You must consult a physician or dentist immediately following the injury. Treatment must begin during the coverage period and be completed prior to returning to your province or territory of residence. An accident report is required from a physician or dentist for claims purposes.

13. **Meals and accommodation:** Up to $150 per day, to a maximum of $3,000 per trip for the cost of commercial accommodation and meals for the participant and/or any of his/her dependants when their trip is extended beyond the last day of the scheduled trip due to the sickness and/or injury suffered by an insured person. This benefit must be authorized in advance by Global Excel. The fact that you are unable to travel must be certified by the attending physician and supported with original receipts from commercial organizations.

14. **Vehicle return:** Up to $5,000 if neither you, nor someone travelling with you, are able to operate your vehicle, whether owned or rented, during your trip due to sickness and/or injury. Arrangements and payment will be made for the return of the vehicle to your home in your province or territory of residence or the nearest appropriate rental agency. Benefits will only be payable for a single person to return the vehicle when approved and/or arranged in advance by Global Excel. This benefit does not cover wages lost by the person driving your vehicle. The insurer will only reimburse covered expenses evidenced by original receipts.

15. **Return of deceased:** Up to $5,000 towards the cost of preparation and transportation of the deceased insured person to their province or territory of residence in the event of death due to a sickness and/or injury.

    In the case of cremation and/or burial at the place of death of the insured person, this benefit is limited to $2,500.

    The cost of the casket or urn is not covered.

16. **Incidental expenses:** Up to $250 for your out-of-pocket expenses such as telephone charges, television rental and parking while you are hospitalized for an emergency and the expenses are incurred as a direct result of such hospitalization. The insurer will only reimburse covered expenses evidenced by original receipts.

Exclusions

The policy does not cover losses or expenses related in whole or in part, directly or indirectly, to any of the following:

1. Treatment or services normally covered or reimbursable under a government health insurance plan or under other insurance you might have.
2. Any trip booked or commenced contrary to medical advice or after you are diagnosed with terminal illness.
3. Any medical condition for which, prior to departure, medical evidence suggests a reasonable expectation that treatment or hospitalization could be required while travelling.
4. Treatment, surgery, medication, services or supplies that are not required for the immediate relief of acute pain and suffering or that you elect to have provided outside your province or territory of residence when medical evidence indicates that you could return to your province or territory of residence to receive such treatment. The delay to receive treatment in your province or territory of residence has no bearing on the application of this exclusion.
5. Treatment or surgery during a trip when the trip is undertaken for the purpose of securing or with the intent of receiving medical or hospital services, whether or not such trip is taken on the advice of a physician.
6. Cardiac catheterization, angioplasty, and/or cardiovascular surgery including any associated diagnostic test(s) or charges unless approved by Global Excel prior to being performed, except in extreme circumstances where such surgery is performed on an emergency basis immediately upon admission to hospital.
7. Magnetic resonance imaging (MRI), computerized axial tomography (CAT) scans, sonograms or ultrasounds and biopsies unless such services are authorized in advance by Global Excel.
8. Hospitalization or services rendered in connection with general health examinations for “check-up” purposes, treatment of an ongoing condition, regular care of a chronic condition, home health

care, investigative testing, rehabilitation or ongoing care or treatment in connection with drugs, alcohol or any other substance abuse or non-compliance with any prescribed medical therapy or treatment and medical treatment of an acute sickness and/or injury after the initial emergency has ended (as determined by the medical director of Global Excel).

9. A disorder, disease, condition or symptom that is emotional, psychological or mental in nature unless hospitalized.
10. Emergency air transportation and/or car rental unless approved and arranged in advance by Global Excel.
11. Treatment not performed by or under the supervision of a physician or licensed dentist.
12. Treatment or hospitalization of mother or child as a result of pregnancy, miscarriage, childbirth or complications of any of these conditions occurring in the four weeks before or after the expected delivery date.
13. War, invasion, act of a foreign enemy, declared or undeclared hostilities, civil war, rebellion, revolution or military power.
14. Terrorism or by any activity or decision of a government agency or any other entity to prevent, respond to or terminate terrorism except for ensuing loss or damage which results directly from fire or explosion. Such loss or damage is excluded regardless of any other cause or event that contributes concurrently or in any sequence to the loss or damage.
15. Committing or attempting to commit an illegal act or a criminal act.
16. Suicide (including any attempt thereof) or self-inflicted injury, whether or not you are sane.
17. Service in the armed forces.
18. Participation in any sport as a professional athlete (for which you are remunerated), or in motorized or mechanically assisted racing or speed contests (defined as an organized activity of a competitive nature in which speed is a determining factor in the outcome of the event).

19. Loss or damage to eyeglasses, sunglasses, contact lenses, or prosthetic teeth, limbs or devices and resulting prescription thereof.

20. The replacement of an existing prescription whether by reason of loss, unless otherwise specified elsewhere in the policy, renewal or inadequate supply or the purchase of drugs and medications (including vitamins) which are commonly available without a prescription or which are not legally registered and approved in Canada or which are not required as a result of an emergency.

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

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

23. Crowns and root canals.

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

25. Any service, treatment or supply related to locating organ donors for transplants, nor any service, treatment or supply in connection with the use of artificial organs.

