PUBLIK™
RETIREE HEALTH PLANS

Employee Benefits Booklet

Publik - Saskatchewan, BC, Manitoba, Alberta

Class E1

Division 1

Opportunity Plan with Dental

Effective Date: Mar 1, 2022

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	0 month(s) continuous employment, 0 hrs/week
Benefit	Flat $10,000.00
Maximum with Evidence	$10,000.00
Non-evidence Maximum	$10,000.00
Reduces by	0% at age 85
Termination Age	Age 85 or prior retirement
Waiver of Premium	To age 65 or prior retirement

Virtual Healthcare

Eligibility	0 month(s) continuous employment, 0 hrs/week
Virtual Healthcare Benefit Description	Virtual Healthcare connects you to a clinician 24/7 for all your urgent and long term healthcare needs, via phone and video chat. Save time and stress when you need convenient access to: Medical diagnosis Prescriptions and requisitions Specialist referrals Mental health support Chronic illness management and prevention Health coaching and advice Maple is brought to you by Simply Benefits and is available to your dependents.

For more details or to register	Please check Simply's employee portal under "resources" or go to https://www.getmaple.ca/simply-benefits/

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%
Preventative Vaccines	Reimbursement: 100%; Maximum: $100.00 per calendar year
Eligibility	0 month(s) continuous employment, 0 hrs/week
Diabetic Supplies and Accessories	Include syringes, lancets, test strips, pin needles and chemical reagent testing
Survivor Benefit	n/a
Termination Age	n/a

Major Health

Reimbursement	100%
Combined Maximum	$3,000.00
Accidental dental	100.00%
Ambulance	Reasonable & Customary
Hearing Aids	$500.00 per 48 consecutive months
Private duty nursing	$7,500.00 per calendar year
Hospital Benefit Reimbursement	100%
Hospital Benefit Type	Semi private
Convalescent Hospital Reimbursement	100%
Convalescent Hospital Daily Maximum	$20.00
Convalescent Hospital Maximum Days	90.00
Apnea machine (CPAP)	n/a
Apnea machine supplies	$350 per calendar year
Artificial eye or limb; initial prosthesis	1 per lifetime
Artificial eye or limb; repair & replacement	$1,000.00 per calendar year
Blood pressure monitor	$100.00 lifetime
Braces with rigid supports	1 per calendar year
Compression stockings	$100.00 per calendar year
Crutches, casts, canes, splints and trusses	Covered (Reasonable and Customary)
Custom-made foot orthotics	$150.00 per calendar year
Diabetic Sensors	n/a
External breast prosthesis	Covered (Reasonable and Customary)
IPP Breathing machine	Covered (Reasonable and Customary)
Orthopaedic Shoes	$150.00 per calendar year
Prosthetics	$3,500.00 lifetime
Ostomy supply	Covered (Reasonable and Customary)
Surgical bras	2 per calendar year
TENS	Covered (Reasonable and Customary)
Viscosupplementation	$600.00 per calendar year
Wheelchair; electric	$3,000.00 lifetime
Wheelchair; manual	$1,000.00 lifetime
Wigs, post-chemotherapy	$500.00 lifetime
Oxigen/Oxigen Equipment	Covered (Reasonable and Customary)
Post-surgical bra	2 per calendar year, per insured
Intrauterine device (IUD)	Covered (Reasonable and Customary)
Blood glucose monitor	$200.00 every 3 years

Diagnostic Services

Reimbursement	100%
Diagnostic Services Maximum	$500.00 per calendar year
X-Rays	Covered (Reasonable and Customary)

