Premier Plan

Policy #814265 | Classes C,G,K,O,S

Welcome to Viking Benefit Solutions. We are pleased to present you with your new PUBLIK Retiree Health Plan. Please read this booklet and be sure to sign up for the equitable life EZclaim app. **Note: Due to the structure of the policy, all PUBLIK members are considered the "employee" and Viking Benefit Solutions Inc. is considered the Employer.**

Sincerely,

Viking Benefit Solutions

Call toll-free: 1.844.811.7672

Policy #814265

Through **EQUITABLE LIFE OF CANADA®**, your Employer is providing you with the group benefits plan outlined in this booklet.

We know how important financial security is to you and your family. With this in mind your group benefits plan is designed to help meet some of your financial needs in the event of sickness or death.

We encourage you to read and understand the benefits that your Employer is providing for you. If you have any questions, please contact the person in your company who administers your group benefits plan.

Where provincial legislation permits, you may obtain copies of the application, evidence of insurability, policy and booklets.

We welcome you as a member of this Equitable Life group benefits plan.

Sincerely,

The Group benefits team

Call toll-free: 1.800.265.4556

IMPORTANT

This booklet is meant to provide information about your group insurance plan. It is not a legal contract. The master policy itself determines the benefits, amounts and effective dates that apply to you.

03/20 – EH

Protecting your privacy

At Equitable Life of Canada, we are committed to protecting the confidentiality and security of your personal information. We follow the privacy principles established by the *Canadian standards association model code for the protection of personal information*.

To protect and safeguard your personal information, we have set up files in which we maintain your personal information that is needed to administer, service, underwrite, adjudicate and process all aspects of the group policy, including the payment of claims.

Your personal information may be accessed by, or exchanged with, authorized employees of Equitable Life and of relevant third parties. These third parties include service providers retained by us, reinsurers, other insurance companies, investigative organizations, health care providers (such as pharmacies, physicians and dentists) and any other person or party whom you authorize.

You have the right to access your personal information held in our files, subject to any legal or business restrictions. If applicable, you can have your personal information corrected.

For more information regarding our privacy policies, please refer to "*Our commitment to protecting your privacy*" which you can find on our website at **www.equitable.ca** under "Privacy".

You may contact us with any questions, concerns or suggestions with respect to our management of your personal information at the address below:

Chief Privacy Officer

One Westmount Road North

P. O. Box 1603, Station Waterloo

Waterloo, On

N2J 4C7

Telephone 1.800.265.8878

Facsimile 519.883.7425

Email: privacyofficer@equitable.ca

Table of Contents

Group benefits contact list

Group benefits administration

General policy Inquiries, personal information changes & web support

Hours of operation:	**Contact:**
8:15AM – 7:00PM EST	groupbenefitsadmin@equitable.ca
6:15AM – 5:00PM MST	Toll free: 1.800.265.4556 ex 283
5:15AM – 4:00PM PST	Fax: 1.888. 878.7747

Health claims

Health claim inquiries

Hours of operation:	**Contact:**
8:15AM – 7:00PM EST	group-health-claims.equitable.ca
6:15AM – 5:00PM MST	Toll free: 1.800.265.4556 ex 606
5:15AM – 4:00PM PST	Fax: 1.888.505.4373

Equitable Life fraud hotline

(Anonymous Call) Phone: 1.800.265.8899

EquitableHealth.ca

Health and wellness solutions that matter™

A standard feature of all Equitable Life® group benefit plans is the easy to access, reliable Canadian health and wellness resources available through EquitableHealth.ca®. This website connects you with Canadian health and wellness resources through the Equitable HealthConnector® platform and Homewood Health® Online.

HealthConnector – Supporting your health:

Whether you need help finding a doctor, are dealing with a family or personal issue, or are looking for valuable health resources, Equitable HealthConnector is there to support you. Go online and connect with the support and information you need. Call 1.800.265.4556 if you have any questions about Equitable HealthConnector.

The first time you visit EquitableHealth.ca, take a moment to click on *My Resources* to see all the health and wellness information and tools available to you through HealthConnector – it will be time well spent.

Homewood Health – Improving Life:

An important part of being truly healthy is recognizing and understanding the variety of factors that can impact your daily life. Homewood Health's online portal (Homeweb.ca/Equitable) provides access to a personalized library of tools, assessments and courses to help you better cope with everyday issues including work-life balance, parenting concerns, financial and legal issues and dealing with aging loved ones. You also have access to an interactive online Health Risk Assessment, and i-Volve, an innovative Cognitive Behavioural Therapy program that provides support for managing anxiety or depression.

Plan member web services through EquitableHealth.ca

Plan member web services is the fast, convenient online way to access information about your group benefits whenever you need to. Plan member web services will help you understand and manage your group benefits more effectively and saves valuable time and effort by allowing you to:

- Get real time coverage information, claim status and claims history;
- Access claims and administration forms;
- View and confirm the details of your coverage, including information on your eligible dependents;
- Update personal information, including your address and banking information; and
- Sign up for Electronic explanation of benefits (E-EOB) and direct deposit payment E-solutions that will allow you to get your claim payments faster.

Use EZClaim online for fast claim submission!

Sign in to your Group Benefits account as a Plan Member.

Click *submit a claim* on the homepage and fill out the interactive health or dental claim form, attach your receipt and submit – it's that EZ!

If you require any assistance in signing up for or accessing your group benefits account, contact Group Administration at: 1.800.265.4556 ext. 283 or email groupbenefitsadmin@equitable.ca.

Schedule of benefits

The Plan described in this booklet is effective as of June 1, 2021.

In this booklet “the Company”, “we” and “us” means The Equitable Life Insurance Company of Canada.

IMPORTANT NOTE

The information in the Schedule of insured benefits and Summary of health benefit maximums in this booklet is only a brief summary of your group plan. These pages outline the benefits, schedules, deductibles, reimbursement percentages and most of the maximums that apply to your plan.

See the descriptive pages following the Summary for more information you need to know, such as eligible expenses, exclusions, specific requirements (such as written prescriptions/referrals from your Physician), definitions of Practitioners (qualifications they must have), and other maximums that may apply.

Protecting you from fraud

Fraudulent claims can result in additional insurance costs for you and your Employer. Equitable Life wants to protect you from the negative results of such criminal activity. To do this, we focus on all means necessary to support the detection, investigation and prosecution of false, incomplete or misleading information. Such criminal actions will result in the claim being denied and coverage being removed.

If you believe someone is involved in fraudulent claims, you can call our anonymous HOTLINE at 1.800.265.8899.

Classification(s)

- Class C: Saskatchewan Residence - Premier health plan, no dental
- Class G: Alberta Residence - Premier health plan, no dental
- Class K: Manitoba Residence - Premier health plan, no dental
- Class O: British Columbia Residence - Premier health plan, no dental
- Class S: Ontario Residence - Premier health plan, no dental
- Class C: All Other Provinces and Territories of Residence - Premier health plan, no dental

General information

Maximum age for dependent children

- Maximum age for dependent children who are not in school full-time: under age 21
- Maximum age for dependent children who are in full-time attendance at school: under age 25

(See the General provisions for dependents section in this booklet for more information on coverage for your eligible dependents, including the requirements for continuing coverage for disabled children.)

Co-habitation requirement for partners

(see the General provisions for dependents section in this booklet for more information on coverage for your eligible dependents)**:**

- 12 consecutive months

Maximum age for coverage

(also refer to 6. “When does your insurance terminate” in the General provisions)**:**

- All benefits terminate on the date of your death.

Waiting period:

(see the General provisions in this booklet for more important information)

- none

Plan member and dependent health benefits

You must be in the plan option you have selected at enrolment for at least a 24 month period, after which time (at any time after), you may choose a different option up or down one option. You can subsequently change your option after you have participated in the option you have selected for at least a 24 month period.

Deductible amount per prescription for the drug plan:

nil

Deductible amount per calendar year for all other benefits:

nil

Reimbursement percentage (up to reasonable and customary charges):

Drug plan: 80%

Major services: 80%, except 100% in respect of Diabetic Supplies, Glucometer, Ambulance and Paramedical Services

Hospital services: 100%

Vision care services: 100%

Benefits:

Pay-direct drug plan #88G

Claim payment type: Electronic submission at the pharmacy

Note: This is a generic drug plan and the maximum that will be eligible is an amount equal to the lowest priced alternative drug in accordance with Equitable Life of Canada's adjudication practices at the time of claim, except where the physician or dentist indicates on the prescription "no substitution".

An alternative drug includes but is not limited to:

(i) an alternative drug (typically a generic) to the brand name drug deemed to be interchangeable by law where the drug is dispensed; or

(ii) a subsequent entry biologic.

a subsequent entry biologic.Maximum per insured person per calendar year: $5,000

Maximum supply eligible: a 34-day supply, except a 100-day supply for maintenance or long-term therapy drugs.

Co-ordination of benefits: reasonable and customary charges will apply when coordinating as a second insurer

In addition, your drug plan has a Specialty Drug Preferred Pharmacy Provider arrangement with BioScript® Pharmacy. BioScript Pharmacy provides preferred pricing for eligible specialty drugs listed on Equitable Life's Specialty Drug Management Program (SDMP). To be eligible for coverage under the drug plan, prescriptions for drugs listed on Equitable Life's SDMP must be filled with BioScript® Pharmacy. Prescriptions for specialty drugs listed on Equitable Life's SDMP filled at a pharmacy or by any provider other than BioScript Pharmacy will not be eligible for coverage under the drug plan and you or your dependent will be responsible for the full cost of the specialty drug. Where Equitable Life is not the first private payer, specialty drugs listed on Equitable Life's SDMP that are coordinated with your spouse's plan are paid based on the standard Coordination of Benefits provisions applied to regular drugs. There is no requirement to fill Specialty Drug prescriptions at a BioScript pharmacy where Equitable Life is the second private payer. The Specialty Drug Preferred Pharmacy Provider drug plan does not apply to you or your dependents if you reside in the province of Quebec. If you are a resident of Quebec, you may choose to fill your prescription for eligible specialty drugs at an accredited pharmacy of your choice.

Major services:

Major services

Hospital services:

Semi-private hospital services:

reasonable and customary charges to a maximum of 80 days per insured person per calendar year

Vision care

(see the Vision care section in this booklet for more details):

- Eye glasses or contact lenses or laser eye surgery: maximum $200
    - This maximum applies in any period of 24 months for both adults and dependent children.
- Special contact lenses (#3 on the Vision care page): Maximum: $300
    - This is a lifetime maximum per insured person.
- Eye examinations: maximum: reasonable and customary charges
    - One eye examination is eligible in any period of 24 months for both adults and dependent children.

Summary of health benefit maximums:

The following maximums apply to the drug plan:

Note: Drug claims for you and/or your dependents who are insured under this drug plan will be administered in accordance with the applicable provincial legislation.

Maximum for fertility drugs:

not eligible

Maximum for smoking cessation products:

(such products must have a DIN and the insured person must have a written prescription from a physician)

not eligible

Maximum for other specified drugs:

Maximum for oral erectile dysfunction drugs: not eligible

Maximum for weight loss drugs: not eligible

Maximum for hypoactive sexual desire disorder (HSDD) drugs: not eligible

Maximum for vaccines and immunizations:

not eligible

The following maximums apply to items covered under major services:

Note: Eligible expenses will be limited to reasonable and customary charges up to the maximums.

The numbers at the left refer to the item numbers on the Major services pages in this booklet. Please see the Major services descriptive section in this booklet for more details about these benefits.

#1 Maximum payable for convalescent home services:

$40 per day for a maximum of 180 days per disability per insured person

#3 Maximum amount payable for private duty nursing care services (PDN):

$5,000 per insured person per calendar year to a $50,000 lifetime maximum.

#4(b) Maximum per insured person for appliances and supplies

Canes, casts, crutches, splints, and trusses: reasonable and customary charges

Extremity pumps for lymphedema: $1,000 lifetime maximum

Intrauterine devices (IUD's): reasonable and customary charges

Laryngeal speaking aids: reasonable and customary charges

Orthopaedic braces required for medical reasons: reasonable and customary charges
(includes over-the-counter braces with rigid supports)

Prosthesis (includes myoelectric prosthesis and artificial eyes): reasonable and customary charges*

Stump socks: 6 pairs per calendar year

Surgical stockings and support hose combined: $250 per calendar year

Transcutaneous nerve stimulator (TENS): $500 lifetime maximum

Viscosupplementation: 3 injections per knee lifetime maximum

Wheelchairs (electric or manual) and hospital bed rental: reasonable and customary charges to a maximum of $10,000 per insured person every 5 calendar years

#4(c) Maximum for breast prosthesis and surgical brassiere(s):

External breast prosthesis: one per insured person per affected breast in any period of 36 consecutive months*

Surgical brassieres: two per insured person per calendar year

*All prosthesis (including myoelectric prosthesis, artificial eyes, and external breast prosthesis) are subject to a combined maximum: $5,000 lifetime per insured person

#4(e) Maximum for hearing aids:

$500 per insured person every 4 calendar years

Hearing aid batteries are not eligible.

#4(f) Maximum amount for orthopaedic shoes and orthotics:

(Note: To be eligible, orthopaedic shoes and orthotics must be specially constructed for the patient and prescribed by a physician, podiatrist or chiropodist.)

$300 per insured person per calendar year for orthopaedic shoes and orthotics combined

#4(h) Maximum for wigs and hairpieces

(required as a result of a medical condition):

$200 lifetime maximum per insured person

#4(i) Maximum for glucometers:

1 per insured person in any period of 48 consecutive months

#4(j) Maximum for diagnostic laboratory procedures:

$500 per insured person per calendar year

#6 Maximum of $1,000 per insured person per calendar year for all of the following Paramedical services combined:

- Athletic therapist
- Audiologist
- Chiropractor (including x-rays)
- Dietician
- Registered massage therapist
- Naturopath (including x-rays but not tests or supplements)
- Osteopath (including x-rays)
- Physiotherapist
- Podiatrist/chiropodist (including x-rays)
- Psychologist (including MSW / Clinical counsellors)
- Specialist in acupuncture
- Speech therapist

A physician's prescription (referral) is not required for any of the paramedical practitioners listed above.

Survivor benefit

For the following benefits only: Health

Maximum period for survivor benefit is the earlier of:

- 60 days, or
- the date that the dependent’s coverage would have terminated had you lived

Schedule of healthconnector™ services

General information

Maximum age for dependent children

Maximum age for dependent children who are not in school full-time: under age 21

Maximum age for dependent children who are in full-time attendance at school: under age 25

(See the General provisions for dependents section in this booklet for more information on coverage for your eligible dependents, including the requirements for continuing coverage for disabled children.)

Co-habitation requirement for partners

(see the General provisions for dependents section in this booklet for more information on coverage for your eligible dependents)**:**

12 consecutive months

Maximum age for coverage

(also refer to 3. "When does your insurance terminate" in the General provisions)**:**

The Cancer Navigation System™ (from CAREpath ™ Inc.) terminates on the 71st birthday.

FeelingBetterNow® (from Mensante Corporation) terminates on the 71st birthday.

Homewood Health® employee and family assistance program (EFAP) terminates on the 71st birthday.

