AUSU Health & Dental Plan

(GroupBenefitz Platform)

POLICY# 815082 | CLASS A

GROUP BENEFITS PLAN BOOKLET

Equitable Life of Canada®

Policy #815082

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

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

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

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

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

Sincerely,

The Group benefits team

Call toll-free: 1.800.265.4556

IMPORTANT

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

08/23 – EH

Protecting your privacy

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

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

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

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

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

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

Chief Privacy Officer

One Westmount Road North

P. O. Box 1603, Station Waterloo

Waterloo, On

N2J 4C7

Telephone 1.800.265.8878

Facsimile 519.883.7425

Email: privacyofficer@equitable.ca

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Group benefits contact list

Group benefits administration

General policy Inquiries, personal information changes & web support

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

Dental claims

Dental claim inquiries

Hours of operation:	**Contact:**
8:15AM – 7:00PM EST	group-dental-claims@equitable.ca
6:15AM – 5:00PM MST	Toll free: 1.800.265.4556 ex 601
5:15AM – 4:00PM PST	Fax: 1.888.505.4373

Health claims

Health claim inquiries

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

Travel Assist 24 hour helpline

Within Canada & U.S.A: 1.800.321.9998 | Elsewhere Call Collect: 519.742.3287

Equitable Life fraud hotline

(Anonymous Call) Phone: 1.800.265.8899

EquitableHealth.ca

Health and wellness solutions that matter™

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

HealthConnector – Supporting your health:

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

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

Homewood Health – Improving Life:

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

Plan member web services through EquitableHealth.ca

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

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

Use EZClaim online for fast claim submission!

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

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

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

Homewood Health is a registered trademark of Schlegel Health Care Inc.
® ™ denote a trademark of The Equitable Life Insurance Company of Canada unless otherwise indicated.

Schedule of benefits

The Plan described in this booklet is effective as of September 1, 2024.

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

IMPORTANT NOTE

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

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

Protecting you from fraud

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

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

Classification(s)

- Class A: All eligible plan members

General information

Maximum age for dependent children

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

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

Co-habitation requirement for partners

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

- None

Maximum age for coverage

(Also refer to 6. "When does your insurance terminate" in the General provisions):

- All benefits terminate on your 70th birthday.

Waiting period:

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

- Nil

Plan member and dependent health benefits

Deductible amount per prescription for the drug plan:

nil

Deductible amount per calendar year for all other benefits:

nil

Reimbursement percentage (up to reasonable and customary charges):

Drug plan: 80%

Major services: 80% except 100% for Services outside the province (#7 under Major services)

Travel assist: 80%

Vision care services: 80%

Benefits:

Pay-direct drug plan #50GA

Claim payment type: Electronic submission at the pharmacy

Note: This is a mandatory generic pricing plan. The maximum that will be reimbursed is an amount equal to the lowest priced alternative drug in accordance with Equitable Life of Canada's adjudication practices at the time of claim.

An alternative drug includes but is not limited to:

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

(ii) a subsequent entry biologic.

Maximum per insured person per calendar year: $2,000

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

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

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

Major services:

Major services, including travel assist

Vision care

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

- Eye glasses or contact lenses or laser eye surgery: maximum $200
    - This maximum applies in any period of 12 months for both adults and dependent children.
- Special contact lenses (#3 on the Vision care page): Maximum: $300
    - This is a lifetime maximum per insured person.
- Eye examinations: maximum: reasonable and customary charges
    - One eye examination is eligible in any period of 24 months for both adults and dependent children.

Summary of health benefit maximums:

The following maximums apply to the drug plan:

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

Maximum for fertility drugs:

not eligible

Maximum for smoking cessation products:

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

not eligible

Maximum for other specified drugs:

Maximum for oral erectile dysfunction drugs: not eligible

Maximum for weight loss drugs: not eligible

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

Maximum for vaccines and immunizations:

not eligible

The following maximums apply to items covered under major services:

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

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

#1 Maximum payable for convalescent home services:

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

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

$10,000 per insured person per calendar year

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

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

Extremity pumps for lymphedema: $1,000 lifetime maximum

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

Laryngeal speaking aids: reasonable and customary charges

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

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

Stump socks: 6 pairs per calendar year

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

Transcutaneous nerve stimulator (TENS): $500 lifetime maximum

Viscosupplementation: 3 injections per knee lifetime maximum

Wheelchairs (electric or manual) $1,000 lifetime maximum

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

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

Surgical brassieres: two per insured person per calendar year

#4(e) Maximum for hearing aids:

$500 per insured person in any period of 60 consecutive months

Hearing aid batteries are not eligible.