Medical Referral

Reimbursement	50%
Medical Referral Maximum	$50,000.00 lifetime coverage

Paramedical

Deductible	N/A
Coinsurance	100%
Combined Paramedical Maximum	$1000 maximum for all benefits combined
Acupuncturist	$1000 all combined per calender year
Audiologist	$1000 all combined per calender year
Chiropodist	$1000 all combined per calender year
Chiropractor	$1000 all combined per calender year
Massage therapist	$1000 all combined per calender year
Naturopath	$1000 all combined per calender year
Occupational Therapist	$1000 all combined per calender year
Osteopath	$1000 all combined per calender year
Physiotherapist	$1000 all combined per calender year
Podiatrist	$1000 all combined per calender year
Registered Dietician	$1000 all combined per calender year
Psychologist	$1000 all combined per calender year
Social worker	$1000 all combined per calender year
Speech-language pathologist	$1000 all combined per calender year

Vision Care

Eye Exam Reimbursement	100%
Eye Exam (child to age 18)	$100.00; 1 exam per period of 12 consecutive months
Eye Exam (adults)	$100.00; 1 exam per period of 24 consecutive months

Out of Country & Province

Maximum Number of Days	90 Days
Termination Age	80 Years
Maximum per insured under age 69	$5,000,000 per insured, per trip (maximum $25,000 if not covered by provincial plan at time of claim)

Dental Care

Benefit Period	Calendar year
Basic Reimbursement	100%
Routine Reimbursement	100%
Basic Maximum	$1,000.00
Months to Recall	6 months to recall
Units of Scaling	8 units of scaling
Periodontics Reimbursement	100%
Endodontics Reimbursement	100%
Eligibility	0 month(s) continuous employment, 0 hrs/week
Survivor Benefit	n/a
Termination Age	n/a

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.

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 Dependent's province of residence;
b) the treatment has been pre-approved by Wawanesa Life and your Provincial Health Plan. Additional expenses will only ben covered if your Provincial Health Plan is participating in the reimbursement; and
c) referrals cannot be due to waiting list or 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.

Vision Care

The Vision Benefit covers Eligible Expenses for certain medical services and medical supplies, as outlined in this Health provision (the "**Vision Benefit**"). For the purpose of this Vision Benefit, an "**Eligible Expense**" is defined as an expense, before any applicable payment limitations, such as deductibles, coinsurance, and maximums (as specified in the Schedule of Benefits) are applied, incurred directly in relation to only the following:

a) If included in the Schedule of Benefits; charges for eye exams (including refractions) on the recommendationof an Optometrist or a Medical Practitioner within the scope of their license, provided the charges are not covered by the Provincial Health Plan; and
b) If included in the Schedule of Benefits; charges for frames, lenses, contact lenses, and laser eye surgery forvision correction, on the recommendation of an Optometrist or a Medical Practitioner within the scope of their license.

Eligible Expenses as per the Schedule of Benefits are only covered by the Vision Benefit when they:

a) are incurred and paid for in Canada;
b) are Reasonable and Customary;
c) are not covered under any Provincial Health Plan or Government-sponsored program; and
d) can legally be covered under the Plan.

Out of Country & Province

In case of an Emergency or if you need more information while traveling, please contact Orion Travel Insurance as follows:

- **Toll Free Phone Number:** 1-888-997-0152
- **Collect Phone Number:** 1-519-251-0152
- **Email address:** orionassistance@globalexcel.com

Orion's team of specialists will ask you for the following information:

- Your name
- Your Group Policy Number with Orion (provided on the back of your Digital Drug card)

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

Important Information:
This Group Policy provides worldwide coverage for all eligible members while temporarily traveling outside their province of residence.
This Certificate of Insurance describes your coverage under the Group Policy. Please read it carefully before you travel. Please download your Simply Benefits Digital Drug Card through the member portal or app and put it in your digital wallet, mobile device photo library or wallet as it contains important emergency telephone numbers.
While all of the information is important, you should pay particular attention to the Conditions and Exclusions, as these sections may limit the benefits payable to you. In addition, by following the instructions in the section: How To File a Claim, you can speed up the assessment and, where applicable, payment of your covered eligible expenses.

Throughout this Certificate you will notice that terms requiring your attention are explained in the Travel Insurance Definition section. Pay particular attention to the definitions as we have given a very specific meaning to these terms.

