Employee Benefits Booklet

Ecotone Industry Plan

Class C

Division 1

EHC + Dental

For Purposes of this contract, "Employer" refers to Ecotone Health Insurance, and "Employee" refers to the Industry Plan member.

Powered by:

Effective Date: Jul 1, 2023

Contact

Plan Administration Support	administration@simplybenefits.ca
General Inquiries	contact@simplybenefits.ca
Support	support@simplybenefits.ca
Phone Number	1-877-815-7751
Website	simplybenefits.ca
Address	601-460 Doyle Ave Kelowna BC, V1Y 0C2

Practice Management Software Setup information

Carrier Name	Simply Benefits
BIN/Carrier ID/CDAnet ID	610361
Network	instream
CDAnet Message Version	4

Supported CDAnet Transactions	Claim Claim Reversal Predetermination Request for Outstanding Transaction Coordination of Benefits

Introduction

Your employer has entered into an agreement with Simply Benefits to provide you with a plan of group insurance benefits.

This information booklet has been prepared in order to give you an informal summary of the benefits and provisions of your Plan. It does not constitute the group Policy and is not a contract of insurance, nor does it confer or grant any contractual or other rights. All rights under this Plan will be governed solely by the provisions of the master Policy and by applicable law.

In the event of any discrepancy between this booklet and the group Policy, the terms and provisions of the group Policy apply.

The booklet contains important information concerning your group insurance coverage. As at the print date, this is the most current version of your group insurance benefits and replaces any previous booklet.

Should you have any questions, please contact your plan administrator or the third-party administrator, Simply Benefits at:

Email:	support@simplybenefits.ca
Telephone:	1-877-815-7751

Important Notice

The group insurance contract consists of the Schedule of Benefits, the contractual provisions and any appendix attached to the contract.

A Schedule of Benefits is provided for each class of employees eligible for insurance. It briefly describes the insurance benefits that are included in the group insurance plan for each class. All information regarding the definitions, insurance terms and conditions, termination of insurance, applicable exclusions and reductions as well as claims are found in the contractual provisions.

Participants and their dependents, if any, are not entitled to any amount of insurance or benefits not expressly indicated in the Schedule of Benefits for the class of eligible employees to which the participant belongs.

The Schedule of Benefits, contractual provisions and any appendix are available on your Simply Benefits Portal, as well as your office Plan Administrator through your employer and/or the policyholder.

Table of Contents

SCHEDULE OF BENEFITS

A summary of the benefits included in your employee benefits plan.

Life Insurance

Eligibility	* 1 month(s) continuous employment, 20 hrs/week
Benefit	Flat $10,000.00
Maximum with Evidence	$10,000.00
Non-evidence Maximum	$10,000.00
Reduces by	50% at age 65
Termination Age	Age 70 or prior retirement
Waiver of Premium	To age 65 or prior retirement

**Employee must be actively working to claim for this benefit*

Accidental Death and Dismemberment

Eligibility	*1 month(s) continuous employment, 20 hrs/week
Benefit	Equal to the amount under the Basic Life Benefit.
Maximum with	Same as Basic Life Benefit.
Non-Evidence Maximum	Same as Basic Life Benefit.
reduces by	Same as Basic Life Benefit.
Termination Age	Same as Basic Life Benefit.

**Employee must be actively working to claim for this benefit*

Employee Family and Assistance Program

Eligibility	1 month(s) continuous employment, 0 hrs/week
EFAP Benefit Description	EFAP benefit provided by Dialogue will give you access to essential wellness services to stay happy and healthy: Mental Health: Mood disorders (depression, anxiety, etc.), insomnia and fatigue, stress, anger & emotion regulation, grief. etc. Family and relationships: Parenting, relationship and intimacy, family dynamics, conflict resolution, etc Work and Career: Professional development, work performance, workplace conflict, etc. Legal Services: Civil & criminal law (consumer protection, contracts), property law (commercial, residentials), etc. Financial Services: Bankruptcy, debt, real estate, mortgage, retirement planning, etc.
How to access Dialogue EFAP	Please check Simply's employee portal under "resources" or go to https://dialogue.co/eap-signup/ to sign up or Log In with your Dialogue account if you have already signed up

Virtual Healthcare

Eligibility	1 month(s) continuous employment, 0 hrs/week
Virtual Healthcare Benefit Description	Virtual Healthcare (Dialogue) provides you with real-time access via chat, phone or video to a multidisciplinary medical team to help treat non-urgent health concerns. • Unlimited virtual medical care 24/7. • Video-based medical consultations. • Support for a wide variety of issues. • Personalized follow-ups after every consultation • Consultations with other allied health professionals for an additional fee that may be covered by your insurance. Dialogue is brought to you by Simply Benefits and is also available to your dependents.
For more details or to register	Please check Simply's employee portal under "resources" or go to https://dialogue.co/signup/

Drug Coverage

Reimbursement	80%
Drug Plan Type	Mandatory Generic
Benefit Period	Calendar year
Overall Maximum (Calendar Year)	$5,000.00
Preferred Provider	Pocket Pills
Preferred Provider Reimbursement	90%
Eligibility	1 month(s) continuous employment, 0 hrs/week
Diabetic Supplies and Accessories	Include syringes, lancets, test strips, pin needles and chemical reagent testing
Survivor Benefit	24 months
Termination Age	Employee Age 70 or prior retirement

Major Health

Deductible	N/A
Reimbursement	80%
Accidental dental	100.00%
Ambulance	Reasonable & Customary
Cardiac Rehabilitation	$500.00 per calendar year
Hearing Aids	$700.00 per 48 consecutive months
Private duty nursing	$10,000.00 per calendar year
Hospital Benefit Reimbursement	100%
Hospital Benefit Type	Private
Convalescent Hospital Reimbursement	100%
Convalescent Hospital Daily Maximum	$40.00
Convalescent Hospital Maximum Days	180.00
Apnea machine (CPAP)	$2,000, 1 per 60 consecutive months
Apnea machine supplies	Covered (Reasonable and Customary)
Apnea mask	1 per calendar year
Artificial eye or limb; initial prosthesis	1 per lifetime
Artificial eye or limb; repair & replacement	$1,000 per calendar year
Blood pressure monitor	$100 lifetime
Braces with rigid supports	1 per calendar year
Compression stockings	$100 per calendar year
Crutches	Covered (Reasonable and Customary)
Custom-made foot orthotics	$300.00 per calendar year
Glucose monitoring equipment and supplies	$4,000 per calendar year
	Continuous Glucose Monitors (CGM)
	Blood Glucose Monitoring Systems (BMG)
	Glucose Monitoring Systems (GMS)
	Flash Type Monitors (FGM)
	Sensors, Receivers & Transmitters
	Patient must be insulin dependent Type 1 diabetic supported by a doctor's prescription.
External breast prosthesis	1 per calendar year
Insulin pump	$5,000 every 5 calendar years
Insulin pump supplies	$3,500 per calendar year
IPP Breathing machine	Covered (Reasonable and Customary)
Orthopaedic Shoes	$300.00 per calendar year
Prosthetics	$25,000 lifetime
Ostomy supply	Covered (Reasonable and Customary)
Medical Referral	50% reimbursement; $50,000 lifetime maximum
Surgical bras	2 per calendar year
TENS	$3,500 lifetime
Viscosupplementation	$600 per calendar year
Wheelchair; electric	$3,000 lifetime
Wheelchair; manual	$1,000 lifetime
Wigs, post-chemotherapy	$500 lifetime

Diagnostic Services

Reimbursement	80%
Diagnostic Services Maximum	$200.00 per calendar year
X-Rays	Covered (Reasonable and Customary)

Paramedical

Deductible	N/A
Coinsurance	80%
Acupuncturist	$350 per calendar year
Audiologist	$350 per calendar year
Chiropodist	$350 per calendar year
Chiropractor	$350 per calendar year
Massage therapist	$350 per calendar year
Naturopath	$350 per calendar year
Occupational Therapist	$350 per calendar year
Osteopath	$350 per calendar year
Physiotherapist	$350 per calendar year
Podiatrist	$350 per calendar year
Registered Dietician	$350 per calendar year
Psychologist	$350 per calendar year
Social worker	$350 per calendar year
Speech-language pathologist	$350 per calendar year

Out of Country & Province

AIG Policy Number	9429103
Maximum Number of Days	60 Days
Maximum per insured	$5,000,000.00 per insured / per trip
Termination Age	70 Years

Dental Care

Benefit Period	Calendar year
Basic Reimbursement	80%
Routine Reimbursement	80%
Basic Maximum	$1,000.00
Months to Recall	9 months to recall
Units of Scaling	10 units of scaling
Periodontics Reimbursement	80%
Endodontics Reimbursement	80%
Eligibility	1 month(s) continuous employment, 0 hrs/week
Survivor Benefit	24 month(s)
Termination Age	Employee age 70 or prior retirement

BENEFITS DETAILS

Further information about your benefits coverage.

Life Insurance

Plan Member Life coverage provides financial protection for your survivors in the event of your death. If you die while covered under the Plan and the eligibility requirements set out and described in the Plan Summary or other-wise in this Plan are met, your Plan Member Life Benefit will be paid to the beneficiary or beneficiaries you have named.

Accidental Death and Dismemberment

Why You Need Accident Insurance

A serious accidental Injury or death can have tremendous consequences for your family that may prevent you or your spouse from meeting your financial obligations. Your employer has provided you with accident insurance coverage underwritten by AIG Insurance Company of Canada. The policy provides a lump sum benefit to your beneficiary to help ease any financial burden if you suffer a Loss of Life as a result of an accident. The policy also provides you with 'living benefits' should you suffer an accident that results in any of the losses listed in the Table of Losses, such as Paralysis or Loss of Hearing.

Eligibility and Principal Sum

Your plan provides Accidental Death and Dismemberment benefits for injuries as a result of covered accidents.

Definitions

"Annual Earnings" means your annual salary from employment with your Employer immediately prior to the date of loss, exclusive of overtime, bonus, incentive payments, profit sharing or commission.