General provisions

1. **Notice to Global Excel:** In the event of a sickness and/or injury likely to give rise to an emergency, you must give immediate notice to Global Excel. Failure to do so may limit the benefits payable under the policy. If you incur any expenses without prior approval by Global Excel, such expenses will be covered, except where the policy expressly requires the prior approval or authorization of Global Excel, on the basis of the reasonable and customary costs that would have been payable for such expenses by the insurer in accordance with the terms and conditions of the policy. Such expenses may be higher than this amount. Therefore, you will be responsible for paying any difference between the amount you incur and the reasonable and customary costs reimbursed by the insurer.

2. **Transfer or medical repatriation:** During an emergency (whether prior to admission or during a covered hospitalization), the insurer reserves the right to:

   a) transfer you to one of Global Excel's preferred health care providers; and/or

   b) return you to your province or territory of residence for the medical treatment of your sickness and/or injury where this poses no danger to your life or health. If you choose to decline the transfer or return when declared medically stable by the medical director of Global Excel, the insurer will be released from any liability for expenses incurred for such sickness and/or injury after the proposed date of transfer or return. Global Excel will make every provision for your medical condition when choosing and arranging the mode of your transfer or return and, in the case of a transfer, when choosing the hospital.

3. **Limitation of benefits:** Once you are deemed medically stable to return to Canada (with or without medical escort) either in the opinion of the medical director of Global Excel or by virtue of discharge from a medical facility, your emergency will be deemed to have ended, whereupon any further consultation, treatment, recurrence or complication related to the emergency will no longer be eligible for coverage under the policy.

4. **Misrepresentation and non-disclosure:** Your entire coverage under the policy shall be considered void if the insurer determines, whether before or after loss, that you or the policyholder have concealed, misrepresented or failed to disclose any material fact or circumstance concerning the policy or your interest therein, or if you or the policyholder refuse to disclose information or to permit the use of such information pertaining to any of the insured persons under the policy. Consequently and following a loss, no claim shall be payable by the insurer and you shall be solely responsible for all expenses relating to your claim, including medical repatriation costs.

5. **Subrogation:** If you suffer a loss covered under the policy, the insurer is granted the right from you to take action to enforce all your rights, powers, privileges, and remedies, to the extent of benefits paid under the policy, against any person, legal person or entity which caused such loss. Additionally, if "no fault" benefits or other collateral sources of payment of medical expenses are available to you, regardless of fault, the insurer is granted the right to make demand for, and recover, those benefits. If the insurer institutes an action, it may do so at its own expense, in your name, and you will attend at the place of loss to assist in the action, in addition to providing the insurer all information, co-operation and assistance the insurer may reasonably require. If you institute a demand or action for a covered loss, you shall immediately notify the insurer so that the insurer may safeguard its rights.

   Notwithstanding any provisions in the policy to the contrary, the insurer's rights under this paragraph shall be governed by the laws of the state, province, or district where the loss occurs, or where benefits under the policy are paid.

   You shall take no action after a loss that will impair the rights of the insurer set forth in this paragraph and shall do all such things as are necessary to secure such rights.

6. **Arbitration:** Notwithstanding any clause in the policy, the parties hereto undertake to submit to an arbitration procedure, to the exclusion of the courts, any present or future dispute relating to a claim. The arbitration proceedings shall be governed by the arbitration law in force in the Canadian province or territory of residence of the participant. The parties agree that any action will be referred to arbitration.

7. **Applicable law:** The policy is governed by the laws of the Canadian province or territory of residence of the participant. Any legal proceeding by the insured person, his heirs or assigns shall be brought in the courts of the Canadian province or territory of residence of the participant.

8. **Other insurance:** If, at the time of loss, you have insurance from another source, or if there is any other party responsible for benefits provided under the policy, the insurer will pay covered expenses only in excess of those covered by that other insurer or other responsible party, including credit cards, private or public health plans, private or provincial auto plans, or any other insurance, whether collectable or not, which provides the insured person with some or all of the benefits and coverage provided under the policy. If, however, that other insurance is also "excess only", the insurer will co-ordinate payment of all eligible claims with that other insurer. All co-ordination follows the Canadian Life and Health Insurance Association guidelines. In no case will the insurer seek to recover against employment-related plans if the lifetime maximum for all in-country and out-of-country benefits is $50,000 or less.

9. **Co-ordination and order of benefits:** If a person has coverage under another plan that does not provide for co-ordination of benefits, that plan will be considered primary carrier and will be responsible for making the initial payment. If the other plan does provide for co-ordination of benefits, the order of benefit will be as follows:

   Participant and dependant spouse: The plan insuring the participant or the participant's dependant spouse as an employee/member pays benefits before the plan insuring the participant or the participant's spouse as a dependant.

   Dependant child: If the dependant child is insured as a dependant under the participant's and the spouse's plans, benefits will first be payable under the plan of the parent whose birthday comes first in the calendar year. The balance of eligible expenses can then be submitted to the plan of the other parent. If both parents have the same birthday (month/day), the claims for children must be submitted to the plan in the alphabetical order of the parents' first names. When a person is insured under other group or individual policies or government plans, the benefits payable from all sources cannot exceed 100 per cent of expenses incurred.

10. **Rights of examination:** To be entitled to payment of benefits provided under the policy, the participant, on his own behalf and on behalf of his dependants, authorizes any physician, health professional, hospital, institution and any other organization to forward to the insurer or its representatives, all information, reports or documents that they may require. The participant hereby authorizes the insurer to communicate directly with any physician, health professional, hospital, institution or other organization to obtain any information required for the assessment of claims and hereby relieves the persons concerned of all legal responsibility which could arise from the disclosure of such information.