Important: you must notify your employer about any changes to your family status or your provincial health plan. Your group benefits administrator will advise Orion of this change to ensure your coverage is adapted to your needs.

Orion Group Travel Benefits Plan Coverage Highlights

Emergency Medical Treatment	
HOSPITAL ACCOMMODATION	$5,000,000.00
PHYSICIANS' FEES	$5,000,000.00
LABORATORY TESTS AND X-RAYS	$5,000,000.00
PRIVATE DUTY NURSING	$5,000,000.00
AMBULANCE SERVICE	$5,000,000.00
PRESCRIPTION DRUGS	$5,000,000.00
MINOR MEDICAL APPLIANCES	$5,000,000.00
PARAMEDICAL SERVICES	Up to $1,000 for all services/benefit year

In the event of an emergency call Orion Assistance immediately prior to receiving treatment. Depending on where you are traveling, there may be a unique toll-free number to assist you.

Please use the numbers to contact Orion from the country listed below. **When contacting Orion Assistance, please provide your name, your group policy number, your employee ID, your Orion ID, your location and the nature of your emergency.**

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

Eligibility For Insurance Coverage

To be eligible for coverage under the group policy you must as of your departure date on any trip, you must:

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

Group Policy Coverage

The effective date of coverage under this Group Policy is the date the Insured is entitled to receive benefits under this insurance.

The termination date of coverage under this Group Policy is the date the Insured is no longer entitled to receive benefits under this insurance.

The termination date of coverage is the earlier of:

- the date the Insured ceases to meet any of the eligibility for insurance coverage requirements as set out in this Certificate of Insurance; or
- the date member reaches termination age; or
- the date this Group Policy is terminated.

Trip Coverage

Your trip coverage starts: The date you leave your province of residence

Your trip coverage ends:

The earliest of:

- the actual date you return to your Canadian province; or
- the maximum number of days per trip within a benefit year has been reached as defined on the Schedule of Benefits

Except that if you are hospitalized while on a trip, your trip coverage ends

- five days after any period of your hospitalization or, the day that is earlier than five days after you are released from hospital when you are deemed medically able to travel in the opinion of the Medical Director of Orion Assistance.

Insured Risks

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

Benefits

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

1. Emergency Medical Treatment

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

b. Physicians' fees;

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

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

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

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

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

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

2. Emergency Dental Expenses

Reimbursement of:

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

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

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

3. Hospital Allowance

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

4. Return of Vehicle

When approved in advance by Orion Assistance:

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

b. repatriation of the Insured(s) and one travel companion (if applicable) if private vehicle is stolen or inoperative due to an accident.

5. Family Transportation

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

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

6. Meals and Accommodation

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

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

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

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

7. Medical Transportation

When approved in advance by Orion Assistance:

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

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

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

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

8. Qualified Medical Attendant

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

9. Trip Interruption and Delay

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

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

10. Return of Excess Baggage

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

11. Domestic Services

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

12. Medical Follow up in Canada

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

a. up to $1,000 for semi-private room in a hospital or rehabilitation centre or convalescent home;
b. up to $50 per day for up to 10 days for home nursing care when medically necessary;
c. up to $150 for the rental of crutches, standard walker, canes, trusses, orthopaedic corset, oxygen; and
d. up to $250 for ambulance or taxi services to receive medical care.

13. Escort and Return of Children

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

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

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

14. Child Care

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

15. Non-Medical Emergency Evacuation

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

16. Return of Remains

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

a. the actual cost incurred for:
   i. preparation of the deceased Insured; and
   ii. return of the deceased Insured in the common carrier's standard transportation container to the scheduled point of departure;Kor
b. up to $5,000 for burial or cremation at the place of death.

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

17. **Pet Return, Pet Care and Commercial Kennel Costs:**
When approved in advance by Orion Assistance, **reimbursement** up to a:

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

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

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

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

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

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

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

22. **Message Centre**
Transmission of urgent messages to family and/or employer by multilingual Orion Assistance co-ordinators if you cannot reach your home due to time zones differences or telephone difficulties. Leave urgent messages for travel companions if you lose contact with one another.