WorldCare ACCESS (remote second opinion service) terminates on the 71st birthday.

Services for your spouse terminate on the earlier of the date your services terminate and your spouse's 71st birthday.

Waiting period:

(see the General provisions in this booklet for more important information)

None

HealthConnector™ services for plan member and dependents

Please note that participation is compulsory for these benefits.

The Cancer Navigation System™ (from CAREpath ™ Inc.)

Please call CAREpath at 1-866-883-5956 as soon as you or a dependent are diagnosed with cancer or have a recurrence of a previously treated cancer so they can provide assistance before and after your first visit to an oncologist.

FeelingBetterNow® (from Mensante Corporation)

Go to http://www.feelingbetternow.com/equitable/ and follow the simple instructions to gain access to this service.

Homewood Health employee and family assistance program (EFAP)

To find out more about how Homewood Health can help, call to speak with a Homewood consultant anytime at 1.888.707.2115 or sign in to Homeweb.ca/Equitable

WorldCare ACCESS (from WorldCare™ Inc.)

To initiate a WorldCare consultation, call 1-877-676-6439.

Note: The following pages are standard descriptive pages. Some sections will tell you to look on the Schedule of insured benefits or Summary of health benefit maximums for the details that apply to your own group plan. It is very important that you read these descriptive pages as they provide information you need to know.

General provisions

1. WHO IS ELIGIBLE TO JOIN THE GROUP PLAN?

   You're eligible if you:

   - are a retired public sector employee plan member and have applied for coverage under this plan within 60 days of your public sector group benefits plan ending, and
   - permanently live in Canada, and
   - have provincial health care coverage in your province of residence, and
   - were actively at work immediately prior to your retirement.

2. WHAT CAN I DO WHEN I DISAGREE WITH A CLAIM DECISION?

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

3. WHEN DOES YOUR INSURANCE TERMINATE?

   Your insurance terminates on the earlier of the following dates:

   - on the date this group policy terminates
   - on the date you no longer qualify for coverage
   - on the date you reach the **maximum age for coverage** shown in the Schedule of insured benefits
   - on the date it is proven to the satisfaction of the Company that you have engaged in fraudulent activity with respect to claims under this policy.

4. EVIDENCE OF INSURABILITY

   The Schedule of insured benefits tells you if evidence of insurability is required for any amounts of insurance coverage. If the amount available without evidence (the no-evidence limit) changes under this group plan, the amount of coverage you're eligible for will be determined by the Company according to the terms of the master policy.

General provisions for dependents

1. WHO ARE ELIGIBLE DEPENDENTS?

Eligible dependents must have provincial health care coverage in the province of residence, and must not be permanent residents outside Canada and include:

Your spouse. This means:

- your legally married husband or wife, or
- your partner (a person of the same or opposite sex who resides with you in a conjugal relationship and who you publicly represent as your partner)

You can only cover one spouse at a time. You must notify us in writing if you want to change your spouse.

Your child. This means:

- your, or your spouse's natural child, adopted child, stepchild, child you have been granted final guardianship or custody of by an order of the Court.

To be eligible, the child must not have a spouse or partner, must be supported by you, and must not be working on a full-time basis (30 hours or more per week). Look in the Schedule of insured benefits to see the maximum age for dependent children.

Note: If dependent children must be in school full-time to be eligible for coverage, proof of this will be required.

Your permanently developmentally or physically disabled child. This means:

- Your developmentally or physically disabled natural child, adopted child, stepchild or child of your spouse.

To be eligible, the child must not have a spouse or partner and we must have a Doctor's certificate stating he/she is incapable of self-sustaining employment and chiefly dependent upon you for support. This child must have been insured under this group policy before reaching the maximum age for dependent children in the Schedule of insured benefits.

2. HOW TO APPLY TO COVER YOUR DEPENDENTS

If you have any eligible dependents when you complete the required application form:

- Fill in the "number of your dependent children" box.
- Fill in the name of your spouse.
- Check off the box marked "family" in the health and/or dental sections if the group plan includes these benefits and you wish to cover your eligible dependents.

If you don't have any eligible dependents when you join the group plan, tell your group plan administrator as soon as you do acquire a dependent (when you get married, start living with your partner, or have a child). Complete the required forms so your spouse or child can be included. We must be notified within 31 days of the date you acquire a dependent or the dependent will be a "late applicant". He/she must then provide satisfactory evidence of insurability. Benefits for your dependents will become effective only if the evidence is approved by the Company. Some or all of your dependent's benefits could be declined or restricted.

If you want to cover your partner, look under co-habitation requirement for partners in the Schedule of insured benefits to see if there's any minimum period that you and your partner must live together before your partner and his/her children become eligible for coverage.

To continue coverage for a developmentally or physically disabled child, you must apply to the Company in the 31-day period before the child's 21st birthday.

If your spouse and/or dependent child(ren) are eligible for benefits elsewhere (such as with your spouse's Employer's group plan), it can still be to your advantage for you and your eligible dependents to be covered under both plans. Please discuss this with your group plan administrator.

3. WHEN DOES COVERAGE FOR YOUR DEPENDENTS BECOME EFFECTIVE?

If you applied for dependent coverage when you joined the group plan, coverage for your dependents is effective on the date your own coverage is effective. If you apply for dependent coverage after you joined, coverage for your dependent will be effective on the date you applied, provided your own coverage is inforce and you notify us within 31 days of acquiring the dependent.

Important: If a dependent, other than a newborn child, is hospitalized on the date coverage would have been effective, coverage will become effective after final discharge from the hospital. If a dependent is a "late applicant", satisfactory evidence of insurability is required and his/her coverage will only become effective on the date the evidence of insurability is approved by the Company.

4. WHEN DOES COVERAGE FOR YOUR DEPENDENTS TERMINATE?

- on the date your own coverage terminates
- on the date the dependent no longer qualifies as an eligible dependent as described in #1 above.
- on the date it is proven to the satisfaction of the Company that the dependent has engaged in fraudulent activity with respect to claims under this policy.

Health benefits

General provisions

1. DESCRIPTION OF THIS BENEFIT

   If you or your eligible dependents incur expenses described on the following pages while insured under this group plan, you'll be reimbursed for the eligible charges. The amount payable is subject to the co-ordination of benefits (see #6 below) and any deductible amount (see #2 below) and reimbursement percentage (see #3 below). Eligible expenses mean reasonable and customary charges for necessary services, supplies, products, appropriate treatments (see #4 below) and drugs (deemed satisfactory by the Company) or materials prescribed by a legally licensed physician or surgeon, or for care provided by a practitioner specifically included as an eligible practitioner in the policy.

2. WHAT IS THE "DEDUCTIBLE AMOUNT"?

   This is the amount you must pay before any benefits become payable under the group plan. The deductible amount for your plan is shown in the Schedule of insured benefits.

   Note: If the family deductible amount is greater than the single deductible amount, no more than the single deductible amount can be taken from any one family member towards satisfying the family deductible amount.

   Eligible claims incurred during October, November and December of a calendar year that are used to satisfy the deductible amount for that year will also be used towards satisfying the deductible amount for the next calendar year. Please note that pay-direct drug claims cannot be used for this purpose.

3. WHAT IS THE "REIMBURSEMENT PERCENTAGE"?

   This is the percentage (portion) of eligible expenses that is paid by the Company after any deductible amount has been reached. The reimbursement percentage for this group plan is shown in the Schedule of insured benefits.

4. WHAT IS CONSIDERED AN APPROPRIATE TREATMENT?

   A treatment is considered to be appropriate if it is:

   a) accepted by the Canadian medical profession; and

   b) medically necessary; and

   c) proven to be effective; and

   d) used for a Health Canada approved indication; and

   e) of a form, intensity, frequency, and duration essential to the management of disease or injury.

   In determining Appropriate Treatment, Equitable Life may also take into consideration evaluation(s) of services, supplies, appliances, products, treatments or drugs by provincial or national public payers or health technology assessment organizations.

5. WHAT IS MEANT BY PRIOR AUTHORIZATION?

   Benefits payable under this policy as indicated in the Schedule of Insurance may be subject to prior authorization. Equitable Life of Canada reviews and maintains a limited list of services, supplies, products, treatments and drugs that require prior authorization.

   Prior authorization is intended to ensure that a service, supply, product, treatment or drug is deemed by Equitable Life of Canada to be an eligible expense and appropriate treatment and potentially a cost effective alternative for you or your dependent.

In the event that there is an alternative service, supply, product, treatment or drug that represents an eligible expense and appropriate treatment and a suitable substitution, Equitable Life of Canada may require you or your dependent to provide medical evidence why the alternative service, supply, product, treatment or drug cannot be used before coverage is confirmed and provided for the service, supply, product, treatment or drug.

6. HOW DOES THE "COORDINATION OF BENEFITS" WORK?

If you and your spouse both have family coverage under the group insurance plans where you each work, each of you must first submit your own claims through your own insurer. Any unpaid balance can then be submitted to the other spouse's insurer for payment, along with a copy of the amount already paid by the first insurance company.

Claims for your dependent children should be submitted as follows:

If you and your spouse are living together, or are separated but have joint custody, claims should first be submitted through the group plan of the parent with the earlier birthday (month and day) in the calendar year. Any balance is then submitted through the other parent's group plan. For example, if your birthday is October 10 and your spouse's birthday is May 25, claims for your dependent children should be sent to your spouse's insurance company first (because your spouse's birthday is earlier in the year). Any unpaid balance would then be submitted to Equitable Life, along with a copy of what your spouse's insurer paid.

If you and your spouse share the same birthday, submission of claims should be determined based on the alphabetical order of the parent's first names.

If you and your spouse are separated, but do not have joint custody, claims should be submitted in the following order:

a) The group plan of the parent with custody of the dependent child,

b) The group plan of the spouse of the parent with custody of the dependent child,

c) The group plan of the parent not having custody of the dependent child,

d) The group plan of the spouse of the parent not having custody of the dependent child.

Total reimbursement for any claim cannot be more than 100% of the eligible expense.

7. WHAT ARE THE OVERALL MAXIMUM AMOUNTS?

The lifetime maximum amount is shown in the Schedule of insured benefits. It applies to each insured person for the entire time he/she is covered under this group plan. Once the lifetime maximum amount has been paid for an insured person, further eligible expenses for him/her are limited to $1,000 per calendar year. Once the lifetime maximum amount has been reached, it can be reinstated if the insured person submits satisfactory evidence of insurability and the Company accepts this in writing.

Any annual maximum amount is shown in the Schedule of insured benefits.

8. DEFINITIONS

Practitioners:

Below is the definition for practitioners (the qualifications they must have for claims to be eligible). In all cases, the practitioner must be a member in good standing of the provincial association and/or regulatory body applicable to his/her specialty and be licensed to practice under the laws of the applicable province. A practitioner is eligible only if included as an eligible expense under this group plan.

Paramedical practitioners:

- "Athletic therapist" means a person who is a certified athletic therapist.
- "Audiologist" means a person who has a masters degree specializing in hearing loss.
- "Dietician" means a person who is registered with the Dieticians of Canada association.
- "Chiropractor", "Naturopath", "Osteopath" and "Speech therapist" means a person who holds a degree from a recognized school.

- "Registered massage therapist" means a person who is a member of the applicable Provincial association of masseurs or a person who has a valid state/territory massage therapy license issued in the United States of America and who is classified as a Registered massage therapist.
- "Master of social work (MSW)" means a person who has a Master's degree in social work.
- "Physiotherapist" and "Podiatrist (Chiropodist)" means a member of the Canadian association or any applicable affiliated provincial association.
- "Psychologist" means a permanently certified psychologist with a doctor's degree in psychology.
- "Specialist in Acupuncture" means a person allowed to perform acupuncture under the laws of the applicable province and who is recognized as a specialist by the Company.

Other practitioners:

- "Dentist" means a person who is legally licensed in dentistry.
- "Optometrist" means a member of the Canadian association of optometrists or any other applicable associated provincial association.
- "Ophthalmologist" means a person who is a medical doctor who is legally licensed to practise ophthalmology.
- "Physician" means a person who is legally licensed to practise medicine.
- "Pharmacist" means a person who is licensed to practise pharmacy and whose name is listed on the pharmacists' registry of the licensing body for the jurisdiction in which the pharmacist is practising.
- "Registered graduate nurse", "Registered nursing assistant", "Certified nursing assistant" and "Licensed practical nurse" means a person listed on the appropriate provincial registry.

'Reasonable and customary charges' means:

a) For practitioners in Canada practising in a province that has an official fee schedule: the provincial fee schedule that is in effect on the date of the service.

b) For other practitioners practising in an area that has an official fee schedule or recommended fee practices and tariff guide: the fee schedule or tariff guide in effect on the date of the service.

c) In all other cases, the charge for similar services, supplies, products, treatments or drugs made by other providers, practitioners or suppliers of the same standing in the geographical area where the charge is incurred, as determined by Equitable Life, or in accordance with a payment schedule established by Equitable Life.

Province of Residence:

For both plan members and dependents, this means the province in which the plan member resides.

'Medical care' means:

The necessary treatment provided or ordered in the treatment of sickness or injury and must be ordered by a physician or other practitioner who is qualified and licensed in the treatment of sickness and injury.

9. WHAT HAPPENS IF YOUR HEALTH BENEFITS TERMINATE?

If you or any of your insured dependents are totally disabled on the date when your Health benefits terminate, coverage for the disabled person can continue while that person is totally disabled, or until one of the following dates, if earlier, provided we receive proof that is acceptable to the Company that the person is totally disabled:

- the date the person is no longer totally disabled, or
- the date the maximum benefits have been paid under this policy, or
- the date the person becomes eligible for similar insurance under another insurance policy, or
- the 91st day after your Health benefits terminated.