    In the event of death, the insurer will require that a death certificate be filed with the claim. Furthermore, the insurer has the right to request an autopsy and review any autopsy report, if not prohibited by law.

11. **Limitation of actions:** An action or proceeding against the insurer for the recovery of a claim under the policy shall not be commenced more than one year (two years in the Northwest Territories, three years in the province of Quebec) after the date the insurance money became payable or would have become payable if it had been a valid claim.

12. **Availability and quality of care:** Neither the insurer nor Global Excel shall be responsible for the availability or quality of any medical treatment (including the results thereof) or transportation at the vacation destination, or your failure to obtain medical treatment during the coverage period.

13. **Evidence of age:** The insurer reserves the right to request proof of age of any insured person.

14. **Assignment:** Benefits under the policy may not be assigned.

15. **When money payable:** All money payable under the policy shall be paid by the insurer within 60 days after it has received due proof of claim.

16. **Continuance of individual coverage during absence from work:** If a participant is absent from work due to disability, temporary lay-off, authorized leave of absence, strike or any other work stoppage, the insurance will be continued as long as the participant remains covered under the policyholder's basic group extended health care plan.

17. **Examination of the policy:** The policy, including any endorsements, will be kept at the office of the policyholder. You may consult the policy during the regular business hours of the policyholder.

Automatic extension of coverage

The coverage period per trip will automatically be extended up to 72 hours, provided the participant has not reached the termination age, if:

a) you are hospitalized due to a medical emergency on the last day of coverage. Your coverage will remain in force for as long as you are hospitalized and the 72-hour extension commences upon release from hospital;

b) a late train, boat, bus, plane, or other vehicle in which you are a passenger causes you to miss your scheduled return to your province or territory of residence (including by reason of weather);

c) the private automobile in which you are travelling is involved in a traffic accident or mechanical breakdown that prevents you from returning to your province or territory of residence on or before your return date; and/or

d) you must delay your scheduled return to your province or territory of residence due to a medical emergency.

All claims incurred after your original scheduled return date must be supported by documented proof of the event resulting in your delayed return.

International Assistance Service

Global Excel is available to take your calls 24 hours a day, seven days a week.

Emergency call centre — No matter where you travel, professional assistance personnel are ready to take your call. Global Excel can also provide you with Canada Direct instructions and codes so that you only deal with Canadian telephone operators.

Referrals — Global Excel can refer you to the preferred medical providers (hospitals, clinics and physicians) that are closest to where you are staying. With a referral, it is less likely that you will have to pay for services out of pocket.

Benefit information — Explanation of your coverage is available to you and to the medical providers who are treating you.

Medical consultants — Global Excel's team of medical professionals, available 24 hours a day, will monitor the services given in the event of a serious emergency. If necessary, Global Excel will help you return to Canada for the care you need.

Urgent message relay — In the event of a medical emergency, Global Excel will contact your travelling companion to keep him/her advised of your medical situation and will help you exchange important messages with your family.

Interpretation service — Global Excel can connect you to a foreign language interpreter when required for emergency services in foreign countries.

Direct billing — Whenever possible, Global Excel will instruct the hospital or clinic to bill the insurer directly.

Claims information

Global Excel will answer any questions you have about the eligibility of your claim, standard verification procedures and the way that the benefits under the policy are administered.

Definitions

Accident means a fortuitous, sudden, unforeseen and unintentional event exclusively attributable to an external cause resulting in bodily injury.

Actively at work means the employee is physically and mentally capable of doing each and every function of his/her occupation, on the basis of the minimum number of hours worked per week (20 hours per week). If an employee is not actively at work due to vacation, holidays, a non-scheduled working day, maternity or parental leave, then actively at work means the capability to perform the employee's normal duties at the employee's normal place of employment on the same basis as the employee who is actively at work.

Coverage period means the number of consecutive days (60 days) during which you are covered under the policy when you take a trip and which is calculated as of the commencement date of your trip.

Dependant means the spouse and the unmarried child of the participant or spouse, who is under the age limit of 21 or if a full-time student at a recognized educational institution, is dependent on the participant for support and is not employed on a full-time basis. A dependant child who is physically or mentally disabled and totally dependent on the participant for support will continue to be eligible provided he/she was covered as a dependant under the policy before attaining such age limit.

Emergency means the occurrence of a sickness and/or injury during the coverage period that requires immediate medically necessary treatment for the relief of acute pain or suffering, other than experimental or alternative treatment, and such treatment cannot be delayed until your return to Canada.

Global Excel and Global Excel Management Inc. mean the company appointed by the insurer to provide medical assistance and claims services under the policy.

Government health insurance plan means the health care coverage provided by Canadian provincial and territorial governments to their residents.

Hospital means an institution which is designated as a hospital by law that: continuously staffed by one or more physicians available at all times; continuously provides nursing services by graduate registered nurses; is primarily engaged in providing diagnostic services and medical and surgical treatment of a sickness and/or injury in the acute phase, or active treatment of a chronic condition; has facilities for diagnosis, major surgery

and in-patient care. The term hospital does not include convalescent, nursing, rest or skilled nursing facilities, whether separate from or part of a regular general hospital, nor a facility operated exclusively for the treatment of persons who are mentally ill, aged, or drug or alcohol abusers.