"Company" means AIG Insurance Company of Canada.

"Dependent Child" means a person who is either your natural child, adopted child or step-child or a child to whom you are in loco parentis and who is 1) under 21 years of age, unmarried and dependent upon you for maintenance and support and not employed for more than 25 hours per week; or 2) under 25 years of age, unmarried and enrolled in post-secondary education and dependent upon you for maintenance and support and not employed for more than 25 hours per week; or 3) by reason of mental or physical infirmity is incapable of self-sustaining employment and who is considered your dependent child within the terms of the Income Tax Act (Canada).

"Employer" means the Policyholder or an affiliate or subsidiary thereof, for which you are employed.

"Hospital" means an establishment which:

- holds a licence as a hospital (if licensing is required in the jurisdiction);
- operates primarily for the reception, care and treatment of sick, ailing or injured persons as in-patients;
- has a staff of one or more licensed Physicians available at all times;
- provides organized facilities for diagnosis, and major medical surgical facilities;
- is not primarily a clinic, nursing, rest or convalescent home or similar establishment; and
- is not, other than incidentally, a place for the treatment of alcohol or drug addiction.

"Immediate Family" means a person who is related to you in any of the following ways: a spouse, brother in law, sister in law, son in law, daughter in law, mother in law, father in law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister), or child (including legally adopted or stepchild).

"Injury" or "Injuries" means bodily injury which is sustained by you as a direct result of an unintended unanticipated accident, provided such accident is external to the body and occurs while your insurance under this policy is in force.

"Insured Employee" means an individual who belongs to an eligible class of Insured Employees specified in the Policy Schedule Declarations provided such individual's name is on file with the Policyholder as being insured under this policy.

"Loss" when used with reference to:

- "Quadriplegia, Paraplegia, and Hemiplegia" means the complete and irreversible paralysis of such limbs;
- "Hand or Foot" means the complete severance through or above the wrist or ankle joint, but below the elbow or knee joint;
- "Arm or Leg" means the complete severance through or above the elbow or knee joint;
- "Thumb and Index Finger" means the complete severance through or above the first phalange;
- "Fingers" means the complete severance through or above the first phalange of all four Fingers of one Hand;
- "Toes" means the complete severance of both phalanges of all the toes of one foot;
- "The Entire Sight of One Eye" means the total and irrecoverable loss of sight such that corrected visual acuity must be 20/200 or less in such eye;
- "The Entire Sight of Both Eyes" means the total and irrecoverable loss of sight in both eyes such that corrected visual acuity must be 20/200 or less and the field of vision must be less than 20 degrees in both eyes. A Physician certified in ophthalmology must clinically confirm the diagnosis in writing;
- "Hearing in One Ear" means the diagnosis of permanent loss of Hearing in One Ear, with an auditory threshold of more than 90 decibels. A Physician certified in otolaryngology must confirm the diagnosis in writing;
- "Hearing" means the diagnosis of permanent loss of Hearing in both ears, with an auditory threshold of more than 90 decibels in each ear. A Physician certified in otolaryngology must confirm the diagnosis in writing;
- "Speech" means complete and irrecoverable loss of the ability to utter intelligible sounds; and
- "Loss of Use" means the total and irrecoverable loss of use provided the loss is continuous for 12 consecutive months and such loss of use is determined to be permanent.

"Loss" when used herein may also include "Loss of Life".

"Physician" means a medical doctor, other than you or your Immediate Family, who is licenced to administer medical treatment and prescribe drugs in the place where he or she provides medical services. The following are not considered to be Physicians: naturopath, herbalist and homeopath.

"Private Passenger Type Automobile" means any means of transportation not operated for commercial purposes, designed to carry passengers and that is pulled, propelled or fuelled in any way, including cars, trucks, motorcycles, mopeds, snowmobiles or boats.

"Spouse" means a person who is under the age of 70 and who is either legally married to you, or if there is no such person, is a person who, although not legally married to you, is cohabitating with you for a period of at least one year and is publicly represented as your domestic partner in the community in which you reside.

Conversion Privilege Benefit:

If you leave your job for any reason, you have 90 days to convert your coverage to an individual insurance policy that provides comparable coverage. The amount of insurance benefit provided for the new policy shall not exceed the lesser of $500,000 or your Principal Sum in force at the time you convert your policy. The premium due will be based on the rates in force for individual policies at time of application.

Aggregate Limit Per Accident:

The maximum amount the Company will pay for two or more Insured Employees injured in one accident is the amount of the Aggregate Limit Per Accident set out in the policy schedule, if any. If the total of the benefits which would be paid by the Company would exceed the Aggregate Limit Per Accident, each Insured Employee shall receive their proportionate share of the amount of the Aggregate Limit Per Accident paid by the Company.

Benefits and Coverages

Accidental Death, Dismemberment, Paralysis and Loss of Use:

If a covered Loss occurs within 365 days after the date of the accident causing the Loss, the Company will pay the indicated percentage of the Principal Sum as set out in the following Table of Losses. If you sustain more than one Loss as a result of the same accident, only one amount, the largest, will be paid.

For Loss of:

Loss	Percentage Principal Sum Payable
Loss of Life	100%
Loss of Both Hands or Both Feet	100%
Loss of Entire Sight of Both Eyes	100%
Loss of One Hand and One Foot	100%
Loss of One Hand and the Entire Sight of One Eye	100%
Loss of One Foot and the Entire Sight of One Eye	100%
Brain Death	100%
Loss of One Arm or One Leg	80%
Loss of One Hand or One Foot	75%
Loss of The Entire Sight of One Eye	75%
Loss of Thumb and Index Finger of the Same Hand	33.3%
Loss of Speech and Hearing	100%
Loss of Speech or Hearing	75%
Loss of Hearing in One Ear	66.7%
Loss of Four Fingers of One Hand	33.3%
Loss of All Toes of One Foot	25%

For Loss of Use of:

Loss of Use	Percentage Principal Sum Payable
Loss of Use of Both Arms or Both Hands	100%
Loss of Use of One Hand or One Foot	75%
Loss of Use of One Arm or One Leg	80%

Paralysis	Percentage Principal Sum Payable
Quadriplegia (total paralysis of both upper and lower limbs)	2x the Principal Sum up to a maximum of $1 million
Paraplegia (total paralysis of both lower limbs)	2x the Principal Sum up to a maximum of $1 million
Hemiplegia (total paralysis of upper and lower limbs of one side of the body)	2x the Principal Sum up to a maximum of $1 million

Additional Benefits

These benefits shall only apply if selected by your Employer and the appropriate premium paid. The Benefit Description is a summary only and does not include all of the provisions, sub-limits, conditions and exclusions.

DISAPPEARANCE	Principal Sum	Pays the Loss of Life Principal Sum if your body has not been found within one year of a forced landing, stranding, sinking or wrecking of a conveyance in which you were an occupant.
REHABILITATION BENEFIT	$15,000	Pays the expenses incurred for occupational training up to the Maximum if such expenses are incurred within three years of the accident and are as a result of an Injury for which you receive a benefit under the policy.
HOME ALTERATION AND VEHICLE MODIFICATION	$15,000	Pays a one-time benefit up to the Maximum for covered home alternation and vehicle modification expenses if you suffer an Injury for which you receive a benefit under the policy and require a wheelchair to be ambulatory.
WORKPLACE MODIFICATION AND ACCOMMODATION	$5,000	Pays a one-time benefit to your Employer up to the Maximum if you suffer an Injury for which you receive a benefit under the policy and require special adaptive equipment or workplace modification in order for you to return to work full-time for the Policyholder
PSYCHOLOGICAL THERAPY	$5,000	Pays a benefit up to the Maximum if you suffer an Injury for which you receive a benefit under the policy and require psychological therapy within two years of the Injury.
IN-HOSPITAL BENEFIT	$2,500/month	Pays a benefit of (i) 1% of the Principal Sum up to the Maximum for hospital confinements of more than 30 nights, or (ii) 1/30th of the amount determined under (i) for hospital confinements of more than five but less than 30 nights, if you suffer an Injury for which you receive a benefit under the policy and are confined to hospital as a result of such Injury, for a maximum of twelve months.

Additional Benefits

FAMILY TRANSPORTATION	$15,000	Pays a benefit up to the Maximum for the expenses incurred for the transportation of an Immediate Family member to your hospital if you suffer an Injury for which you receive a benefit under the policy and as a result are confined to a hospital more than 100 kilometers from home.
REPATRIATION BENEFIT	$15,000	Pays a benefit up to the Maximum to cover the expenses to return your body to your city of residence if you suffer a covered accidental death while at least 50 kilometers from home.
IDENTIFICATION BENEFIT	$5,000	Pays a benefit up to the Maximum for the transportation and commercial lodging of an Immediate Family member to identify your body if you suffer a covered accidental death at least 150 kilometers from home and a law enforcement agency requests such identification.
DAY CARE BENEFIT	$5,000/year	Pays an annual benefit of up to 5% of the Principal Sum up to the Maximum for the day care costs of each Dependent Child under age 13 who is enrolled, or who enrolls within 90 days, in a day care facility if you suffer a covered accidental death. The benefit is payable for up to four consecutive years.
DEPENDENT CHILD EDUCATIONAL BENEFIT	$5,000/school year	Pays an annual benefit of up to 5% of the Principal Sum up to the Maximum for the tuition costs of each Dependent Child who is enrolled as a full-time student in post-secondary education if you suffer a covered accidental death. The benefit is payable for up to four consecutive years.
SPOUSAL EDUCATIONAL BENEFIT	$15,000	Pays a benefit up to the Maximum for your Spouse's expenses in enrolling in a professional or trades training program for the purpose of obtaining an independent source of income, if you suffer a covered accidental death and such expenses are incurred within 36 months of your death.
FUNERAL EXPENSE	$5,000	Pays a benefit up to the Maximum to reimburse funeral expenses if you suffer a covered accidental death.
BEREAVEMENT BENEFIT	$1,000	Pays up to the Maximum if you suffer loss of life in a covered accident and your eligible dependents require counselling within one year of your loss of life.
SEAT BELT AND AIR BAG BENEFIT	$50,000	Pays a benefit of 10% of the Principal Sum up to the Maximum if you suffer a covered accidental death while operating or riding as a passenger in a Private Passenger Type Automobile in which your seatbelt was properly fastened. If the seat belt benefit is payable and you were in a seat protected by a properly functioning supplemental restraint system which inflated on impact, an additional benefit of 10% of the Principal Sum will be paid. The Seat Belt and Air Bag Benefit is payable up to the Maximum combined.

