All Employees

Interlake School Division Local 2972 - 813153

GROUP INSURANCE BENEFITS

Employee Benefits are important, not only for the financial assistance they provide, but also for the security they provide for you and your family, especially in case of unforeseen needs.

This booklet has been specifically designed with your needs in mind, providing easy access to the information you need to know about the benefits made available to you. Your Certificate of Insurance confirms the benefit and the level/amount you are currently insured with.

The information contained in this booklet summarizes all possible benefits available under the TotalGUARD Program. Please refer to your Certificate of Insurance page to determine which benefits are applicable to you. In the event of a discrepancy between this booklet and the Group Insurance Contract, the terms of the Contract will apply.

At Western Financial Group Insurance Solutions we can answer any questions you may have about your benefits, or how to submit a claim. Please call us at 1-800-665-8990.

Group Insurance Solutions

Booklet Version – 1.1

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CERTIFICATE OF INSURANCE

Employee Name: All Employees
Interlake School Division Local 2972

Enrollment Date:
Certificate No.: **Greenshield No:**

BENEFIT SCHEDULE

Extended Health Care

80% Drugs, unlimited. $7 dispensing fee cap.
80% Medical services & supplies.
80% Professional services, $400 Cal.Yr. maximum.
Dr's referral not req'd for Massage Therapy.
Trip Duration: 90 days.
Nil deductible.

Vision Care

$200 per 2 calendar years.
1 Eye exam/2 calendar years up to the R & C max amount.

Dental

Levels I & II (basic) 80%.
Levels III & IV (major) 50%.
$750 combined Cal. Yr. maximum.
Maximum of 16 units of endo & perio scaling/planing
per calendar year.
Nil deductible, 6 month recall,
Current fee guide.

This group benefit is administered by Western Financial Group Insurance Solutions.
E.&O.E. – Western Financial Group (Network) Inc. August 17, 2016

DEFINITIONS

For the purposes of this booklet, the masculine pronoun and adjective include the feminine, unless a different meaning is plainly to be taken from the context. All words have their usual meaning, unless a special meaning is indicated.

Accidental Injury

Any bodily lesion, sustained while your insurance is in force, directly and solely due to an external sudden, violent and unintentional cause, independent of any illness and requiring within 30 days of the event the care of a physician or an appropriate specialist.

Actively At Work

The status of a participant who is physically and mentally capable of doing each and every personal job-related work function and who is actually working full-time and in a permanent manner on the basis of a minimum 20 hour work week at the policyholder's place of business or at any other place designated for the performance of a specific job-related task.

Associated Company

A person, firm, corporation, partnership or proprietorship which is associated with the Policyholder as a member in good standing and which is in a classification of insurance risk approved by the company.

Benefit Percentage (Co-Insurance)

The percentage of Covered Expenses which is payable as per the terms of the contract.

Deductible

The amount of covered expenses that must be incurred and paid by you or your dependent before benefits are payable.

Dependents

Your spouse or your children or your spouse's children, whether taken individually or collectively. If dependents are insured under this policy, the words spouse and child have the following meanings.

Spouse

- Your legal spouse;
- A person whom you publicly acknowledge as your spouse, with whom you have been living in a permanent manner for over one year.

The person you have designated in writing to the insurer as your spouse is recognized as your dependent, until such time as you advise otherwise. Any dissolution of a marriage through divorce or annulment or, in the case of common-law marriage, actual separation for over three months, results in the loss of status of spouse.

Child

All unmarried children of the participant, of the spouse or of both, including the legally adopted children or those for whom the participant or the spouse exercises or would exercise, in the case of a minor, parental authority and whom the participant or the spouse supports and who is:

- Under age 21;
- Over age 21 but under age 25, being a full-time student in an accredited educational institution, subject to evidence to the satisfaction of the Insurer;
- Not regularly employed;

- Regardless of age, suffering from a severe, incurable and chronic physical or mental disability while meeting the requirements indicated above of a dependent child, rendering such child unable to pursue a substantially gainful occupation, subject to adequate medical evidence.

Dispensing Fee

Of the total prescription drug cost, that portion charged for the pharmacist's professional services for filling a prescription. The dispensing fee maximum is the maximum amount that will be reimbursed.

Drug

Medications that have been approved for use by the Federal Government of Canada and have a Drug Identification Number (DIN).

Earnings

Your regular rate of earnings from your employer, excluding bonuses, overtime, fees, lodging and meal allowances, amounts paid by the employer as fringe benefits, isolation allowances and any lump sum payment, but including the weekly equivalent of the amount of commissions received by you from your employer during the two calendar years ending on the immediately preceding December 31st, as reported on your T4 forms.

The Salary used for applying provisions under the Disability insurance benefit if the higher of the Salary defined above and insurable earnings as defined in the Employment Insurance Act.

Elimination Period

The continuous period during which you must be absent due to disability before you can begin to receive disability benefits.

Employee

A person actively working in a permanent manner on a full-time basis for the employer and receiving regular income for services rendered.

Hospitalization

Admission to a hospital for a minimum period of 24 hours or one day surgery preformed in a hospital.

Illness, Disease, Sickness

Any pathological condition resulting from a deviation of health requiring both regular and continuous medical care actually given by a physician or an appropriate specialist and an appropriate therapy, considered satisfactory by the insurer.

Income

Your remuneration as declared by your employer to the insurer.

Net Income

Your annual income, less the income tax deducted according to the tax tables established under the Canadian Income Tax Act and by any similar legislation of your province of residence.

Non-Evidence Limit

You must submit satisfactory medical evidence for benefit amounts greater than the non- evidence limit.

Physician

A person duly authorized by a provincial law to practice medicine and who is a member in good standing of a professional medical body.

Provincial Plan

Any plan which provides hospital, medical or dental benefits established by the government in the province where the insured person lives and which is governed by the Canada Health Act.

Reasonable and Customary

Within the usual range of charges being made by others of similar standing in the area in which the charge is incurred when providing the same or comparable service or supplies.

Specialist

A physician practicing a specialty of medicine for which he is certified by the Royal College of Physicians and Surgeons of Canada or by the Corporation professionnelle des médecins due Québec, or both.

Waiting Period

The period of continuous employment with your employer, which you must complete before you are eligible for Employee Benefits.

Ward

A hospital room with 3 or more beds, which provides standard accommodation for patients.

GENERAL INSURANCE PROVISIONS

Eligibility

You must complete an application form supplied by your employer for yourself and your dependents, if any. You are eligible for insurance on the date that you have satisfied the waiting period specified by your employer.

Dependents Eligibility

Your dependents are eligible for insurance at the later of the day on which you become eligible, or, the day on which you have a dependent for the first time.

If your employer receives your application more than 31 days after your eligibility date, you must provide evidence of insurability at no expense to the insurer.

Effective Date of Insurance

Your insurance and your dependents' insurance become effective on one of the following dates:

- Your eligibility date, provided an application has been received by the Insurer before such date or within the 31 days thereafter.
- The first of the month following the date after which the insurer accepts your required evidence of insurability. Such evidence must be provided at no expense to the insurer.
- However, for an employee who is a resident of Québec, the Health Insurance Benefit will take effect, without evidence of insurability, on the date your employer receives the application.
- If you were not actively at work on the date your insurance would have otherwise become effective, the insurance takes effect on the date you return to active work.

If your dependents are already insured, any person who subsequently becomes a dependent and meets the eligibility guidelines is immediately insured. Dependent children are eligible for coverage as of 24 hours of age. Please notify your customer service representative of any dependent additions.

Change in Coverage

To ensure that your coverage is kept up to date for yourself and your dependents, it is vital that you immediately report any changes to Western Financial Group Insurance Solutions in writing within 31 days. Such changes could include:

- Name
- Beneficiary
- Dependent Coverage
- Salary
- Applying for coverage previously waived

To make such changes, forms can be downloaded from our web site at www.westernfgis.ca.

Beneficiary

You may designate one or several beneficiaries, or if your beneficiary should predecease you, the benefit will be paid to your estate. You are the beneficiary of your dependents' life insurance, if your plan covers your dependents.

Subrogation

The Insurer is subrogated in all the rights of the participant and the insured against the third party liable for the damage that has given rise to an entitlement to payment of benefits under this contract up to the limitation of amounts paid by the Insurer.

The Insurer may, in the exercise of its right of subrogation and if it deems that a third party is liable, require that the participant and the insured sign, if applicable, an act of subrogation in its favour at the time of paying any benefits.

Termination of Insurance

Your insurance or your dependents' insurance terminates at the earliest of the following dates:

- On the date you cease to qualify as an eligible employee;
- On the date the benefit or contract is terminated;
- On the last day of the period for which your employer has paid the premium.

The termination date for each benefit and the reduction formula for the insurance amounts are specified in the Certificate of Insurance.

EXTENDED HEALTH CARE

General Description

If you or your dependents incur charges for any of the Covered Expenses specified in this booklet, your Extended Health Care benefit can provide financial assistance.

Payment of Covered Expenses is subject to any maximum amounts and deductibles shown on the Certificate of Insurance.

Covered Expenses

The expenses specified are covered to the extent that they are reasonable and customary:

- Medically necessary for the treatment of sickness or injury and recommended by a physician;
- Incurred for the care of a person while insured under this Group Benefit Program;
- Reasonable, taking all factors into account;
- Not covered under the Provincial Plan or any other government sponsored program;
- Legally insurable.

Payment of any Covered Expenses under this benefit, which may be purchased in large quantities, will be limited to the purchase of up to a 3-month supply at any one time.

Hospital Care

Charges in excess of the hospital's public ward charge, for semi-private accommodation, provided:

- The person was confined to hospital on an in-patient basis;
- The accommodation was specifically elected by the patient.

Semi-private accommodation for confinement in a convalescent care facility.

Prescription Drugs

Drugs or medicines dispensed by a licensed pharmacist, and which by law or convention require a written prescription of a physician or dentist:

- Oral contraceptives, intrauterine devices and diaphragms;
- Injectable medications;
- Life sustaining drugs;
- Preventive vaccines;
- Non-prescription drugs and supplies required for the treatment of diabetes (excluding automatic jet injectors or similar equipment).
- Ileostomy, colostomy and incontinence supplies.

Charges for the following expenses are not covered, even when prescribed:

- The administration of serums, vaccines or injectable drugs;
- Charges for drugs, biological and related preparations which are intended to be administered in hospital on an in-patient or out-patient basis and are not intended for a patient's use at home;
- Fertility drugs;

- Anti-smoking drugs;
- Anti-obesity drugs;
- Erectile dysfunction drugs;
- Hair growth stimulants;
- Coagulatherapy or Radiotherapy.

Overall Drug Maximum

Please refer to your Certificate of Insurance.

Benefit Percentage

Please refer to your Certificate of Insurance.