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

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

$350 per insured person per calendar year for orthopaedic shoes and orthotics combined

#4(h) Maximum for wigs and hairpieces

(required as a result of a medical condition):

$200 lifetime maximum per insured person

#4(i) Maximum for glucometers:

$175 per insured person in any period of 48 consecutive months

#4(j) Maximum for diagnostic laboratory procedures:

$500 per insured person per calendar year

#6 Maximum of $800 per insured person per calendar year for all of the following Paramedical services combined:

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

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

#7 Services outside the province:

Time limit for commencement of emergency treatment *(see #7 (b) under Major services)*:

- 30 days

Lifetime maximum amount per insured person

(see 7. What are the overall maximum amounts?" in the health general provisions)**:**

Unlimited, except there is a $1,000,000 lifetime maximum for services received outside the plan member's province of residence.

Plan member and dependent dental benefits

Deductible amount per calendar year:

- nil

Type A - Basic services.

Recall examination period:

- once in any period of 6 months (Note: This is 6 months from the last paid checkup.)

This Dental plan includes the following Basic services options:

- Space maintainers
- Major surgical services
- Periodontal services
- Maximum units* for periodontal scaling and root planing combined: 8 units per calendar year.
  *one unit is equivalent to 15 minutes
- Endodontic services
- Denture repair services

Reimbursement percentage:

- Type A: 70%

Maximum amount:

- Annual calendar year maximum for Type A: $750

Dental fee guide:

For all plan members:

- The current Dental association fee guide for the province or territory of residence of the plan member.
-

Survivor benefit

For the following benefits only: Health and dental

Maximum period for survivor benefit is the earlier of:

- 24 months, or
- the date that the dependent's coverage would have terminated had you lived.

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

General provisions

1. WHO IS ELIGIBLE TO JOIN THE GROUP PLAN?

   You're eligible if you:

   - live in Canada, and
   - have provincial health care coverage in your province of residence, and
   - belong in one of the Classifications shown in the Schedule of insured benefits, and
   - do not reside in the province of Quebec, and
   - are not eligible for other government sponsored health and dental benefits other than provincial health care coverage; and
   - are enrolled as a student at Athabasca University.

2. WHEN AM I ELIGIBLE TO JOIN THE GROUP PLAN - IS THERE A WAITING PERIOD?

   You are eligible to apply for coverage under this group plan after you have served the **waiting period** shown in the Schedule of insured benefits.

3. HOW DO YOU JOIN?

   - Complete the required application form.
   - We must receive your application form **before** (but **not later than 31 days** after) you become eligible to join the group plan.

   Important: If we don't receive your form within the 31 days, you will not be eligible to join the plan.

4. WHEN DOES YOUR INSURANCE COVERAGE BECOME EFFECTIVE?

   You'll be given a **wallet card** showing the effective date of your entry into the group plan.

   You must be insured under this group plan to be eligible for any benefits.

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

   Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the *Insurance act* or other applicable legislation. With respect to disagreements with a notice of decline or termination of Short or Long Term Disability claims, you may appeal by submitting additional medical information within 60 days of the date of our notice.

6. WHEN DOES YOUR INSURANCE TERMINATE?

   Your insurance terminates on the earlier of the following dates:

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

General provisions for dependents

1. WHO ARE ELIGIBLE DEPENDENTS?

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

Your spouse. This means:

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

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

Your child. This means:

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

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

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

Your permanently developmentally or physically disabled child. This means:

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

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

2. HOW TO APPLY TO COVER YOUR DEPENDENTS

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

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

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

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

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

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

3. WHEN DOES COVERAGE FOR YOUR DEPENDENTS BECOME EFFECTIVE?

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

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

4. WHEN DOES COVERAGE FOR YOUR DEPENDENTS TERMINATE?

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

Health benefits

General provisions

1. DESCRIPTION OF THIS BENEFIT

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

2. WHAT IS THE "DEDUCTIBLE AMOUNT"?

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

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

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

3. WHAT IS THE "REIMBURSEMENT PERCENTAGE"?

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

4. WHAT IS CONSIDERED AN APPROPRIATE TREATMENT?

   A treatment is considered to be appropriate if it is:

   a) accepted by the Canadian medical profession; and

   b) medically necessary; and

   c) proven to be effective; and

   d) used for a Health Canada approved indication; and

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

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

5. WHAT IS MEANT BY PRIOR AUTHORIZATION?

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

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

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

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

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

Claims for your dependent children should be submitted as follows:

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

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

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

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

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

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

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

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

7. WHAT ARE THE OVERALL MAXIMUM AMOUNTS?

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

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

8. DEFINITIONS

Practitioners:

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

Paramedical practitioners:

- "Chiropractor", "Naturopath", "Osteopath" and "Speech therapist" means a person who holds a degree from a recognized school.
- "Registered massage therapist" means a person who is a member of the applicable Provincial association of masseurs or a person who has a valid state/territory massage therapy license issued in the United States of America and who is classified as a Registered massage therapist.