Immediate family member means your spouse, son, daughter, father, mother, brother, sister, stepson, stepdaughter, stepfather, stepmother, mother-in-law, father-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandson, granddaughter, grandfather or grandmother.

Injury means any unexpected and unforeseen harm to the body that is caused by an accident, that you sustained during the coverage period and that requires emergency treatment that is covered by the policy.

In-patient means a patient who occupies a hospital bed for more than 24 hours for medical treatment and for which admission was recommended by a physician when medically necessary .

Insurer means Royal & Sun Alliance Insurance Company of Canada.

Medical Assistance Card means the card provided to the participant and on which the following information is shown: name of the policyholder, policy number, coverage period per trip and emergency telephone numbers.

Medically necessary, in reference to a given service or supply, means such service or supply:

a) is appropriate and consistent with the diagnosis according to accepted community standards of medical practice;

b) is not experimental or investigative in nature;

c) cannot be omitted without adversely affecting the condition of the insured person or quality of medical care;

d) cannot be delayed until the insured person returns to his/her province or territory of residence.

Ongoing condition means an acute sickness and/or injury that requires continuing care and/or treatment after the initial emergency has ended as determined by the medical director of Global Excel.

Participant means an employee or a member whom the policyholder identifies as being entitled to coverage under the policy and for whom the policyholder has paid the required premium.

Physician means a medical practitioner whose legal and professional standing within his or her jurisdiction is equivalent to that of a doctor of medicine (MD) licensed in Canada, who is duly licensed in the jurisdiction in which he or she practices, who prescribes drugs and/or performs surgery and who gives medical care within the scope of his or her licensed authority. A physician must be a person other than you or your immediate family member.

Policy means the group travel emergency medical insurance contract issued to, and on file with, the policyholder, bearing the policy number.

Policyholder means the company or organization (the Ottawa Catholic School Board) to which the policy is issued.

Reasonable and customary costs means costs that are incurred for approved, covered medical services or supplies that do not exceed the standard fee of other providers of similar standing in the same geographical area, for the same treatment of a similar sickness and/or injury.

Sickness means a disease or disorder of the body that results in loss while this coverage is in effect. The sickness must be sufficiently serious to prompt a reasonably prudent person to consult a physician for the purpose of medical treatment.

Spouse as provided for under the policyholder's basic group extended health care plan.

Terminal illness means you have a condition that is cause for the physician to estimate that you have less than six months to live.

Termination age means the age at which the participant's coverage terminates which is 70 or retirement, whichever is earlier. Dependants beyond the termination age may be covered provided that the participant has not yet reached the termination age.

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

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

Vehicle means any automobile, station wagon, mini-van, sports utility vehicle (for on-road use), motorcycle, pick-up truck or a mobile home, camper truck or trailer home under 11 meters (36 feet) in length, used exclusively for the transportation of passengers other than for hire, in which the insured person is a passenger or driver during the trip.

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

Notice and proof of claim

In the event that Global Excel is not contacted immediately, the insured person, or a beneficiary entitled to make a claim, or the agent of any of them, shall:

a) give written notice of claim by delivery thereof or by sending it by registered mail to Global Excel not later than 30 days from the date the claim arises under the policy;

b) within 90 days from the date a claim arises under the policy, furnish Global Excel such proof of claim as is reasonably possible in the circumstances of the emergency giving rise to the claim and the loss occasioned thereby, the right of the claimant to receive payment, his age and the age of the beneficiary, if relevant; and if required by Global Excel, provide a satisfactory certificate stating the cause for which the claim is made and the duration of the disability, if applicable.

Failure to give notice or proof

Failure to give notice of claim or furnish proof of claim within the prescribed period above does not invalidate the claim if the notice or proof is given or furnished as soon as is reasonably possible, and in no event later than one year from the date of injury or the date a claim arises under the policy on account of sickness if it is shown that it was not reasonably possible to give notice or furnish proof within the time so prescribed.

Insurer to furnish forms for proof of claim

Global Excel, on behalf of the insurer, shall furnish forms for proof of claim within 15 days after receiving notice of claim, but where the claimant has not received the forms within that time he/she may submit the proof of claim in the form of a written statement of the cause or nature of the emergency giving rise to the claim.

Claims procedures

You are responsible for providing all the documents outlined below and for any charges levied for these documents. To file a claim, you must:

a) include the policy number, the patient's name (married and maiden, if applicable), date of birth, and Canadian provincial or territorial government health insurance plan number with its expiry date or version code (if applicable);

b) submit all original itemized bills from the medical provider(s) stating the patient's name, diagnosis, all dates and type of treatment, and the name of the medical facility and/or physician;

c) provide the original prescription drug receipts (not cash receipts) from the pharmacist, physician or hospital showing the name of the prescribing physician, prescription number, name of preparation, date, quantity and total cost;

d) provide proof of the departure date(s) and return date(s);

e) provide written proof of claim within 90 days of the date of receipt of services covered under the policy;

f) provide additional information pertinent to your claim, as may be required by Global Excel after receipt of your claim;

g) sign and return the authorization form, provided by Global Excel, allowing the insurer to recover payment from the Canadian provincial or territorial government health insurance plan. The insurer will co-ordinate and pay your claim to the participating medical providers and where permitted, co-ordinate claims directly with the Canadian provincial or territorial government health insurance plan on your behalf; and

h) return the unused portion of your air ticket to Global Excel if the emergency air transportation benefit is used.