23. **Lost Document and Ticket Replacement:**
Assistance in contacting local authorities to help an Insured replace lost or stolen passports, visas, tickets or other travel documents.

Conditions

These conditions apply to all insurance coverages under this Certificate:

1. In the event of a medical emergency please call Orion Assistance immediately.
2. Coverage may never extend beyond maximum number of days per trip within the Group Benefit Year or your benefits under this Group Policy may be limited.
3. If any benefit is duplicated under a similar benefit in this Certificate of insurance or any other of our group or individual policies, or under any other similar coverage with another insurer, the maximum you are entitled to is the largest amount specified under any one benefit or insurance coverage. The total amount paid to you from all sources cannot exceed the actual expenses you incur.
4. Where not specified, airfares are one-way and economy class.
5. If we pay your health care provider or reimburse you for covered expenses, we will seek reimbursement from your government health insurance plan and from any other medical reimbursement plan under which you may have coverage. You may not claim or receive in total more than 100% of your total covered expenses.
6. You or someone acting on your behalf must, unless it is otherwise not possible, first contact Orion Assistance in advance any surgery or invasive procedure (including, but not limited to, cardiac catheterization). You must inform your attending physician to call Orion Assistance, except in extreme circumstances where such action would delay surgery required to resolve a life-threatening medical crisis.
7. During a medical emergency (whether prior to admission or during a covered hospitalization), we reserve the right to:
    a. transfer you to one of our preferred health care providers; and/or
    b. return you to your province of residence, for the medical treatment of your sickness or injury. If you choose to decline the transfer or return when declared medically able by the Medical Director of Orion Assistance, we shall have no liability for expenses incurred for such sickness or injury after the proposed date of transfer or return.
8. We are not responsible for the availability, quality or results of any medical treatment or transportation, or the Insured's failure to obtain medical treatment or hospitalization.

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

10. Any benefits payable for acts of terrorism are excess to all other recovery sources including, but not limited to, alternative or replacement travel options offered by airlines, tour operators, cruise lines and other travel suppliers and other insurance coverage (even when suchKcoverage is described as excess) and are payable only after you have exhausted all such other recovery sources.
    Any benefits payable are subject to an overall aggregate maximum limit relating to all in-force Certificates and Policies issued by us, including this group policy. Coverage is available for up to two acts of terrorism within a calendar year and the maximum payable for eachKact of terrorism is $8 million.
    If total claims resulting from one or more acts of terrorism exceed the applicable aggregate maximum limit stated above, then each Insured is entitled to his/her pro rata share of such aggregate maximum limit.
    If, in our judgment, the total of all payable claims under one or more acts of terrorism may exceed the applicable aggregate maximumK limit, your prorated claim will be paid after the end of the calendar year in which you qualify for benefits.

Exclusions

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

1. a. Under Age 70 - Any sickness, injury or medical condition that is not stable ninety (90) days prior to departure from your province of residence.

    b. Ages 70 - Any sickness, injury or medical condition that is not stable one hundred and eighty (180) days prior to departure fromK your province of residence.

2. Any hospital/medical expenses exceeding a maximum of $25,000 if you are not covered by a government health insurance plan at time ofK claim.

3. Sickness, death or injury as a result of the abuse of medication, drugs, alcohol or any other toxic substance during the trip. Alcohol abuse includes having a blood alcohol level in excess of 80 milligrams of alcohol per 100 milliliters of blood.

4. A sickness, injury or related condition during a trip undertaken for the purpose of obtaining treatment or surgery.

5. Asickness, injury or related condition for which future investigation or treatment (except routine monitoring) is planned before your trip.