Payment of Covered Expenses

- Payment will be subject to the Drug Dispensing Fee Maximum and benefit percentage as shown on the Certificate of Insurance;
- Covered expenses for any prescribed drug or medicine will not exceed the price of the lowest cost generic equivalent product that can legally be used to fill the prescription;
- If there is no generic equivalent product for the prescribed drug or medicine, the amount covered is the cost of the prescribed product.
- Special authorization medications may be subject to a $10,000 annual maximum. Green Shield will notify you of any medications requiring special authorization.

No Substitution Prescriptions

- If your prescription contains a written direction from your physician or dentist that the prescribed drug or medicine is not to be substituted with another product and the drug or medicine is a covered expense under this benefit, the full cost of the prescribed product will be considered;
- The amount payable subject to the Drug Dispensing Fee Maximum and benefit percentage as shown on your Certificate of Insurance.

Payment of Drug Claims

Your Pay Direct Drug Card provides your pharmacist with immediate confirmation of covered drug expenses. This means that when you present your Pay Direct Drug Card to your pharmacist at the time of purchase, you and your eligible dependents will not incur out-of- pocket expenses for the full cost of the prescription. The Pay Direct Drug Card is honoured by participating pharmacists displaying the appropriate Pay Direct decal. To fill a prescription for covered drug expenses:

- Present your Pay Direct Drug Card to the pharmacist at the time of purchase, and;
- Pay any amounts that are not covered under this benefit.

You will be required to pay the full cost of the prescription at the time of purchase if:

- You cannot locate a participating Pay Direct Drug Pharmacy;
- You do not have your Pay Direct Drug Card with you at that time;
- The prescription is not payable through the Pay Direct Drug Card system.

Drug Dispensing Fee Maximum

Please refer to your Certificate of Insurance.

Professional Services

Services provided by the following licensed practitioners:

- Chiropractor
- Osteopath
- Massage Therapist* (A written Physician's referral is required.)
- Podiatrist
- Naturopath
- Physiotherapist
- Psychologist
- Speech Therapist
- Psychiatrist – if treatment is rendered in the province of Québec and the treatment is not covered under Québec's Provincial Plan.

***Note: Massage therapy is not covered if you have bronze coverage.**

**For dollar amount per visit and maximum per calendar year, please refer to your Certificate of Insurance.*

Expenses for some of these Professional Services may be payable in part by Provincial Plans. Coverage for the balance of such expenses prior to reaching the Provincial Plan maximum may be prohibited by provincial legislation. In those provinces, expenses under this Benefit Program are payable after the Provincial Plan's maximum for the benefit year has been paid.

Private Duty Nursing

Services which are deemed to be within the practice of nursing and which are provided in the patient's home by:

- A registered nurse, or;
- A registered nursing assistant (or equivalent designation) that has completed an approved medications training program.

Covered Expenses are subject to a maximum of $10,000 per calendar year.

Charges for the following services are not covered:

- Service provided primarily for custodial care, homemaking duties or supervision;
- Service performed by a nursing practitioner who is related to or lives with the patient;
- Service performed while the patient is confined in a hospital, nursing home, or similar institution;
- Service, which can be performed by a person of lesser qualification, a relative, friend or a member of the patient's household.

The insurer suggests that a detailed treatment plan be submitted with cost estimates before Private Duty Nursing Services begin. You will then be advised of any benefit that will be provided.

Ambulance

Licensed ambulance service provided in the patient's province of residence, including air ambulance, to and from the nearest hospital where adequate treatment is available.

Medical Services and Equipment

For all medical equipment and supplies covered under this provision, Covered Expenses will be limited to the cost of the device or item that adequately meets the patient's fundamental medical needs.

Rental or, when approved by the insurer, purchase of:

- Laboratory tests, up to a maximum of $250 per eligible test;
- Ultrasound, up to a maximum of $250 per eligible test;
- Mobility Equipment: crutches, canes, walkers and wheelchairs;
- Durable Medical Equipment: manual hospital beds, respiratory and oxygen equipment, and other durable equipment usually found only in hospitals;
- Artificial eyes, limbs;
- Surgical stockings, up to a maximum of 4 pairs per calendar year;
- Stump socks, up to a maximum of 12 every 12 months;
- Mastectomy bra, up to a maximum of 4 per calendar year;
- Braces (other than foot braces), trusses, collars, leg orthosis, casts and splints;
- Stock-item orthopedic shoes and modifications or adjustments to stock-item orthopedic shoes or regular footwear, up to a maximum of $150 per calendar year for shoes which are attached to and form part of a brace and $75 per calendar year for shoes which are not attached to and do not form part of a brace (recommendation of either a physician or a podiatrist is required);
- Custom-made shoes which are constructed by a Certified Orthopedic Footwear Specialist (C.F.S.O.) and are required because of a medical abnormality, up to a maximum of $150 per calendar year;
- Casted, custom-made orthotics, up to a maximum of $400 per 3 calendar years (recommendation of either a physician or podiatrist is required);
- Cost and installation of initial hearing aids (including charges for batteries) to a maximum of $500 per 5 calendar years;
- Initial pair of glasses or contact lenses, which are required as a result of an accidental injury;
- Breast Prostheses, up to a maximum of $385 in a benefit year.

Other Supplies and Services

- Ileostomy, colostomy and incontinence supplies;
- Medicated dressings and burn garments;
- BIPAP/CPAP/APAP machines, supplies, repairs and rentals to a lifetime maximum of $1,400;
- Wigs and hairpieces for patients with temporary hair loss as a result of medical treatment, up to a maximum of $250 per lifetime;
- Oxygen and diagnostic services;
- Glucometers prescribed by a specialist, up to a lifetime maximum of $700;

- Charges for the treatment of accidental injuries to natural teeth or jaw, provided the treatment is rendered within 12 months of the accident, excluding injuries due to biting or chewing, to a maximum of $3,000 per accident.

Submitting a Claim

To submit a claim, you must complete an Extended Health Care Claim form, except when claiming for physician or hospital expenses incurred outside your province of residence. For these expenses, you must complete an Out-of-Province/Out-of-Canada claim form. Claim forms are available from Western Financial Group Insurance Solutions' web site (www.westernfgis.ca). All applicable receipts must be attached to the completed claim form when submitting to the claims provider.

All claims must be submitted within 12 months after the date the expense was incurred. However, upon termination of your insurance, all claims must be submitted no later than 90 days from the termination date.

Claims for Out-of-Canada expenses must first be submitted to the Provincial Plan for payment. Any outstanding balance should be submitted to the claims provider, along with the explanation of payment from the Provincial Plan.

Payment of Claims

Once the claim has been processed, you will be sent an Explanation of Benefits statement. This statement provides the information that may be required for tax purposes (the information provided on a receipt) as well as any deductibles, maximums, or co-payments applied to the payment of your claim. This statement can also be used to submit Co-ordination of Benefit (COB) claims.

Co-ordination of Benefits

If you or your dependents are insured for similar benefits under another Plan, Western Financial Group Insurance Solutions will take this into account when determining the amount of expenses payable under this program.

This process is known as Co-ordination of Benefits. It allows for reimbursement of insured health expenses from all plans, up to a total of 100% of the actual expenses incurred.

Plan means:

- Other Group Benefit Programs;
- Any other arrangement of coverage for individuals in a group;
- Individual travel insurance plans.

Plan does not include school insurance or Provincial Plans.

Order of Benefit Payment

A variety of circumstances will affect which Plan is considered as the "Primary Carrier" (i.e. responsible for making the initial payment toward the eligible expense), and which Plan is considered as the "Secondary Carrier" (i.e. responsible for making the payment to cover the remaining eligible expense).

- If the other Plan does not provide for Co-ordination of Benefits, it will be considered as the Primary Carrier, and will be responsible for making the initial payment toward the eligible expense;
- If the other Plan does provide for Co-ordination of Benefits, the following rules are applied to determine which Plan is the Primary Carrier.

For claims incurred by you or your Dependent Spouse:

- The Plan insuring you or your Dependent Spouse as an employee/member pays benefits before the Plan insuring you or your Spouse as a dependent.

In situations where you or your Spouse has coverage as an employee/member under more than one Plan, the order of benefits payable will be determined as follows:

- The Plan where the person is covered as an active full time employee, then;
- The Plan where the person is covered as an active part time employee, then;
- The Plan where the person is covered as a retiree.

For claims incurred by your Dependent Child:

The Plan covering the parent whose birthday (month/day) is earlier in the calendar year pays benefits first. If both parents have the same birth date, the Plan covering the parent whose first name begins with the earlier letter in the alphabet pays first.

However, if you and your Spouse are separated or divorced, the following order applies:

- The Plan of the parent with custody of the child, then;
- The Plan of the spouse of the parent with custody of the child (i.e. if the parent with custody of the child remarries or has a common-law spouse, the new spouse's Plan will pay benefits for the Dependent Child), then;
- The Plan of the parent not having custody of the child, then;
- The Plan of the spouse of the parent not having custody of the child (i.e. if the parent without custody of the child remarries or has a common-law spouse, the new spouse's Plan will pay benefits for the Dependent Child);
- A claim for accidental injury to natural teeth will be determined under Extended Health Care

Plans with accidental dental coverage before it is considered under Dental Plans;

- If the order of benefit payment cannot be determined from the above, the benefits payable under each Plan will be in proportion to the amount that would have been payable if Co- ordination of Benefits did not exist;
- If the insured person is also covered under an individual travel insurance plan, benefits will be coordinated in accordance with the guidelines provided by the Canadian Life and Health Insurance Association.

Submitting a Claim for Co-ordination of Benefits

To submit a claim when Co-ordination of Benefits applies, refer to the following guidelines:

- As per the Order of Benefit Payment section, determine which Plan is the Primary Carrier and which is the Secondary Carrier;
- Submit all necessary claim forms and original receipts to the Primary Carrier;
- Keep a photocopy of each receipt or ask the Primary Carrier to return the original receipts to you once your claim has been settled;
- Once the Primary Carrier has settled your claim, you will receive a statement outlining how your claim has been handled. Submit this statement along with all necessary claim forms and receipts to the Secondary Carrier for further consideration of payment, if applicable.

Drug Benefit For Québec Residents

If you and your dependents reside in Québec, the following provisions apply to your drug benefit coverage. The following expenses are covered:

- Drugs that are on the List of Insured Drugs that is published by the Régis de l'assurance-maladie du Québec (RAMQ List), provided such drugs are on the list at the time the expense is incurred; and;
- Drugs that are listed as a covered expense in this Benefit Booklet, but are not on the RAMQ List.

The following provisions apply only to the coverage of drugs that are on the RAMQ List. Coverage for all other drugs will be subject to the regular provisions included in this Booklet.

Benefit Percentage

Prior to the annual out-of-pocket maximum being reached, the percentage of covered drug expenses payable under this benefit will be as follows:

- For any drug on the RAMQ List which is not otherwise covered under the terms of this Benefit, the percentage payable at the time of claim, and;
- For any drug on the RAMQ List, which is covered under the terms of this Benefit, the percentage is the greater of: the benefit percentage stated under The Benefit; and the percentage at the time of claim.