All sums in the plan are in Canadian currency unless otherwise indicated. If you have paid a covered expense in a currency other than Canadian currency, you will be reimbursed in Canadian currency at the prevailing rate of exchange on the date that the claim payment is made. This insurance will not pay interest.

Any information not provided may result in a delay in processing your claim.

All pertinent documents should be sent to:

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

Tel.: 1-866-870-1898 (toll free) or
(819) 566-1898 (collect) during business hours (EST)

6. Dental care

Benefits are based on the current Dental Association Fee Guide for general practitioners or Denturist Fee Guide in the province in which the services are rendered. Charges must be for reasonable and customary dental care or denture therapy or supplies provided or ordered by a dentist or physician.

Reasonable and customary charges means charges for services whose nature and severity are in accordance with:

1. the fee practices and tariffs of the official fee schedule; or
2. if there is no official fee schedule, representative fee practices and tariffs of the profession in the area.

Dental expenses means expenses for dental treatment recommended as necessary by a dentist that are not in excess of the maximum fee specified for general practitioners in the current Dental Fee Guide in the province in which services are rendered. If treatments are performed by a specialist, the plan will only reimburse up to the General Practitioners' Fee Schedule in the province in which the dentist practices.

For denturists, *dental expense* means expenses for dental treatment recommended as necessary by a denturist that are not in excess of the minimum fee specified in the current Denturist Fee Guide in the province in which the services are rendered.

ELIGIBLE EXPENSES

Coverage is available for the following:

1. routine services;
2. dentures;
3. crowns and bridgework; and
4. orthodontic services.

ROUTINE SERVICES

Only those treatments listed below are eligible.

Examinations

- Complete oral examination (once every 36 months)
- Recall oral examination (once every nine months)
- Emergency examination
- Specific oral area examination

Diagnostic services

- Radiographic examination (X-ray)
- Complete intra-oral film series (once every 36 months)
- Periapical films
- Occlusal films
- Posterior bitewing films (once every six months)
- Extra-oral films
- Sinus examination
- Sialography
- Use of radiopaque dyes to demonstrate lesions
- Panoramic films (once every 36 months)
- Cephalometric films
- Interpretation of radiographs from another source
- Tomography
- Hand and wrist (as diagnostic aid for dental treatment)

Tests and laboratory examinations

- Bacterial cultures for determination of pathologic agents
- Dental caries susceptibility test
- Biopsy, soft-hard tissue
- Cytological examination
- Pulp vitality tests.

Case presentation

- Treatment planning, two units of time every 12 months
- Consultation with patient

Preventive services

- Light scaling and/or polishing (up to one unit of time every nine months)
- Fluoride treatment (once every nine months)
- Oral hygiene instruction (once every nine months)
- Pit and fissure sealants (children up to age 18)
- Caries/pain control
- Interproximal dicing of teeth
- Space maintainers (primary teeth only)
- Therapeutic scaling (eight units of time per calendar year combined with root planing)

Restorative services

- Amalgam restorations for primary teeth, permanent anterior and bicuspid teeth, permanent molar teeth
- Pin reinforcement
- Acrylic or composite restorations

Endodontic services

- Pulp capping
- Vital pulpotomy
- Root canal therapy
- Apexification
- Periapical services
- Root amputation
- Gingival curettage
- Alveolectomy
- Banding of teeth to maintain sterile operating field
- Hemisection
- Endodontic bleaching
- Intentional removal, apical filling and re-implantation
- Emergency procedures

Periodontal services

- Application of displacement dressing
- Management of acute infections and other oral lesions
- De-sensitization of tooth surface
- Root planing (eight units of time per calendar year, combined with therapeutic scaling)

Surgical services

- Gingival curettage
- Gingivoplasty
- Gingivectomy
- Osseous surgery

- Osseous grafts
- Soft tissue grafts
- Vestibuloplasty
- Post-surgical treatment

Adjunctive periodontal services

- Provisional splinting - intra-coronal, extra-coronal per unit of time
- Occlusal equilibration (eight units of time every calendar year)
- Periodontal scaling and root planing (combined eight units of time every calendar year)
- Special periodontal appliances, including occlusal guards (excluding temporomandibular appliance)
- Maintenance, adjustments and repairs to periodontal appliances (not eligible at time of insertion)

Other services

- Denture adjustments (complete or partial dentures)
- Minor adjustments (after three months from insertion)
- Denture repairs
- Denture re-basing and/or re-lining

Surgical services

- Removal of erupted tooth (uncomplicated)
- Removal of single tooth
- Removal of each additional tooth in the same surgical site
- Removal of erupted tooth (complicated)
- Removal of impacted tooth
- Removal of residual roots

- Fibrotomy
- Surgical exposure of tooth
- Transplantation of tooth
- Surgical repositioning of tooth
- Enucleation of an unerupted tooth and follicle
- Alveoplasty
- Gingivoplasty and/or stomatoplasty
- Osteoplasty
- Surgical excision (cysts and neoplasms)
- Surgical incision
- Fractures
- Frenectomy
- Miscellaneous surgical services

Anaesthesia

- In relation to surgical procedures only

Consultation

- With another dentist, two units every 12 months combined with consultation with patient.

Professional visits

Adjunctive general services

- Drugs (injections)

2. DENTURES

Dentures are reimbursed at 50 per cent to a maximum of $2,000 per person per calendar year.