10. WHAT IS NOT COVERED?

Health benefits are not payable for expenses that result from the following:

a) wilfully self-inflicted injury or any attempt at self-destruction (whether the person is sane or insane)

b) active participation in a riot, rebellion or insurrection

c) war or hostilities of any kind (whether or not war is declared)

d) committing or attempting to commit a criminal offence

e) services performed by a person who usually lives in the patient's home or is related to the patient by birth or marriage, or related to the patient through the patient's spouse

f) services that are provided free or for a nominal (small) amount by public authorities or tax-supported agencies, by the workers' compensation act or some other law, or where no charge would be made if the person didn't have any insurance

g) charges that are covered under a provincial health care plan (whether or not the person is actually insured under it), or by any other insurance carrier, or as a result of legal action or settlement

h) charges for un-kept appointments, telephone time, or to complete forms or reports

i) charges for periodic or routine health examinations or examinations for a third party (for example, if you need to get a medical exam in order to get a license)

j) costs involved if you have to move or travel for health reasons

k) services for which it's not legal to provide insurance

l) expenses for treatment or materials for dental care, eyeglasses, physician services, or services outside the province of residence (unless they're specifically included under this group plan)

m) cosmetic surgery or treatment or medication (unless it's required as the result of accidental injuries and provided the surgery or treatment begins within 90 days of the accident)

n) charges for lifestyle counselling (such as counselling for weight loss or to stop smoking)

o) charges for treatment or materials, which (in the opinion of the Company's medical advisors) are experimental or illegal to use or are not a recognized form of treatment

p) any charge related to in vitro fertilization or any other fertility programme (other than the maximum amount for fertility drugs, if any, shown in the Summary of health benefit maximums)

q) services, supplies, products, treatments and drugs for an out-patient at a hospital, such as anaesthesia for a surgical procedure, use of an examination or operating room, drugs administered at the hospital, bandages, dressings and casts

r) anaesthesia, blood and blood plasma

s) expenses that are not actually charged to you or your eligible dependent

t) lifestyle drugs (unless shown on the Summary of health benefit maximums), such as drugs to treat erectile dysfunction (such as Viagra) and for weight loss

u) sphygmomanometer (blood pressure monitor) and insulin pumps for diabetes, unless shown as an eligible expense in the Summary of health benefits maximums.

v) any services, supplies, products, treatments or drugs purchased from a provider who is not approved by Equitable Life of Canada may be ineligible

w) an expense for a service, supply, product, treatment or drug may be limited or not payable at the discretion of Equitable Life if alternative funding is available through a government or other patient support program including situations where such funding exists for an alternative appropriate treatment.

x) upon request by Equitable Life, you or your dependent shall provide evidence satisfactory to Equitable Life that available alternative funding through a government or other patient support program has been pursued by you or your dependent, and a decision regarding such funding has been rendered by the government or patient support program. Until such satisfactory evidence is provided, the expense may not be eligible for coverage under this Policy and no benefit may be paid as determined by Equitable Life.

y) expense may not be eligible for coverage under the Policy and no benefit may be paid at the discretion of Equitable Life.

z) any portion of an eligible expense for a service, supply, product, treatment or drug may be limited to that of a lower cost alternative that represents appropriate treatment

aa) No benefits are payable under the Health Benefits of the Policy for any services, appliances, supplies, products, treatments, or drugs listed on the Equitable Life's Schedule of Services, Appliances, Supplies, Products and Treatments Not Eligible for Coverage (the "Product Schedule"). Should there be any inconsistency between the limitation in this sub-paragraph and any other provision or benefit in the Policy, or any inconsistency between the Product Schedule and any other provision or benefit in the Policy, the limitation in this sub-paragraph and the Product Schedule shall prevail in all circumstances.

bb) An expense for a drug may be eligible for certain conditions only if selected lower cost drugs of similar safety and efficacy are used first, as determined by Equitable Life. For certain conditions, this may involve a series of steps whereby eligibility of each list of drugs for a condition is dependent on the previous list of drugs being used first.

Pay-direct Drug Plan #88 Comprehensive health care plan (RX and selected OTC products)

1. WHAT IS COVERED SUBJECT TO THE EXCLUSIONS?

   a) Expenses for drugs which require a prescription by law, approved by Equitable Life, and prescribed by a physician or dentist are eligible. In addition, certain drugs prescribed by other health professionals who are qualified and registered will be considered if the applicable provincial legislation permits the professional to prescribe these drugs. In either case, the prescription must be dispensed by a registered pharmacist at an accredited pharmacy.

   b) Selected prescription requiring medications, which have been assigned a valid Drug identification number (DIN) by Health Canada and are listed as prescription requiring in the federal or provincial drug schedules are eligible, with the exception of those drugs listed in the Exclusion section.

   c) Selected injectable drugs, injectable vitamins, insulins and non-patient specific allergy extracts bearing a valid DIN are eligible.

   d) Extemporaneous preparations or compounds are eligible if the primary active ingredient is eligible, medically necessary, legally requires a prescription and is compounded by a registered pharmacist and is dispensed at an accredited pharmacy.

   e) Selected products from within the following classes of non-prescription requiring drugs are eligible:

      potassium supplements, iron supplements and vasodilating nitrates.

   f) Disposable needles, disposable syringes, lancets and chemical reagent testing materials used for insulin administration and monitoring in diabetes are eligible benefits.

2. MAXIMUM SUPPLY

   The maximum eligible at any one time is shown in the Schedule of insured benefits, including the maximum supply for the following drugs and medicines used for maintenance or long-term therapy: antiasthmatics, antibiotics for acne, anticoagulants, anticonvulsants, antidepressants, antiparkinsons, cardiac drugs, diabetes drugs, female hormone replacement therapy, oral and transdermal contraceptives, potassium replacements, and thyroid agents.

3. EXCLUSIONS:

   (a) Atomizers, appliances, prosthetic devices, colostomy supplies, first aid kits or equipment, electronic diagnostic monitoring or testing equipment (such as a "Glucometers"), non-disposable insulin delivery devices (such as "Novolin Pen" and "Insulin Pumps"), spring loaded devices to hold lancets, alcohol, alcohol swabs, disinfectants, cotton, bandages, delivery or extension devices for inhaled medications (such as "Diskhaler" or "Aerochamber"), or supplies and accessories for the aforementioned are not eligible

   (b) Oral vitamins, minerals, dietary supplements, infant formulas, or injectable Total parenteral nutrition (TPN) solutions, whether or not such a prescription is given for a medical reason, except where federal or provincial law requires a prescription for their sale, are not eligible.

   (c) Diaphragms, condoms, contraceptive jellies/foams/sponges/suppositories, non-medicinal Intrauterine Devices (IUDs) such as Gyne-T, contraceptive implants or appliances normally used for contraception whether or not such a prescription is given for a medical reason are not eligible.

   (d) Herbal and homeopathic preparations are not eligible benefits, even if combined with a prescription requiring medicine or with a product considered to be an eligible benefit.

   (e) Any prescriptions administered to an outpatient in a hospital, or by any agency or provider controlled by a hospital or by any agency or provider funded in whole or part by a government at any level including emergency status and investigational status drugs are not eligible.

   (f) All preventative immunization vaccines and toxoids are not eligible, unless otherwise indicated in the Summary of health benefit maximums.

   (g) All patient specific allergy extracts, compounded in a lab, and not bearing a DIN are not eligible.

(h) Items deemed to be cosmetic in nature (even if a prescription is legally required), such as topical Minoxidil, or sunscreens, whether or not a prescription is given for medical reasons are not eligible.

(i) Any medication the person is eligible to receive under the Provincial Drug Benefit Plan is not eligible.

(j) Smoking cessation products are not eligible, unless otherwise indicated in the Summary of health benefit maximums.

(k) Anti-obesity drugs are not eligible, unless otherwise indicated in the Summary of health benefit maximums.

(l) Oral erectile dysfunction drugs are not eligible, unless otherwise indicated in the Summary of health benefit maximums.

(m) Medications and compounded products deemed to be fertility drugs are not eligible. , unless otherwise indicated in the Summary of health benefit maximums

(n) Products not bearing a valid Health Canada issued DIN are not eligible.

(o) Fees to administer medication, consultation charges and/or professional fees for services rendered by a registered physician, pharmacist, or other qualified health professionals (other than dispensing fees) are not eligible.

(p) Drugs listed on the Equitable Life Schedule of Drugs Not Eligible for Coverage are not eligible (the "Schedule"). Should there be any inconsistency between the Schedule and any other drug list, schedule or formulary maintained by: i) Equitable Life, including without limitation, the Equitable Life's Specialty Drug Management Program list of specialty drugs; ii) the Equitable Life's pharmacy benefits manager; iii) the Equitable Life's pay direct drug provider; or, iv) any other third party acting for or on behalf of the Equitable Life; the Schedule shall prevail in all circumstances.

(q) Products bearing a valid Natural product number (NPN) by Health Canada is not eligible.

(r) Mixtures and compounds that do not conform to the pay direct drug provider's current compound policy.

4. SERVICES OUTSIDE THE PROVINCE

The maximum amount eligible will be an amount up to (but not more than) the following:

a) if the drug was purchased at a pharmacy that has signed an agreement with the Pay-Direct Drug Plan provider for the direct submission and payment of drugs, payment will be made for reasonable and customary charges and eligible expenses of the province in which the drug was purchased, or

b) in all other circumstances, payment will be made according to the reasonable and customary charges and eligible expenses allowed in your province of residence.

5. HOW TO SEND IN A CLAIM?

Present your Pay-direct drug card to your pharmacist each time you have a prescription filled. This way, your Pharmacist can tell you if the prescription is covered under your plan, and can also submit your drug claim electronically on your behalf. This means that you will only have to pay the pharmacist for any expenses not covered under your plan.

If you forget to present your card at the pharmacy, you may have to pay the full cost of the prescription and then submit a claim to get your covered expenses reimbursed.

Note: Drug claims must be received within 365 days of the date the claim is incurred.

6. CLAIMS

IMPORTANT: If your insurance terminates, or if the Drug benefit under this policy terminates, or if this group policy terminates, all claims incurred prior to the date of termination must be received by the Company within **90 days** of the date of termination. However, if this group policy terminates and the General information box in the Schedule of insurance indicates that the Health benefit is Administration services only (ASO), no benefits (including claims incurred prior to the date the policy terminates) are payable after the policy terminates.

Major services

The following pages describe the expenses under the Major services benefit, if shown as eligible in the Schedule of insured benefits. "Insured person" means you, your eligible spouse, or your eligible dependent child insured under this group plan for Health benefits.

1. CONVALESCENT HOME SERVICES

   Reasonable and customary charges for room and board if the insured person is confined in a convalescent home such as:

   - a sanitarium
   - a skilled nursing home
   - a special wing of a hospital that has a transfer agreement with a hospital.

   (Homes for the aged and treatment centres for drug addiction and alcoholism are not included.)

   Services are eligible as long as:

   - confinement in the convalescent home occurs within 7 days after the person was confined for at least 3 days in a licensed hospital and the provincial health care plan paid benefits for the same sickness or injury when the person was in the licensed hospital, and
   - confinement in the convalescent home is for rehabilitation purposes and not for custodial care.

   See the Summary of health benefit maximums for the maximum payable for convalescent home services.

2. AMBULANCE SERVICES

   Reasonable and customary charges for professional ambulance services to or from the nearest hospital where the required treatment can be provided. If certified as medically necessary, air ambulance and charges for a registered nurse or paramedical assistant are eligible expenses.

3. PRIVATE DUTY NURSING CARE SERVICES (PDN)

   Reasonable and customary charges for eligible expenses for private duty nursing care provided in the home of an acutely ill patient, if such care is prescribed in writing by a physician and is provided at a minimum of one 4-hour shift per day by a Registered graduate nurse, Registered nursing assistant, Certified nursing assistant or Licensed practical nurse who is not normally resident in the patient's home and is not related to the patient by blood or marriage. Only medical services that should reasonably be performed by one of the qualified practitioners listed above are eligible. Respite care is not covered.

   The maximum amount payable for nursing care services for each insured person in a calendar year is shown in the Summary of health benefit maximums.

4. APPLIANCES AND SUPPLIES

   Eligible expenses include the following, provided they are prescribed by a physician (we'll need a copy of the Doctor's written prescription):

   a) reasonable and customary charges for the rental of:

      - a standard hospital bed
      - equipment to administer oxygen
      - equipment for the treatment of respiratory paralysis provided the rental is:
        - for therapeutic use only, and
        - required for a period not exceeding 180 days.

        (Rental of other durable medical equipment may be considered if required for therapeutic use.)

b) reasonable and customary charges for the purchase of eligible items shown under maximum per insured person in respect of (b) under 4. appliances and supplies on the Summary of health benefit maximums. They must be required for medical reasons and be prescribed by a physician. Note that we may ask for additional information.

   The following is not eligible:

   - replacement or repair, except for replacement or adjustments required by pathological changes in the condition necessitating the equipment, or repairs as necessary to wheelchairs.
   - Devices used primarily to allow the person to participate in sports.

c) reasonable and customary charges for the purchase of an external breast prosthesis and surgical brassiere(s) required as the result of a mastectomy, subject to the maximum for breast prosthesis and surgical brassiere(s) shown in the Summary of health benefit maximums.

d) reasonable and customary charges for the purchase of ileostomy or colostomy supplies.

e) reasonable and customary charges for the purchase or repair of hearing aids obtained on the written prescription of a certified otolaryngologist up to the maximum for hearing aids shown in the Summary of health benefit maximums. Hearing aid batteries are not eligible unless specifically shown as an eligible expense in the Summary of health benefit maximums.

f) reasonable and customary charges for the purchase of the following, provided they are custom made for the patient and are prescribed by a physician, podiatrist or chiropodist:

   - orthopaedic shoes (lifts, wedges, flares or similar shoe modifications)
   - orthotics

   - Custom made means the fabrication of the footwear/orthotics must include the creation of a 3-dimensional cast unique to the person's feet and must be constructed using 100% raw materials that use the 3-dimensional cast to create the footwear/orthotics. Measurements of the cast do NOT meet the requirement of being custom made.
   - In addition, the footwear/orthotics must be prescribed to accommodate bony and structural abnormalities of feet and/or lower legs resulting from trauma, disease or congenital deformities subject to the Maximum for Orthopaedic Shoes and Orthotics shown in the summary of Health Benefit Maximums.

     Orthopaedic shoes and orthotics are expensive so if you have any questions about eligibility after reading the requirements, please call in advance to our Group claims service team at 1.800.265.4556 to ensure that the item you have or plan to purchase is eligible.

     Note: Stock orthopaedic shoes that can be purchased off-the-shelf are eligible only if they have been significantly modified for the patient and the Summary of health benefit maximums specifies that they are eligible. Stock shoes that have not been modified for the patient are not eligible under any circumstances unless shown in the Summary of health benefit maximums in the Schedule of insurance.

     The following is required for proper claim review:

     - A medical referral must be provided from a physician, podiatrist or chiropodist, and include the diagnosis or medical condition necessitating the product;
     - The paid receipt should show the name, credentials and college registration number of the person who dispensed the custom made product;
     - The technique/process used for casting your foot (the casting method used must be three dimensional to be considered a custom made product);
     - A description of how the foot orthotic or custom made shoe was constructed including what raw materials were used; (please include a description of the modifications made to the shoes including a breakdown of the costs and the brand name and model of the shoe); and
     - The contact information of the laboratory where the custom made product was manufactured. The invoice must indicate the name of the patient and shipment date or date of completion.

g) reasonable and customary charges for oxygen and oxygen equipment including cannulas & tubing, regulators, oxygen cylinders, and bubble humidifiers (with a physician's prescription). Ineligible expenses include adapters, batteries, delivery charges, pulse oximeter, set-up fees.

h) reasonable and customary charges for wigs and hairpieces required as a result of a medical condition while insured under this group plan, subject to the maximum for wigs and hairpieces shown in the Summary of health benefit maximums.

i) reasonable and customary charges for standard syringes, needles and diagnostic test material, including glucometers, required to treat diabetes. The maximum for glucometers is shown in the Summary of health benefit maximums. Other supplies, such as automatic jet injectors, insulin pumps or other special equipment, swabs and rubbing alcohol are not covered, unless specifically shown as an eligible expense on the Summary of health benefit maximums. However, for pay-direct drug plans, disposable needles (including disposable needles only, for non-disposable insulin delivery devices), disposable syringes, lancets and chemical reagent testing materials used for monitoring diabetes are eligible under the pay-direct drug plan.

j) Diagnostic laboratory procedures: reasonable and customary charges for medically necessary lab tests (including Prostate specific antigen tests - PSA tests), and x-rays (including Magnetic resonance imaging - MRI), if performed in the province of residence (but not in a hospital), subject to the maximum for diagnostic laboratory procedures shown in the Summary of health benefit maximums. Genetic and fertility testing is excluded.