Policy Exclusions

The policy will not cover any losses caused in whole or in part by, or resulting in whole or in part from, the following:

- suicide or any attempt thereat by you while sane;
- self inflicted Injury or any attempt thereat by you while sane or insane;
- declared or undeclared war or any act thereof;
- sickness, disease, or bodily infirmity whether the Loss or claim results directly or indirectly from any of these;
- mental incapacity whether the Loss or claim results directly or indirectly from any mental incapacity;
- Injury sustained while you are undergoing the medical or surgical treatment of sickness, disease, or bodily or mental infirmity;
- Stroke or cerebrovascular accident or event; cardiovascular accident or event; myocardial infarction or heart attack; coronary thrombosis; aneurysm;
- Travel or flight in or on (including getting in or out of, or on or off of) any aircraft, if you are:
    - riding as a passenger in any aircraft not intended or licensed for the transportation of passengers;
    - performing, learning to perform or instructing others to perform as a pilot or crew member of any aircraft; or
    - riding as a passenger in an aircraft owned, leased or chartered by the Policyholder;

- Travel or flight in or on (including getting in or out of, or on or off of) any aircraft or craft designed to fly or glide above the Earth's surface:
    - except as a passenger on a regularly scheduled commercial airline; or
    - being used for crop dusting, spraying or seeding, fire-fighting, traffic patrol, air ambulance, pipeline or power line inspection, aerial photography or exploration, racing, endurance tests, stunt or acrobatic flying; or
    - operating to or from off-shore landing sites; or
    - used in any operation that requires a special permit from the Civil Aviation Branch of Transport Canada, even if it is granted (this does not apply if the permit is required only because of the territory flown over or landed on).

- infections of any kind regardless of how contracted, except bacterial infections that are directly caused by botulism, ptomaine poisoning or an accidental cut or wound independent and in the absence of any underlying sickness, disease or condition including but not limited to diabetes;
- Injury or Loss sustained if you are on full-time active duty in the armed forces or organized reserve corps of any country or international authority;
- Injury or Loss sustained while you are under the influence of alcohol and operating any vehicle or means of transportation or conveyance while your blood alcohol is over 80 milligrams in 100 milliliters of blood;
- Injury or Loss sustained while you are under the influence of a drug or substance which is controlled as specified under the Controlled Drug and Substances Act (Canada) unless taken pursuant to the advice of and in strict accordance with the instructions of a duly licensed Physician;
- the commission or attempted commission by you or Injury incurred while you are in the course of committing or attempting to commit any act which if adjudicated by a court would be an indictable offence under the laws of the jurisdiction where the act was committed; and
- an act, attempted act or omission taken or made by you, or an act, attempted act or omission taken or made with your consent, for the purposes of interrupting the blood flow to your brain or to cause asphyxiation to you whether with intent to cause harm or not; and
- natural causes.

Claims Process

Beneficiary Designation
You have the option to designate a beneficiary, should you choose not to, in the event of accidental Loss of Life, the benefit will be paid to the beneficiary you have designated in writing under your Employer's current group life policy. If there is no written designation then the benefit will be paid to your estate.

All other benefits will be payable to you.

How to Make a Claim
In the event of claim, claim forms can be obtained from your Employer.

Written notice of claim to the Company must be given no later than 30 days from the date of accident. Within 90 days from the date of the accident, proof of claim must be submitted to the Company. Proof may include a certificate as to the cause and nature of the accident or Injury caused thereby, for which the claim is made and as to the duration of the Injury or Loss, from legally qualified medical practitioner.

Failure to give notice of claim or furnish proof of claim within the time prescribed above will not invalidate the claim if 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 Injury and if it is shown that it was not reasonably possible to give notice or furnish proof within the time as prescribed.

Drug Coverage

Prescription Drug Expenses

A "**Prescription Drug**" means drugs, medicines, and diabetic supplies with a Drug Identification Number that require a Prescription By Law and are dispensed by a Pharmacist. Subject to the terms of this Plan, expenses related to Prescription Drugs, including, the cost of drugs, medicines and diabetic supplies that are dispensed by a Pharmacist and require a Prescription By Law, will constitute Eligible Expenses under this Health Benefit. Prescription Drug expenses may require approval under the Prescription Drugs Formulary Management Policy as outlined further in this Health provision.

The prescription charges are limited to the Lowest-Cost Alternative for eligible drugs and medicines when an inter-changeable Drug is available.

Charges are subject to any limitations and maximums specified in the Plan Summary.

Prescription Drugs Formulary Management Policy

The insurer reserves the right to manage its drug formularies and the coverage for Prescription Drugs provided under this Health provision through an evidence-based review process. This process evaluates drugs based on overall value, which includes (without limitation) consideration of:

a) clinical efficacy;
b) safety;
c) unmet need; and
d) affordability.

Without limiting the foregoing, formulary management includes the right to:

a) add a drug to the insurer's formularies;
b) exclude or remove a drug from the insurer's formularies regardless of any governmental approval or existing coverage under a Provincial Health Plan; and
c) place restrictions on a formulary drug as determined by the insurer. Restrictions may include, but are not limited to the insurer's:

    i) pre-approval of the drug before the claim can be reimbursed;
    ii) requirement to obtain the drug through a provider approved by the insurer;
    iii) limitation of the drug's day supply, depending on the drug's proven efficacy; and
    iv) requirement to obtain a lower-cost alternative of the same treatment such as a generic or biosimilar drug.

Concurrent Drug Utilization Review

Claims for drugs covered under this Benefit which are purchased in Canada and submitted electronically to the insurer are subject to concurrent drug utilization review at point-of-sale to determine if

a) an adverse interaction is possible between a prescribed drug and another drug you are already taking;
b) a prescribed drug may be harmful to a patient who is a Dependent Child or a senior;
c) a refill prescription is being filled too soon or too late;
d) a prescribed drug contains ingredients in the same therapeutic class as another drug currently being taken or that has recently been taken and the ingredients remain active in your system;
e) the prescribed therapy duration falls outside the drug manufacturer's recommended minimum and maximum limits;
f) the prescribed daily dosage of a drug falls outside the age band limits established by the drug manufacturer; and
g) a prescribed drug is intended solely for the use of a person of the opposite gender to that of the patient.

(such an assessment being the "**Concurrent Drug Utilization Review**")

Based on the outcome of the Concurrent Drug Utilization Review, the Pharmacist may refuse to dispense a drug as prescribed. Claims for drugs covered under this Benefit are not subject to Concurrent Drug Utilization Review if:

a) the drugs are dispensed at a pharmacy not properly equipped to provide the service; or
b) the drugs are extemporaneous preparations or compounds

The insurer makes no guarantees, representations, or warranties about the accuracy or completeness of the patient information provided for the Concurrent Drug Utilization Review or about the review results, nor is the insurer liable for any decision made by a Pharmacist as a result of, or in connection with, directly or indirectly, the review process.

Prescription Drugs Limitations

The insurer may, in its sole and unrestricted discretion, from time to time participate in and utilize available drug management strategies which, in its discretion, will ensure a cost-efficient method to protect access to Prescription Drugs you need, while ensuring benefits are safe, sustainable, effective, and affordable for Plan Sponsors ("**Drug Management Strategies**").

These Drug Management Strategies may include, without limitation, participating in third-party programs regarding drug pricing, drug utilization review, narcotic management, and migraine management. The terms and conditions of this Health Benefit will in all circumstances be subject to applicable rules, regulations, policies, procedures, terms, and conditions of such Drug Management Strategies.

Prescription Drug Exclusions

No amount will be payable under this Health Benefit for:

a) charges for the delivery and administration of medications, injectable drugs, serums, and vaccines;
b) over-the-counter drugs;
c) vitamins, minerals, dietary products, and supplements;
d) Ethical Drugs;
e) preventative vaccines; unless covered under the Schedule of Benefits
f) anti-obesity drugs; unless covered under the Schedule of Benefits
g) fertility therapy or drugs; unless covered under the Schedule of Benefits
h) erectile dysfunction drugs; unless covered under the Schedule of Benefits or
i) smoking cessation products; unless covered under the Schedule of Benefits

Major Health

Your Provincial Health Plan provides basic health services such as hospital ward accommodations, fees for Physicians and other hospital practitioners, and any drugs or blood products you may need during your hospital stay. Your group Plan is designed to cover many additional medical expenses on a Reasonable and Customary basis for you and your family, over and above the coverage provided by your Provincial Health Plan.

Eligible Expenses for Medical Services and Medical Supplies

For the purpose of the Health Benefit, an "Eligible Expense" is defined as an expense incurred directly in relation to a Medical Service or Medical Supply, before any applicable payment limitations, such as deductibles, coinsurance, and maximums (as specified in the Plan Summary) are applied. Eligible Expenses are covered in accordance with the terms and conditions of this Plan, and are only covered under this Plan when all of the following apply in relation to the particular Medical Service or Medical Supply:

a) the Medical Service or Medical Supply must be a Medically Necessary treatment of an Illness or Injury;
b) the Medical Service or Medical Supply must be recommended by a Medical Practitioner within the scopeof their license;
c) the Eligible Expenses must be Reasonable and Customary charges, as determined by the insurer;
d) the Eligible Expenses are not covered under any Provincial Health Plan or Government-sponsored program; and
e) the Eligible Expenses can legally be covered under the Plan.