Prosthodontic services, removable

- Complete maxillary denture
- Complete mandibular denture
- Complete maxillary and mandibular dentures
- Immediate complete denture
- Transitional complete denture
- Transitional partial denture
- Removable partial denture, cast chrome cobalt (or gold)
- Replacement every three years.

3. CROWNS AND BRIDGEWORK

The following eligible expenses will be reimbursed at 50 per cent up to a maximum of $2,000 per person per calendar year:

Restorative services

- 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

Crowns

- Acrylic, processed
- Acrylic, processed to metal
- Acrylic or plastic, transitional, direct (chairside)
- Acrylic or plastic, transitional, indirect
- Porcelain (not for molar tooth)
- Porcelain fused to metal base (not for molar tooth)
- Metal full cast
- Metal 3/4 cast
- Metal transition, direct (chairside)
- Cast metal post and core as a separate procedure
- Cast metal post and core concurrent with impression for crown

Other restorative services

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

Prosthodontic services, fixed

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

Pontics

- Metal cast pontic
- Slotted facing
- Porcelain fused to metal pontic

- Porcelain pontic, aluminous
- Acrylic processed to metal pontic
- Acrylic pontic processed, transitional during healing
- Acrylic pontic transitional, acid etched to adjacent teeth
- Reverse pin pontic
- Retainers, inlays and onlays
- Metal inlay
- Metal onlay
- 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 3/4 cast crown
- Metal full cast crown
- Intra-oral indexing for soldering purposes
- Retentive pins in abutments

Adjunctive general services

- In-office laboratory charges

Major restorative treatment

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

1. replacement is necessitated by the extraction of additional natural teeth;
2. the existing prosthesis is at least three years old and cannot be made serviceable;
3. the existing prosthesis is temporary and is replaced with a permanent one within 12 months.

Any charges for a temporary prosthesis will be deducted from the cost of the permanent prosthesis at the time of insertion.

4. ORTHODONTIC SERVICES

Orthodontic services are reimbursed at 50 per cent up to a maximum of $2,500 per person per lifetime.

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 the initial claim. Reimbursement for the initial orthodontic fee will not exceed 35 per cent of the total treatment. The balance of the 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.

DENTAL CARE BENEFIT PROVISIONS

Pre-determination of benefits

Where a course of treatment will involve the use of crowns, inlays, onlays, bridges or dentures, or is expected to cost $300 or more, or if you want to know the exact reimbursement of a certain detail procedure, it is recommended that the covered person obtain from the attending dentist a written estimate outlining the procedures and itemized charges, including X-rays, if and when required. 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 covered person on the amount of benefit payable.

Alternate benefit provision

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

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

The alternate benefit clause cannot be applied to excluded expenses.

Spousal coverage

If your comparable dental coverage terminates because that group contract terminates, or because you cease to be eligible for the comparable coverage, you and your dependants may acquire the dental coverage under this plan without restrictions, providing you apply for coverage within 31 days.

If you apply after the 31-day period, coverage for all services except orthodontic services will be restricted to $100 for the first 12 consecutive months your insurance is in force. For orthodontic services, the amount payable will be limited to $100 for the first 36 consecutive months the insurance is in force.

Other than when first hired, to join the dental plan without late restrictions, you must apply within 31 days of a change such as the loss of spousal coverage, marriage or birth/adoption of a child.

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

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

7. Definition of terms: extended health care and dental care

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

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

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

8. Limitations

No payment will be made for expenses resulting from:

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

14. experimental medical procedures or treatment methods not approved by the provincial medical association or the appropriate medical specialty society;
15. any charges for porcelain crowns on molar teeth (this policy will cover metal allowance only);
16. charges for treatment by a family member who is treating an employee related to him/her by blood or marriage; and
17. dispensing fees that are in excess of the published Ontario Drug Benefit (ODB) plan maximum per prescription or refill; and/or
18. MRIs in private clinics.

Extension of benefits

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

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

Extension of extended health care and dental benefits will cease when the contract terminates.

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

1. where an impression for a denture, bridge, crown, inlay or onlay had been taken prior to the date your coverage terminates and the termination of coverage; related dental expenses incurred within 30 days after the termination of coverage, are eligible;

2. if your coverage terminates due to your death, dental expenses incurred on behalf of your dependants will be eligible for payment provided:

   A. the services are rendered within 90 days following your death; and

   B. they are part of a series of planned dental services started prior to your death or rendered at definite dental appointments made prior to your death.

9. Claims procedures

When you have a claim, be sure to obtain the necessary forms from *First Class* in the *Benefits Conference,* or from Coughlin & Associates Ltd., the plan administrator. The *Benefits Conference* contains a link to Coughlin & Associates Ltd. where forms can be printed from its website. When they are completed and signed, forward them to Coughlin & Associates Ltd.

Samples of medical and dental claim forms appear at the back of the booklet.

It is only reasonable for you to expect prompt settlement of claims when they arise. Feel free to contact Coughlin for assistance or to ensure that that you have completed the form(s) correctly. For your assistance, a table of policy numbers has been included at the beginning of this booklet.

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

PRE-AUTHORIZED DEPOSIT AVAILABLE

Members and employees of benefit plans administered by Coughlin & Associates Ltd. can now have their health and dental claim reimbursements deposited directly to their bank accounts.