5. DENTAL ACCIDENT

This section of Major services covers reasonable and customary charges for treatment by a dental surgeon for a fractured jaw or injuries to sound natural teeth that result from an accident that occurs while insured under this group plan. The accidental injuries must be caused by external, violent and accidental means. Coverage is not provided for injuries caused by an object placed in the mouth (even while eating or drinking).

Treatment must be completed within 365 days of the accident.

Pre-determination: If the dental surgeon tells you that it will cost more than $300 to treat the injuries, a treatment plan and estimates of the charges should be sent to us before treatment begins. We'll then be able to tell you in advance how much will be eligible under the group plan.

Alternate treatment: If there is a less expensive course of treatment that will give a professionally adequate result, the amount payable under this group plan is equal to the cost of the less expensive treatment. If you choose to proceed with the more expensive treatment, then you will be responsible for the additional costs.

6. PARAMEDICAL SERVICES

Reasonable and customary charges for expenses incurred for services performed by eligible paramedical practitioners, subject to the maximums for paramedical services in the Summary of health benefit maximums. See practitioners under #8 (Definitions) under the Health benefits - general provisions for the definition/qualifications of the various practitioners.

Note: In some provinces, if your provincial health care plan pays any portion of the charges made by paramedical practitioners, no payment is eligible under this group plan until the overall maximum allowed for that type of practitioner has been paid out by the provincial plan. For example, if a practitioner charges $20 per visit and your provincial health care plan only pays $10 per visit, the difference is not covered under the group plan. Once your provincial plan has paid the overall maximum that they allow for a practitioner (or if your provincial health care plan doesn't cover a particular practitioner), charges may then be eligible for payment under your group plan.

If your province does allow private insurers to pay the excess charged by certain practitioners over what the provincial health care plan pays, and if your Employer has chosen to include these in your group plan, this will be indicated in the paramedical section in the Summary of health benefit maximums.

7. HOW TO SEND IN A CLAIM

Use Form #466 - Supplementary medical benefits claim form. Follow the instructions on the form. Be sure to fill in:

- the group policy number
- your certificate number
- the full birth date (day/month/year) if the claim is for a dependent
- all information on a dependent child, especially if he/she is in school (include the name of the school) or if he/she is employed full-time or part-time.

Remember to attach all original receipts, written prescriptions, referral letters, etc.

Note: In all cases, the original receipts, written prescriptions, referral letters, etc. which show the patient's name and the service provided or item purchased must be submitted to Equitable Life. A charge card or debit card receipt is not sufficient proof of claim.

Claims must be submitted within 90 days of the date of treatment.

Important: If your insurance terminates, or if the Major services benefit under this policy terminates, or if this group policy terminates, all claims that were incurred prior to the date of termination must be received by the Company within 90 days of the date of termination.

Semi-private hospital

1. WHAT IS COVERED?

   If you or one of your eligible dependents are confined as an inpatient in a semi-private room (a room with two beds) in a licensed hospital while insured under this group plan, a reimbursement will be made to the hospital for reasonable and customary charges made by the hospital (taking into account any deductible amount and reimbursement percentage shown in the Schedule of insured benefits).

   Expenses are not eligible:

   - if the person is confined in a special ward or unit that would qualify as a "convalescent home" under the policy or which would otherwise not qualify as a hospital
   - if the semi-private room is the lowest level of accommodation available
   - if the semi-private room is required for medical reasons.

   The maximum amount eligible is the excess of:

   - reasonable and customary charges actually made by the hospital for semi-private care and the greater of:
     - the provincial health care plan allowance, or
     - the amount the hospital charges for standard ward care.

   The maximum amount eligible if confined in a private room is the amount that would be eligible if the person was in a semi-private room (but not more than the hospital actually does charge).

2. WHAT IS MEANT BY "REASONABLE AND CUSTOMARY" CHARGES?

   These are the standard hospital charges for semi-private or standard ward care, as the case may be. If there are no "standard" charges, it means the average daily room and board charges made by the hospital.

3. SERVICES OUTSIDE THE PROVINCE

   The maximum amount eligible if confined in a hospital outside the province of residence is the amount that would be eligible if confined in the plan member's own province of residence.

4. HOW TO SEND IN A CLAIM

   The hospital will usually send the claim directly to Equitable Life.

   Important: If your insurance terminates, or if the Hospital benefit under this policy terminates, or if this group policy terminates, all claims incurred prior to the date of termination must be received by the Company within 90 days of the date of termination. However, if this group policy terminates and the General information section in the Schedule of insurance indicates that the Health benefit is Administration services only (ASO), no benefits (including claims incurred prior to the date the policy terminates) are payable after the policy terminates.

Vision care services

1. EYE GLASSES OR CONTACT LENSES OR LASER EYE SURGERY

   Charges incurred for:

   - lenses and frames for eye glasses (including fitting, replacement or repair) or for contact lenses that aren't eligible under #3 below, as long as they're prescribed by a physician or optometrist, or
   - laser eye surgery to correct vision, if performed by a physician or ophthalmologist.

   See the Schedule of insured benefits for the **maximum amount** and **how often expenses are eligible** for you and your eligible dependents.

   If the Schedule of insured benefits indicates that Vision care benefits are payable **in any period of "x" months** (such as any period of 12 months or any period of 24 months), and not by calendar years, the date used to determine if a claim is eligible is **the date the service (the eye glasses/contact lenses/laser eye surgery) is paid for**.

   Example: If Vision care is payable in any period of 24 months and the patient had paid for the services on October 5, 2016, the next time a claim will be eligible is October 6, 2018.

2. WHAT IS NOT COVERED?

   Glasses used only for cosmetic reasons and safety glasses where a corrective prescription is not required are not eligible.

3. "SPECIAL" CONTACT LENSES

   These are contact lenses prescribed by an ophthalmologist who certifies that they're medically necessary because of severe corneal astigmatism, corneal scarring, or as the result of surgery or treatment for keratoconus or aphakia. They are eligible only if vision can't be corrected to 20/40 or better with eye glasses. The maximum eligible for special contact lenses is shown in the Schedule of insured benefits.

4. HOW TO SEND IN A CLAIM

   The Health section in the Schedule of insured benefits tells you if a change in prescription is required in order for benefits to be eligible under Vision care.

   If a change in prescription is required, use **Form #948 - Vision Care**. Follow the instructions on the form. Fill in:

   - the group policy number
   - your certificate number
   - the full birthdate (day/month/year) if the claim is for a dependent
   - all information on a dependent child, especially if he/she is in school (include the name of the school) or if he/she is employed full-time or part-time.

   If a change in prescription is not required, use **Form #466 - SUPPLEMENTARY MEDICAL BENEFITS**. Be sure all data listed above is completed on the form. If the claim is for special contact lenses (#3 above), include the prescription or letter from your ophthalmologist explaining the reason they are required.

   Note: In all cases, the original receipt from the supplier which shows the patient's name and the service provided or item purchased (such as eyeglasses or contact lenses) must be submitted to Equitable Life. A charge card or debit card receipt is not sufficient proof of claim.

   Claims must be submitted **within 90 days** of the date of treatment.

   Important: If your insurance terminates, or if the Vision care benefit under this policy terminates, or if this group policy terminates, all claims that were incurred prior to the date of termination must be received by the Company within **90 days** of the date of termination. However, if this group policy terminates and the General information

section in the Schedule of insurance indicates that the Health benefit is Administration services only (ASO), no benefits (including claims incurred prior to the date the policy terminates) are payable after the policy terminates.

Eye examinations

1. EYE EXAMINATIONS

   Routine (general assessment) eye examinations are eligible, subject to the following:

   a) the eye examination must be performed by an optometrist or ophthalmologist, and

   b) eye examinations are eligible only if they are not listed under your provincial health care plan.

   See the Schedule of insured benefits for the **maximum amount** and **how often expenses are eligible** for you and your eligible dependents.

   Other tests, such as contact lens assessments, visual testing and other special diagnostic services are not eligible, unless shown in the Schedule of insured benefits.

2. HOW TO SEND IN A CLAIM

   Use Form #466 - SUPPLEMENTARY MEDICAL BENEFITS. Follow the instructions on the form. Be sure to fill in:

   - the group policy number
   - your certificate number
   - the full birthdate (day/month/year) if the claim is for a dependent
   - all information on a dependent child, especially if he/she is in school (include the name of the school) or if he/she is employed full-time or part-time.

   Note: In all cases, the original receipt from the supplier which shows the patient's name and the service provided or item purchased (such as eyeglasses or contact lenses) must be submitted to Equitable Life. A charge card or debit card receipt is not sufficient proof of claim.

   Claims must be submitted **within 90 days** of the date of treatment.

   Important: If your insurance terminates, or if the Vision care (eye examination) benefit under this policy terminates, or if this group policy terminates, all claims that were incurred prior to the date of termination must be received by the Company within **90 days** of the date of termination. However, if this group policy terminates and the General information section in the Schedule of insurance indicates that the Health benefit is Administration services only (ASO), no benefits (including claims incurred prior to the date the policy terminates) are payable after the policy terminates.

Survivor benefit

Premium waived

1. DESCRIPTION OF THIS BENEFIT

   If you and your eligible dependents are insured under this group policy on the date of your death for the benefits included under the Survivor benefit, those benefits will continue for your eligible dependents.

   Premiums are "waived" (are not payable) once the Survivor benefit begins.

2. WHAT BENEFITS ARE INCLUDED IN THE SURVIVOR BENEFIT?

   The Schedule of insured benefits in this booklet shows:

   - what benefits are included
   - the maximum period for survivor benefit (the maximum length of time that the survivor benefit could be in effect)

3. WHEN DO THE SURVIVOR BENEFITS TERMINATE?

   Survivor benefits and the premium waiver terminate on the earliest of the following dates:

   - the date the maximum period for Survivor benefit ends
   - the date your spouse or a dependent child becomes eligible for similar coverage somewhere else
   - the date a dependent child no longer meets the definition of an eligible dependent (as shown under the General provisions for dependents and in the Schedule of insured benefits in this booklet)
   - the date this group plan terminates.

CAREpath™- The cancer navigation system

The Cancer Navigation System™ is a service provided by a Canadian company called CAREpath Inc., and is designed to help ensure you and your dependents get the emotional and medical support needed to deal with a cancer diagnosis or cancer recurrence, its treatment, and the many issues that will arise afterwards (the "CAREpath services").

The CAREpath services are not insured benefits under your plan member group insurance policy. The fees for the CAREpath services are paid by your employer.

Please call CAREpath at 1-866-883-5956 as soon as you or a dependent are diagnosed with cancer or have a recurrence of a previously treated cancer so they can provide assistance before and after your first visit to an oncologist.

The CAREpath services will assist you and your dependents in dealing with a cancer diagnosis or cancer recurrence. The CAREpath services complement the services provided by the public health care system and help reduce the physical and emotional impact of a cancer diagnosis or cancer recurrence by assisting with medical and emotional needs.

At the time of diagnosis or recurrence, CAREpath will assist by having a team of experienced cancer specialists review the medical information and assign a personal CAREpath oncology nurse. The oncology nurse schedules telephone appointments to guide you through active treatment.

CAREpath does not test, prescribe or treat patients. CAREpath works in collaboration with the treating physicians to help reduce the negative impact of cancer and to assist with treatment.

CAREpath will work with the treating physicians and the treating physicians will have an opportunity to consult with some of the world's leading cancer specialists regarding your care. The assigned personal oncology nurse will provide:

- Emotional support
- Informed answers to your questions
- Education regarding treatment options
- Questions to ask the oncologist
- Advice and support throughout active treatment
- Advice on how to access other support services, if necessary
- Facilitate access to a second opinion, if necessary
- Guidance to alternate treatment locations, if requested or required

The CAREpath services are not a substitute for discussing your or your dependent's health concerns with your physician. As such, it is critical that you and your dependents discuss the advice and information received with your physician so the physician can provide the care and treatment required.

You and your dependents can access the CAREpath services if you or a dependent are diagnosed with cancer or have a recurrence of a previously treated cancer, provided: a) the new diagnosis or recurrence occurs after the exclusion period, which is the 90 day period following the effective date of your employer's enrollment for the CAREpath services; and, b) you or a dependent satisfy the requirements in the healthconnector optional services eligibility requirements. If you or a dependent do not satisfy the exclusion period, you or the dependent will not be eligible to receive the CAREpath services at any time. If you are not eligible to receive the CAREpath services, your dependents who satisfy the exclusion period will be eligible to receive the CAREpath services. If one of your dependents is not eligible to receive the CAREpath services, you and your dependents who satisfy the exclusion period will be eligible to receive the CAREpath services. The exclusion shall not apply if there are 500 or more plan member enrolled for the CAREpath services on the date the CAREpath services become effective.

Your access to the CAREpath services shall terminate on the earlier of the date: a) you no longer satisfy the eligibility requirements; or, b) your employer or Equitable Life terminate the CAREpath services. A dependent's access to the CAREpath services shall terminate on the earlier of the date: a) you no longer satisfy the eligibility requirements; b) the dependent no longer satisfies the eligibility requirements; or, c) your employer or Equitable Life terminate the CAREpath services.

Equitable Life is facilitating access to the CAREpath services which are being provided by CAREpath Inc. As a result, CAREpath Inc. is responsible for providing the CAREpath services and will be liable for any negligence or omission in providing the CAREpath services. Equitable Life is not responsible for any negligence or omission of CAREpath Inc. in providing the CAREpath services.

To learn more about the CAREpath Navigation System™: Sign in to your Group Benefits account and select EquitableHealthConnector™ under *My Resources*. You will find a link to CAREpath under *My Services* on the HealthConnector landing page.

FeelingBetterNow® from Mensante Corporation

FeelingBetterNow® is a service provided by a Canadian company called Mensante Corporation, and is designed to help you and your dependents with mental health issues through a web-based mental health care program (the "Mensante services").

The Mensante services are not insured benefits under your plan member group insurance policy. The fees for the Mensante services are paid by your employer.

Go to http://ww.feelingbetternow.com/equitable and follow the simple instructions to gain access to this service.

Managing mental illness is one of the toughest problems faced by individuals and physicians. Early diagnosis and proper treatment are crucial to successful recovery. To help address this issue, Mensante Corporation developed an innovative web-based mental health care program called FeelingBetterNow®.

FeelingBetterNow® is Canada's only medically based and approved web site designed to assist family physicians and patients in the early diagnosis, treatment and ongoing management of mental health problems using medical best practices. The FeelingBetterNow® web site promotes the correct use of available and effective tools by both patients and physicians. The College of family physicians of Canada has reviewed and approved FeelingBetterNow® as a practice management tool available to assist family physicians in patient care.

There are times when you or a dependent may have concerns about your emotional and mental health. To address these concerns, you or a dependent can access FeelingBetterNow® to help you and your physician identify emotional and mental health issues as early as possible. The FeelingBetterNow® web site is completely confidential and anonymous. You or your dependent will be asked to create your own username and password and only you will have access to the username, password and individual feedback. No one will know that you have accessed FeelingBetterNow® or how you have responded to the program.