After the annual out-of-pocket maximum has been reached, the percentage of covered drug expenses payable under this Benefit will be 100%.

Annual Out-of-Pocket Maximum

The annual out-of-pocket maximum is the portion of covered drug expenses, which must be paid by you and your spouse in a calendar year, before the percentage payable under this benefit will be 100%. Amounts that will be applied to the annual out-of-pocket maximum are:

- Deductible amounts, and;
- The portion of covered expenses that are paid by an insured person, when the percentage of covered expenses payable under this benefit is less than 100%.

The annual out-of-pocket maximum for you and your spouse is that determined by the RAMQ, including those portions of covered expenses paid for your dependent children.

For the purposes of calculating the out-of-pocket maximum for you and your spouse, dependent children are combined with the plan member.

Deductible

Deductible amounts, if any, for the drug benefit will apply, until the annual out-of-pocket maximum is reached. Thereafter, the deductible will not apply.

Lifetime Maximums

Lifetime maximums, if any, for the drug benefit will not apply. Drug coverage provided after the lifetime maximum stated under The Benefit is reached is subject to the following conditions:

- Only drugs that are on the RAMQ List are covered, and;
- The percentage payable by the insurer for covered expenses at time of claim.

Dependent Children

All unmarried children of the participant, of the spouse or of both, including the legally adopted children or those for whom the participant or the spouse exercises or would exercise, in the case of a minor, parental authority and whom the participant or the spouse supports and who is:

- Under age 21;
- Over age 21 but under age 25, being a full-time student in an accredited educational institution, subject to evidence to the satisfaction of the Insurer;
- Regardless of age, suffering from a severe, incurable and chronic physical or mental disability while meeting the requirements indicated above of a dependent child, rendering such child unable to pursue a substantially gainful occupation, subject to adequate medical evidence.

Subrogation (Third Party Liability)

The insurer retains the right to subrogation if benefits have or should have been paid or provided by a third party. In cases of third party liability, you must advise your lawyer of these rights.

Exclusions & Limitations

- Any Eligible Service, which is or would in the absence of benefits, have been provided gratuitously to a Participant or for which payment is made on behalf of the Participant by a

not-for-profit prepayment association, insurance carrier, third party administrator, like agency or a party other than the current claims provider, the Group or the Participant;

- Any Eligible Service which:
    a) is not provided by a health practitioner legally qualified to provide such Service; or
    b) is provided by a health practitioner whose license by the relevant provincial regulatory and/or professional association has been suspended or revoked; or
    c) is not provided by a designated Provider of Service in response to a prescription issued by a legally qualified health practitioner;
- Any Eligible Service prior to its provision to a Participant;
- Any service which is not an Eligible Service or that is otherwise excluded by the covered expenses;
- Any Eligible Service rendered in connection with a condition due to or arising out of any act of war, riot, or insurrection, including, but not limited to, any war declared or undeclared and armed aggression resisted by the armed forces of any country, combination of countries or international organizations, nor for any Eligible Service rendered while the Participant serves in the armed forces of any country;
- Any Eligible Service which arises out of, or is occasioned by, a criminal act of a Participant;
- Any Eligible Service provided or paid for by any governmental body, or agency, which is identical or similar to the Eligible Services set forth in the covered expenses:
    a) any workers' compensation board or tribunal; or
    b) any provincial health insurance plan; or
    c) any other governmental body or agency;
- Any service or supply that is identical or similar to any of the Eligible Services set forth in the covered expenses, which were previously provided or paid for by any governmental body or agency, but which have been modified, suspended or discontinued as result of changes in provincial health plan legislation or de-listing of any provincial health plan services or supplies;

- Any Eligible Service, including but not limited to, drugs, laboratory services, diagnostic testing or any other service which is identical or similar to any of the Eligible Services set forth in the covered expenses, which is provided by and/or administered in any public or private health care clinic or like facility, medical practitioner's office or residence, where the treatment or drug does not meet the accepted standards or is not considered to be effective (either medically or from a cost perspective, based on Health Canada's approved indication for use);
- Any Eligible Service which is identical or similar to any of the Eligible Services set forth in the covered expenses, which is provided by a medical practitioner who has opted out of any provincial health insurance plan and the provincial health insurance plan would have otherwise paid for such Eligible Service;
- Any part of the cost of an Eligible Service which is in excess of the lower of:
    a) the reasonable and customary charge for such Eligible Services; or
    b) the maximum with respect thereto as established in the covered expenses;
- Any Eligible Service for the treatment of congenital malformations or which are primarily for cosmetic or aesthetic purposes;
- Any Eligible Service rendered to a Participant in treatment of a self-inflicted injury whether or not the Participant is mentally incompetent;
- Any Eligible Service which is deemed to be experimental;
- Any Eligible Service rendered by a Provider of Service employed or engaged by an employer, mutual benefit association, fraternal or cooperative association, trustee, or similar person or group, other than services from a Provider of Service employed or engaged by a group under an employee assistance plan;
- Any drug or medicine which is not legally available for sale in Canada;
- Any Eligible Service that relates to treatment of injuries arising out of a motor vehicle accident;
- Any Eligible Service rendered to any Participant who has been removed from enrollment or any Eligible Service, for which the Participant has been deemed ineligible, by reason of practices in respect of claims or Eligible Services in which the Participant has in the opinion of the claims payment provider, been engaged that, in the opinion of the claims payment provider, are inappropriate or abusive;
- Any Eligible Service which, by law, the claims payment provider is prohibited from paying;
- Any specific treatment or drug or medicine which:
    a) does not meet accepted standards of medical, dental or ophthalmic practice or is not considered to be effective (either medically or from a cost perspective, based on Health Canada's approved indication for use);
    b) is an adjunctive drug prescribed in connection with any treatment or drug that is not an Eligible Service;
    c) will be administered in a hospital;
    d) is not dispensed by the pharmacist in accordance with the Benefit Plan;
    e) is not being used and/or administered in accordance with Health Canada's approved indication for use, even though such drug or procedure may customarily be used in the treatment of other illnesses or injuries; and
- Any cognitive or administrative services or other fees charged by a Provider of Service for services other than those directly relating to the delivery of the service or supply.

Survivor Benefit

If you die while your dependents are insured under this Group Benefit Program, the insurer will continue the benefits without payment of premium, until the earliest of:

- The date your dependent is no longer a dependent, according to the definition of dependent;
- The date similar coverage is obtained elsewhere;
- The date which is 2 years from your death, or;
- The date the Group Plan terminates. This benefit terminates at age 70.

Termination Age

At age 70 or retirement, whichever is earlier.

**Please refer to your Certificate of Insurance to see if this benefit applies to you.*

TRAVEL PLAN

Travel Medical Emergency Insurance

Emergency medical treatment of a sickness or injury which occurs while temporarily outside the province of residence, provided the insured person who receives the treatment is also covered by the Provincial Plan during the absence from the province of residence. A medical emergency is a sudden, unexpected injury, which occurs, or an unforeseen illness, which begins while an insured person is travelling outside their province of residence and requires immediate medical attention. Such emergency no longer exists when, in the opinion of the attending physician, the insured person is able to return to his province of residence.

Referral

Referral services paid to a maximum of $50,000 per calendar year.

If, while outside Canada on referral for medical treatment, the insured person requires treatment for a medical condition which is related directly or indirectly to the referral treatment, the total expenses payable for all treatments are subject to the maximum.

For all non-emergency medical treatment outside of Canada, the insurance provider requires:

- That it be recommended by a physician practicing in Canada, and;
- Prior to the commencement of any referral treatment, written pre-authorization must be obtained from your provincial health plan and the claims provider. You will then be advised of any benefit that will be provided.

Charges for the following are payable under this expense:

- Physician's services;
- Hospital room and board at semi-private rates;
- The cost of special hospital services;
- Hospital charges for out-patient treatment.

The amount payable for these expenses will be the reasonable and customary charges less the amount payable by the Provincial Plan or which would have been payable had proper application been made. Charges incurred outside the province of residence for all other Covered Extended Health Care Expenses are payable on the same basis as if they were incurred in the province of residence.

Quick Reference Numbers:	
Canada/United States	Toll Free: 1.800.936.6226
Outside Canada/United States	0.519.742.3556

Definitions

Unless specifically stated otherwise, the following definitions will apply throughout this booklet.

Calendar year means the 12 consecutive months January 1st to December 31st of each year.

Covered person means the plan member who has been enrolled in the plan or his or her enrolled dependents.

Dependent means

a) your spouse, if you are legally married or if not legally married, you have lived in a common-law relationship for more than 12 continuous months. Only one spouse will be considered at any time as being covered under the group contract;

b) your unmarried child under age 21;

c) your unmarried child under age 25, if enrolled and in full-time attendance in an accredited college, university or educational institute;

d) your unmarried child at any age, if totally disabled by reason of mental or physical disability and remains continuously disabled and is considered a dependant as defined under the Income Tax Act.

Your child (you or your spouse's natural, legally adopted or step children) must reside with you in a parent-child relationship or be dependent upon you (or both) and not regularly employed.

Children who are in full time attendance at an accredited school do not have to reside with you or attend school in your province. If the school is in another province, you must apply to your provincial health insurance plan for an extension of coverage to ensure your child continues to be covered under a provincial health insurance plan. (Please note that the limitations of the Travel plan still apply).

Injury means an unexpected or unforeseen event that occurs as a direct result of a violent, sudden and unexpected action from an outside source.

Plan member means you, when you are enrolled for coverage.

Reasonable and customary means in the opinion of Green Shield, the usual charge of the provider for the service or supply, in the absence of insurance, but not more than the prevailing charge in the area for a like service or supply.

Please refer to the back of your wallet card for your Travel Assistance Group # and emergency phone numbers.

This Travel Plan is incorporated into and forms part of the Group's Schedule of Eligible Benefits, which forms part of the Green Shield Canada Benefit Plan Group Agreement. The purpose of this booklet is to summarize the main provisions of the contract for your general guidance. If there are any discrepancies or omissions found in this booklet, the provisions of the master contract will apply as the final basis for the settlement of all claims.

Eligibility for coverage is subject to the Definitions outlined in the Green Shield Canada Benefit Plan Group Agreement and Administrative Policies.

Eligible travel benefits will be paid at 100% based on reasonable and customary charges in the area where they were received, less the amount payable by your provincial government health plan. “Reasonable and customary” is defined as the usual charge of the provider for the service or supply, in the absence of insurance, but not more than the prevailing charge in the area for a like service or supply.

All maximums and limitations stated are in Canadian currency. Reimbursement will be made in Canadian funds or U.S. funds for both providers and employees, based on the country of the payee. For payments that require currency conversion, the rate of exchange used will be the rate in effect on the date of service of the claim.