Any expense can be submitted to the insurer for an estimate of what the insurer, acting reasonably, anticipates the amount of coverage the insurer will provide for a specific expense (a "**Predetermination Estimate**")

Receipt of a Predetermination Estimate will not be binding on the insurer, and does not guarantee any specific, whether full or partial, reimbursement of any expense.

Medical Services and Medical Supplies

The medical services and medical supplies listed in this Medical Services and Medical Supplies provision are a non-exhaustive list of the types of services and supplies covered, strictly in accordance with the terms and conditions of this Health provision, under the Health Benefit. The insurer may, from time to time, and strictly in accordance with the terms and conditions of this Plan, cover additional types of medical services (such medical services, together with those listed in this Medical Services and Medical Supplies provision, being a "**Medical Service**") or additional medical supplies (such medical supplies, together with those listed in this Medical Services and Medical Supplies provision, being a "**Medical Service**") where, in the insurer's discretion, acting reasonably, it is appropriately covered by the Health Benefit.

Medical Services must be performed in Canada and Medical Supplies must be purchased in Canada to be eligible for coverage under this Health Benefit.

Medical Supplies must be dispensed by a pharmacy, medical facility, or medical supply retail store to be eligible for coverage under this Health Benefit.

The maximum amount payable in relation to any Medical Services or Medical Supplies will in no event exceed any maximums specified in the Plan Summary.

Accidental Dental Injury

Charges for the services of a Dental Practitioner for treatment of an Accidental Dental Injury to whole or sound natural teeth, including replacement of such damaged teeth, providing the accident causing such injuries occurred while covered. Expenses must be incurred within 1 year of the Accident.

Payments made in relation to an Accidental Dental Injury under this Health Benefit will be in accordance with the Dental Fee Guide for the province where services are rendered.

Where any 2 or more courses of treatment would produce professionally adequate results for a given condition, the insurer will pay benefits as if the least expensive course of treatment covered under this Health Benefit was used.

Ambulance

Ambulance expenses include charges for:

a) response only, without any subsequent transportation; and;
b) response and transportation in an Ambulance by ground vehicle or air transport from the emergency site to a Hospital where adequate treatment may be rendered.

Cardiac Rehabilitation Program

Charges for treatment rendered in connection with a cardiac rehabilitation program adhering to the standards of the Heart and Stroke Foundation of Canada, as they may change or be replaced from time to time, and prescribed by the attending Physician for rehabilitation within 6 months after any 1 or combination of the following:

1. myocardial infarction;
2. percutaneous coronary intervention (coronary angioplasty);
3. coronary artery bypass graft; or
4. heart valve surgery.

Custom-Made Foot Orthotics

Charges for custom-made foot orthotics. Custom-made foot orthotics are orthotics made from a three-dimensional model of the patient's foot and is fabricated from raw materials.

Custom-made foot orthotics must be dispensed by an orthotist, pedorthotist, podiatrist, chiropodist, or chiropractor to be eligible for coverage under this Health Benefit.

Custom-Made Orthopedic Shoes

Charges for custom-made orthopedic shoes. Custom-made orthopedic shoes are shoes made from a full casting of the patient's foot and ankle or a three-dimensional image of the plantar dorsal aspects of the foot and ankle. The shoe is fabricated from raw materials.

Custom-made orthopedic shoes must be dispensed by an orthotist, pedorthotist, podiatrist, chiropodist, or chiropractor to be eligible for coverage under this Health Benefit.

Diagnostic Procedures

Charges for diagnostic laboratory services and radiological treatments, including x-rays and radium therapy.

Hospital Room and Convalescent Hospital Room

Charges for Hospital Room Rate in excess of coverage under any applicable Provincial Health Plan, provided you or your Dependents were confined in the Hospital.

Charges for Convalescent Hospital Room Rate in excess of coverage under any applicable Provincial Health Plan, pro-vided you or your Dependents were confined in the Hospital.

Paramedical Services

Charges for the services of a Paramedical Practitioner within the scope of the Paramedical Practitioner's license and training.

Professional Nursing Services

When recommended by the treating Physician, charges for the services of a Professional Nurse which are rendered in the patient's home up to the maximum amount specified in the Schedule of Benefits. No amount will be paid for services which are custodial or services which do not require the skill level of a Registered Nurse.

A pre-authorization form for Professional Nursing Services must be completed by the treating Physician and submitted to the insurer.

Medical Services and Medical Supplies Limitations

The insurer will determine whether a Medical Supply should be purchased or rented. The determination will be made based on your or your Dependents' Medical Condition.

Medical Services and Medical Supplies Exclusions

In addition to the Claim Exclusions listed in the "Making a Claim" section in this booklet, no amount will be payable under this Health Benefit for:

a) services or supplies which are used for athletic or recreational purposes;
b) services or supplies not required for daily regular activities;
c) replacement batteries; and
d) services and supplies for maintenance and adjustments to medical equipment.

Medical Referral for Treatment

If medically necessary treatment is not available in Canada, Wawanesa Life will cover expenses relevant to the treatment in excess of your Provincial Health Plan provided that:

a) the treatment is ordered in writing by a Physician located in your or your Dependents' province of residence;
b) the treatment has been pre-approved by Wawanesa Life and your Provincial Health Plan. Additional expenses will only be covered if your Provincial Health Plan is participating in the reimbursement; and
c) referrals cannot be due to waiting lists or a lack of resources, such as strike or lack of organ donations. If the condition is not immediately dangerous, in the opinion of a Physician, and treatment will soon be available in Canada, in the opinion of Wawanesa Life, you or your Dependents may be asked to wait for such treatment and coverage under this Out-of-Country Referral for Treatment provision will be denied.

Health Coverage Exclusions

No amount will be payable under this Health Benefit for:

a) any service or supply not listed as a payable benefit in the Plan;
b) any replacement of a prosthetic device, appliance, or other Medical Supply which has been broken, damaged, lost, or stolen;
c) any purchase of a duplicate prosthetic device, appliance, or other Medical Supply for the purpose of having a spare or alternate;
d) medical examinations for use by a third party;
e) services and supplies, including any Medical Services or Medical Supplies, received outside of Canada, unless the Emergency Out-of-Province or Out-of-Country Benefit is included in this Plan, and the expense is specified as eligible under that benefit;
f) any services or supplies, including any Medical Services or Medical Supplies, that are not usually provided to treat an Illness in the reasonable opinion of the insurer, including those that are experimental;
g) any form of medical cannabis for the treatment of any Medical Condition, regardless of whether it is authorized by way of a medical document or prescription from a legally authorized Medical Practitioner and obtained from a properly licensed producer pursuant to any federal or provincial legislation or regulation regarding access to or distribution of medical cannabis;
h) services or supplies, including any Medical Services or Medical Supplies, which are reimbursable under the Criminal Injuries Compensation Act or similar legislation;
i) confinement or treatment insured or insurable under any other group benefit or other insurance plans that are maintained by the Employer in conjunction with the Plan;
j) services and supplies, including any Medical Services or Medical Supplies, for which a government or government agency prohibits the payment of benefits; or
k) services and supplies, including any Medical Services or Medical Supplies, which are covered by a Provincial Health Plan, Workers Compensation, or any other government plan.

Out of Country & Province

AIG Travel Guard

Protection and assistance services that respond effectively to travel medical emergencies.
In Canada & USA, Toll Free: 1-877-204-2017
Outside Canada & USA (collect): +1-715-295-9967

IMPORTANT GUIDELINES

Why You Need Emergency Out of Province Medical Coverage

Each Canadian Province and Territory provides a Health Plan with comprehensive benefits for Hospital confinement, the service of medical Doctors and other health practitioners, ambulance services etc. In many cases, the benefits provided by these plans will pay all, or almost all, of the expenses you incur in your home province. Unfortunately, there is often a tremendous difference between the cost of these services outside Province and the amounts allowed by your Health Plan, which you would have to pay were it not for this valuable benefit.

This Plan provides extensive coverage for many services rendered outside Province. It is important to note that such expenses are covered provided that they were unexpected and of an emergency nature. The Plan does not provide benefits for medical treatment if the purpose of your trip outside Province is to obtain that medical treatment.

How It Works

You are automatically covered under this plan, if you are an active employee of the Policyholder indicated on the cover of this employee booklet, under the termination age specified in the schedule of benefits and who is covered by a GHIP of a Canadian province or territory.

Here's What You Get
Broad Emergency Out of Province Medical Coverage - Your plan provides extensive coverage for medical emergencies outside the Province in which you reside.

Guaranteed Acceptance - Coverage is provided regardless of your health history.

Benefit Payment

All amounts payable will be reimbursed to the individual who has paid the expense or will be paid directly to the provider.

Definitions
"Insured Employee" means you, if you are a permanent, active full-time employee or retiree of the Policyholder who is under the termination age specified in the Schedule of Benefits and are covered by a GHIP of a Canadian province or territory.

"Insured Person" means you, if you are a permanent, active full-time employee of the Policyholder who is under the termination age specified in the Schedule of Benefits and are covered by a GHIP of a Canadian province or territory. If you are covered under **'Duo Coverage'** includes your Spouse, and if covered under **'Family Coverage'** includes your Spouse your Dependent Children, also referred as eligible dependents.

Eligible Dependents:
"Spouse" means a person who is under the age of 85 and who is either legally married to you, or if there is no such person, is a person who, although not legally married to you, is cohabitating with you for a period of at least one year and is publicly represented as your domestic partner in the community in which you reside.

"Dependent Child" means a person who is either your natural child, adopted child or step-child or a child to whom you are *in loco parentis* and who is (i) under 21 years of age, unmarried and dependent upon you for maintenance and support and not employed for more than 25 hours per week; or (ii) under 25 years of age, unmarried and enrolled in post-secondary education and dependent upon you for maintenance and support and not employed for more than 25 hours per week; or (iii) by reason of mental or physical infirmity is incapable of self-sustaining employment and who is considered your Dependent Child within the terms of the Income Tax Act (Canada).