Following use of the web site, you will have a preliminary assessment of your emotional and mental health. In the event that you are at high risk for a clinical disorder, you will be provided with a set of online tools to help you and your physician identify and treat emotional and mental health problems. You will receive:

- A patient specific risk map indicating the severity of the condition;
- A patient specific care map to assist you in the detection, treatment and follow up of your emotional and mental health problems; and
- Follow up maps every 3 weeks to be able to track your progress and recovery.

The personal maps will empower you with accurate knowledge about mental disorders, the nature of the difficulties you might be facing, suggestions regarding treatment and management. By providing you with follow up maps, which use a graph of your mental health information that is plotted over time along with a written description, you will become more sensitive to the early onset of difficulties, appreciate the changes in your symptoms and will become more informed overall about strategies for looking after yourself.

The Mensante services are not a substitute for discussing your and your dependent's mental health concerns with your physician. As such, it is critical that you and your dependents discuss your mental health concerns and provide the personal maps to your physician so the physician can provide the care and treatment required.

Your access to the Mensante services shall terminate on the earlier of the date: a) you no longer satisfy the eligibility requirements; or, b) your employer or Equitable Life terminate the Mensante services. A dependent's access to the Mensante services shall terminate on the earlier of the date: a) you no longer satisfy the eligibility requirements; b) the dependent no longer satisfies the eligibility requirements; or, c) your employer or Equitable Life terminate the Mensante services.

Equitable Life is facilitating access to the Mensante services which are being provided by Mensante Corporation. As a result, Mensante Corporation is responsible for providing the Mensante services and will be liable for any negligence or omission in providing the Mensante services. Equitable Life is not responsible for any negligence or omission of Mensante Corporation in providing the Mensante services.

For more information on Mensante's FeelingBetterNow® Mental Healthcare System: Sign into your Group Benefits account and select EquitableHealthConnector™ under *My Resources*. You will find a link to FeelingBetterNow under *My*

Services on the HealthConnector landing page. If you have questions about web site content or technical issues, please e-mail Mensante Corporation at equitable@mensante.com.

Homewood Health employee and family assistance program (EFAP)

The Homewood Health Employee and Family Assistance Program provides services across the mental health continuum to support you and your eligible dependents in leading a healthy, balanced life (the “Homewood Services”).

The Homewood Services are not insured benefits under your plan member group insurance policy. The fees for the Homewood services are paid by your employer.

The Homewood Services can provide you and your dependents with support, advice and information on a wide range of every day issues including:

- Parenting & child care
- Education
- Older adults
- Midlife & retirement
- Disability
- Financial
- Legal
- Everyday issues
- Work
- Managing people
- Health
- Emotional well-being
- Grief & loss
- Addiction & recovery

The Homewood Services can also provide:

- confidential, personal support;
- English and French counsellors available through a toll free number 24 hours a day, seven days a week, 365 days a year;
- Homeweb, a personalized online portal that provides content unique to your interests;
- interactive tools, assessments and e-courses including an online Health Risk Assessment and online Cognitive Behavioural Therapy; and
- a commitment to always being there when you have a question or need help.

To find out more about how Homewood Health can help, call to speak with a Homewood consultant anytime at 1.888.707.2115 or sign in to Homeweb.ca/Equitable

Bilingual intake counsellors are available 24/7 and have access to simultaneous translation for more than 140 other languages. To access TTY/TDD lines, call 1.888.384.1152. Service disponible en français: 1.888.707.2115

Homewood Health Services are designed to help you and your dependents find the support, advice and resources you need. No question is too small, it’s never too early or too late to reach out for help.

Confidentiality is critical to the success of the program and the utmost care is taken to protect the identity of those who use Homewood Health Services. Homewood Health employees are bonded, and bound to the principles of confidentiality and their professional ethical requirements.

Annually, employers receive a usage report summarizing the number of people who have used Homewood Health Services. This report will not reveal the identity of individuals who have used Homewood Health Services.

When attending a face-to-face counselling session, the counsellor will:

- establish an environment that makes you feel comfortable discussing problems and concerns
- listen and ask questions in order to clearly understand the problem
- explore the expectations that you have to resolve this problem
- work with you to identify options and solutions
- develop strategies to reduce or resolve the problem

The counsellor will also give objective feedback and provide problem solving and support when needed. Together, you and the counsellor will establish a helpful and effective action plan.

The counsellors have been carefully screened and credentialed by Homewood Health, and only those with extensive experience are selected. Typically, counsellors are registered professionals with a minimum of a Master's level degree, in areas where there are no Master's level professionals available, we seek out professionals with a Bachelor's degree and relevant clinical experience.

Short-term, solution-focused counselling is provided. Homewood Health Services can be accessed for each problem or issue that you or your dependents are experiencing. The number of sessions varies and is determined on a case-by-case basis. Where the problem may be ongoing in nature, the counsellor will discuss the appropriateness of a referral to a community resource and will work with you to access the resource.

If you are in a state of crisis, Homewood Health will offer the necessary support to stabilize the situation regardless of whether your issues are short-term or ongoing.

For crisis situations, immediate access to a telephonic counsellor is possible. Appointments will be offered within three business days for non-emergencies.

The Homewood Services are not a substitute for you and your dependents discussing your health concerns with your physician. As such, it is critical that you and your dependents discuss your health concerns with your physician so the physician can provide the care and treatment required.

Your access to the Homewood Services shall terminate on the earlier of the date: a) you no longer satisfy the eligibility requirements; or, b) your employer or Equitable Life terminate the Homewood Services. A dependent's access to the Homewood Services shall terminate on the earlier of the date: a) you no longer satisfy the eligibility requirements; b) the dependent no longer satisfies the eligibility requirements; or, c) your employer or Equitable Life terminate the Homewood Services.

Equitable Life is facilitating access to the Homewood Services which are being provided by Homewood. As a result, Homewood is responsible for providing the Homewood Services and will be liable for any negligence or omission in providing the Homewood Services. Equitable Life is not responsible for any negligence or omission of Homewood in providing the Homewood Services.

For more information on the Homewood Employee and Family Assistance Program (EFAP): Sign in to your Group Benefits account and select Equitable HealthConnector under *My Resources*. You will find a link to the Homewood EFAP under *My Services* on the HealthConnector landing page.

WorldCare ACCESS (remote second opinion service)

The WorldCare ACCESS program is a service provided by a non-Canadian company called WorldCare Inc. and delivers highly specialized and personalized electronic second medical opinions from the best medical centers in North America. WorldCare ACCESS provide a multi-disciplinary review of your and your dependent's medical records and supporting diagnostic information by sub-specialist(s) at a WorldCare Consortium® institution, to provide diagnosis and treatment recommendations, based upon the latest cutting-edge research, for the 29 conditions set out below (the "WorldCare services").

The WorldCare services are not insured benefits under your plan member group insurance policy. The fees for the WorldCare services are paid by your employer.

To initiate a WorldCare ACCESS consultation, call 1.877.676.6439.

The WorldCare Services include the following:

- A multi-disciplinary review of complete, relevant medical records and supporting diagnostic information by the appropriate specialist(s) and/or sub-specialist(s) at a WorldCare Consortium® institution.
- Review of relevant medical records and supporting diagnostic information, and the interpretation of CT scan, MRI scan, X-ray, ultrasound, or other radiology or pathology studies by specialists at the WorldCare Consortium institutions, and the transmittal to you or your dependents of a written report which confirms a diagnosis and provides a suggested treatment plan;
- One follow-up consultation, if necessary, if additional diagnostic/consultation reports or questions related to the initial consultation request are submitted within thirty (30) days of receipt of the initial consultation report;
- Conference call, if needed, between your or your dependent's referring physician and the consulting physician from the WorldCare Consortium Institution.
- In complex cases, two independent consultations from two separate institutions.
- Reports delivered to you or your dependents and their local treating physicians, typically within five (5) working days of receiving the complete medical information and reviewing pathology (if any.) Certain cases involving pathology, translation, or multiple second opinions from different hospitals, may take longer.
- Shipping costs for the medical record or supporting diagnostics such as EKG, MRI, CT, ultrasound, PET scan, laboratory reports, pathology specimens.
- Professional medical translation, when needed, of medical information.
- Comprehensive quality assurance for in-country case assembly and consultation return.
- A comprehensive second opinion package with:
    - Educational material including an overview of the condition to familiarize you or your dependents with relevant health information relating to their diagnosis;
    - Suggestions for next steps, including a list of follow-up questions for you or your dependents to consider with the referring physician;
    - A list of local and online support groups, reference websites and resources to help you or your dependents obtain more information and assistance;
    - A complete package of your or your dependent's medical records which were used to render the second opinion(s);
    - Information on the medical institution(s) rendering the second opinion(s);
    - Backgrounds and qualifications of the physicians rendering the second opinion(s).
- Up to two (2) second opinions for you and each dependent each 12 month period following the effective date of the WorldCare Services, with a limit of six (6) second opinions for you and each dependent during your and their lifetime.

- Access to referral services to a U.S. hospital is provided to you and your dependents who have received a second opinion and decide to travel to the U.S. for care. This includes:
    - Assistance in selecting the appropriate medical facility from any U.S. hospital, based on the patient's history, medical diagnosis, proposed treatment plan, expected costs, location preferences, and availability of services;
    - Provision of price estimate;
    - Coordination of medical appointments & assistance with travel arrangements;
    - Coordination of actual hospital admission;
    - Coordination of discharge;
    - WorldCare case manager available to assist you or your dependents with arrangements and serve as point of contact for arrangements with the hospital.

CONDITIONS:

1. AIDS
2. Alzheimer's disease
3. Amputation
4. Anxiety disorders
5. Any life threatening illness
6. Attention deficit disorder
7. Benign brain tumor
8. Cancer
9. Cardiovascular conditions
10. Chronic pelvic pain
11. Coma
12. Deafness
13. Depression/bipolar disease
14. Emphysema
15. Hip and knee replacement
16. Loss of speech
17. Major burns
18. Major organ transplants
19. Major trauma
20. Multiple sclerosis
21. Neuro-degenerative diseases
22. Obsessive compulsive disorder
23. Paralysis
24. Parkinson's disease
25. Renal insufficiency or kidney failure
26. Rheumatoid arthritis
27. Stroke
28. Sudden blindness due to sickness
29. Thrombophlebitis and embolism

The WorldCare services are not a substitute for discussing your and your dependent's health concerns with their physician. As such, it is critical that you and your dependents discuss the Reports with your physician so the physician can provide the care and treatment required.

EXCLUSIONS AND LIMITATIONS

You and each dependent are entitled to two second opinions in each 12 month period following the effective date of the WorldCare services, up to maximum of six second opinions, while the WorldCare services are in effect.

The WorldCare services are not available and are excluded for conditions resulting from the following:

- Attempted suicide, self-inflicted injuries or injuries caused by a third person with your or your dependent's knowledge.
- Alcohol or drug abuse.
- Radioactive contamination.
- War or warlike operations (whether war is declared or not), riot, civil commotion, revolution, insurrections, conspiracy, or any events or causes which determine the proclamation or maintenance of martial law or state of siege.
- Natural disasters such as fire, flood, earthquake, tornado, hurricane, and other acts of God.
- Poisoning or poisonous gas inhalation.

Right of refusal: WorldCare Consortium physicians make every effort to provide a consultation based upon the information provided. In certain cases, the medical information submitted may not be sufficient, or of adequate quality to render an opinion. For example, if the quality of the submitted imaging is sub-standard for interpretation and you or your dependent does not provide optimal imaging, the radiologist will maintain the right to refuse delivering a diagnostic report. In such cases, WorldCare will inform you or your dependent within 24 hours of the reasons for the inability to deliver a report. You or your dependent will have the opportunity to deliver additional or alternative material to WorldCare.

Your access to the WorldCare services shall terminate on the earlier of the date: a) you no longer satisfy the eligibility requirements; or, b) your employer or Equitable Life terminate the WorldCare services. A dependent's access to the WorldCare services shall terminate on the earlier of the date: a) you no longer satisfy the eligibility requirements; b) the dependent no longer satisfies the eligibility requirements; or, c) your employer or Equitable Life terminate the WorldCare services.

Equitable Life is facilitating access to the WorldCare services which are being provided by WorldCare Inc. As a result, WorldCare Inc. is responsible for providing the WorldCare services and will be liable for any negligence or omission in providing the WorldCare services. Equitable Life is not responsible for any negligence or omission of WorldCare Inc. in providing the WorldCare services.

To learn more about WorldCare ACCESS: Sign in to your Group Benefits account and select EquitableHealthConnector™ under *My Resources*. You will find a link to WorldCare ACCESS under *My Services* on the HeatlhConnector landing page.

Certificate of Insurance

Important Information

The insurance policy and the Confirmation of Coverage which contains mandatory and customizable forms are part of the Certificate of Insurance. The *Group Policy* provides worldwide coverage for all eligible *members* while temporarily traveling outside their province of residence.

This Certificate of Insurance describes *your* coverage while *your* Welcome Letter describes the policy terms under the *Group Policy*. Please read both of these carefully before *you* travel. *You* will be provided with a wallet-size Insurance Card that provides important emergency telephone numbers. Carry this card with *you* at all times and bring this Certificate of Insurance with *you* when travelling.

While all of the information is important, *you* should pay particular attention to the Conditions and Exclusions, as these sections may limit the benefits payable to *you*. In addition, by following the instructions in the section: How To File a Claim, *you* can speed up the assessment and, where applicable, payment of *your* covered eligible expenses.

Throughout this Certificate *you* will notice that certain terms are brought to *your* attention with italics. These terms are explained in the Definitions section. Pay particular attention to the definitions as *we* have given a very specific meaning to these terms.

Eligibility

To be eligible for coverage under the *Group Policy,* as of *your departure date* on any *trip, you* must:

- be an eligible member of a PUBLIK Retiree Health Plan, including *spouses* and *dependents*;
- be a surviving dependent, in the case of death of an eligible *member*, who may choose to continue existing benefit coverage indefinitely, provided that they continue to meeting the remaining eligibility criteria;
- be an employee or council *member* who is still employed, including *spouses* and *dependents,* but has aged out from their employer's sponsored benefit program and will be losing their employer's group benefit plan coverage;
- be an ex-spouse or ex-common-law partner of the eligible *member*, who may choose to continue existing benefit coverage indefinitely, provided that they continue to meet the remaining eligibility criteria;
- be a surviving *dependent*, in the case of death of an eligible *member*, who may choose to continue existing benefit coverage indefinitely, provided that they continue to meeting the remaining eligibility criteria;
- be an eligible *member* of the *Policyholder*, including *spouses* and *dependents*, who are residing and/or working in Canada;
- be covered under a Canadian *government health insurance plan* (*GHIP*) for the full duration of any *trip*;
- not have been diagnosed with a *terminal illness* for which a *physician* has estimated *you* have less than six months to live;
- not have been advised by a *physician* against travel; and
- not require kidney dialysis.