Eligible Benefits

Emergency services will be paid to a **maximum of $5,000,000 per calendar year**.

Referral services will be paid to a **maximum of $50,000 per calendar year**.

Reimbursement of eligible benefits for emergency services will be made only if the services were required as a result of emergency illness or injuries which occurred while you were vacationing or travelling for other than health reasons.

Upon notification of the necessity for treatment of an accidental injury or medical emergency **the patient must contact Green Shield Canada within 48 hours of commencement of treatment.**

- "Emergency" means a sudden, unexpected occurrence (disease or injury) that requires immediate medical attention. This includes treatment (non-elective) for immediate relief of severe pain, suffering or disease which cannot be delayed until you or your dependent is medically able to return to your province of residence.
- Any invasive or investigative procedures must be pre-approved by our Green Shield Canada Assistance Medical Team.

Eligible benefits are **limited to a maximum number of days per trip** (refer to your Certificate of Insurance) commencing with the date of departure from your province of residence. If you are hospitalized on the 30th day, benefits will be extended until the date of discharge.

1. **Hospital services and accommodation** up to a standard ward rate in a public general hospital.
2. **Medical/surgical services** rendered by a legally qualified physician or surgeon to relieve the symptoms of, or to cure an unforeseen illness or injury.
3. **Emergency Transportation**
    - **Land ambulance** to the nearest qualified medical facility.
    - **Air ambulance** – the cost of air evacuation (including a medical attendant when necessary) between hospitals and for hospital admission into Canada when approved in advance by your provincial government health plan or to the nearest qualified medical facility.
4. **Referral services** – (a) hospital services and accommodation, up to a standard ward rate in a public general hospital, and/or (b) medical surgical services rendered by a legally qualified physician or surgeon.
    - **Prior to the commencement of any referral treatment, written pre-authorization** from your provincial government health plan and Green Shield Canada **must be obtained.** Your provincial government health plan may cover this referral benefit entirely. You must provide Green Shield Canada with a letter from your attending physician stating the reason for the referral, and a letter from your provincial government health plan outlining their liability. **Failure to comply in obtaining pre-authorization will result in non-payment.**
5. **Services of a registered private nurse** up to a maximum of $5,000 per calendar year, at the reasonable and customary rate charged by a qualified nurse (R.N.) registered in the jurisdiction in which treatment is provided. You must contact Green Shield Canada for pre-approval.
6. **Diagnostic laboratory tests and x-rays** when prescribed by the attending physician. Except in emergency situations, Green Shield Canada must pre-approve these services (i.e. cardiac catheterization or angiogram, angioplasty and bypass surgery).

7. **Reimbursement of prescriptions** by Green Shield Canada for drugs, serums and injectables which require a prescription by law and are prescribed by a legally qualified medical practitioner (vitamins, patent and proprietary drugs are excluded). Submit to Green Shield Canada the original paid receipt from the pharmacist, physician or hospital outside your province of residence showing the name of the prescribing physician, prescription number, name of preparation, date, quantity and total cost.

8. **Medical appliances** including casts, crutches, canes, slings, splints and/or the temporary rental of a wheelchair when deemed medically necessary and required due to an accident which occurs, and when the devices are obtained outside your province of residence.

9. **Treatment by a dentist** only when required due to a direct accidental blow to the mouth up to a maximum of $2,000. Treatments (prior to and after return) must be provided within 90 days of the accident. Details of the accident must be provided to Green Shield Canada along with dental x-rays.

10. **Coming Home** – when your emergency illness or injury is such that:

    - our Assistance Medical Team specifies in writing that you should immediately return to your province of residence for immediate medical attention, reimbursement will be made for the extra cost incurred for the purchase of a one way economy airfare, plus the additional economy airfare if required to accommodate a stretcher, to return you by the most direct route to the major air terminal nearest the departure point in your province of residence.

      This benefit assumes that you are not holding a valid open-return air ticket. Charges for upgrading, departure taxes, cancellation penalties or airfares for accompanying family members or friends are not included.

    - our Assistance Medical Team or commercial airline stipulates in writing that you must be accompanied by a qualified medical attendant, reimbursement will be made for the cost incurred for one round trip economy airfare and the reasonable and customary fee charged by a medical attendant who is not your relative by birth or marriage and is registered in the jurisdiction in which treatment is provided, plus overnight hotel and meal expenses if required by the attendant.

11. **Cost of returning your personal use motor vehicle** to your residence or nearest appropriate vehicle rental agency when you are unable due to sickness, physical injury or death, up to a maximum of $1,000 per trip. We require original receipts for costs incurred, i.e. gasoline, accommodation and airfares.

12. **Meals and accommodation** up to $1,500 (maximum of $150 per day for up to 10 days) will be reimbursed for the extra costs of commercial hotel accommodation and meals incurred by you when you remain with a travelling companion or a person included in the "family" coverage, when the trip is delayed or interrupted due to an illness, accidental injury to or death of a travelling companion. This must be verified in writing by the attending legally qualified physician or surgeon and supported with original receipts from commercial organizations.

13. **Transportation to the bedside** including round trip economy airfare by the most direct route from your province of residence, for any one spouse, parent, child, brother or sister, and up to $150 per day for a maximum of 5 days for meals and accommodation at a commercial establishment will be paid for that family member to:

    - be with you or your covered dependent when confined in hospital. This benefit requires that the covered person must eventually be an inpatient for at least 7 days outside your province of residence, plus the written verification of the attending physician that the situation was serious enough to have required the visit.

    - identify a deceased prior to release of the body.

14. **Return airfare** if the personal use motor vehicle of you or your covered dependent is stolen or rendered inoperable due to an accident, reimbursement will be made for the cost of a one way economy airfare to return you by the most direct route to the major airport nearest your departure point in your province of residence. An official report of the loss or accident is required.

15. **Return of deceased** up to a maximum of $5,000 toward the cost of embalming or cremation in preparation for homeward transportation in an appropriate container of yourself or your covered dependent when death is caused by illness or accident. The body will be returned to the major airport nearest the point of departure in your province of residence. The benefit excludes the cost of a burial coffin or any funeral-related expenses, makeup, clothing, flowers, eulogy cards, church rental, etc.

Travel Assistance Service

The following services are available 24 hours per day, 7 days per week through Green Shield Canada's international medical service organization. These services include:

- Access to Pre-trip Assistance (prior to departure): Canada Direct Calling Codes; information about vaccinations; government issued travel advisories; and VISA/document requirements for entry into country of destination
- Multilingual Assistance
- Assistance in locating the nearest, most appropriate medical care
- International preferred provider networks
- Our Assistance Medical Team’s consultative and advisory services, including second opinion and review of appropriateness and analysis of the quality of medical care
- Assistance in establishing contact with family, personal physician and employer as appropriate
- Monitoring of progress during treatment and recovery
- Emergency message transmittal services
- Translation services and referrals to local interpreters as necessary
- Verification of insurance coverage facilitating entry and admissions into hospitals and other medical care providers
- Special assistance regarding the co-ordination of direct claims payment
- Co-ordination of embassy and consular services
- Management, arrangement and co-ordination of emergency medical transportation and evacuation as necessary
- Management, arrangement and co-ordination of repatriation of remains
- Special assistance in making arrangements for interrupted and disrupted travel plans resulting from emergency situations to include:
    - the return of unaccompanied travel companions
    - travel to the bedside of a stranded person
    - rearrangement of ticketing due to accident or illness and other travel related emergencies
    - the return of a stranded personal use motor vehicle and related personal items
- Knowledgeable legal referral assistance

- Co-ordination of securing bail bonds and other legal instruments
- Special assistance in replacing lost or stolen travel documents including passports
- Courtesy assistance in securing incidental aid and other travel-related services
- Emergency and payment assistance for major health expenses which would result in payments in excess of $200

Here's How Travel Assistance Service Works

For assistance dial 1-800-936-6226 within Canada and the United States or call collect 0-519-742-3556 when travelling outside Canada and the United States. These numbers appear on your Green Shield Identification Card.

Quote the Green Shield Canada travel assist group number and your Green Shield Identification Number, found on your Green Shield Identification Card, and explain your medical emergency. You must always be able to provide your Green Shield Identification Number and your provincial government health plan number.

A multilingual Assistance Specialist will provide direction to the best available medical facility or legally qualified physician able to provide the appropriate care.

Upon admission to a hospital or when consulting a legally qualified physician or surgeon for major emergency treatment, we will guarantee the provider (hospital, clinic or physician), that you have both provincial government health coverage and Green Shield Canada travel benefits as detailed above.

The provider may then bill Green Shield Canada directly for these approved services for amounts in excess of $200.

Our Assistance Medical Team will follow your progress to ensure that you are receiving the best available medical treatment. These physicians also keep in constant communication with your family physician and your family, depending on the severity of your condition.

When calling collect while travelling outside Canada and the United States, you may require a Canada Direct Calling Code. In the event that a collect call is not possible, keep your receipts for phone calls made to Green Shield Canada's Travel Assistance Service and submit them for reimbursement upon your return to Canada.

Limitations

1. Benefits will be eligible only if existing or pre-diagnosed conditions are completely stable and you are fit to travel (in the opinion of Green Shield Canada's Assistance Medical Team) at the time of departure from your province of residence. Green Shield reserves the right to review your medical information at the time of claim.
2. The eligible benefits must be required for the immediate relief of acute pain or suffering as recommended by a legally qualified physician or surgeon. Eligible benefits will not be reimbursed for treatment or surgery which could reasonably be delayed until you return to your province of residence.
3. Reimbursement for eligible benefits will be made only if your provincial government health plan covers and provides payment toward the cost of the services received.
4. Coverage becomes effective at the time you or your dependent crosses the provincial border departing from your province of residence and terminates upon crossing the border returning to your province of residence on the return home. If travelling by air, coverage becomes effective at the time the aircraft takes off in the province of residence and terminates when the aircraft lands in the province of residence on the return home.

5. Upon notification of the necessity for treatment of an accidental injury or medical emergency, Green Shield Canada Travel reserves the right to determine whether repatriation is appropriate if the patient's medical condition will require immediate or scheduled care. Such repatriation is mandatory, where the Assistance Medical Team determines that the patient is medically fit to travel and appropriate arrangements have been made to admit the patient into the provincial health care system of their province of residence. Repatriation will ensure continued coverage under the plan. Should the patient opt not to be repatriated or elects to have such treatment or surgery outside their province of residence, the expense of such continuing treatment will not be an eligible benefit.

   The patient must contact Green Shield Canada within 48 hours of commencement of treatment.

   Failure to notify us within 48 hours may result in benefits being limited to only those expenses incurred within the first 48 hours of any and each treatment/incident or the plan maximum, whichever is the lesser of the two.