"Injury" means bodily injury which is sustained as a direct result of an unintended and unanticipated accident, occurring anywhere in the world outside of your province of residence, that is external to the body and that occurs while your coverage under this Policy is in force, which causes a loss covered by this Policy.

"Sickness" means the onset of sickness or disease requiring medical treatment, care or advice while you or your eligible dependents are travelling anywhere in the world outside your province of residence which causes a loss covered by this Policy.

"Emergency" means medical treatment or surgery for an unforeseen Sickness or Injury which makes it necessary to receive immediate treatment from a Physician for the immediate relief of an acute symptom of which upon the advice of a Physician cannot be delayed until you or your eligible insured dependents return to your province of residence.

Period of Coverage

You and your eligible dependents are covered under this plan while travelling outside your Province of residence, for a period not to exceed the maximum amount of days listed in the Schedule of Benefits under maximum trip duration for Travel Medical.

Benefits and Coverages
Emergency Coverage for Hospital, Medical and Therapeutic Services
If you or your eligible insured dependents suffer a Sickness or an Injury that results in Emergency Stay in a Hospital or Emergency medical or therapeutic services as specifically listed herein, the Company will pay benefits, for the period this contract is in force, not to exceed $5,000,000 for Active Employees for the actual expenses you or your eligible insured dependents incurred outside your Province of residence that exceed the amount which is payable with respect to such expenses under any government hospitalization or medical plan in Canada, or if you or your eligible insured dependents are not covered under any such plan, to the extent you exceeded any amount which would be payable with respect to such expenses under the government hospitalization or medical care plan if you or your eligible insured dependents were covered under any such plan.

Emergency Hospital Confinement

If you or your eligible insured dependents suffer a Sickness or an Injury which results in an Emergency confinement as a resident in-patient in a Hospital, including semi-private accommodation, for reasonable and customary charges made by the Hospital for services and supplies to the extent that such are medically necessary, the Company will pay benefits hereunder, subject to all limitations and conditions of your policy.

In the event you or your eligible insured dependents are confined to a Hospital at the end of your trip outside your province of residence and thus prevented from returning to your province of residence, insurance will continue for the period of such confinement, but in no event for more than 12 months from the date the first covered expense was incurred.

Emergency Medical and Therapeutic Services:

The Company will pay benefits hereunder in the event you or your eligible insured dependents require Emergency medical or therapeutic services to treat an Injury or Sickness to the extent that such are Medically Necessary. Benefits are payable to reimburse Reasonable and Customary expenses for:

(a) the services of a Physician or legally qualified surgeon (other than an Immediate Family Member of the Insured Person),
(b) laboratory tests and X-ray examinations (not including MRI) ordered by a Physician or legally qualified surgeon for the purpose of diagnosis,
(c) MRI, for diagnostic purposes when Medically Necessary, to a maximum per Insured Person per Trip of $7,500;
(d) the services of a registered graduate nurse (other than an Immediate Family Member of the Insured Person), up to a maximum of 50 nursing shifts at a fee not to exceed $100 per shift,
(e) rental of crutches or a Hospital type bed, or the cost of splints, canes, slings, trusses, braces or other prosthetic appliances approved by the Company,
(f) the services of a Physician who is an anaesthetist,
(g) drugs or medicines that require a Physician or legally qualified surgeon's written prescription,
(h) services of a chiropodist, chiropractor, osteopath, physiotherapist or podiatrist (other than an Immediate Family Member of the Insured Person) up to a maximum of $300 for each class of practitioner,
(i) expenses for accidental Injury to natural and sound teeth (capped or crowned teeth are considered whole or sound natural teeth) which require treatment by a legally qualified dentist or dental surgeon within 30 days from the date of the accident, not to exceed in the aggregate the amount of $2,000 as the result of any one accident, and
(j) out-patient services provided by a Hospital.

Repatriation Benefit
Pays a benefit of up to $15,000 to cover the expenses to return your body to your city of residence if you or your eligible insured dependents suffer a death while outside your province of residence.

Identification Benefit
Pays a benefit of up to $5,000 for the transportation of an immediate family member to identify your body if you or your eligible insured dependents suffer a covered death and a law enforcement agency requests such identification.

Automobile Return Benefit
Pays a benefit of up to $1,000 per occurrence to return your private or rental vehicle used for your trip, to your Province of residence or nearest rental agency if you or your eligible insured dependents become totally disabled due to a sickness or injury and you are unable to continue your trip.

Out-Of-Pocket Expense Benefit
Pays a benefit of up to $150 per day to a maximum of $1,500 per occurrence for reasonable and necessary commercial living expenses incurred by you or your travel companion if you or your eligible insured dependents become totally disabled and cannot continue your trip.

Family Transportation Benefit
Pays a benefit of up to $15,000 per occurrence for the expenses incurred for the transportation of an immediate family member to your hospital if you or your eligible insured dependents are confined to a hospital, as well as incidental travel expenses up to a maximum of $250.

Return Transportation for Travelling Companion
If you or your eligible insured dependents are repatriated to your home province or territory in accordance with the Repatriation Benefit or the Ground and Air Transportation Benefit, then the Company will pay a benefit of up to $2,000 for the transportation of one Travel Companion to his/her home province or territory on a one-way economy air fare of a commercial flight.

Return and Escort of Dependent Children Under Age
If you or your eligible insured dependents are repatriated to your home province or territory in accordance with the Repatriation Benefit or the Ground and Air Transportation Benefit, then the Company will pay a benefit of up to $5,000 for the transportation of your Dependent Children under age 16 to their home province or territory on a one-way economy air fare of a commercial flight, plus reasonable overnight hotel accommodation and meal expenses for the services of an attendant to escort your Dependent Children, if required.

Extended Coverage after Termination
In the event of a delayed arrival of a common carrier or your stay in a Hospital, coverage will automatically be extended for you at no charge for (i) 24 hours in the event of a delayed common carrier, (ii) the period of the Medically Necessary stay in Hospital plus 24 hours after you are released from Hospital.

Emergency Transportation Benefit
Ground Transportation
Pays up to $5,000 per occurrence for the use of ground ambulance.

Air Transportation
Pays up to $300,000 per occurrence if you or your eligible insured dependents medical condition require air transportation to the nearest hospital or to return to your province of residence. This service must be coordinated and approved by AIG Insurance Company of Canada.

Exclusions and Limitations
The Plan will not cover any losses caused in whole or in part by, or resulting in whole or in part from, the following:

(a) Injury, Sickness or Loss sustained while you or your eligible dependents are on full-time active duty in the armed forces or organized reserve corps of any country or international authority;
(b) Injury or Loss sustained while you or your eligible dependents are under the influence of alcohol and operating any vehicle or means of transportation or conveyance while your blood alcohol is over 80 milligrams in 100 millilitres of blood;
(c) Injury or Loss sustained while you or your eligible dependents are under the influence of a drug or substance which is controlled as specified under the Controlled Drug and Substances Act-(Canada) (even if such drug or substance is taken outside Canada) unless taken pursuant to the advice of and in strict accordance with the instructions of a Physician;
(d) the abuse of medication or drugs or non-compliance with prescribed medical therapy or treatment whether prior to or during a Trip;
(e) the commission or attempted commission by you or your eligible dependents of, or Injury incurred while you or your eligible dependents are in the course of committing or attempting to commit, any act which if adjudicated by a court would be an indictable offence under the laws of the jurisdiction where the act was committed;

(f) pregnancy, miscarriage, voluntary termination of pregnancy, childbirth or their complications except that in the case of an unexpected pregnancy complication which occurs before the end of the 7th month;
(g) Sickness or Injury where the Trip is undertaken for the purpose of securing medical treatment or advice for such Sickness or Injury;
(h) Sickness or Injury due to participation in any professional sport;
(i) suicide or any attempt at suicide while sane or insane;
(j) intentionally self-inflicted Injury or any attempt at intentionally self-inflicted Injury, while sane or insane;
(k) an act of declared or undeclared war, civil war, rebellion, revolution or insurrection;
(l) treatment or services when reimbursement or coverage by the Company would contravene any GHIP in Canada;
(m) expenses incurred on an elective (non-emergency) basis;
(n) any treatment, investigation or surgery for a specific condition, or a related condition, which had caused a physician to advise you or your eligible dependents not to travel;
(o) any services or supplies provided by you, your eligible dependents or a member of your Immediate Family;
(p) a sickness or Injury that, at the time of departure, might reasonably be expected to require you or your eligible dependents to undergo treatment, investigation, surgery or hospitalization;
(q) any service, treatment, surgery or stay in Hospital not required for the immediate relief of acute pain or suffering or which is not Medically Necessary;
(r) any treatment or surgery which reasonably could be delayed until you or your eligible dependents return to your province or territory of residence;
(s) anticipated medical treatments required on an ongoing basis or for continued stabilization of a medical condition known to you or your eligible dependents prior to departure from your province or territory of residence;
(t) a medical condition that had deteriorated, or had to be treated or investigated in the three (3) months immediately preceding your or your eligible dependent's departure from the province or territory of residence; and
(u) that portion, if any, of any expenses for treatment, advice or hospitalization which are not Reasonable and Customary.

The Insurer will not be liable to provide any coverage or make any payment hereunder if to do so would be in violation of any sanctions law or regulation which would expose the insurer, its parent company or its ultimate controlling entity to any penalty under any sanctions law or regulation.