Trip Coverage

YOUR TRIP COVERAGE STARTS	The date *you* leave *your* province of residence
YOUR TRIP COVERAGE ENDS	**The earliest of:** i) the actual date *you* return to *your* Canadian province; or ii) the maximum number of *days* per *trip* within a *benefit year* has been reached as defined on the Welcome Letter and *Group Policy*. **Except, if *you* are *hospitalized* while on a *trip, your trip* coverage ends** iii) five *days* after any period of *your hospitalization* or, the *day* that is earlier than five *days* after *you* are released from the *hospital* when *you* are deemed medically able to travel in the opinion of the Medical Director of *Orion Assistance*.
MAXIMUM AGE	80 years old
MAXIMUM BENEFIT	Up to $5 million per *Insured* per *trip* (maximum of $25,000 if not covered by *GHIP* at time of claim)
MAXIMUM *TRIP DAYS*	**PUBLIK Retiree Health Plans:** Lite - 30 *days* per *trip* Premier – 60 *days* per *trip* Elite – 60 *days* per *trip* Deluxe – 90 *days* per *trip*

Group Policy Coverage Termination Date

The coverage of an *Insured* under this *Group Policy* terminates immediately upon the earliest of:

a. the date the *Insured* ceases to meet any of the eligibility for insurance coverage requirements as set out in this Certificate of Insurance; or

b. the date the *member* reaches age eighty (80);

c. for a *dependent* of an eligible *Insured*, once the *dependent* reaches 26 years of age; or

d. the date this *Group Policy* is terminated.

Insured Risks

This insurance provides payment for the *reasonable and customary costs* incurred by *you* for emergency *medical treatment* occurring outside *your* province of residence during a *trip*. Such expenses must be in excess of those reimbursable by *your government health insurance plan* (*GHIP*) and by any other insurance policy or health plan (group or individual) under which *you* are entitled to benefits.

Benefits

The following benefits are payable as part of a covered medical emergency to a maximum of $5 million per Insured, per trip provided such services are required to respond to a medical emergency and are unforeseen and medically necessary as per the terms and conditions of this policy:

1. EMERGENCY *MEDICAL TREATMENT*

a. *Hospital* accommodation up to the semi-private room rate (or an intensive or coronary care unit where *medically necessary*). If *your trip* coverage expires during *your hospitalization*, coverage is extended for a period of five *days*, or for the period of *hospitalization* plus five *days* after discharge from the *hospital*, or until *you* are deemed medically able to travel in the opinion of the Medical Director of *Orion Assistance*, whichever is earlier;

b. *Physicians'* fees;

c. Laboratory tests and X-rays prescribed by the attending *physician* and approved in advance by *Orion Assistance*. Note: This *policy* does not cover magnetic resonance imaging (MRI), cardiac catheterization, computerized axial tomography (CAT) scans, sonograms, ultrasounds or biopsies unless such services are approved in advance by *Orion Assistance*;

d. Private duty nursing (other than by an *immediate family member*) during *hospitalization* when ordered by the attending *physician* and approved in advance by *Orion Assistance*;

e. Local licensed ground ambulance service to the nearest *hospital*, *physician* or medical service provider in the event of a *medical emergency* (also covers local taxi fare in lieu of local ground ambulance service where an ambulance is *medically necessary*);

f. Drugs requiring a prescription by a *physician*, excluding those necessary for the continued stabilization of a chronic medical condition;

g. Casts, splints, trusses, braces, crutches, rental of wheelchair or other minor medical appliances when prescribed by a *physician* and approved in advance by *Orion Assistance*; and

h. Treatment by a chiropodist, chiropractor, osteopath, physiotherapist or podiatrist (other than an *immediate family member*), including X-rays will be limited to $1,000 for all services per benefit year, when approved in advance by *Orion Assistance*.

2. EMERGENCY DENTAL EXPENSES

Reimbursement of:

a. emergency dental treatment (other than by an *immediate family member*) at *trip* destination to repair or replace sound natural teeth or permanently attached artificial teeth injured as the result of an accidental blow to the face, provided *you* consult a *physician* or dentist immediately following the *injury*;

b. necessary emergency dental treatment (other than by an *immediate family member*) described in a. above, that must be continued upon return to *your* province of residence, provided treatment is completed within 180 *days* from the date of the accident, to a maximum of $2,000;

c. other emergency dental treatment (other than by an *immediate family member*) at *trip* destination (excluding root canal treatment) to a maximum of $500.

3. *HOSPITAL* ALLOWANCE

You are entitled to a *hospital* allowance of up to $50 per *day* to a maximum of $2,000 for *your* incidental expenses (for example, long distance calls, television rental) while *hospitalized* for at least 48 hours. This benefit will be **reimbursed** as a lump sum after *your r*elease from *hospital* and upon approval of *your* claim.

4. RETURN OF *VEHICLE*

When approved in advance by *Orion Assistance*:

a. *reasonable and customary* costs for the return of *your* private or rental *vehicle* in the event of *your* medical incapacitation, *hospitalization*, *your* death on a *trip* during or immediately following *your hospitalization* or *your* accidental death; or

b. repatriation of the *Insured(s)* if a private *vehicle* is stolen or inoperative due to an accident.

5. FAMILY TRANSPORTATION

When approved in advance by *Orion Assistance,* a return economy airfare for an *immediate family member* or close friend to attend *your* bedside (upon the recommendation of the attending *physician*) provided the *hospitalization* lasts at least three consecutive *days*. This benefit is provided immediately if *you* are mentally or physically handicapped, or under 26 years of age and dependent for support on the visiting *immediate family member*.

The person attending *your* bedside will be covered under the same terms and conditions of *your* Out-of-Province/Out-of-Canada Travel Insurance. Reasonable out-of-pocket expenses incurred for commercial accommodation and meals, essential taxis and telephone calls by the attending *immediate family member* or close friend will be **reimbursed** to a maximum of $3,500, subject to a limit of $350 per *day*.

6. MEALS AND ACCOMMODATION

You are eligible for a subsistence allowance of $350 per *day* after the scheduled return date or relocation date to a maximum of $3,500 for commercial accommodation, meals, laundry, essential taxis and telephone calls when approved in advance by *Orion Assistance* in the event that:

a. *your* scheduled return date is delayed due to *sickness* or *injury* of an accompanying *family member, travel companion*, or *yourself*; or

b. *you*, an accompanying *family member* or *travel companion* must be relocated for the purpose of obtaining treatment for a *medical emergency*.

If *sickness* or *injury* delays *your* return more than 10 *days* beyond the scheduled return date, this allowance will only be paid upon submission of proof that *you*, or the accompanying *family member* or *travel companion* was admitted and confined to a *hospital* for at least 72 hours within the 10 *day* period.

7. MEDICAL TRANSPORTATION

When approved in advance by *Orion Assistance*:

a. up to the cost of a one-way economy airfare to *your* Canadian province or territory of residence; or

b. the fare for additional airline seats to accommodate a stretcher to return *you* to *your* Canadian province or territory of residence; or

c. where *medically necessary* and approved in advance by *Orion Assistance* as a covered expense, air ambulance (paid in advance) to the nearest appropriate *hospital* or to a *hospital* in *your* province or territory of residence, for the purpose of obtaining immediate *medical treatment*; and

d. repatriation to the point of departure in economy class of each *Insured* and one *travel companion* (if applicable) in the event of *your* medical repatriation.

8. QUALIFIED MEDICAL ATTENDANT

Fees for a qualified medical attendant (other than an *immediate family member*) to accompany *you,* when recommended by the attending *physician* and approved in advance and arranged by *Orion Assistance*. This includes return economy airfare and overnight lodging and meals (where necessary).

9. *TRIP* INTERRUPTION AND DELAY

If the *trip* is interrupted or delayed due to a *sickness* or *injury* of an *Insured,* a one-way economy transportation will be arranged to enable each *Insured* and one *travel companion* (if applicable) to rejoin the *trip* or return home.

If the *Insured* chooses to rejoin the *trip*, further expenses incurred which are related directly or indirectly to the same *sickness* or *injury*, will not be paid.

10. RETURN OF EXCESS BAGGAGE

When approved in advance by *Orion Assistance*, up to $500 for the return of *your* excess baggage. This benefit is payable if *you* are returned to *your* departure point by *us* by any medical repatriation or in the event of *your* death on a *trip* following *your hospitalization* or accidental death.

11. DOMESTIC SERVICES

When *you* have been repatriated under the **Medical Transportation Benefit #7** and when approved in advance by *Orion Assistance*, **reimbursement** up to a maximum of $250 per *trip* in total for the *Insured* and all of his or her *dependents* on the *trip* for domestic services such as housekeeping to *your* principal residence.

12. MEDICAL FOLLOW-UP IN CANADA

When *you* have been repatriated under the **Medical Transportation Benefit #7** , after being *hospitalized* during *your trip*, **reimbursement** for the following is covered in *your* province of residence within 15 *days* of the repatriation:

a. up to $1,000 for semi-private room in a *hospital* or rehabilitation centre or convalescent home;

b. up to $50 per *day* for up to 10 *days* for home nursing care when *medically necessary*;

c. up to $150 for the rental of crutches, standard walker, canes, trusses, orthopaedic corset, oxygen; and/or

d. up to $250 for ambulance or taxi services to receive medical care.

13. ESCORT AND RETURN OF *CHILD(REN)*

When approved in advance by *Orion Assistance* in the event an *Insured* parent or legal guardian (on the *trip*) must be medically repatriated or *hospitalized*:

a. organization, escort and payment up to the cost of a one-way economy airfare for the return of *Insured child(ren)*. This benefit is limited to *child(ren)* under the age of 19 unless the *child(ren)* is mentally or physically handicapped; or

b. **reimbursement** for services of a *caregiver* (other than an *immediate family member*) contracted by *you* for *your Insured child(ren)*. This benefit is limited to *child(ren)* under the *age* of 19 unless the *child(ren)* is mentally or physically handicapped. Provision of an attendant will be arranged by *Orion Assistance*.

14. *CHILD* CARE

When approved in advance by *Orion Assistance*, in the event their parent or legal guardian is attending the bedside of an *Insured* who is *hospitalized* at their *trip* destination, **reimbursement** of up to $1,000 for *child* care provided in *your* province of residence by someone other than an *immediate family member*. This benefit is limited to *child(ren)* under the age of 19 unless the *child(ren)* is mentally or physically handicapped.

15. NON-*MEDICAL EMERGENCY* EVACUATION:

Emergency evacuation from mountain, sea or other remote location of *you* to the nearest accessible point by *professional* services up to $5,000.

16. RETURN OF REMAINS

Subject to prior approval by *Orion Assistance*, in the event of *your* death on a *trip* following *your hospitalization* or accidental death, reimbursement of:

a. the actual cost incurred for:

   i. preparation of the deceased *Insured*; and

   ii. return of the deceased *Insured* in the *common carrier's* standard transportation container to the scheduled point of departure; or

b. up to $5,000 for burial or cremation at the place of death.

In addition, and subject to prior approval of *Orion Assistance*, return transportation for an *immediate family member* or close friend to identify the deceased *Insured*. The person identifying the deceased *Insured* will be covered under the same terms and conditions of *your* Out-of-Province/Out-of-Canada Travel Insurance, but for no longer than three *days*. Reasonable out-of-pocket expenses for commercial accommodation and meals, essential taxis and telephone calls by the attending *immediate family member* or close friend will be reimbursed to a maximum of $350 per *day* to a maximum of three *days*.

17. *PET* RETURN, *PET* CARE AND COMMERCIAL KENNEL COSTS:

When approved in advance by *Orion Assistance*, **reimbursement** up to a:

a. maximum of $500 for one-way transportation of *your pet(s)* and/or *service animal(s)* to *your* province of residence in the event *you* are *hospitalized* at *your trip* destination and cannot return on *your* scheduled return date or *you* are returned to *your* province of residence by any repatriation or death benefit provided by this Certificate of Insurance;

b. maximum of $300 for emergency veterinary services in the event *your pet(s)* and/or *service animal(s)* suffers an accidental bodily *injury* while accompanying *you* on the *trip*; and

c. maximum of $100 per *policy* for commercial kennel costs for *your pet(s)* and/or *service animal(s)* when *you* are not able to return on *your* scheduled return date.

18. PRESCRIPTION ASSISTANCE

Assistance to co-ordinate replacement at *your trip* destination of lost or stolen essential prescription medication (excluding birth control pills or other non-vital prescription medication). Costs of replacement are *your* responsibility.

19. VISION CARE

Reimbursement up to $300 for the replacement at *your trip* destination of prescription eyeglasses due to theft, loss or breakage during *your trip* and assistance to co-ordinate the replacement.

20. HEARING AID

Reimbursement up to $200 for the replacement at *your trip* destination of a hearing aid due to theft, loss or breakage during *your trip* and assistance to co-ordinate the replacement. Does not include batteries or ear molds.

21. TERRORISM COVERAGE

You are entitled to **reimbursement** of covered expenses when an *act of terrorism* directly or indirectly causes *you* a loss for which benefits would otherwise be payable in accordance with the terms and conditions of this Certificate.

22. MESSAGE CENTRE

Transmission of urgent messages to family and/or employer by multilingual *Orion Assistance* co-ordinators if *you* cannot reach *your* home due to time zone differences or telephone difficulties. Leave urgent messages for *travel companions* if *you* lose contact with one another. Telephone numbers are located in the Orion Assistance section.

23. LOST DOCUMENT AND TICKET REPLACEMENT

Assistance in contacting local authorities to help an *Insured* replace lost or stolen passports, visas, tickets or other travel documents.

CONDITIONS

These conditions apply to all insurance coverages under this Certificate of Insurance:

1. In the event of a *medical emergency* please call *Orion Assistance* immediately or *your* benefits under this *Group Policy* may be limited. Telephone numbers are located in the Orion Assistance section.

2 Coverage may never extend beyond the maximum number of *days* per *trip* within the *group benefit* year.

3. If any benefit is duplicated under a similar benefit in this Certificate of Insurance or any other of *our* group or individual policies, or under any other similar coverage with another insurer, the maximum *you* are entitled to is the largest amount specified under any one benefit or insurance coverage. The total amount paid to *you* from all sources cannot exceed the actual expenses *you* incur.

4. Where not specified, airfares are one-way and economy class.

5. If *we* pay *your* health care provider or reimburse *you* for covered expenses, *we* will seek reimbursement from your *GHIP* and from any other medical reimbursement plan under which *you* may have coverage. *You* may not claim or receive in total, more than 100% of *your* total covered expenses.

6. *You* or someone acting on *your* behalf must, unless it is otherwise not possible, first contact *Orion Assistance* in advance of any surgery or invasive procedure (including, but not limited to, cardiac catheterization). *You* must inform *your* attending *physician* to call *Orion Assistance*, except in extreme circumstances where such action would delay surgery required to resolve a life-threatening medical crisis.

7. During a *medical emergency* (whether prior to admission or during a covered *hospitalization*), *we* reserve the right to:

   a. transfer *you* to one of *our* preferred health care providers; and/or

   b. return *you* to *your* province or territory of residence, for the *medical treatment* of *your sickness* or *injury*. If *you* choose to decline the transfer or return when declared medically able by the Medical Director of *Orion Assistance*, *we* shall have no liability for expenses incurred for such *sickness* or *injury* after the proposed date of transfer or return.