6. Air ambulance services will only be eligible if:

   - they are pre-approved by Green Shield Canada
   - there is a medical need for you or your dependent to be confined to a stretcher or for a medical attendant to accompany you during the journey, and
   - you or your dependent are admitted directly to a hospital in your province of residence, and
   - medical reports or certificates from the dispatching and receiving legally qualified physicians are submitted to Green Shield Canada, and
   - proof of payment (including air ticket vouchers or air carrier invoices) is submitted to Green Shield Canada.

7. If planning to travel in areas of political or civil unrest, contact Green Shield Canada for pre-travel advice as we may be unable to guarantee assistance services.

8. Green Shield Canada reserves the right without notice, to suspend, curtail or limit its services and eligible benefits in any area in the event of political or civil unrest, including rebellion, riot, military uprising, labour disturbance or strike, act of God, or refusal of authorities in a foreign country to permit Green Shield Canada to provide service.

9. No services shall be provided during any trip undertaken for the purpose of seeking medical treatment or advice unless pre-authorized as outlined in referral services.

Exclusions

In addition to the General Exclusions found under the General Information section of your contract, Eligible Benefits do not include and reimbursement will not be made for:

1. Treatment or service required for ongoing care, rest cures, health spas, elective surgery, check-ups or travel for health purposes, even if the trip is on the recommendation of a physician.
2. Treatment or service which you elect to have performed outside Canada when the medical condition would not prevent your return to Canada for such treatment.
3. Treatment or service required as a result of suicide, attempted suicide, intentionally self-inflicted injury of you, a travelling companion, or immediate family member while sane or insane.
4. Amounts paid or payable under any Workplace Safety Insurance Board or similar plan.
5. Hospital and medical care for childbirth occurring within 8 weeks of the expected delivery date from the date of departure, or deliberate termination of pregnancy.
6. Treatment or service provided in a chronic care or psychiatric hospital, chronic unit of a general hospital, Long Term Care (LTC) facility, health spa or nursing home.
7. Services received from a chiropractor, chiropodist, podiatrist or for osteopathic manipulation.
8. Cataract surgery or the purchase of eyeglasses or hearing aids.
9. Green Shield Canada does not assume responsibility for nor shall it be liable for any medical advice given, but not limited to a physician, pharmacist or other healthcare provider or facility recommended by Green Shield Canada.

Claiming Information

Green Shield Canada must be contacted by phone within 48 hours of commencement of treatment.

Call our Customer Service Centre at 1-888-711-1119 for detailed claims submission instructions.

If you have incurred out of pocket expenses, claims must be submitted together with supporting original receipts to Green Shield Canada who will then coordinate with the provincial plan reimbursement of those approved, eligible expenses.

To make a claim, submit the patient name, provincial health plan number, address and Green Shield Identification Number with a detailed statement showing the services rendered and the fees charged for each service.

All claims must be received by Green Shield Canada no later than 12 months from the date the eligible service was incurred.

Termination Age

At age 70 or retirement, whichever is earlier.

Before You Travel/FAQ's

Before you travel, please take a moment to familiarize yourself with the following FAQs regarding your Travel Plan.

Q. What insurance documents do I need to take with me when I travel?
A. Always have your Green Shield ID card with you, along with a copy of your travel booklet to reference all the phone numbers you may require.

Q. Who is Green Shield Canada's Travel Assistance provider?
A. Allianz Global Assistance is the international medical service organization that Green Shield Canada has arranged to facilitate their travel claims processing. All of Green Shield Canada's out-of-province/Canada claims are adjudicated and managed by Allianz Global Assistance, the undisputed worldwide leader in travel insurance and assistance. Allianz Global Assistance deals directly with provincial plans and ensures that all liabilities are properly assessed. They have a 24/7 toll-free Call Centre that provides assistance to callers in over 20 languages, 365 days a year.

Q. What do I do if I have a medical emergency while outside of my province of residence? What number do I call?
A. First and foremost, evaluate your emergency. If your emergency requires immediate medical assistance, call for an ambulance (911 if available where you are located). Once you arrive at the hospital, have a family member contact Green Shield Canada Travel Assistance to open a case. The toll-free number is 1-800-936-6226. If the toll-free number doesn't work, you can use the collect number: operator+519-742-3556. If your emergency is one that does not require urgent medical assistance, contact Green Shield Canada Travel Assistance to open a case prior to seeking medical treatment. When contacting Green Shield Canada Travel Assistance, quote the group number and the Green Shield Canada ID number on your card.

Q. Why do I need to contact Green Shield Canada Travel Assistance anyway?
A. If you contact Green Shield Canada Travel Assistance prior to seeking treatment, they can assist you in finding a clinic/hospital closest to your area that can provide the best medical treatment appropriate for your condition. They can contact the hospital or clinic in advance to let them know that you are coming in, and where possible, make billing arrangements for direct payment of the medical bills. If you are admitted to a hospital, they will make billing arrangements, manage your care to ensure that all procedures performed will be covered under your plan, and, if necessary, make arrangements to have you returned home to Canada for continued medical treatment. Green Shield Canada Travel Assistance maintains contact with the treating physicians, case workers and nurses to evaluate your condition.

Q. How long does it take to open a case when I call?
A. Typically it will take 10-15 minutes to open a case. During the case opening process, Green Shield Canada Travel Assistance will require you to answer some brief medical questions, provide your home and travelling contact numbers, certificate number, group number, and date of birth. Claim forms are required to be completed in order to process your claims for the medical emergency, and will be sent to you once your eligibility has been confirmed.

Q. Am I assigned a case worker to be my main contact?
A. As complications may occur at any time of the day, all of the medical staff and case managers need to access your file to assist at any time. You can call 1-866-222-0427 for updates regarding your emergency. Please note that upon case opening, if you wish for a family member to have access to your medical updates regarding your case, you must provide authorization. Due to privacy laws, we cannot disclose personal information without prior consent.

Q. What pre-trip assistance can Green Shield Canada Travel Assistance provide?
A. One of the most important items provided would be international dialing codes for the location you are travelling to. With the proper dialing code, you will be able to easily contact Green Shield Canada Travel Assistance should an emergency arise. If you have any questions regarding health benefits before you travel, Green Shield Canada Travel Assistance can assist. Green Shield Canada Travel Assistance can break down the process of opening a claim and what to expect. They can also advise you of any Canadian Trip Advisories that are issued to the country you are visiting and provide some useful tips to remember, such as bringing your Green Shield ID card.

Q. What can I do to help the claim payment process?
A. Insurance coverage is intended to supplement Government Health Insurance Plan (GHIP) coverage, and claim reimbursement is dependent on the service being a GHIP approved benefit. All original bills and supporting documentation must be sent to GHIP under the GHIP approved regulations. A common delay is following up on these bills after the plan member has already come home. If you are incurring a claim in the United States, it is helpful to obtain a UB92 or HCFA which will assist in processing your claim faster. When you seek treatment at a clinic/hospital, be sure to tell the facility that you have emergency travel coverage. Green Shield Canada Travel Assistance requires itemized billing statements as well as your discharge summaries, otherwise a wait time of up to four weeks can ensue. In all cases, please make every effort to obtain copies of all documentation. This may help expedite or support the information being received by Green Shield Canada Travel Assistance. Complete your claim forms right away and forward them to Green Shield Canada Travel Assistance.

Q. Assuming my claim was properly submitted, what is the standard turnaround time for reimbursements?
A. If all documents are complete and received, there is a ten business day processing time line (up to cheque printing time – does not include any mailing delays).

Q. If there is a problem with my claim, how will I be notified?
A. If Allianz Global Assistance requires any further documentation they will issue a letter request. If you call for an update you will be instructed at that time what is required. Some items like proper original bills will be followed up on by the claims team on behalf of the plan member.

Q. I have only a partial reimbursement. What now?
A. You should receive an Explanation of Benefits Statement that will explain why you only received a partial reimbursement. Items may not have been covered under your policy. Part of the items may be covered under your regular benefits and would be forwarded to Green Shield Canada to issue payment. Some of the bills may have been processed while others need original bills and Green Shield Canada Travel Assistance is following up. If you receive partial reimbursement and have questions, you can call the claims department for a more detailed explanation at 1-800-363-1835.

Q. Green Shield Canada said they have paid all of the bills relating to my medical emergency, however I received a bill from a collection agency. Why?
A. If you receive a bill from a collection agency, do not worry. Contact the Green Shield Canada Travel Assistance claims department at 1-800-363-1835 immediately. They will contact the facility and the collection agency and have this rectified. This sometimes happens because billing departments are not located within the medical facility or are a separate service. There are also times when a payment has been made to the medical facility, but this information has not yet reached the billing department.

VISION CARE

Benefit

- Eye exams as per your Certificate of Insurance;
- Purchase and fitting of prescription glasses or elective contact lenses, as well as repairs, to a maximum per your Certificate of Insurance;
- If contact lenses are required to treat a severe condition, or if vision in the better eye can be improved to a 20/40 level with contact lenses but not with glasses, the maximum payable as per your Certificate of Insurance;
- Visual training, to a maximum of $200 per lifetime;
- Laser eye surgery to a maximum of prescription glasses or elective contact lenses as per your Certificate of Insurance.

Benefit Maximum

Please refer to your Certificate of Insurance.

Termination Age

At age 70 or retirement, whichever is earlier.

**Please refer to your Certificate of Insurance to see if this benefit applies to you.*

DENTAL CARE

General Description

Dental care coverage pays for eligible expenses that are incurred for dental procedures provided by a licensed dentist, denturist, dental hygienist and anaesthetist while you are covered by this group plan.

For each dental procedure, reasonable and customary charges will be covered. Payments will be based on the Dental Association Fee Guide for general practitioners in the province where the employee lives at the time treatment is received. If you reside in Alberta, the current Fee Guide is considered to be the 1997 Alberta Dental Association Fee Guide for General Practitioners plus an inflationary adjustment.

Benefits

Level I - Basic Services

- One complete oral exam during any 3 calendar years;
- Full-mouth X-rays during any 2 calendar years;
- One unit of light scaling and one unit of polishing, or prophylaxis (light scaling and polishing), when the service is performed in Québec; recall frequency as per your Certificate of Insurance;
- Recall exams, bitewing X-rays, and fluoride treatments; recall frequency as per your

Certificate of Insurance;

- Routine diagnostic and laboratory procedures;
- Initial oral hygiene instruction, plus one recall;
- Fillings, retentive pins and pit and fissure sealants;
- Pre-fabricated full coverage restorations (stainless steel crowns) for primary teeth only, excluding crowns of porcelain fused to metal, acrylic, plastic, gold, porcelain and other substances;
- Space maintainers (appliances placed for orthodontic purposes are not covered);
- Minor surgical procedures and post surgical care;
- Extractions (including impacted and residual roots);
- Consultations and conscious sedation;
- Denture repairs, relines and rebases;
- Injection of antibiotic drugs when administered by a Dentist in conjunction with dental surgery.