Pre-Existing Condition is any medical or physical condition, symptom, illness or disease for which Treatment was received or for which an ordinarily prudent person would have sought Treatment in the ninety (90) days immediately prior to the Insured Person's Departure Date unless such condition was Stable and Controlled. A Pre-Existing Condition does not include:

(a) the unchanged use of prescribed medication for a medical condition, symptom or problem which is Stable and Controlled;
(b) treatment that is a medical or physical examination in which a Physician observes no change in a previously identified condition, symptom or problem and no new treatment is prescribed or recommended;
(c) a Physician-prescribed decrease or cessation in cholesterol lowering medication;
(d) a change in any medication from a brand name medication to a generic brand medication (provided the dosage is not modified); and
(e) the adjustment in dosage of medication that is either Coumadin (warfarin) or insulin only to ensure correct blood levels are maintained provided

Stable and Controlled means, during the ninety (90) days immediately prior to the Eligible Person's Departure Date:

(a) the medical or physical condition, symptom, illness or disease did not first manifest itself; and/or
(b) the medical or physical condition, symptom, illness or disease was not first investigated; and/or
(c) the medical or physical condition, symptom, illness or disease has not worsened; and/or
(d) no change in any medication or its usage or dosage occurred, was prescribed and/or recommended by a physician; and/or
(e) no Treatment was received, prescribed or recommended.

Effective Date
Your coverage begins on the date you satisfy the definition of “Insured Employee or Insured Person”

Termination Date
Coverage ends on the earliest of:

1. the date the policy is terminated;
2. the premium due date if premiums are not paid when due;
3. the date you no longer satisfy the definition of an Insured Employee or Insured Person; or
4. the first day of the month following the date you no longer belong to an Eligible Class of Employees.

This brochure provides only brief descriptions of the coverage available. The full details of the coverage are contained in the Policy including limitations, exclusions and termination provisions. If there are any conflicts between this document and the Policy, the Policy shall govern. Insurance is underwritten by AIG Insurance Company of Canada.

Dental

Definitions

The following definitions apply specifically to dental care insurance, in addition to the definitions provided in the General Definitions section.

- Fee guide: The annual fee guide and description of dental treatment services approved by the dentists' association of the insured's province of residence. In the absence of fees recommended by an appropriate professional association, eligible expenses are limited to reasonable amounts that uninsured individuals would normally pay for the service, care, treatment and supply in question, taking into account standards that the Insurer deems applicable to the dentist's province of practice.
- Sextant or quadrant: Division of the dentition in six or four parts respectively.
- Unit: A period of 15 minutes or any portion thereof.

Purpose of the Coverage

The Insurer reimburses expenses incurred by the insured for services, care, treatment and supplies that are recommended by a dentist dentist and justified by current dental practice. In this respect, the only expenses eligible for reimbursement under this contract are expenses for services, care, treatment and supplies that are explicitly included in the modules described in the Schedule of Benefits

The description of eligible dental care expenses below is based on the fee guide in force at the time of the most recent update of the Insurer's contractual documents. However, for administration purposes, when applying the description of these fees, the Insurer takes into account changes to dental practice and updates to the guide.

Reimbursement Terms and Conditions

Eligible expenses for services, care, treatment and supplies are reimbursed according to the terms and conditions indicated in the Schedule of Benefits. For the first contract year and in the case of a group not covered by this insurance benefit under the previous contract, any maximum mentioned in the schedule is proportional to the number of months between the effective date of the contract and the end of the calendar year.

These expenses are eligible up to a maximum of the suggested fees for general practitioners for the reference year specified in the Schedule of Benefits.

When deductible carryover is included in the Schedule of Benefits, any amounts paid for the deductible during the last three months of a calendar year are subtracted from the deductible applicable in the following year.

When more than one type of service, care, treatment or supply exists for the Insured's dental condition, the Insurer reserves the right to limit reimbursement of eligible expenses to the least expensive cost.

Treatment plan

In the event of major restorative services or orthodontic care, when such coverage is included in the Schedule of Benefits, it is recommended that the insured submit a detailed treatment plan to the Insurer before beginning treatment. After reviewing the treatment plan, the Insurer informs the insured of the reimbursement amount available in accordance with the provisions of this contract.

Dental Care Expenses

Eligibility conditions for dental care expenses:

The Insurer reimburses dental care expenses if all of the following conditions are met:

- The dental care must be recommended by a dentist and in compliance with current dental practice.
- The dental care must be provided by a dental care professional who is legally authorized to practice.
- The dental care must be provided while the insured is covered under this insurance benefit, even if the treatment plan was approved by the Insurer before the termination date of coverage.

The Insurer reimburses expenses incurred by the insured for services, care, treatment, and supplies that are recommended by a dentist and justified by current dental practice. In this respect, the only expenses eligible for reimbursement under this contract are expenses for services, care, treatment, and supplies that are explicitly included in the modules described in the Schedule of Benefits.

The description of eligible dental care expenses below is based on the fee guide in force at the time of the most recent update of the Insurer's contractual documents. However, for administration purposes, when applying the description of these fees, the Insurer takes into account changes to dental practices and updates to the guide.

Basic

Routine Care:

Clinical oral examinations:

- Complete oral examination: One examination per period of 36 consecutive months.
- Recall examination and Periodontal recall examination: One examination per period indicated in the Schedule of Benefits.
- Oral examination for children, not payable under the public health insurance plan of the province of residence: One examination per period of 12 consecutive months.
- Emergency examination or specific examination: One of these examinations per period of 6 consecutive months. insured
- Complete periodontal examination, examination of stomatognathic system dysfunctions or prosthodontic examination: One of these examinations per period of 36 months.
- Periodontal recall examination.

Radiographs:

- Radiographs, intraoral;
- Periapical

Exclusions and limitations: Reimbursement of expenses for bitewing radiographs is limited to what is indicated in the Schedule of Benefits. In addition, reimbursement of expenses for a complete series or panoramic radiograph is limited to once per period of 36 consecutive months.

Expenses for cephalometric radiographs and hand and wrist radiographs are eligible under Orthodontic care, when this care is included in the Schedule of Benefits.

Lab examinations and tests:

- Pulpal test
- Test, dental caries susceptibility
- Cytological test
- Photographs, diagnostic. Reimbursement is limited to three photographs per period indicated in the Schedule of Benefits
- Biopsy of soft or hard tissue (by incision, excision or puncture)
- Test, bacteriologic
- Consultation

Preventive Services:

- Polishing of coronal portion of teeth: One treatment per period indicated in the Schedule of Benefits
- Topical application of fluoride. One application per period indicated in the Schedule of Benefits
- Finishing restorations and removal of surplus subgingival filling material
- Pit and fissure sealants for dependent child under age 16
- Interproximal disking and enameloplasty
- Scaling: units of time per period indicated in the Schedule of Benefits
- Space maintainers for dependent child under age 19
- Control of oral habits for dependent child under age 19

Restorative Services:

Restorations:

- Sedative filling
- Recontouring and polishing of traumatized tooth
- Bonding and cementation of broken tooth chip
- Amalgam restorations
- Composite or resin restorations
- Veneer application - chairside
- Diastema closure
- Retentive pins
- Full preformed restorations

Limitation: Expenses for replacing a restoration are eligible only if a minimum period of 12 months has elapsed since the previous restoration was performed.

Endodontics:

- Endodontic emergency
- General endodontic treatments
- Root canal therapy
  Limitation: Root canal therapy is limited to one standard treatment per tooth every 5 years. Such frequency will be determined by the date of the final root canal treatment as the date the expense was incurred.
- Endodontic surgery.
- Bleaching of a non-vital tooth
  Limitation: Reimbursement of expenses for bleaching of a non-vital tooth is limited to two sessions per calender year.

Other endodontic services:

- Supplement for endodontic treatment through a crown
- Unsuccessful attempt to complete root canal treatment

Periodontics:

- Treatment of acute infection or inflammation
- Desensitization
  Limitation: Reimbursement of desensitization expenses is limited to three units per calendar year or two sessions per calendar year, according to the insured's province of residence.

Minor occlusal equilibration:
Limitation: Reimbursement of minor occlusal equilibration expenses is limited to six units of time per calendar year or six sessions per calendar year, according to the insured's province of residence.

Major occlusal equilibration
Limitation: Reimbursement of major occlusal equilibration expenses is limited to three units of time per calendar year or one sessions per calendar year, according to the insured's province of residence.

Periodontal services, surgical
Limitation: Reimbursement of root planing expenses is limited to six units of time per calendar year or one treatment per tooth, per period of 24 consecutive months, according to the insured's province of residence.

Periodontal procedures, adjunctive:

- Splint
- Intraoral appliance to control parafunction
  Limitation: Reimbursement of expenses for the purchase of an intraoral appliance is limited to one appliance per period of 60 consecutive months. Reimbursement of expenses for repairs and relines is limited to one time per calendar year.
- Irrigation
- Application of antimicrobial agents

Oral surgery

- Removal of erupted teeth and suturing
- Surgical removals, with the exception of the surgical exposure of tooth, including orthodontic attachment
- Removal and curettage of tumor, cyst, or intraosseous granuloma
- Surgical incision and drainage
- Soft tissue laceration or through and through laceration, repair
- Hemorrhage, control
- Remodeling and recontouring of oral tissues

Exclusion: Expenses for the preservation of the ridge after extraction or alveolar ridge reconstruction are not eligible for reimbursement.

General services

- Local anesthesia for diagnostic purposes
- Conscious sedation
- Special office visit after regular office hours

Exclusions and limitations: Expenses for the services listed above are eligible for reimbursement only if performed more than six months after insertion of the denture and at least 36 consecutive months after the last reline or rebase, whichever applies. However, expenses for these services are not eligible if performed on a transitional denture.

Insurance Terms and Conditions

ELIGIBILITY FOR COVERAGE

Employee

For you to become eligible as a Covered Person under the Plan, you must have coverage under a Provincial Health Plan. You are eligible for coverage:

a) on the effective date of the Plan if you satisfy the Waiting Period, and work for the Required Number of Hours, outlined in the Eligibility Requirements specified in the Schedule of Benefits (the " **Eligibility Requirements** "); or
b) after the effective date of the Plan on the date you meet the Eligibility Requirements specified in the Schedule of Benefits.

Dependent Spouse

For your Spouse to become a Covered Person under the Plan, they must have coverage under a Provincial Health Plan. A Dependent Spouse is defined as:

a) your legal spouse;
b) the person you have been continuously living with in a role like that of a marriage partner for less than 12 months, if the person is the parent of your child by birth or adoption; or
c) your common-law partner living with you in a conjugal relationship for at least 12 continuous months.