- "Master of social work (MSW)" means a person who has a Master's degree in social work.
- "Physiotherapist" and "Podiatrist (Chiropodist)" means a member of the Canadian association or any applicable affiliated provincial association.
- "Psychologist" means a permanently certified psychologist with a doctor's degree in psychology.
- "Specialist in Acupuncture" means a person allowed to perform acupuncture under the laws of the applicable province and who is recognized as a specialist by the Company.

Other practitioners:

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

‘Reasonable and customary charges’ means:

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

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

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

Province of Residence:

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

‘Medical care’ means:

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

9. WHAT HAPPENS IF YOUR HEALTH BENEFITS TERMINATE?

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

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

10. WHAT IS NOT COVERED?

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

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

b) active participation in a riot, rebellion or insurrection

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

d) committing or attempting to commit a criminal offence

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

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

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

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

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

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

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

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

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

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

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

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

q) anaesthesia, blood and blood plasma

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

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

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

u) an expense for a service, supply, product, treatment or drug may be limited or not payable at the discretion of Equitable Life if alternative funding is available through a government or other patient support program including situations where such funding exists for an alternative appropriate treatment. Upon request by Equitable Life, you or your dependent shall provide evidence satisfactory to Equitable Life that available alternative funding through a government or other patient support program has been pursued by you or your dependent, and a decision regarding such funding has been rendered by the government or patient support program. Until such satisfactory evidence is provided, the expense may not be eligible for coverage under this Policy and no benefit may be paid as determined by Equitable Life.

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

w) any services, supplies, products, treatments or drugs that require prior authorization may be ineligible if the service, supply, product, treatment or drug has not been approved by Equitable Life of Canada

x) No benefits are payable under the Health Benefits of the Policy for any services, appliances, supplies, products or treatments listed on the Equitable Life's Schedule of Services, Appliances, Supplies, Products

and Treatments Not Eligible for Coverage (the “Product Schedule”). Should there be any inconsistency between the limitation in this sub-paragraph and any other provision or benefit in the Policy, or any inconsistency between the Product Schedule and any other provision or benefit in the Policy, the limitation in this sub-paragraph and the Product Schedule shall prevail in all circumstances.

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

PAY-DIRECT DRUG PLAN #50 Managed Care Plan based on Ontario Provincial Formulary

1. WHAT IS COVERED SUBJECT TO THE EXCLUSIONS?

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

   b) Selected over-the-counter and prescription-requiring medications, which have been assigned a valid Drug Identification Number (DIN) by Health Canada and are listed in the most current edition of the Ontario Provincial Formulary are eligible, with the exception of those drugs listed in the Exclusion section.

   c) Selected natural health products, which have been assigned a valid natural product number (NPN) by Health Canada and are listed in the most current edition of the Ontario Provincial Formulary are eligible, with the exception of those products listed in the Exclusion section.

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

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

   f) Selected products from within the following classes of non-prescription requiring drugs are eligible: Acne preparations, analgesics, antacids, antidiarriheals, antifungals, antihistamines, antinauseants, antipsoriatics, antiseptics, cough & cold preparations, digestants, laxatives, mucolytic agents, muscle relaxants, pediculocides, potassium supplements, scabicides, calcium supplements, fluorides, iron supplements, topical corticosteroids, topical emollients, and vasodilating nitrates.

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

2. MAXIMUM SUPPLY

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

3. EXCLUSIONS:

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

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

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

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

e) Prescriptions dispensed by a physician, clinic, dentist or in any non-accredited hospital pharmacy, or for treatment as an inpatient or outpatient in a hospital including emergency status and investigational status drugs are not eligible.

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

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

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

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

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

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

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

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

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

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

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

q) All 'Limited Use" drugs in the Ontario Provincial Formulary are not eligible.

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

4. SERVICES OUTSIDE THE PROVINCE

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

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

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

5. HOW TO SEND IN A CLAIM?

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

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

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

6. CLAIMS

IMPORTANT: If your insurance terminates, or if the Drug Benefit under this Policy terminates, or if this Group Policy terminates, all claims incurred prior to the date of termination must be received by the Company within 90 days of the date of termination.