Level II - Supplementary Services

- Surgical procedures not included in Level I (excluding implant surgery);
- Periodontal scaling not covered under Level I, and root planing, up to a combined maximum per your Certificate of Insurance:
- Provisional splinting;
- Occlusal equilibration, up to a maximum of 8 units per calendar year;
- Endodontic services, which include root canals and therapy, root amputation, apexifications and periapical services.

Level III - Dentures

- Initial provision of full or partial removable dentures;
- Replacement of removable standard dentures, provided the dentures are required because:
- A natural tooth is extracted and the existing appliance cannot be made serviceable;
- The existing appliance is at least 60 months old; or
- The existing appliance is temporary and is replaced with the permanent dentures within 12 months of its installation.
- Dentures required solely to replace a natural tooth, which was missing prior to becoming insured for this covered expense are not covered.

Level IV - Major Restorative Services

- Crowns and onlays when the function of a tooth is impaired due to cuspal or incisal angle damage caused by trauma or decay;
- Initial provision of fixed bridgework;
- Replacement of bridgework, provided the new bridgework is required because:
- A natural tooth is extracted and the existing appliance cannot be made serviceable;
- The existing appliance is at least 60 months old, or;
- The existing appliance is temporary and is replaced with the permanent bridge within

12 months of its installation;

- Bridgework required solely to replace a natural tooth, which was missing prior to becoming insured for this covered expense is not covered.

**For breakdown of co-insurance or to see if this applies to you, please refer to your Certificate of Insurance.*

Level V - Orthodontics

- Orthodontic services, for dependent children only, provided treatment commences prior to reaching age 19.

**For breakdown of co-insurance, or to see if this applies to you, please refer to your Certificate of Insurance.*

Deductible

Nil.

Benefit Percentage

Please refer to your Certificate of Insurance.

Benefit Maximums

Please refer to your Certificate of Insurance.

Late Applicant Limitation

If you or your dependents become insured for dental benefits more than 31 days after you first become eligible to apply, the amount payable in the first 12 months of coverage will be limited to $250 for each insured person.

Submitting a Claim

This program gives you the ability to submit your claim electronically, as long as you present your dentist with your wallet card.

To submit a paper claim, you and your dentist must complete a Dental Claim form, which is available from Western Financial Group Insurance Solutions' web site (www.westernfgis.ca). Once the form has been completed, submit it to claims provider.

All claims must be received within 12 months after the date the expense was incurred. However, upon termination of your insurance, all claims must be received no later than 90 days from the termination date.

Pre-Determination

If the cost of any proposed dental treatment is expected to exceed $300, Western Financial Group Insurance Solutions suggests that you submit a detailed Pre-Authorization, available from your dentist, before the treatment begins. You can then be advised of the amount you are entitled to receive under this benefit.

Dental Fee Guide

Current Fee Guide for General Practitioners for your Province of Residence, unless you reside in Alberta.

Alternate Treatment

Where any two or more courses of treatment covered under this benefit would produce professionally adequate results for a given condition, the insurer will pay benefits as if the least expensive course of treatment were used. The insurer will determine the adequacy of the various courses of treatment available, through a professional dental consultant.

Co-ordination of Benefits

If you or your dependents are insured for similar benefits under another Plan, Western Financial Group Insurance Solutions will take this into account when determining the amount of expenses payable under this program.

This process is known as Co-ordination of Benefits. It allows for reimbursement of insured dental expenses from all plans, up to a total of 100% of the actual expenses incurred.

Plan means:

- Other Group Benefit Programs;
- Any other arrangement of coverage for individuals in a group;
- Individual travel insurance plans.

Plan does not include school insurance or Provincial Plans.

Order of Benefit Payment

A variety of circumstances will affect which Plan is considered as the “Primary Carrier” (i.e. responsible for making the initial payment toward the eligible expense), and which Plan is considered as the “Secondary Carrier” (i.e. responsible for making the payment to cover the remaining eligible expense):

- If the other Plan does not provide for Co-ordination of Benefits, it will be considered as the Primary Carrier, and will be responsible for making the initial payment toward the eligible expense;
- If the other Plan does provide for Co-ordination of Benefits, the following rules are applied to determine which Plan is the Primary Carrier.

For Claims Incurred by You or Your Dependent Spouse:

- The Plan insuring you or your Dependent Spouse as an employee/member pays benefits before the Plan insuring you or your Spouse as a dependent.

In situations where you or your Spouse has coverage as an employee/member under more than one Plan, the order of benefit payable will be determined as follows:

- The Plan where the person is covered as an active full time employee, then;
- The Plan where the person is covered as an active part time employee, then;
- The Plan where the person is covered as a retiree.

For Claims Incurred by Your Dependent Child:
The Plan covering the parent whose birthday (month/day) is earlier in the calendar year pays benefits first. If both parents have the same birth date, the Plan covering the parent whose first name begins with the earlier letter in the alphabet pays first. However, if you and your Spouse are separated or divorced, the following order applies:

- The Plan of the parent with custody of the child, then;
- The Plan of the spouse of the parent with custody of the child (i.e. if the parent with custody of the child remarries or has a common-law spouse, the new spouse's Plan will pay benefits for the Dependent Child), then;
- The Plan of the parent not having custody of the child, then;
- The Plan of the spouse of the parent not having custody of the child (i.e. if the parent without custody of the child remarries or has a common-law spouse, the new spouse's Plan will pay benefits for the Dependent Child);
- A claim for accidental injury to natural teeth will be determined under Extended Health Care Plans with accidental dental coverage before it is considered under Dental Plans;
- If the order of benefit payment cannot be determined from the above, the benefits payable under each Plan will be in proportion to the amount that would have been payable if Co-ordination of Benefits did not exist;
- If the insured person is also covered under an individual travel insurance plan, benefits will be co-ordinated in accordance with the guidelines provided by the Canadian Life and Health Insurance Association.

Submitting a Claim for Co-ordination of Benefits
To submit a claim when Co-ordination of Benefits applies, refer to the following guidelines:

- As per the Order of Benefit Payment section, determine which Plan is the Primary Carrier and which is the Secondary Carrier;
- Submit all necessary claim forms and original receipts to the Primary Carrier;
- Keep a photocopy of each receipt or ask the Primary Carrier to return the original receipts to you once your claim has been settled;
- Once the Primary Carrier has settled your claim, you will receive a statement outlining how your claim has been handled. Submit this statement along with all necessary claim forms and receipts to the Secondary Carrier for further consideration of payment, if applicable.

Payment of Claims
Once the claim has been processed, you will be sent an Explanation of Benefits. This statement provides the information that may be required for tax purposes (the information provided on a receipt) as well as any deductibles, maximums, or co-payments applied to the payment of your claim. This statement can also be used to submit Co-ordination of Benefit (COB) claims.

Subrogation (Third Party Liability)

If your expenses result from an injury caused by another person and you have the legal right to recover damages, the insurer may request that you complete a subrogation reimbursement agreement when you submit a claim for such expenses.

On settlement or judgement of your legal action, you will be required to reimburse the insurer those amounts you recover which, when added to the payments you received from the insurer, do not exceed 100% of your incurred expenses.

Exclusions & Limitations

- Any Eligible Service, which is or would in the absence of benefits, have been provided gratuitously to a Participant or for which payment is made on behalf of the Participant by a not-for-profit prepayment association, insurance carrier, third party administrator, like agency or a party other than the current claims provider, the Group or the Participant;

- Any Eligible Service which:

    a) is not provided by a health practitioner legally qualified to provide such Service; or

    b) is provided by a health practitioner whose license by the relevant provincial regulatory and/or professional association has been suspended or revoked; or

    c) is not provided by a designated Provider of Service in response to a prescription issued by a legally qualified health practitioner;

- Any Eligible Service prior to its provision to a Participant;
- Any service which is not an Eligible Service or that is otherwise excluded by the covered expenses;
- Any Eligible Service rendered in connection with a condition due to or arising out of any act of war, riot, or insurrection, including, but not limited to, any war declared or undeclared and armed aggression resisted by the armed forces of any country, combination of countries or international organizations, nor for any Eligible Service rendered while the Participant serves in the armed forces of any country;
- Any Eligible Service which arises out of, or is occasioned by, a criminal act of a Participant;
- Any Eligible Service provided or paid for by any governmental body, or agency, which is identical or similar to the Eligible Services set forth in the covered expenses:

    a) any workers' compensation board or tribunal; or

    b) any provincial health insurance plan; or

    c) any other governmental body or agency;

- Any service or supply that is identical or similar to any of the Eligible Services set forth in the covered expenses, which were previously provided or paid for by any governmental body or agency, but which have been modified, suspended or discontinued as result of changes in provincial health plan legislation or de-listing of any provincial health plan services or supplies;
- Any Eligible Service, including but not limited to, drugs, laboratory services, diagnostic testing or any other service which is identical or similar to any of the Eligible Services set forth in the covered expenses, which is provided by and/or administered in any public or private health care clinic or like facility, medical practitioner's office or residence, where the treatment or drug does not meet the accepted standards or is not considered to be effective (either medically or from a cost perspective, based on Health Canada's approved indication for use);
- Any Eligible Service which is identical or similar to any of the Eligible Services set forth in the covered expenses, which is provided by a medical practitioner who has opted out of any provincial

health insurance plan and the provincial health insurance plan would have otherwise paid for such Eligible Service;

- Any part of the cost of an Eligible Service which is in excess of the lower of:

  a) the reasonable and customary charge for such Eligible Services; or

  b) the maximum with respect thereto as established in the covered expenses;

- Any Eligible Service for the treatment of congenital malformations or which are primarily for cosmetic or aesthetic purposes;
- Any Eligible Service rendered to a Participant in treatment of a self-inflicted injury whether or not the Participant is mentally incompetent;
- Any Eligible Service which is deemed to be experimental;
- Any Eligible Service rendered by a Provider of Service employed or engaged by an employer, mutual benefit association, fraternal or cooperative association, trustee, or similar person or group, other than services from a Provider of Service employed or engaged by a group under an employee assistance plan;
- Any Eligible Service that is a dental service and is not contained within one of the procedure codes developed and maintained from time to time by the Canadian Dental Association and adopted by the provincial or territorial dental association of the province or territory in which the service is provided and in effect at the time of providing such service (where a dental service has been provided outside Canada, the applicable procedure code shall be that one developed by the Canadian Dental Association and adopted and in effect at the time by the provincial or territorial dental association of the province or territory in which the Participant resides at the time the service is provided);
- Any Eligible Service that relates to treatment of injuries arising out of a motor vehicle accident;
- Any Eligible Service rendered to any Participant who has been removed from enrollment or any Eligible Service, for which the Participant has been deemed ineligible, by reason of practices in respect of claims or Eligible Services in which the Participant has in the opinion of the claims payment provider, been engaged that, in the opinion of the claims payment provider, are inappropriate or abusive;
- Any Eligible Service which, by law, the claims payment provider is prohibited from paying;
- Any cognitive or administrative services or other fees charged by a Provider of Service for services other than those directly relating to the delivery of the service or supply.