Only one Spouse is eligible for coverage or benefits under this Plan. The Spouse that is covered under the Plan will be as the person you indicate on the applications for coverage under the Plan. Where this information is not contained on your application, the person who qualifies last under the Plan's definition of Spouse will be the eligible Spouse. If your Spouse changes, you must update your information in connection with the Plan.

Dependent Child

For your Dependent Child to become a Covered Person under the Plan, they must have coverage under a Provincial Health Plan. Your Dependent Child may include your natural or adopted child, stepchild, or a child under your legal guardianship, who is:

a) unmarried;
b) not employed on a full-time basis;
c) not eligible for coverage as an Employee under this or any other group plan; and
d) less than 21 years of age, or, if a full-time student at an accredited school, college, or university less than 25 years of age; or

A newborn child will become covered as an eligible Dependent under this Plan from the moment of live birth.

A child covered under this Plan who is incapacitated due to a mental or physical disability on the date they reach the age when they would otherwise cease to be an eligible Dependent will continue to be an eligible Dependent under this Plan.

A child is considered incapacitated if they are incapable of engaging in any substantially gainful activity and are de-pendent on the Plan Member for support, maintenance, and care due to a mental or physical disability.

The insurer may require written proof of the Dependent's condition as often as may reasonably be necessary.

Application for Coverage

When you first apply for coverage:

You must complete all applicable sections of the online Enrollment Form, applying for coverage on all your eligible Dependents, and submit it to Simply Benefits. To be a Covered Person under the Plan, your application should be signed and submitted to Simply Benefits no later than 31 days after the completion of your Waiting Period.

When you have a change in family status:

- If your family status changes from single to duo or to family, your coverage can be changed to add your new Dependent(s) to this Plan. If you complete the applicable sections in the Group Change Form and submit it to Simply Benefits within 31 days of the effective date of your change in family status, your Dependent(s) will be added without any Medical Evidence. If you notify Simply Benefits more than 31 days after the effective date of your change in family status, Simply Benefits will require your Dependent(s) to submit Medical Evidence.

- If you do not wish to change your level of coverage because you already have family coverage, but need to add a new Dependent, complete applicable section of the Group Change Form to register your new De-pendent. Without this notification, claims for your new Dependent will be unnecessarily delayed.

- If you wish to change your level of coverage from family or duo to single due to divorce or the death of a Dependent, complete the applicable sections of the Group Change Form and submit it to Simply Benefits. If it is received within 31 days of the effective date of the change, Simply Benefits will credit premiums back to the effective date of the change. If you notify Simply Benefits more than 31 days after the effective date of the change, Simply Benefits will make the change effective the day notification is received, and no premium credit will be given. If your family is covered by your Spouse's plan for Health or Dental Benefits and your family loses this coverage, your family maybe eligible for immediate enrollment under this Plan. To ensure immediate enrollment, you must notify Simply Benefits of the loss in coverage within 31 days. Otherwise, Simply Benefits will require your Dependents to submit Medical Evidence.

Beneficiaries you designated under a prior plan have not been transferred to this Plan.

Beneficiary designations in respect of Quebec Residents only:

a) Your designation, in a form of writing other than a will, of your married or civil union spouse as Beneficiary cannot be changed, unless otherwise stipulated. The designation of any other person as beneficiary can be changed unless otherwise stipulated in a separate form of writing other than a will;
b) Designations and revocations are valid only from the day the insurer is advised of such changes in writing. Where several irrevocable designations of Beneficiaries are made separately and at different times, they are given priority according to their dates of receipt by the insurer. The insurer is discharged by payment in good faith in accordance with these rules to the last known person entitled to it;
c) Separation from bed and board does not affect the rights of your spouse; and
d) Divorce or nullity of marriage or the dissolution or nullity of a civil union causes any designation of your spouse to lapse.

Coverage Effective Date

You must first complete a period of continuous active employment with your Employer before your coverage becomes effective. This period of time is known as your Waiting Period and it must be satisfied before you can be considered eligible for coverage. Refer to the Schedule of Benefits for information on your Waiting Period.

When you complete your online Enrollment Form:

a) during the Waiting Period, your coverage will become effective when the Waiting Period has been satisfied;
b) more than 31 days after you or your Dependents first become eligible for coverage, you will be required to submit Medical Evidence. The insurer will review this information and determine if you or your Dependents are eligible for coverage. If your enrollment is approved, your coverage is effective on the day the insurer gives its approval.

If you are away from work because of Illness or Injury on the day that your coverage should be effective, or the day when an increase in your coverage should take effect, your coverage effective date or increased coverage effective date will be delayed until you return to work for 1 full day.

Coverage Termination

Your coverage will end on the earliest of:

a) the date you no longer have Provincial Health Plan coverage;
b) the date you are no longer eligible for coverage under an eligible Class;
c) the date you are no longer working the Required Number of Hours (as specified in the Plan Summary);
d) the date you cease to be Actively at Work, unless the Termination of Coverage Exceptions apply;
e) the date you enter active service with the armed forces of any country;
f) the date the Plan terminates, or the date coverage terminates for an eligible Class to which you belong;
g) the date you reach the Coverage Termination Age, as specified under each coverage in the Plan Summary;
h) the date you retire; or
i) the date you die.

Prescription Drug expenses incurred in the 31 days prior to the termination date of the Plan will be limited to an amount equal to a 30-day supply of such a drug.

Termination of Dependent Coverage

Coverage for your Dependent(s) will end on the earliest of:

a) the date your coverage terminates;
b) the date your Dependent is no longer eligible for coverage under the provisions of the Plan; or
c) the date written notification is received from you to cease Dependent coverage because your Dependents which are a Covered Person are covered under another group plan for benefits similar to those under the Plan.

Survivor Extension

If you die while covered for Health or Dental Benefits, coverage will be continued for your surviving Covered De-pendents for 24 months without premium.

This coverage will terminate on the earliest of:

a) the date the Covered Dependent no longer qualifies for coverage;
b) the date the Covered Dependent obtains similar coverage elsewhere; or
c) the date the Plan terminates.

Termination of Coverage Exceptions

Coverage for you and your Dependents may be continued for a period of time if you are absent from work. The following examples describe in general terms when coverage may be continued. You should confirm with your Plan Administrator the specific details of your absence from work and its effect on your continued eligibility for coverage, which is generally subject to the terms and conditions of the group contract between your Employer and the insurer.

- **Due to Illness or Injury**
  If you are absent from work because you are Ill or Injured, coverage, excluding Disability, can continue on apremium-paying basis for up to 24 months. Some of your benefits may be continued without premium if yousubmit a Waiver of Premium claim prior to the filing deadline and the claim is approved by the insurer .
- **Due to Maternity, Parental, or Compassionate Care Leave of Absence**
  If you are absent from work because of a Maternity Leave of Absence, Parental Leave of Absence, or Compassionate Care Leave of Absence, all coverage can continue for the leave period according to the legislation in your province of residence.
- **Due to Other Leave of Absence or Temporary Lay-off**
  If you are absent from work due to an Other Leave of Absence or Temporary Lay-off, coverage, excluding Disability, can continue for up to 120 days after your last day of work.
- **Legislated Coverage Extension**
  When legislation mandates that coverage under the Plan must continue for a limited period after your employment terminates, the insurer will extend coverage for the minimum period required by law, provided that:

  a) your Employer continues your coverage without interruption and pays all the premium for the extensionof coverage period; and
  b) the group contract between your Employer and the insurer remains in force.

Covered Persons in Quebec

If you are a resident of the Province of Quebec, meeting all residency criteria as outlined by the Quebec Government (a "**Quebec Resident**"), and any applicable laws declared by the Province of Quebec impose mandatory minimum entitlements in connection with any of the benefits provided by the Plan to Quebec Residents, including any minimum entitlements provided by the Civil Code of Quebec, CQLR, c. CCQ-1991, the Act respecting Prescription Drug Insurance, CQLR c. A-29.01 and its regulations, and the Regulation under the Act respecting Insurance, CQLR, c. A-32.1, r.1, the benefits provided by this Plan will, only in relation to Quebec Residents, meet the minimum entitlements allowed by such applicable laws. If this Plan allows benefits greater than the mandatory minimum entitlements, Quebec Residents will receive the superior entitlements allowed under this Plan.

MAKING A CLAIM

Forms and Submission

You can submit a claim for Prescription Drugs, Paramedical Practitioners, Vision, and Dental using Simply Benefits Member portal.

If you have a Pay Direct Drug card plan, prescription drug claims can be submitted by your Pharmacist after presenting your Simply Benefits identification card and prescription from your Physician.

Making a claim for Disability Benefits or Waiver of Premium Benefits will require 3 separate forms to be completed by you, your Employer, and your Physician. The insurer must receive all medical information in order to assess your claim for Disability Benefits or Waiver of Premium Benefits.

Proof of Claim

The insurer will require proof of your claim. Obtaining proof will be at your expense. The proof required will depend on the circumstances and context of your claim, including type of claim. Some examples of proof are:

If you have a Pay Direct Drug card plan, prescription drug claims can be submitted by your Pharmacist after presenting your Simply Benefits identification card and prescription from your Physician.

Making a claim for Disability Benefits or Waiver of Premium Benefits will require 3 separate forms to be completed by you, your Employer, and your Physician. The insurer must receive all medical information in order to assess your claim for Disability Benefits or Waiver of Premium Benefits.

a) receipts or bills;
b) medical or dental reports;
c) x-rays; and
d) prescriptions

- **Proof of Payment for Supplies Received and Services Rendered**

  If you are absent from work because you are Ill or Injured, coverage, excluding Disability, can continue on apremium-paying basis for up to 24 months. Some of your benefits may be continued without premium if yousubmit a Waiver of Premium claim prior to the filing deadline and the claim is approved by the insurer .