Major services

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

1. CONVALESCENT HOME SERVICES

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

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

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

Services are eligible as long as:

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

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

2. AMBULANCE SERVICES

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

3. PRIVATE DUTY NURSING CARE SERVICES (PDN)

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

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

4. APPLIANCES AND SUPPLIES

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

a) reasonable and customary charges for the rental of:

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

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

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

The following is not eligible:

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

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

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

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

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

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

Custom made means the fabrication of the footwear/orthotics must include the creation of a 3-dimensional cast unique to the person's feet and must be constructed using 100% raw materials that use the 3-dimensional cast to create the footwear/orthotics. Measurements of the cast do NOT meet the requirement of being custom made.

In addition, the footwear/orthotics must be prescribed to accommodate bony and structural abnormalities of feet and/or lower legs resulting from trauma, disease or congenital deformities subject to the Maximum for Orthopaedic Shoes and Orthotics shown in the summary of Health Benefit Maximums.

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

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

The following is required for proper claim review:

- A medical referral must be provided from a physician, podiatrist or chiropodist, and include the diagnosis or medical condition necessitating the product;
- The paid receipt should show the name, credentials and college registration number of the person who dispensed the custom made product;

- The technique/process used for casting your foot (the casting method used must be three dimensional to be considered a custom made product);
- A description of how the foot orthotic or custom made shoe was constructed including what raw materials were used; (please include a description of the modifications made to the shoes including a breakdown of the costs and the brand name and model of the shoe); and
- The contact information of the laboratory where the custom made product was manufactured. The invoice must indicate the name of the patient and shipment date or date of completion.

g) reasonable and customary charges for oxygen (with a physician's prescription).

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

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

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

5. DENTAL ACCIDENT

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

Treatment must be completed within 365 days of the accident.

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

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

6. PARAMEDICAL SERVICES

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

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

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

7. SERVICES OUTSIDE THE PROVINCE

Reasonable and customary charges for eligible expenses incurred outside the plan member's province of residence, provided:

a) The services are covered under the plan member's provincial health care plan.

b) The services are for emergency treatment (see the definition of "emergency treatment" on the following page) for an injury or illness which occurs within the number of days shown under time limit for commencement of emergency treatment shown in the Summary of health benefit maximums after the insured person begins a temporary absence from the plan member's province of residence, or

c) The services (or similar services) are not available in the plan member's province of residence but they are available elsewhere in Canada. If the services aren't available in Canada, services performed outside Canada will be eligible. In either case, we require the written referral of the insured person's regular physician in the province of residence and confirmation from the provincial health care plan that the services are not available in that province and prior written approval has been granted by the provincial government and the Company.

“Emergency” means a sudden, unexpected, acute illness or accidental injury that requires immediate, medically necessary treatment, prescribed by a doctor. An emergency ends when the insured person is deemed medically stable to return to their province of residence. When an insured person has a chronic condition, emergency services do not include treatment provided as part of an established management program that existed prior to the person leaving their province of residence.

The following expenses are eligible for reimbursement, subject to reasonable and customary charges for the services in the geographical area where the expense is incurred. Any part of the expenses that are covered by a provincial health care plan will be deducted from the amount payable under your group plan:

a) services by a physician or surgeon

b) charges for daily room and board in a public ward of a hospital (or for a semi-private or private room if shown in the Schedule of insured benefits); the maximum payable for any period of disability is 180 days of confinement

c) hospital charges for medically necessary services and supplies for an in-patient, as long as these charges aren't included in the daily room and board rate; the maximum payable for any period of disability is an amount equal to 30 times the hospital's standard public ward rate

d) professional ambulance services (including air ambulance if medically necessary) to the nearest hospital where the required treatment can be provided

e) other charges for out-of-province services are included only up to the amount that would have been payable under this group plan if the service had been performed in the plan member's province of residence.

In addition to Health benefits, General Provisions, 10. What is not covered, the following limitations and exclusions apply to Services outside the province:

a) No benefit is payable under the out-of-province services for services performed in a country for which the Canadian government or World Health Organization (WHO) issued a travel warning or restriction indicating to avoid all travel or non-essential travel prior to the insured’s entry into the country.

b) No benefit is payable for any injury sustained by the insured person in the following circumstances or situations:

   i) While participating in a sport or activity for remuneration or where monetary prizes are awarded to the winners; or

   ii) While participating in any kind of motor vehicle or any other form of motorized competition, speed event or other high risk activity involving the use of a motorized vehicle or apparatus on land, water or air, including training activities, whether on approved tracks or elsewhere; or

iii) While participating in any kind of dangerous or violent sport or activity such as but not limited to: off track snow sports; show jumping obstacles, rock or mountain climbing, parachuting, gliding, hang gliding, paragliding, kitesurfing, skydiving, bungee jumping, canyoning, spelunking, rodeo, mountain biking, scuba diving (outside the limits of current certification) or any activity with a high level of physical stress or risk involved; or

iv) While participating in any sport or activity that requires a waiver to be signed to participate. This clause does not apply to sports or activities that are normally offered to the general public without specialized training or qualifications.