Survivor Benefit

If you die while your dependents are insured under this Group Benefit Program, the insurer will continue the Dental Care benefits without payment of premium, until the earliest of:

- The date your dependent is no longer a dependent, according to the definition of dependent;
- The date similar coverage is obtained elsewhere;
- The date which is 2 years from your death, or;
- The date the Group Plan terminates. This benefit terminates at age 70.

Termination Age

At age 70 or retirement, whichever is earlier.

**Please refer to your Certificate of Insurance to see if this benefit applies to you.*

EMPLOYEE OPTIONAL LIFE INSURANCE

General Description

Your Life coverage provides a benefit for your beneficiary if you die while covered. The amount of your Life coverage shown on the Certificate of Insurance in effect on the date of your death will be paid when the Insurer receives due written proof of death.

Beneficiary

If you die while covered, the Insurer will pay the full amount of your benefit to your last named beneficiary on file with Western Financial Group Insurance Solutions.

If you have not named a beneficiary, the benefit amount will be paid to your estate. Anyone can be your beneficiary. You can change your beneficiary at any time, unless a law prevents you from doing so or you indicate that the beneficiary is not to be changed by filing a new designation form. The change will be effective on the date the form is signed, but if will not apply to any payment made by the Insurer prior to the date the form is received by the Insurer.

Benefit Amount

Increments of $25,000, to a maximum of $250,000.

Non-Evidence Limit

All amounts are subject to Evidence of Insurability.

Waiver of Premium

If you become Totally Disabled while insured prior to age 65 and meet the Entitlement Criteria outlined below, your Insurance will continue without payment of premium, after the elimination period of 180 days.

Definition of Totally Disabled

Totally Disabled means a restriction or lack of ability due to an illness or injury which prevents you from performing the essential duties of any occupation for which you are qualified or may reasonably become qualified by training, education or experience.

The availability of work will not be considered by the insurer in assessing your disability.

If you must hold a government permit or license to perform the essential duties of your job, you will not be considered Totally Disabled solely because your permit or license has been withdrawn or not renewed.

Entitlement Criteria

To be entitled to Waiver of Premium, you must meet the following criteria:

- You must be continuously Totally Disabled throughout the Elimination Period. If you cease to be Totally Disabled during this period and then become disabled again within 3 weeks due to the same or related illness or injury, your Elimination Period will be extended by the numberof days during which you ceased to be Totally Disabled;
- The insurer must receive medical evidence documenting how your illness or injury causes restrictions or lack of ability, such that you are prevented from performing the essential duties of any occupation for which you are qualified, or may reasonably become qualified by training, education or experience;
- You must be receiving from a physician, regular, ongoing care and treatment appropriate for your disabling condition, as determined by the insurer.

At any time, the insurer may require you to submit to a medical, psychiatric, psychological, educational and/or vocational examination or evaluation by an examiner selected by them.

Termination of Waiver of Premium

Your Waiver of Premium will cease on the earliest of:

- The date you cease to be Totally Disabled, as defined under this benefit;
- The date you do not supply the insurance carrier with appropriate medical evidence documenting how your illness or injury causes restrictions or lack of ability, such that you are prevented from performing the essential duties of any occupation for which you are qualified, or may reasonably become qualified, by training, education or experience;
- The date you are no longer receiving from a physician, regular, ongoing care and treatment appropriate for the disabling condition, as determined by the insurer;
- The date you do not attend an examination by an independent expert chosen by the insurer;
- The end of the month following the date of your 65th birthday;
- The date of your death.

Recurrent Disability

If you become Totally Disabled again from the same or related causes as those for which premiums were previously waived and such disability recurs within 6 months of cessation of the Waiver of Premium benefit, the insurer will waive the Elimination Period.

Your amount of insurance on which premiums were previously waived will be reinstated.

If the same disability recurs more than 6 months after cessation of the Waiver of Premium benefit, such disability will be considered a separate disability.

Two disabilities, which are due to unrelated causes, are considered separate disabilities if they are separated by a return to work of at least one day.

Submitting A Claim

To submit a claim, your beneficiary must complete the Life Claim form, and upon completion of the form, proof of death documents should be attached and the form returned to Western Financial Group Insurance Solutions.

A completed claim form must be submitted within 90 days from the date of the loss.

To submit a claim for the Waiver of Premium you must complete a Waiver of Premium claim form, which is available from Western Financial Group Insurance Solutions. Your attending physician must also complete a portion of this form.

A completed claim form must be submitted within 90 days from the end of the Elimination period.

Conversion Privilege

If your Employee Benefits terminate or reduce, you may be eligible to convert your Employee Optional Life Insurance to an individual policy, without medical evidence. You must apply for the individual policy, and pay the first monthly premium within 31 days of the termination of your Employee Optional Life Insurance. If you die during this 31 day period, the amount of Employee Optional Life Insurance available for conversion will be paid to your beneficiary estate, even if you didn't apply for conversion.

For more information on the Conversion Privilege, please call us at 1-800-665-8990.

Exclusions

If death results from suicide any amount of Optional Life Insurance that has been in effect for less than one year will not be payable.

Termination Age

At age 70 or retirement, whichever is earlier.

**Please refer to your Certificate of Insurance to see if this benefit applies to you.*

SPOUSAL OPTIONAL LIFE INSURANCE

General Description

If your Spouse dies while insured, the amount of this benefit will be paid to you. The amount of Life coverage shown on the Certificate of Insurance in effect on the date of death will be paid when the Insurer receives due written proof of death.

Beneficiary

You are the beneficiary of your Spouse's benefit.

Benefit Amount

Increments of $25,000, to a maximum of $250,000.

Non-Evidence Limit

All amounts are subject to Evidence of Insurability.

Waiver of Premium

If you become Totally Disabled while insured prior to age 65 and meet the Entitlement Criteria outlined below, the Insurance will continue without payment of premium, after the elimination period of 180 days.

Definition of Totally Disabled

Totally Disabled means a restriction or lack of ability due to an illness or injury which prevents you from performing the essential duties of any occupation for which you are qualified or may reasonably become qualified by training, education or experience.

The availability of work will not be considered by the insurer in assessing your disability.

If you must hold a government permit or license to perform the essential duties of your job, you will not be considered Totally Disabled solely because your permit or license has been withdrawn or not renewed.

Entitlement Criteria

To be entitled to Waiver of Premium, you must meet the following criteria:

- You must be continuously Totally Disabled throughout the Elimination Period. If you cease to be Totally Disabled during this period and then become disabled again within 3 weeks due to the same or related illness or injury, your Elimination Period will be extended by the number

of days during which you ceased to be Totally Disabled;

- The insurer must receive medical evidence documenting how your illness or injury causes restrictions or lack of ability, such that you are prevented from performing the essential

duties of any occupation for which you are qualified, or may reasonably become qualified by training, education or experience;

- You must be receiving from a physician, regular, ongoing care and treatment appropriate for your disabling condition, as determined by the insurer.

At any time, the insurer may require you to submit to a medical, psychiatric, psychological, educational and/or vocational examination or evaluation by an examiner selected by them.

Termination of Waiver of Premium

Your Waiver of Premium will cease on the earliest of:

- The date you cease to be Totally Disabled, as defined under this benefit;
- The date you do not supply the insurer with appropriate medical evidence documenting how your illness or injury causes restrictions or lack of ability, such that you are prevented from performing the essential duties of any occupation for which you are qualified, or may reasonably become qualified, by training, education or experience;
- The date you are no longer receiving from a physician, regular, ongoing care and treatment appropriate for the disabling condition, as determined by the insurer;
- The date you do not attend an examination by an independent expert chosen by the insurer;
- The end of the month following the date of your 65th birthday;
- The date of your death.

Recurrent Disability

If you become Totally Disabled again from the same or related causes as those for which premiums were previously waived and such disability recurs within 6 months of cessation of the Waiver of Premium benefit, the insurer will waive the Elimination Period.

Your amount of insurance on which premiums were previously waived will be reinstated.

If the same disability recurs more than 6 months after cessation of the Waiver of Premium benefit, such disability will be considered a separate disability.

Two disabilities, which are due to unrelated causes, are considered separate disabilities if they are separated by a return to work of at least one day.

Submitting A Claim

To submit a claim, you must complete the Life Claim form, and upon completion of the form, proof of death documents should be attached and the form returned to Western Financial Group Insurance Solutions.

A completed claim form must be submitted within 90 days from the date of the loss.

To submit a claim for the Waiver of Premium you must complete a Waiver of Premium claim form, which is available from Western Financial Group Insurance Solutions. Your attending physician must also complete a portion of this form.

A completed claim form must be submitted within 90 days from the end of the Elimination period.

Conversion Privilege

If your Employee Benefits terminate or reduce, you may be eligible to convert Spousal Optional Life Insurance to an individual policy, without medical evidence. You must apply for the individual policy, and pay the first monthly premium within 31 days of the termination. If your spouse dies during this 31 day period, the amount of Spousal Optional Life Insurance available for conversion will be paid to you, even if you didn't apply for conversion.

For more information on the Conversion Privilege, please call: 1-800-665-8990.

Exclusions

If death results from suicide any amount of Optional Life Insurance that has been in effect for less than one year will not be payable.

Termination Age

At age 70 or retirement, whichever is earlier.

**Please refer to your Certificate of Insurance to see if this benefit applies to you.*

EMPLOYEE OPTIONAL ACCIDENTAL DEATH AND DISMEMBERMENT

General Description

If you sustain an accidental injury while insured and suffer a loss specified in the Schedule of Losses below, this benefit provides financial assistance to you or your beneficiary. In the event of your death, the benefit is payable to your beneficiary. If your beneficiary dies before you or if there is no designated beneficiary, this benefit is payable to your estate. For losses other than Loss of Life, the benefit is payable to you.

Benefit Amount

Increments of $25,000 to a maximum of $250,000.

Schedule of Losses

The losses covered by this benefit must:

- be caused directly and independently of any other cause, by bodily injuries resulting exclusively from external, violent and accidental means;
- be a direct result of the accidental injury;
- occur within 365 days from the date of the accidental injury;
- be total and irreversible or irrecoverable.

In the case of loss of speech or hearing, or loss of use of an arm, hand or leg, the loss must be continuous for 12 months and determined to be permanent, after which time the benefit is payable.

The amount payable for each loss is a percentage of your Accidental Death and Dismemberment benefit amount, which was in effect as of the date of the injury.