Date Expenses Incurred for Services

While the coverage for the benefit is in force, the expense for a service is incurred on the date the service is performed.

If a procedure involves multiple appointments, the expense is incurred on the date the procedure is completed. If the coverage for the benefit terminates and the procedure is not complete, only the expense relating to the procedures performed while the coverage was in force will be eligible.

Date Expenses Incurred for Services

While the coverage for the benefit is in force, the expense for a supply is incurred on the date the supply is received.

If the supply must be ordered, the expense will be considered incurred on the date payment was made for the supply.

If You Are Covered Under Two Benefit Plans

The insurance industry has set guidelines for coordinating your Health and Dental Benefits with another insurance program, such as your Spouse's plan. Coordination of benefits allows you to potentially claim under both plans for up to a combined maximum of 100% of the eligible expense. For instance, if your plan covers 80% of the cost of an eligible expense, the 20% not covered may be claimed under your Spouse's plan, depending on their plan. Check to ensure that your Spouse's plan provides Health and Dental coverage, that your family is covered under your Spouse's plan, and that the plan allows for coordination of benefits.

If Dependents are covered under two plans, claims for Dependent children are submitted first to the plan that covers the Spouse whose birthday falls earliest in the calendar year. Any part of the claim not covered under the first plan can-then be submitted to the other Spouse's plan. For example, if your birthday falls in January and your Spouse's birthday falls in March, you should submit your children's claims to your plan first. Proof of your plan's reimbursement along with copies of any expense receipts would then be sent to your Spouse's plan for reimbursement of the balance if the expense is covered under their plan.

Recovery of Claim Amounts from a Third Party

Where coverage exists for Plan Member Short-Term Disability, Plan Member Long-Term Disability, Health, or Dental Benefits under the Plan and under a third-party plan, the insurer may pay you benefits eligible under the Plan while the entitlement for third-party benefits is being concluded by the third party, if you enter into a reimbursement agreement with the insurer thereby agreeing to:

a) take all steps necessary to receive from the third-party plan benefits for which you are entitled; and
b) repay the insurer the amount received from the third-party plan for these same benefits.

The insurer reserves the right to pursue recovery directly from third parties on your behalf.

Claim Exclusions

No benefit will be paid under the Plan for claims arising directly or indirectly from, as a result of, or in connection with:

a) charges for a missed, late, or cancelled appointment;
b) charges for the completion of forms;
c) expenses considered to be facility fees, service fees, block fees, or tray fees;
d) treatment or care for cosmetic purposes, except when directly attributable to an Illness or Injury;
e) experimental treatment or care;
f) expenses incurred for ordinary living expenses such as room, board, travel, or clothing;
g) services performed by a person ordinarily resident in the home of the Covered Person or related to the Covered Person by birth or marriage;
h) the committing of or an attempt to commit an offence under the Criminal Code(Canada), RSC 1985, C-46, as amended, or under the criminal laws of any other jurisdiction (where the events giving rise to the claim occurred in such other jurisdiction), whether or not the Covered Person is charged for or convicted of an offense;
i) use of any prohibited or controlled substance, including but not limited to any substances listed under the Controlled Drugs and Substances Act(Canada), SC 1996, c 19, as amended, restated, or replaced including all Schedules or any substance listed under comparable legislation in another jurisdiction if such use occurred in that jurisdiction, unless taken as prescribed by a licensed Physician;
j) an incident occurring during the use or operation by the Covered Person of a Vehicle, Off-road vehicle, vessel, or aircraft while the Covered Person was under the influence of any intoxicant, any prohibited or controlled substance, or cannabis;
k) war, insurrection, the hostile actions of any armed forces, or participation in a riot or civil commotion, whether the Covered Person is an active or passive participant; or
l) medical or surgical care which is not Medically Necessary, except when attributable to an Illness or Injury.

Refer to the benefit sections of this booklet for additional exclusions (together with the claim exclusions listed above, the "**Claim Exclusions**"). These Claim Exclusions do not apply to the Plan Member Life Benefit.

Claim Submission Deadlines

Claims received outside the time frames specified under this Claim Submission Deadlines section will be denied.

Claim forms and proof that benefits are payable must be submitted by you or on your behalf and received by the insurer as follows:

a) for a Plan Member Life claim, within 180 days from the date of death;
b) for a Plan Member Accidental Death and Dismemberment claim, within 180 days from the date of death or the date of the loss;
c) for a Plan Member Short-Term Disability claim, within 30 days from the end of the Qualifying Period;
d) for a Plan Member Long-Term Disability claim or a Waiver of Premium claim, within 180 days from the date of Disability;
e) for a Plan Member Critical Illness claim, within 180 days from the end of the Survival Period; and
f) for a Health or Dental claim, within 365 days from the date that service or supplies were rendered.

If your coverage with the insurer terminates, you only have 90 days from the date of termination or the above 365-day rule, whichever day comes first, to submit your Health or Dental claim.

If your coverage terminates due to termination of a benefit provision or termination of the Plan andis replaced by another insurer within 31 days of the termination date,a claim for a loss that occurred prior to the Plan's termination date may be submitted up to 6 months from the date of termination for Plan Member Life, Plan Member Accidental Death and Dismemberment, and loss of income due to Disability.

Legal Action

Subject to the terms and conditions of the group contract between your Employer and the insurer, 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 legislation applicable to your province of residence.

Earnings

Your regular annual earnings, which are reportable on your T4, paid by the Plan Sponsor and reported to the insurer, exclusive of bonuses, dividends, and overtime.

In the first 12 months of service, Earnings will be calculated as the average of regular monthly earnings which are reportable on your T4, paid by the Plan Sponsor and reported to the insurer, exclusive of bonuses, dividends, and overtime, over the available length of service with the Plan Sponsor.

Where you are paid commission, Earnings will be the average of earnings from the previous 24 months, which are reportable on your T4, paid by the Plan Sponsor and reported to the insurer, exclusive of bonuses, dividends, and overtime. If you are employed for less than 24 months, Earnings will be the average over the available length of service with the Plan Sponsor.

If your group benefit planincludes Short-Term Disability and the Short Term Disability planis less than the benefit that would be payable under the Employment Insurance Act, Earnings will be increased by the amount of bonuses, overtime, or incentive pay, earned on a regular basis, required to calculate the amount of benefit payable under the Employment Insurance Act.

For the purposes of determining the amount of your benefit at the time of claim, your Earnings will be the lesser of:

a) the amount reported on the benefit claim form; or
b) the amount reported by the Plan Sponsor to the insurer and for which premiums have been paid.

ACCESS TO PERSONAL INFORMATION

At Simply Benefits we create enrollment, medical and claims files in order to determine the amount of coverage you and/or your dependents (if applicable) are eligible for and to process any claims you or your dependents may incur. The information contained in these files, which is used by various departments, may allow you and/or your dependents to be identified. However, any file containing your medical status is accessible only to authorized individuals within the insurer Medical Underwriting and Claims Departments.

Subject to the exceptions established by applicable law, you may request access to your files either in person, by showing proper identification at our Head Office, or by contacting our Head Office in writing with your request. You have the right to rectify any information which is incorrect (dependent on the circumstance, proof may be required) in your file and also to have any information reproduced and transmitted to you for a reasonable charge. If you prefer, you may contact Simply Benefits with your request and we will communicate your request to the insurer.

You may request a copy of any record or written statement not otherwise part of the application that you provided to Simply Benefits as evidence of insurability.

Providers

Benefit	Provider
Employee Family and Assistance Program	**Dialogue**
Out Of Country	**AIG**
Virtual Healthcare	**Dialogue**
Life Insurance	**Wawanesa**
Accidental Death and Dismemberment	**AIG**
Drugs	**Wawanesa**
Major Medical	**Wawanesa**
Paramedicals	**Wawanesa**
Dental	**Wawanesa**

Respecting Your Privacy

At Simply Benefits, protecting your privacy is a priority.

When you request or obtain any product or service from Simply Benefits, we need certain personal information. Personal information may be needed about you, your spouse or dependents if applicable, depending on the product or service. We use this information to evaluate insurance risk, to determine eligibility, to administer your plan, or to adjudicate and manage claims. We only collect information that is pertinent and necessary to the effective conduct of our business.

Your consent is required. Your express consent may be provided in writing, verbally, or electronically. When you request, obtain, or use any of our products or services, the transfer of information necessary to meet your needs may also be by your implied consent. You may withdraw your consent, but doing so may prevent us from being able to provide you with your requested product or service.

Whenever practical, your information will be collected directly from you. We also collect information about you through our authorized representatives or third party service providers. Other sources of information may include other insurers or financial institutions, government and governmental agencies, your employer, or your plan administrator. We will in some cases ask an independent source to verify and supplement personal information.

Where health information about you is required, we may collect such information directly from you, or from sources such as your doctor, healthcare professional or hospital, but only with your consent.

We will limit the use and disclosure of your personal information by our organization, our subsidiaries and affiliated companies, and with your insurers. From time to time we may need to share some of your information with our authorized representatives or third party service providers. The use and disclosure of your personal information is done only where necessary to perform our duties and where required by our contractual obligations and/or the law.

We have developed and continue to enhance security measures and procedures designed to protect your personal information from unwarranted intrusion, theft, accidental release, loss, or unauthorized disclosure, use, copying, or modification. When we destroy your personal information, we will use appropriate safeguards.

You have the right to access your personal information. With satisfactory verification of your identity, Simply Benefits will provide you with the information you request. If your request is made through a third party, we will need satisfactory proof of your consent and authorization to release information to that party, and we will ensure their entitlement to such information. There are certain legal exceptions to your right of access. Should your request fall into such a category, we will inform you of the reason for not providing access and any recourse you may have. Generally, we will provide access to medical information only through the appropriate healthcare professional.

A copy of Simply Benefits' Privacy brochure is available at your request.

Phone Number	1-877-815-7751
Website	simplybenefits.ca
Address	601-460 Doyle Ave Kelowna BC, V1Y 0C2