6. Suicide (including any attempt thereat) or self-inflicted injury whether or not you are sane.

7. a. Your routine prenatal care or childbirth at any time during your trip;
    b. Any costs for your child(ren) born during your trip;
    c. Complications, conditions or symptoms of pregnancy during the nine weeks prior to or after the expected delivery date.

8. Death or injury sustained:
    a. during your professional participation in any sport; or
    b. your participation in any motorized or mechanically assisted speed contests.

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

10. The replacement cost of an existing prescription, whether by reason of loss, renewal or inadequate supply, or the purchase of drugs andK medications (including vitamins) which are commonly available without a prescription or which are not legally registered and approved in Canada. Orion Assistance will assist you with replacement of the Prescription Assistance Benefit.

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

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

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

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

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

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

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

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

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

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

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

    a. $2.5 million CAD, per Insured, when you have received at least one Health Canada approved COVID-19 vaccination at least 14 days prior to departure; or
    b. $5 million CAD per Insured, when you have received all vaccine doses of Health Canada approved COVID-19 vaccinations atK least 14 days prior to departure.

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

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

20. Noncompliance with prescribed medical treatment or therapy.

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

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

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

24. Payment for repatriation under the Trip Interruption and Delay Benefit, , when the original ticket may be used. Original tickets will become the property of Orion Travel Insurance Company (Ontario) in the event of a repatriation.

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

Orion Assistance

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

What to do if you need Orion Assistance

Have your group policy number with you at all times and contact Orion Assistance.

The telephone number(s) are listed on your Digital Drug Card.

What Happens when you call Orion Assistance?

Orion Assistance will work closely with you to:

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

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

Why are you required to call Orion Assistance?

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

Limitation on Orion Assistance Services

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

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

How To File A Claim

Payment to Medical Providers

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

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

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

Submitting your Claim

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

Orion Travel Insurance
Active Care Management Inc.
PO Box 308 Station A
Windsor, Ontario N9A 6K7
Email: orionclaims@globalexcel.com

Emergency Medical Claims

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

All Other Claims

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

Travel Insurance Definition

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

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

- use, or a threat to use, force or violence; or
- commission, or a threat to commit, a dangerous act; or
- commission, or a threat to commit, an act that interferes or disrupts an electronic, information or mechanical system; and the effect or intention of the above is to:
- intimidate, coerce or overthrow a government (whether de facto or de jure) or to influence, affect or protest against its conduct or policies; or
- intimidate, coerce or put fear in the civilian population or any segment thereof; or
- disrupt any segment of the economy; or
- further political, ideological, religious, social or economic objectives to express (or express opposition to) a philosophy or ideology.

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

Benefit Year means a 12-month period beginning on the effective date of your group benefits plan.

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

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

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

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

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

Dependent means an employee's spouse or child(ren) who is/are insured under a government health insurance plan, provided that the employee has dependent coverage under their Plan Sponsor's group policy.

Employee means a person who is hired on a permanent full-time or part-time basis, has satisfied any qualifying period for employer group benefit coverage.

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

Family member means the employee and/or their dependent spouse and/or the employee's dependent natural child(ren), adopted child(ren) or step-child(ren).

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

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

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

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

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

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

Insured means individually the employee and each of his/her eligible dependents and **Insureds** means the employee and his/her eligible dependents.

Insurer means Orion Travel Insurance Company.

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

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

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

a. is appropriate and consistent with the diagnosis according to accepted community standards of medical practice;
b. is not experimental or investigative in nature;
c. cannot be omitted without adversely affecting your condition or quality of medical care;
d. cannot be delayed until your return to your province of residence; and
e. is delivered in the most cost effective manner possible, at the most appropriate level of care and not primarily by reason of convenience.

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

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

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

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

- who was thus licensed at the time of treatment and who remains so;
- whose legal and professional standing, within the jurisdiction where treatment was rendered, is equivalent to that of a doctor of medicine (M.D.) licensed to practice in any province or territory of Canada; and
- who is not an immediate family member.