- Loss of Life - 100%
- Loss of Both Hands or Both Feet or Sight of Both Eyes - 100%
- Loss of Sight of Both Eyes - 100%
- Loss of One Hand and One Foot - 100%
- Loss of One Hand or One Foot and Loss Sight of One Eye - 100%
- Loss of Hearing in Both Ears and Speech - 100%
- Loss of One Arm or One Leg - 75%
- One Hand or One Foot or Loss of Sight of One Eye or Speech or Hearing in Both Ears - 66.67%
- Loss of Thumb and Index Finger or at least Four Fingers of the Same Hand - 33.33%
- Loss of All Toes of One Foot - 25%
- Loss of Hearing in One Ear - 25%
- Hemiplegia, Paraplegia, or Quadriplegia - 200%

The word "loss" means:

- For a hand or foot, total, permanent and irrecoverable loss of use of the limb or amputation at the wrist or ankle, or above;
- For a leg or arm, total, permanent and irrecoverable loss of use of the limb or amputation at the knee or elbow, or above;
- For the thumb and index finger, total, permanent and irrecoverable loss of use of the digit or amputation at the joint between the hand and the digit;
- For sight, hearing or speech, total, permanent and irrecoverable loss of sight, hearing in both ears or of speech.

Exposure and Disappearance

If a loss occurs due to unavoidable exposure to the elements, after a conveyance in which you were travelling made a forced landing, or was lost, wrecked, stranded or sunk, a benefit will be payable for that loss. The amount payable will be determined in accordance with the Schedule of Losses. If you disappear after a conveyance in which you were travelling made a forced landing, or was lost, wrecked, stranded or sunk, a benefit for loss of life will be payable if your body is not found within 365 days after the incident occurred.

Evidence and Examinations

Evidence of the loss must be submitted to the Insurer within 90 days of the date of the loss, failing which no benefit is payable. The Insurer is entitled to have the participant examined and, as the case may be, have an autopsy performed within the limits of the law.

Waiver of Premium

If you become Totally Disabled while insured prior to age 65 and meet the Entitlement Criteria outlined below, your Insurance will continue without payment of premium, after the elimination period of 180 days.

Exclusions

No benefit is payable for a loss attributable directly or indirectly, in whole or in part, to any of the following causes:

- Suicide, attempted suicide or self-inflicted injuries, whether the participant was sane or insane at the time;
- Perpetration or attempted perpetration by the participant of a crime or his participation in a crime;
- The participant's active participation in a riot or insurrection;
- War or civil war, whether declared or undeclared;
- Active service in the armed forces of any country;
- A flight in any aircraft or flying machine when the participant is a member of the crew or carries out any duty in regard to such flight;
- Injuries which exhibit no visible wound or contusion on the outside of the body (except drowning and internal injuries revealed by surgery or autopsy), poisoning, intoxication or drug use.

Termination Age

The earlier of attained age 70, or retirement.

FAMILY OPTIONAL ACCIDENTAL DEATH AND DISMEMBERMENT

General Description

If one of your dependents sustains an accidental injury while insured and suffer a loss specified in the Schedule of Losses below, this benefit provides financial assistance to you or your beneficiary. In the event of your death, the benefit is payable to your beneficiary. If your beneficiary dies before you or if there is no designated beneficiary, this benefit is payable to your estate. For losses other than Loss of Life, the benefit is payable to you.

Benefit Amount

Increments of $25,000 to a maximum of $250,000.

Schedule of Losses

The losses covered by this benefit must:

- be caused directly and independently of any other cause, by bodily injuries resulting exclusively from external, violent and accidental means;
- be a direct result of the accidental injury;
- occur within 365 days from the date of the accidental injury;
- be total and irreversible or irrecoverable.

In the case of loss of speech or hearing, or loss of use of an arm, hand or leg, the loss must be continuous for 12 months and determined to be permanent, after which time the benefit is payable.

The amount payable for each loss is a percentage of your Accidental Death and

Dismemberment benefit amount, which was in effect as of the date of the injury.

- Loss of Life - 100%
- Loss of Both Hands or Both Feet or Sight of Both Eyes - 100%
- Loss of Sight of Both Eyes - 100%
- Loss of One Hand and One Foot - 100%
- Loss of One Hand or One Foot and Loss Sight of One Eye - 100%
- Loss of Hearing in Both Ears and Speech - 100%
- Loss of One Arm or One Leg - 75%
- One Hand or One Foot or Loss of Sight of One Eye or Speech or Hearing in Both Ears - 66.67%
- Loss of Thumb and Index Finger or at least Four Fingers of the Same Hand - 33.33%
- Loss of All Toes of One Foot - 25%
- Loss of Hearing in One Ear - 25%
- Hemiplegia, Paraplegia, or Quadriplegia - 200%

The word "loss" means:

- For a hand or foot, total, permanent and irrecoverable loss of use of the limb or amputation at the wrist or ankle, or above;
- For a leg or arm, total, permanent and irrecoverable loss of use of the limb or amputation at the knee or elbow, or above;
- For the thumb and index finger, total, permanent and irrecoverable loss of use of the digit or amputation at the joint between the hand and the digit;
- For sight, hearing or speech, total, permanent and irrecoverable loss of sight, hearing in both ears or of speech.

Exposure and Disappearance

If a loss occurs due to unavoidable exposure to the elements, after a conveyance in which you or one of your dependents were travelling made a forced landing, or was lost, wrecked, stranded or sunk, a benefit will be payable for that loss. The amount payable will be determined in accordance with the Schedule of Losses. If you or one of your dependents disappear after a conveyance in which you were travelling made a forced landing, or was lost, wrecked, stranded or sunk, a benefit for loss of life will be payable if your body is not found within 365 days after the incident occurred.

Evidence and Examinations

Evidence of the loss must be submitted to the Insurer within 90 days of the date of the loss, failing which no benefit is payable. The Insurer is entitled to have the participant examined and, as the case may be, have an autopsy performed within the limits of the law.

Waiver of Premium

If you become Totally Disabled while insured prior to age 65 and meet the Entitlement Criteria outlined below, your Insurance will continue without payment of premium, after the elimination period of 180 days.

Exclusions

No benefit is payable for a loss attributable directly or indirectly, in whole or in part, to any of the following causes:

- Suicide, attempted suicide or self-inflicted injuries, whether the participant was sane or insane at the time;
- Perpetration or attempted perpetration by the participant of a crime or his participation in a crime;
- The participant's active participation in a riot or insurrection;
- War or civil war, whether declared or undeclared;
- Active service in the armed forces of any country;
- A flight in any aircraft or flying machine when the participant is a member of the crew or carries out any duty in regard to such flight;
- Injuries which exhibit no visible wound or contusion on the outside of the body (except drowning and internal injuries revealed by surgery or autopsy), poisoning, intoxication or drug use.

Termination Age

The earlier of attained age 70, or employee's retirement.

LEGISLATIVE AMENDMENTS

Legislative Amendments effective July 1, 2012 affecting individual life, group and A & S policies.

While the changes in legislation apply only to policies sold in Alberta and British Columbia, revisions are being made to all policies referencing these changes. Other provinces are in the process of implementing similar provisions.

Beneficiary

This policy contains a provision removing or restricting the right of the group person insured to designate persons to whom or for whose benefit insurance money is to be payable.

Limitation of Action

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 (Alberta and B.C.).

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 (Manitoba).

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 Limitations Act, 2002 (Ontario).

Otherwise, in Quebec every action must be brought within three (3) years after the date evidence is furnished, and in all other provinces within one (1) year from the date of loss or such longer period as may be required under the law applicable in such province.

Insured Right of Access

As required by your provincial legislation, or if you reside in Alberta or B.C., the Insured Person and any claimant may request a copy of the Insured Person's application, any written evidence of insurability and the Group Policy (other than confidential commercial information or other information exempted from disclosure by applicable law).

PRIVACY ACT

PIPEDA

By Act of Parliament, the Federal Government of Canada passed the Personal Information Protection and Electronic Documents Act (PIPEDA), commonly referred to as Bill C-6, to deal with the issue of protecting personal information. Initially the Act applied to federally regulated private sector businesses (e.g. federal corporations, banking and telecommunications). Effective January 1, 2004 the Act applied more broadly (other than where provinces and territories have passed substantially similar legislation), to every private sector organization engaged in commercial activities in respect to how personal information is collected, used and disclosed in the course of its regular business activities.

What Does This Mean?

An organization must comply with a series of obligations and be accountable for compliance to ten principles set out in Schedule 1 of the Act (www.privcom.gc.ca). The office of the Privacy Commissioner is empowered to receive, investigate and remedy complaints where warranted.

Western Financial Group Insurance Solutions' Commitment to Privacy Protection

Protecting the privacy and confidentiality of personal information has always been fundamental to the way we do business and is the responsibility of every employee of Western Financial Group Insurance Solutions during the course of providing products and services to our clients. The range of products and services we offer our groups and benefit plan participants continues to expand along with the technology we use for their delivery and storage. No matter how our business changes, we remain committed to protecting and respecting your right to privacy and confidentiality.

With particular reference to PIPEDA, we have reviewed and where needed, revised our current privacy policies and information handling procedures, having developed a Privacy Code which appears below. This to further safeguard the use and handling of essential personal information obtained with the express consent of our clients and only for the purpose for which consent was granted when this information was collected.

The Personal Information Protection and Electronic Documents Act (PIPEDA), came into effect for insurers on January 1, 2004.

You are assured that Western Financial Group Insurance Solutions is focused on respecting your privacy and maintaining confidentiality of information to the extent we have safeguards in place to protect your personal, business, and financial information which adheres to the Ten Privacy Principles as covered by the PIPEDA (www.privcom.gc.ca).

Principle 1 - Accountability
Principle 2 - Identifying Purposes
Principle 3 - Consent
Principle 4 - Limiting Collection
Principle 5 - Limiting Use, Disclosure and Retention
Principle 6 - Accuracy
Principle 7 - Safeguarding Customer Information
Principle 8 - Openness
Principle 9 - Customer Access
Principle 10 - Handling Customer Complaints and Suggestions

The collection of personal information is important; it is limited to the details that are needed to provide our programs and services that best meet your needs and to assess your future needs. Most of that information is obtained from you, but it might also come from other third parties. By example, information about you may be used:

- For ongoing customer service and other contact matters;
- In connection with our offering and delivery of products and services;
- To obtain claims history;
- To prevent fraud;
- To share or exchange reports and information with any corporation or enterprise with whom you have a financial relationship;
- For billing and accounting services related to your business activity with Western Financial Group Insurance Solutions;
- To comply with legal and regulatory requirements.

Personal information is collected only for its intended purpose and is not disclosed to any other parties without consent of the individual.

If you would like further information about privacy and security, please contact us at privacy@westernfg.ca. In addition you may request this information by writing to our corporate office at the following address:

Western Financial Group Insurance Solutions
201-600 Empress Street
Winnipeg, Manitoba R3G 0R5
Attention: Privacy Officer

There is no charge to access your information unless you request copies of records, in which case you will be advised in advance. If you find that your information is inaccurate or incomplete, we will make changes to our records accordingly.

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