8. *We* are not responsible for the availability, quality or results of any *medical treatment* or transportation, or the *Insured's* failure to obtain *medical treatment* or *hospitalization*.

9. Once *you* are deemed medically able to return to *your* province of residence (with or without a medical escort) either in the opinion of the Medical Director of *Orion Assistance* or by virtue of discharge from the *hospital*, *your medical emergency* is considered to have ended, whereupon any further consultation, treatment, recurrence or complication related to the *medical emergency* will no longer be eligible for coverage under this Certificate of Insurance.

10. Any benefits payable for *acts of terrorism* are excess to all other recovery sources including, but not limited to, alternative or replacement travel options offered by airlines, tour operators, cruise lines and other *travel suppliers* and other insurance coverage (even when such coverage is described as excess) and are payable only after *you* have exhausted all such other recovery sources.

    Any benefits payable are subject to an overall aggregate maximum limit relating to all in-force certificates and policies issued by *us*, including this *Group Policy*. Coverage is available for up to two

acts of terrorism within a calendar year and the maximum payable for each *act of terrorism* is $8 million.

If total claims resulting from one or more *acts of terrorism* exceed the applicable aggregate maximum limit stated above, then each *Insured* is entitled to his/her pro rata share of such aggregate maximum limit.

If, in *our* judgment, the total of all payable claims under one or more *acts of terrorism* may exceed the applicable aggregate maximum limit, *your* prorated claim will be paid after the end of the calendar year in which *you* qualify for benefits.

EXCLUSIONS

No coverage shall be provided under the *Group Policy* or under this Certificate of Insurance and no payment shall be made for any claim resulting in whole or in part from, or contributed to by, or as a natural and probable consequence of any of the following:

1. a. Under Age 70

   Any *sickness, injury* or *medical condition* that is not *stable* ninety (90) *days* prior to departure from *your* province of residence.

   b. Ages 70 -80

   Any *sickness, injury* or *medical condition* that is not *stable* one hundred and eighty (180) *days* prior to departure from *your* province of residence.

2. Any *hospital*/medical expenses exceeding a maximum of $25,000 if *you* are not covered by *GHIP* at time of claim.
3. *Sickness*, death or *injury* as a result of the abuse of medication, drugs, alcohol or any other toxic substance during the *trip.* Alcohol abuse includes having a blood alcohol level in excess of 80 milligrams of alcohol per 100 millilitres of blood.
4. A *sickness*, *injury* or related condition during a *trip* undertaken for the purpose of obtaining treatment or surgery.
5. A *sickness*, *injury* or related condition, for which future investigation or treatment (except routine monitoring) is planned before *your trip*.
6. Suicide (including any attempt thereat) or self-inflicted *injury* whether or not *you* are sane.
7. a. *Your* routine prenatal care or childbirth at any time during *your trip;*

   b. Any costs for *your* child(ren) born during *your trip;*

   c. Complications, conditions or symptoms of pregnancy during the nine weeks prior to or after the expected delivery date.

8. Death or injury sustained:

   a. during *your professional* participation in any sport; or

   b. *your* participation in any motorized or mechanically assisted *speed contests*.

9. Treatment, surgery, medication, services or supplies that are not *medically necessary*, or that *you* elect to have provided outside *your* province of residence when medical evidence indicates that *you*could return to *your* province of residence to receive such treatment. The delay to receive treatment in *your* province of residence has no bearing on the application of this exclusion.

10. The replacement cost of an existing prescription, whether by reason of loss, 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. *Orion Assistance* will assist *you* with replacement **(see the Prescription Assistance Benefit #19)**.

11. a. Cardiac catheterization, angioplasty and/or cardiovascular surgery including any associated diagnostic test(s) or charges unless approved in advance by *Orion Assistance* prior to being performed, except in extreme circumstances where such surgery is performed as a *medical emergency* immediately upon admission to *hospital*; and/or

    b. Magnetic resonance imaging (MRIs), computerized axial tomography (CAT) scans, sonograms, ultrasounds or biopsies unless approved in advance by *Orion Assistance*.

12. Services in connection with alternative *medical treatments* or general health examinations, regular care of a chronic condition, the continuing care and/or *medical treatment* of an acute *sickness* or *injury* after the initial *medical emergency* has ended (as determined by the Medical Director of *Orion Assistance*) or a medical consultation where the *physician* observes no *change* in a previously noted condition, symptom or problem.

13. Medical care or surgery that is cosmetic in nature.

14. Cataract surgery or services provided by a naturopath or an optometrist or in a convalescent home, nursing home, rehabilitation centre or health spa, except for the **Medical Follow-Up In Canada Benefit #12**.

15. Air ambulance services unless approved in advance and arranged by *Orion Assistance*.

16. Upgrading charges or cancellation penalties for airline tickets, unless approved in advance by *Orion Assistance*.

17. Damage to or loss of sunglasses (non-prescription), contact lenses, or prosthetic teeth or limbs, and resulting prescription thereof.

18. Emergency medical benefits in *your* province of residence except for the **Domestic Services Benefit #11** and the **Medical Follow-up in Canada Benefit #12**.

19. An official travel advisory was issued by the Canadian government stating “Avoid non-essential travel or Avoid all travel” regarding the country, region or city of *your* destination, before *your effective date*.
    - This exclusion does not apply to claims for an *emergency* or a *medical condition* unrelated to the travel advisory.
    - This exclusion does not apply to emergency medical insurance claims when:
        i. the travel advisory stating “Avoid non-essential travel” is in effect and is due to COVID-19 (SARS-CoV-2); **and**
        ii. *you* have received at least one Health Canada approved COVID-19 vaccination at least 14 *days* prior to *your departure date* (except where *you* do not meet the minimum age requirements for a COVID-19 vaccination, as defined by Health Canada).

If conditions (i) and (ii) are satisfied and when the travel advisory stating "Avoid non-essential travel" is in effect and is due to COVID-19 (SARS-CoV-2), the maximum benefit payable for *reasonable and customary costs* incurred as a result of emergency *medical treatment r*elated to COVID-19 (SARS-CoV-2) and related complications is:

a. $2.5 million CAD, per *Insured*, when *you* have received at least one Health Canada approved COVID-19 vaccination at least 14 days prior to departure; or

b. $5 million CAD per *Insured,* when *you* have received all vaccine doses of Health Canada approved COVID-19 vaccinations at least 14 days prior to departure.

The maximum benefits payable for all policy coverages insured under the policy and policy endorsements remains at $5 million CAD per *Insured.*

You must adhere to COVID-19 vaccination protocols / schedules including receiving all vaccine doses as defined by the Ministry of Health of *your* province or territory of residence. To view the travel advisories, visit the Government of Canada Travel site.

20. Noncompliance with prescribed *medical treatment* or therapy.

21. Commission or attempted commission of a criminal, criminal-like, illegal or negligent act by *you.*

22. Any *act of war*.

23. Any loss resulting from a specific or related medical condition which you contracted in a country during your trip when, before your trip start date, a written formal or official warning was issued by Global Affairs Canada, advising Canadian residents not to travel to that country, region or city.

24. Despite any provision to the contrary within this Certificate of Insurance or any amendment thereto, this Certificate does not cover any liability, loss, cost or expense whatsoever which is directly or indirectly caused by, resulting from, arising out of or in connection with any acts of terrorism perpetrated by biological, chemical, nuclear or radioactive means, regardless of any other cause contributing concurrently or in any other sequence to the liability, loss, cost or expense.

25. Payment for repatriation under the **Trip Interruption and Delay Benefit #9**, when the original ticket may be used. Original tickets will become the property of Orion Travel Insurance Company (Ontario)i n the event of repatriation.

26. Reimbursement of the cost of the original ticket when reimbursing the cost of a one-way economy fare back to the departure point. This exclusion is only applicable to the **Trip Interruption and Delay Benefit #9.**

Orion Assistance

Orion Assistance is available 24 hours per *day,* 365 *days* per year.

WHAT TO DO IF *YOU* NEED *ORION ASSISTANCE*

Have *your Group Policy* number and *your* insurance wallet card with *you* at all times and contact *Orion Assistance* at the telephone number(s) are listed below:

Country	Toll-Free Number
IN CANADA & MAINLAND U.S.	1-888-997-0152
AUSTRALIA	0011 800-8877-9000
BAHAMAS	1-800-389-0701
BERMUDA	1-800-204-8226
CAYMAN ISLANDS	1-800-204-8226
COSTA RICA	00 800-8877-9000
DOMINICAN REPUBLIC	1-800-203-9591
ITALY	00 800-8877-9000
JAMAICA	1-800-204-0004
MEXICO	001-800-248-8561
NEW ZEALAND	00800-8877-9000
SAINT LUCIA	1-800-300-3229
SOUTH AFRICA	00 800-8877-9000
THAILAND	001 800-8877-9000
UNITED KINGDOM	00 800-8877-9000
CALL COLLECT FROM ANYWHERE ELSE	+1-519-251-0152
EMAIL IF CALLING IS NOT POSSIBLE	orionassistance@acmtravel.ca

When contacting *Orion Assistance*, please provide *your* name, *your Group Policy* number, *your* location and the nature of *your emergency*.

WHAT HAPPENS WHEN *YOU* CALL *ORION ASSISTANCE*?

Prior to receiving all relevant medical information, *we* will handle *your emergency* assuming *you* are eligible for benefits under the *Group Policy*. If it is later determined that a term, limitation, condition and exclusion, general and/or specific, applies to *your* claim, *you* will be required to reimburse *us* for any payments *we* have made on your behalf.

Orion Assistance will work closely with *you* to:

- direct *you* to an appropriate *physician, hospital,* dentist, pharmacist or appropriate medical facility at *your trip* destination, wherever possible;
- provide multilingual interpreters to communicate with *physicians* and *hospitals*;
- monitor *your* care so that only appropriate, *medically necessary* treatment is given and to ensure that *your* medical needs are met;
- contact *your* family and *physician* on *your* behalf;
- pay *hospitals*, *physicians* and other medical providers directly, whenever possible;
- approve and arrange air ambulance transportation when *medically necessary*;
- inform *you* of any expenses that at the time, it is apparent, are not covered or explain the terms and provisions of this Certificate as they relate to *your medical emergency*.

Where a claim is payable *we* will arrange, wherever possible, to have any medical expenses billed directly to *us*.

WHY ARE *YOU* REQUIRED TO CALL *ORION ASSISTANCE*?

1. If *you* call *Orion Assistance you* will receive information about *medical treatment* or services which are not considered *medically necessary* as defined in this Certificate. If the *medical treatment* or services are not *medically necessary* they are not covered.
2. *Orion Assistance* must be contacted in advance for certain benefits. Check the particular benefits section to see which benefit(s) this applies to.
3. If *you* pay eligible expenses directly to a health service provider without prior approval by *Orion Assistance*, these services will be reimbursed to *you* on the basis of the *reasonable and customary costs* that would have been paid directly to such provider by *us*. Medical charges that *you* pay may be higher than this amount, therefore *you* will be responsible for any difference between the amount *you* paid and the *reasonable and customary costs* reimbursed by *us*.

LIMITATION ON *ORION ASSISTANCE* SERVICES

Orion Assistance reserves the right to suspend, curtail or limit services in any area or country in the event that war, political instability, or hostility, renders the area inaccessible by *Orion Assistance*. *Orion Assistance* will use its best efforts to provide services during any such occurrence.

You may contact *Orion Assistance* prior to *your* departure to confirm coverage for *your trip* destination.

How to File a Claim

PAYMENT TO MEDICAL PROVIDERS

Orion Assistance will pay *hospitals*, *physicians* and other medical providers directly, whenever possible. While most medical providers will agree to accept direct payment from *us,* there are some providers who will require that *you* pay them directly.

Where direct payment cannot be arranged, *we* will **reimburse** eligible expenses on the basis of *reasonable and customary costs*.

Please note that some benefits are only **reimbursable** on *your* return. Check the particular benefit section to see which benefit(s) this applies to.

SUBMITTING *YOUR* CLAIM

You must substantiate *your* claim by providing the documents described below and other supporting documentation as requested by *us*. *We* are not responsible for charges levied in relation to any such documents.

Orion Travel Insurance
Active Care Management Inc.
PO Box 308 Station A
Windsor, Ontario N9A 6K7
Email: orionclaims@acmtravel.ca
Telephone numbers are located in the Orion Assistance section.

Emergency Medical Claims

1. A completed Medical Expenses Claim Form (provided by *Orion Assistance* upon notification of claim).
2. For accidental dental expenses *you* must provide an accident report from the *physician* or dentist.
3. Original itemized bills from the licensed medical provider(s) stating the patient's name, diagnosis, date and type of treatment, and the name, address and telephone number of the provider, as well as the original transaction documents proving that payment was made to the provider. Copies of itemized bills are accepted only if the *Insured* has already dealt directly with *your GHIP*.
4. Original prescription drug receipts from the pharmacist, *physician* or *hospital* indicating the name of the prescribing *physician*, prescription number, name of preparation, date, quantity and total cost.
5. For out of pocket expenses, an explanation of expenses accompanied by the original receipts.
6. Other supporting documentation as requested by *us*.

All Other Claims

For forms and instructions, contact *Orion Assistance* at the telephone number(s) located on *your* Insurance Card.

Definitions

ACM or ***Active Care Management Inc.*** means the company appointed by the *Insurer* to provide the assistance and claims services under this policy.

Act of Terrorism means any activity occurring within a 72 hour period, save and except an *act of war* against persons, organizations, property (whether tangible or intangible) or infrastructure of any nature by an individual or a group based in any country that involves the following or preparation for the following:

- use, or a threat to use, force or violence; or
- commission, or a threat to commit, a dangerous act; or
- commission, or a threat to commit, an act that interferes or disrupts an electronic, information or mechanical system;

and the effect or intention of the above is to:

- intimidate, coerce or overthrow a government (whether de facto or de jure) or to influence, affect or protest against its conduct or policies; or
- intimidate, coerce or put fear in the civilian population or any segment thereof; or
- disrupt any segment of the economy; or
- further political, ideological, religious, social or economic objectives to express (or express opposition to) a philosophy or ideology.

Act(s) of war means hostile or warlike action, whether declared or not, in a time of peace or war, whether initiated by a local government, foreign government or foreign group, civil unrest, insurrection, rebellion or civil war.

Benefit Year means a 12 month period beginning on the effective date described on the Welcome Letter.

Caregiver means a person *you* have entrusted with the care of *your dependent(s)* on a permanent, full-time basis and whose services cannot reasonably be replaced.

Child(ren) means an *Insured's* unmarried and *dependent* natural, adopted or step-*child(ren)* under 26 years of age (under *age* 19 for Escort of *Insured Children* benefit), who are not employed on a full-time basis OR who are full-time students at a post-secondary institution OR mentally or physically handicapped *child(ren)* of any age, all of whom reside with the *Insured* and depend on the *Insured* for support and who is/are not eligible for insurance as an *member* under the *Group Policy* or any other *Group Policy*.

Common carrier means a conveyance (bus, taxi, train, boat, airplane or other *vehicle*) which is licensed, intended and used to transport paying passengers.

Day(s) means 24 consecutive hours beginning at 12:01 a.m.