With Coughlin's new Pre-Authorized Deposit (PAD) reimbursement program, you can receive your reimbursement within two to five days following the approval of your dental claims. You will not have to wait for the arrival of a cheque and a trip to the bank before depositing your reimbursement.

To enrol in Coughlin's PAD program, just log-on to the Coughlin website at www.coughlin.ca and click on the *"Pre-authorized payment form"* icon in the *"Important forms"* section and follow the instructions.

LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT

Taking a lump sum settlement is only one way of settling a life insurance or accidental death and dismemberment claim. A settlement option, such as a life income, should be considered. If you do not make a settlement

option election, your beneficiary may do so at the time of the claim. Make sure that your beneficiary knows that these options are available.

In the event of your death, your beneficiary should immediately contact the benefits administrator in the Ottawa Catholic School Board Human Resources department.

EXTENDED HEALTH CARE

Keep a record of all out-of-pocket expenses incurred by you and your covered dependants. It is important that all original receipts for eligible expenses, including those for prescription drugs, accompany any claim that is submitted manually. Clearly indicate the name of the person for whom the expense was incurred. Complete the appropriate claim form and submit it along with these receipts to Coughlin & Associates Ltd.

In co-ordination of benefits situations where Coughlin & Associates Ltd. is the second payer, the original explanation of benefits from the original insurer, and copies of the relevant receipts or dental claim forms, must be submitted.

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

Use the pay direct drug card for prescription drug claims

Drug claims can also be submitted using the pay direct drug card. With the pay direct drug card, your prescription drug claims *will be processed on-the-spot at your local pharmacy when you purchase prescription medications.* There are no forms to complete, and no waiting for a reimbursement cheque to arrive. **Simply present the card to your pharmacist when you purchase prescription drugs. Your claim payment will be processed *immediately.***

DENTAL CARE

Standard dental claim forms are available on *First Class* in the *Benefits Conference*. Be sure to include employer information and/or policy number. A claim form must be completed by the covered person as well as the dentist. A separate claim must be completed for each person receiving treatment.

Payment may be made directly to the dentist, if so desired, by assigning the benefit to the dentist in the appropriate space provided on the claim form.

Claims must be submitted by the end of the calendar year following the year in which the expense was incurred. If your coverage terminates for any reason, written proof of claim must be submitted within 90 days of the termination of coverage.

Submit claims electronically through Coughlin's EDI service

Coughlin & Associates Ltd. can process your dental claim using its electronic data interchange (EDI) claims processing service.

With EDI, your dental claim can be sent directly from your dental office to the Coughlin claims department for adjudication.

EDI service uses the secure data networks of Emergis, the dedicated claims processing network sponsored by the Canadian Dental Association. To take advantage of Coughlin's EDI service, tell your dentist that Coughlin & Associates Ltd. is your claims administrator and present him/her with the following security codes:

- the Coughlin & Associates Ltd. Emergis carrier identification number (also known as the BIN number), which is **610105** on the Emergis network;
- your unique employee identification number; and
- the policy number of your group benefit plan, **9400**.

Your human resources department will be able to provide you with your employee identification number.

An important note: If you do transmit your claim electronically through Emergis, your reimbursement will be mailed to you within two to four business days. The Coughlin walk-in claim reimbursement service is not linked to Emergis.

WALK-IN CLAIMS SERVICE

Employees seeking immediate reimbursement of eligible expenses can bring their claims to the plan administrator's office where they will be assessed promptly. All such claims and inquiries should be directed to the plan administrator:

COUGHLIN™
employee benefits specialists

Street address
466 Tremblay Road
Ottawa, ON K1G 3R1

Mailing address
Box 3517, Station C
Ottawa, ON K1Y 4H5

Telephone: 613-231-2266
Toll-free: 1-888-613-1234
Fax: 613-231-2345

E-mail: webmaster@coughlin.ca

Web address: www.coughlin.ca

CHECK THE *BENEFITS CONFERENCE* FOR INFORMATION AND FORMS

For more information, check the *Benefits Conference* site. You'll find a copy of this booklet, the latest listing of the Coughlin & Associates Ltd. Preferred Provider Network of pharmacies and a link to the Coughlin website for claims forms and other useful information.

Ottawa Catholic School Board

10. Sample extended health care and dental care claim forms

MEDICAL EXPENSE CLAIM FORM

Plan Member - insured

Group or employer

Personal Identification No.

Plan Member's Full Name

Date of Birth y m d

Address

Language Preference ☐ English ☐ French

City Province Postal Code Residence Telephone No. Work Telephone No. ext.

Are any health benefits or services provided under any other group insurance or health plan, workers' compensation or government plan?

☐ NO ☐ YES

If YES, who is the member of this other pla

Name of other insuring agency or plan

Dependants Please comple
For co-ordination o

Last Name

Spouse

Child(ren)

☐ Daughter ☐ Son
☐ Other (describe)
☐ Daughter ☐ Son
☐ Other (describe)
☐ Daughter ☐ Son
☐ Other (describe)

☐ Drug Expenses

☐ Vision Care Ex
Attach original itemized re

Is this a new prescription?