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

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

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

Sickness means a disease or disorder of the body which results in loss while this coverage is in effect. The sickness must be sufficiently serious to prompt a reasonably prudent person to consult a physician for the purpose of medical treatment and for the physician to certify in writing the necessity of cancelling, interrupting or delaying the trip.

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

Spouse means the person to whom you are legally married or with whom you have resided with and whom you present publicly as your spouse.

Stability means:

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

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

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

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

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

Trip means travel undertaken by the employee or their eligible dependents taken outside such person's Canadian province of residence. A trip must commence after the employee or his or her eligible dependents are eligible for coverage. A trip is deemed to end on the date the "Trip Coverage Ends" as further described on page 1 of this Certificate.

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

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

You, **your** and **yourself** refers individually to the employee and to each of their eligible dependent(s).

General Terms Of Agreement

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

You agree that we and Orion Assistance have:

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

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

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

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

Deductible
No deductible applies to the insurance coverages described herein.

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

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

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

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

Co-ordination of Benefits
If, at the time of loss, you have insurance from another source, or if any other party is responsible for benefits also provided under the group policy, we will pay eligible expenses only in excess of those covered by that other insurer or other responsible party, including but not limited to credit cards, private or provincial or territorial auto plans or any other insurance, whether collectable or not. This insurer is a secondary payor. All other sources of recovery, indemnity payments or insurance coverage must be exhausted before any payments will be made under any of our policies. If, however, that other insurance is also "excess only", we will co-ordinate payment of all eligible claims with that other insurer. All co-ordination follows guidelines set by the Canadian Life and Health Insurance Association.
In no case will we seek to recover against employment related plans if the lifetime maximum for all in-country and out-of-country benefits is **$100,000** or less. If your lifetime maximum is greater than **$100,000**, we will co-ordinate benefits only above this amount.

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

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

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

Collecting Personal Information
We may collect personal information about the Insureds such as:

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

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

Collecting Personal Information
We may collect personal information about the Insureds such as:

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

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

Using Personal Information
This information may be used for the following purposes:

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

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

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

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

Notice on Privacy and Confidentiality
To protect the confidentiality of the employee's and/or dependent's information, Orion Travel Insurance Company and Orion Assistance will establish a "financial services file" from which this information will be used to administer services and process claims. Access to this file will be restricted to those Orion Travel Insurance Company/Orion Assistance employees, mandataries, administrators or agents who are responsible for the assessment of risk (underwriting), marketing and administration of services and the investigation of claims, and to any other person you authorize or as authorized by law. These people, organizations, and service providers may be in jurisdictions outside Canada, and subject to the laws of those foreign jurisdictions.
Your file is secured in our offices or those of Orion Assistance. You may request to review the personal information it contains and make corrections by writing to:

Chief Privacy Officer
Orion Travel Insurance Company
60 Commerce Valley Drive East
Thornhill, Ontario L3T 7P9
Tel: 905-747-4900 ext 25043
Fax: 905-771-3357
Email: Privacy@orionti.ca
The information for the Ombudsman's office is: https://www.oriontravelinsurance.ca/Contact%20Us.aspx

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

Other Conditions

Waiver

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

Notice and Proof of Claim

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

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

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

Failure to Give Notice or Proof

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

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

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

Limitation of Arbitration Proceedings

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

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 planning expenses is limited to the number of units specified for this plan in the Schedule of Benefits.

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 Eligibility Requirements specified in the Schedule of Benefits 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 24 hours from 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.

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 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 enter active service with the armed forces of any country;
d) the date the Plan terminates, or the date coverage terminates for an eligible Class to which you belong;
e) the date you reach the Coverage Termination Age, as specified under each coverage in the Plan Summary; or
f) 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.

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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.

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:

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

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.

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 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**").

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 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.

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.

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
Out Of Country	**Orion**
Virtual Healthcare	**Maple**
Life Insurance	**Wawanesa**
Drugs	**Wawanesa**
Major Medical	**Wawanesa**
Paramedicals	**Wawanesa**
Vision	**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