Departure date means the date *you* left *your* Canadian province of residence for *your trip*.

Dependent means a *member's spouse* or *child(ren)* who is/are insured under *GHIP*, provided that the *member* has *dependent* coverage under his/her Plan Sponsor's *Group Policy*.

Experimental or investigative means not approved or broadly accepted and recognized by the Canadian medical profession, as an effective, appropriate and essential treatment of a *sickness* or *injury*, in accordance with Canadian medical standards.

Family member means the *Insured* and/or *his/her dependent spouse* and/or the *Insured's dependent* natural *child(ren)*, adopted *child(ren)* or step-*child(ren)*.

Government Health Insurance Plan (GHIP) means a Canadian provincial or territorial *government health insurance plan*.

Group Policy means this document, the *Group Policy*, the Application, the Welcome Letter and any riders, amendments or documentations to the group insurance contract all of which form the entire *Group Policy*.

Hospital means a medical facility which is legally accredited to provide medical, diagnostic and surgical treatment to in-patients during the acute phase of their *sickness* or *injury*, which is primarily engaged in the aforesaid activities and which operates under the supervision of a staff of *physicians* and has a registered nurse continuously on duty. The *hospital* must not be licensed as a home for the aged, rest home, nursing home, convalescent *hospital*, health spa, rehabilitation centre or treatment facility for drug or alcohol abuse and/or addiction.

Hospitalization or ***hospitalized*** means *you* are admitted to a *hospital* and are receiving *medical treatment* on an in-patient basis while on a *trip*.

Immediate family member means *spouse* (legal or common-law), natural, adopted, foster or step-*child(ren),* brother, sister, step-brother, step-sister, parent, step-parent, grandparent, grandchild(ren), aunt, uncle, nephew, niece, son-in-law, daughter-in-law, parent-in-law, brother-in-law, sister-in-law, legal guardian, or legal ward of the *Insured*.

Injury means accidental bodily harm which results in loss unrelated to *sickness* or any other cause and which occurs while this coverage is in effect. The *injury* must be sufficiently serious to prompt a reasonably prudent person to consult a *physician* for the purpose of *medical treatment* and for the *physician* to certify in writing the necessity of cancelling, interrupting or delaying the *trip.*

Insured means individually the *member* and each of his/her eligible *dependents* and *insureds* means the *member* and his/her eligible *dependents.*

Insurer means Orion Travel Insurance Company.

Medical emergency means the unforeseen and emergent occurrence of symptoms for a *sickness* or *injury* which, unless *treated* immediately by a *physician*, may lead to death or to serious impairment of *your* health.

Medical treatment means any reasonable procedure which is medical, therapeutic or diagnostic in nature, which is *medically necessary* and which is prescribed by a *physician*. *Medical treatment* includes *hospitalization*, basic investigative testing, surgery, prescription medication (including prescribed as needed) or other treatment directly related to the *sickness*, *injury* or symptom.

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 *your* condition or quality of medical care;
d. cannot be delayed until *your* return to *your* province of residence; and
e. is delivered in the most cost effective manner possible, at the most appropriate level of care and not primarily by reason of convenience.

Member means a person who is a PUBLIK *member* and meets the eligibility requirements of the policy. Any Person who is covered by this policy as a *member* may not be covered as a *dependent.* The surviving spouse, ex-spouse or *ex-common law partner* of a *member*, who meets eligibility requirements, shall be deemed to be a *member.*

Orion Assistance means the claims and assistance service provider, appointed by *us* from time to time to perform all assistance services and administer claims on *our* behalf under the *Group Policy*.

Pet(s) means domestic dog(s), *service animal(s)* and/or cat(s) only.

Physician means a medical practitioner licensed to prescribe and administer *medical treatment* or a surgeon licensed to perform surgery:

a. who was thus licensed at the time of treatment and who remains so;

b. whose legal and *professional* standing, within the jurisdiction where treatment was rendered, is equivalent to that of a doctor of medicine (M.D.) licensed to practice in any province or territory of Canada; and

c. who is not an *immediate family member*.

Professional means a person who is engaged in a specific activity and receives remuneration.

Reasonable and customary costs means costs incurred for approved, eligible 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* or *injury*.

Service Animal(s) means any dog(s) that is individually trained to do work or perform tasks for the benefit of an *Insured* with a disability, including a physical, sensory, psychiatric, intellectual or other mental disability. The work or tasks performed by a *service animal* must be directly related to the *Insured's* disability.

Sickness means a disease or disorder of the body which 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* and for the *physician* to certify in writing the necessity of cancelling, interrupting or delaying the *trip*.

Speed contest means an organized activity of a competitive nature in which speed is a determining factor in the outcome of the event.

Spouse means the person to whom *you* are legally married or with whom *you* have resided for at least 12 months and whom *you* present publicly as *your spouse* (regardless of sex).

Stability means:

1. There has not been any new treatment prescribed or recommended, or change(s) to existing treatment including a stoppage in treatment; and
2. There has not been any change to any existing prescribed drug (including an increase, decrease, or stoppage to prescribed dosage), or any recommendation or starting of a new prescription drug; and
3. The medical condition has not become worse; and
4. There have not been any new, more frequent or more severe symptoms; and
5. There has been no hospitalization or referral to a specialist; and
6. There have not been any tests, investigation or treatment recommended, but not yet complete, nor any outstanding test results; and
7. There is no planned or pending treatment.

All of the above conditions must be met for a medical condition to be considered *stable.*

Terminal illness means that *you* have a medical condition for which a *physician* has estimated that *you* have less than six months to live.

Travel companion means a person accompanying *you* on the *trip*, who shares accommodation or transportation with *you* and who has paid such accommodation or transportation in advance of *your departure date*. A maximum of six persons will be considered a *travel companions* (including the *Insured*).

Treated means that *you* have been *hospitalized*, have been prescribed (including prescribed as needed), have taken or are currently taking medication.

Trip means travel undertaken by the *Insured* or his or her eligible *dependents* taken outside such person's Canadian province of residence. A *trip* must commence after the *Insured* or his or her eligible *dependents* are eligible for coverage. A *trip* is deemed to end on the date the "Trip Coverage Ends" as further described in in the Trip Coverage section of this Certificate.

Vehicle means any private or rental automobile, motorcycle, mobile home or trailer.

We, us, or ***our*** means Orion Travel Insurance Company.

You, your and ***yourself*** refers individually to the *Insured, spouse* and to each of his/her eligible *dependent(s)*.

General Terms Of Agreement

These general terms of agreement apply to all coverages described herein.

You agree that *we* and *Orion Assistance* have:

a. *your* consent to verify *your* Canadian *government health insurance plan* (*GHIP*) card number and other information required to process *your* claim, with the relevant government and other authorities;

b. *your* authorization to *physicians*, *hospitals* and other medical providers (where applicable) to provide to *us* and *Orion Assistance* any and all information they have regarding *you* while under observation or treatment, including *your* medical history, diagnoses and test results;

c. *your* agreement to the collection, use and if necessary, disclosure of the information available under a. and b. above from and to other sources, as may be required for the consideration and if applicable, processing of *your* claim including but not limited to for co-ordination of benefits obtainable from other sources; and

d. the right to collect from *you* any amount *we* have paid on *your* behalf to medical providers or any other parties in the event that *you* are found to be ineligible for coverage or that *your* claim is invalid or benefits are reduced in accordance with any provisions of this *Group Policy*.

Deductible

No deductible applies to the insurance coverages described herein.

Where Coverage is Applicable:

Coverage is applicable worldwide, except in countries at war or countries where political instability or hostility renders the area inaccessible by *Orion Assistance* services. *You* may contact *Orion Assistance* prior to *your departure date* to confirm coverage for *your trip* destination. Telephone numbers are located in the *Orion Assistance* section.

Payment of Benefits

All payments under the *Group Policy* are payable to *you* or on *your* behalf. Benefits for loss of life are made to *your* estate. *You* do not have the right to designate persons to whom or for whose benefit insurance money is to be payable.

Any benefits paid will be payable in Canadian funds. Where benefits are payable in foreign currency, the rate of exchange is based on the rate effective on the date when the benefit is paid. No sum payable shall bear interest. **All benefit limits indicated are in Canadian currency.**

Rights of Subrogation

We have the right to proceed at *our* own expense in *your* name against third parties who may be responsible for giving rise to a claim under the *group policy* or who may be responsible for providing indemnity, compensation or benefits similar to this insurance. *We* have full rights of subrogation. This right of subrogation is in addition to and does not limit any other right of subrogation under common law, equity or statute. *You* will co-operate fully with *us* and not do anything to prejudice such rights. If *you* institute a demand or action for a covered loss, *you* shall immediately notify *us* so that *we* may safeguard *our* rights.

Co-ordination of Benefits

If, at the time of loss, *you* have insurance from another source, or if any other party is responsible for benefits also provided under the *group policy*, *we* will pay eligible expenses only in excess of those covered by that other insurer or other responsible party, including but not limited to, credit cards, private or provincial or territorial auto plans or any other insurance, any applicable benefit plans, contracts or any other insurance, whether collectible or not. This *insurer* is a secondary payor. All other sources of recovery, indemnity payments or insurance coverage must be exhausted before any payments will be made under any of our policies. If, however, that other insurance is also "excess only", we will co-ordinate payments of all eligible claims with that other insurer. All co-ordination follows guidelines set by the Canadian Life and Health Insurance Association.

In no case will *we* seek to recover against employment related plans if the lifetime maximum for all in-country and out-of-country benefits is **$100,000** or less. If *your* lifetime maximum is greater than **$100,000**, *we* will co-ordinate benefits only above this amount.

Misrepresentation and Non-disclosure

The *Insured's* entire coverage under this Certificate of Insurance shall be voidable if *we* determine, whether before or after loss, that any *Insured* has concealed, misrepresented or failed to disclose any material fact or circumstance concerning his or her interest therein, or if the *Insured* shall refuse to disclose information or permit the use of such information, pertaining to any of the *Insureds* under this policy of insurance.

Arbitration

We and the *Insured(s)* hereto agree that any dispute, controversy or claim arising out of or relating to this *policy*, including any question regarding its existence, interpretation, validity, breach, termination or claim made pursuant to it, shall be submitted to an arbitrator in the Canadian province in which this *policy* was issued. The laws of the Canadian province in which the *policy* was issued shall apply in the determination of any such dispute, controversy or claim. The decision of the arbitrator shall be final and no party may appeal the decision to any court.

Applicable Law

This *policy* of insurance is governed by the law of the Canadian province of residence of the *Insured*.

Collection And Use Of Personal Information

Collecting Personal Information

We may collect personal information about the the *Insureds* such as:

- information establishing identity (for example, name, address, phone number, date of birth, etc.) and personal
- background;
- information related to or arising from the relationship with and through *us*;
- information provided through the claim process for any insurance products and services; and
- information for the provision of products and services.

We may collect information from the the *Insured*, either directly or through representatives. *We*

may collect and confirm this information during the course of *our* relationship. *We* may also obtain this information from a variety of sources including *hospitals*, *physicians* and other health care providers, the government (including *government health insurance plans*) and other governmental agencies, other insurance companies, financial institutions and motor *vehicle* reports. Health information will not be shared without the consent of the *Insured*.

Using Personal Information

This information may be used for the following purposes:

- to verify the identity and investigate the background of the *Insured*;
- to issue and maintain insurance products and services that may be requested;
- to evaluate insurance risk and manage claims;
- to better understand the insurance situation of *our* clients;
- to determine eligibility for Orion Travel Insurance products and services;
- to help *us* better understand the current and future needs of *our* clients;
- to communicate to *our* clients any benefit, feature and other information about Orion products and services
- maintained by *us*;
- to help *us* better manage *our* business and the relationship with *our* clients; and
- as required or permitted by law.

For these purposes, *we* may make this information available to *our employees*, *our* agents and service providers, and third parties, who are required to maintain the confidentiality of this information. If *you* are *insured* under a group insurance policy obtained through *your* employer, *we* may also share *your* information with *your* employer when necessary for the services *we* provide to *you*. *Your* health information will not be shared with *your* **employer without *your* consent.**

In the event *our* service provider is located outside Canada, the service provider is bound by, and the information may be disclosed in accordance with, the laws of the jurisdiction in which the service provider is located. Third parties may include other insurance companies and financial institutions.

We may also use this information to manage *our* risks and operations and those of *our* affiliates to comply with valid requests for information about *you* from regulators, government agencies, public bodies or other entities who have a right to issue such requests.

Notice on Privacy and Confidentiality

To protect the confidentiality of the *Insured's* and/or *dependent's* information, Orion Travel Insurance Company and *Orion Assistance* will establish a "financial services file" from which this information will be used to administer services and process claims. Access to this file will be restricted to those Orion Travel Insurance Company/*Orion Assistance* employees, mandataries, administrators or agents who are responsible for the assessment of risk (underwriting), marketing and administration of services and the investigation of claims, and to any other person *you* authorize or as authorized by law. These people, organizations, and service providers may be in jurisdictions outside Canada, and subject to the laws of those foreign jurisdictions.

Your file is secured in *our* offices or those of *Orion Assistance*. *You* may request to review the personal information it contains and make corrections by writing to:

Chief Privacy Officer
Orion Travel Insurance Company
60 Commerce Valley Drive East
Thornhill, Ontario L3T 7P9

Tel: 905-747-4900 ext 25043
Fax: 905-771-3357
Email: Privacy@caasco.ca
The information for the Ombudsman's office is: https://www.oriontravelinsurance.ca/Contact%20Us.aspx

Our Privacy Policies

You may obtain more information about *our* privacy policies by calling *us* at the toll free number shown above or by visiting *our* web site at https://www.oriontravelinsurance.ca/~/media/Orion/Documents/Orion%20Privacy%20Policy.pdf

Other Conditions

Waiver

We shall be deemed not to have waived any condition of the *Group Policy* or this Certificate, either in whole or in part, unless the waiver is clearly expressed in writing and signed by the *Insurer*.

Notice and Proof of Claim

The *Insured*, or a beneficiary entitled to make a claim, or the agent of any of them shall:

a. within 90 *days* from the date a claim arises under the contract on account of an insured risk, furnish to *Orion Assistance* such proof as is reasonably possible in the circumstances of the happening of the accident or the commencement of the *sickness* or *injury*, and the loss occasioned thereby, the right of the claimant to receive payment, his or her age, and the age of the beneficiary; and

b. if so required by *Orion Assistance,* furnish a satisfactory certificate as to the cause or nature of the accident, *sickness*, *injury* or insured risk for which the claim may be made under the contract and as to the duration and/or extent of loss.

Failure to Give Notice or Proof

Failure to give notice of claim or furnish proof of claim, within the time prescribed by this statutory condition, does not invalidate the claim if:

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

b. in the case of the death of the person insured, if a declaration or presumption of death is necessary, the notice or proof is given or furnished no later than one year after the date a court makes the declaration.

Limitation of Arbitration Proceedings

Every action or proceeding against an *insurer* for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the *Insurance Act* (AB, BC and MB), the *Limitations Act, 2002* (ON), or other applicable legislation under the contract is absolutely barred unless commenced within the time set out in the *Limitations Act, 2002*.