If NOT, reason for replacement

Check One
☐ Single ☐ Bifo
☐ Contact lenses ☐ Trifo

☐ Other Expense

Nature of expense

I authorize Coughlin & Associates Ltd. to co
Insurance Number for the purposes of gover
parties: Health care providers; financial instit
information on file to provide me with addition
on their behalf. **I agree** that a photocopy or e

I certify that the information given is true, co

Date y m d

Protecting your personal information Th
information is provided to us, we establish a c
We limit access to information in your file to C

Send all claims and inquiries to:

COUGHLIN
employee benefits specialists

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

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

Tel.:
local
613-231-8540

E-mail:
ottclaims@coughlin.ca

www.coughlin.ca

Toll free:
1-877-768-3378

DENTAL CLAIM FORM

PART 1 - TO BE COMPLETED BY DENTIST

PATIENT

LAST NAME FIRST NAME

ADDRESS APT.

CITY PROV. POSTAL CODE

UNIQUE NO. SPEC. PATIENT'S OFFICE ACCOUNT NO.

DENTIST

PHONE NUMBER

I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM TO THE NAMED DENTIST AND AUTHORIZE PAYMENT DIRECTLY TO HIM/HER.

SIGNATURE OF PLAN MEMBER

FOR DENTIST'S USE ONLY, FOR ADDITIONAL INFORMATION, DIAGNOSIS, PROCEDURES, OR SPECIAL CONSIDERATION.

I UNDERSTAND THAT THE FEES LISTED IN THIS CLAIM MAY NOT BE COVERED BY OR MAY EXCEED MY POLICY BENEFITS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO MY DENTIST FOR THE ENTIRE COST OF THE TREATMENT.

I ACKNOWLEDGE THAT THE TOTAL FEE OF $ _____ IS ACCURATE AND HAS BEEN CHARGED TO ME FOR SERVICES RENDERED. I AUTHORIZE RELEASE OF THE INFORMATION CONTAINED IN THIS CLAIM FORM TO MY INSURANCE COMPANY/PLAN ADMINISTRATOR.

SIGNATURE OF PATIENT (PARENT/GUARDIAN)

DUPLICATE FORM ☐

OFFICE VERIFICATION / DENTIST'S SIGNATURE

DATE OF SERVICE Y	M	D	PROCEDURE CODE	INT. TOOTH CODE	TOOTH SURFACES OR UNITS	DENTIST'S FEE	LABORATORY CHARGE	TOTAL CHARGES

THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND THE TOTAL FEE DUE AND PAYABLE. E. & OE.

TOTAL FEE SUBMITTED

INSTRUCTIONS
1. Have your dentist complete part 1.
2. Complete all questions in part 2.
3. Send form to **Coughlin & Associates Ltd.**

Send all claims and inquiries to:

COUGHLIN
employee benefits specialists

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

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

E-mail:
ottclaims@coughlin.ca

Fax:
613-231-2345

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

www.coughlin.ca

PART 2 - TO BE COMPLETED BY PLAN MEMBER

GROUP OR EMPLOYER

PLAN MEMBER'S FULL NAME

PERSONAL IDENTIFICATION NUMBER (PI.N.)

LANGUAGE PREFERENCE ☐ ENGLISH ☐ FRENCH

TELEPHONE NUMBER

PLAN MEMBERS ADDRESS

APT.

CITY PROVINCE

POSTAL CODE DATE OF BIRTH YEAR MONTH DAY

1. IS THIS CLAIM DUE TO AN ACCIDENT? YES ☐ NO ☐

DATE OF ACCIDENT

IF "YES" ATTACH DETAILS OF THE ACCIDENT.

2. IF TREATMENT INVOLVES THE PLACEMENT OF A CROWN / BRIDGE OR DENTURE.

IS THIS THE INITIAL PLACEMENT? UPPER YES ☐ NO ☐ LOWER YES ☐ NO ☐

IF "NO", GIVE THE DATE OF PRIOR PLACEMENT AND ATTACH AN EXPLANATION.

YEAR MONTH DAY

DATE

Are any dental benefits or services provided under any other group insurance or dental plan, Worker's Compensation or government plan?

Yes ☐ **No** ☐

If **yes,** indicate member under other plan: If spouse indicate: Self ☐ Spouse ☐

Name DOB Year Month Day

Name of other insuring agency or plan

Policy No. PI.N.

N.B. **For coordination of benefits,** children must claim under the plan of parent with the earlier day and month of birth in the calendar year.

COMPLETE ONLY IF CLAIM IS FOR A DEPENDENT

DEPENDENT'S LAST NAME FIRST NAME

DATE OF BIRTH Year Month Day RELATIONSHIP TO PLAN MEMBER

If this claim is for a dependent child age 21 or over, what was the date the child last attended school on a full time basis? Year Month Day

Name of school

I authorize Coughlin & Associates Ltd. to collect and exchange personal information about me and/or my dependents to process this claim and administer my group plan. **I authorize** Coughlin the use of my Social Insurance Number for the purposes of government reporting, identification and administration of my group benefits; Coughlin to exchange my personal information with the following persons, organizations or parties: Health care providers; financial institutions; government agencies; insurance companies; employers or former employers; my local union or plan trustees and auditors; and Coughlin to use the personal information on file to provide me with additional information regarding any benefits to which I am entitled. When providing personal information for my spouse and/or dependants, **I confirm** that I am authorized to act on their behalf. **I agree** that a photocopy or electronic copy of this Authorizations & Declarations section is as valid as the original.

I certify that the information given is true, correct and complete to the best of my knowledge.

PLAN MEMBER'S SIGNATURE

dtp.12/02/2008.dentalct.cdr

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