Please contact your out of province travel assist provider for travel assistance or to confirm coverage before or during your trip. The number is provided on your wallet card or in the Group benefits contact list at the beginning of this booklet.

c) No benefit is payable for injury that results from flight in any aircraft if the insured person has any duties relating to such aircraft or flight, or is flying in the course of aviation training or instruction, or in training or manoeuvres in the Armed Services.

d) No benefit is payable for non-emergency treatment or treatment which is not medically necessary.

e) No benefit is payable for claims incurred by the insured person while they are operating a motorized vehicle under the influence of alcohol, drugs, or other substances and is deemed impaired and/or over the legal limit in the location the insured person was in at the time of the incident which resulted in the claim.

f) No benefit is payable for claims incurred related to pregnancy or delivery including infant care after the 34th week of pregnancy, or at any time during the pregnancy if the insured person's medical history indicates a higher than normal risk of any early delivery or pregnancy related complications.

g) No benefit is payable for continuing treatment, a recurrence, or complication related to an injury or illness incurred while an insured person is travelling outside of their province of residence, if the insured person has been assessed as medically fit for travel by a physician or other health care professional and refuses to return to their province of residence.

Benefits are not payable under the out-of-province services for services performed outside Canada if the insured person lives outside Canada, except as shown below.

A dependent child will be eligible only for emergency treatment (see the definition of "emergency treatment" above) for an injury or disease which occurs while the child is a student outside Canada. The student must be enrolled in and attending an accredited educational institution on a full-time basis for the purpose of attaining a post-secondary degree or diploma. The following provisions apply:

a) We will require a letter from the post-secondary institution at the beginning of each school term confirming the enrolment and attendance of the student. A school term will include a co-op work term placement outside Canada which is part of the degree or diploma program.

b) We will require a letter from the provincial health care plan of the student's province of residence confirming that coverage for the student will continue under that plan while the student is attending school outside Canada.

c) The student must immediately contact the Travel assist provider when an eligible expense is incurred while outside Canada. The telephone numbers for the Travel assist provider are shown in the Travel assist section of this booklet and on the wallet card.

d) Except for drugs, the emergency services must be eligible under the provincial health care plan of the student's province of residence.

e) The provisions of the policy will apply, including the limitations and exclusions, except for the out-of-province time limit for commencement of emergency treatment shown on the Summary of health benefit maximums.

f) The student is covered only during the school term.

g) Coverage is not provided during holidays or student absences during or between school terms that are longer than one month.

h) Coverage will not be provided if the dependent child is a student in a country that is deemed to be high risk for travel on the date the school term begins.

In all cases, payment for services performed outside Canada will be in Canadian dollars at the exchange rate in-force on the date the claim and all supporting information has been received by the Company's head office in Waterloo, Ontario.

8. HOW TO SEND IN A CLAIM

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

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

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

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

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

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

Major services – travel assist

"Insured traveller" means you or your eligible dependent, provided the person is covered for Health benefits under this group plan and meets the conditions for coverage outside the province as described in 7. Services outside the province under the Major services.

1. ASSISTANCE SERVICES
    a) access to multilingual help by telephone, telex and fax 24 hours a day, 365 days a year for both the insured traveller and the medical service provider
    b) required emergency referral to a physician, dentist or appropriate medical facility
    c) if the insured traveller is hospitalized, the Travel assist provider's medical staff will contact the patient's attending physician to monitor the care and services being given and will, if necessary, contact the patient, the attending physician, and the patient's personal physician and family
    d) referrals to a local legal advisor and, when necessary, help in arranging a cash advance from credit cards or funds from family and friends to post bail and pay legal fees
    e) assistance in replacing necessary travel documents or tickets that have been lost or stolen (the cost of replacement is the responsibility of the insured traveller)
    f) emergency telephone interpretation services in most major languages
    g) exchange of emergency messages between the insured traveller and his/her family (messages are held up to 15 days)
    h) trying to ensure that the insured traveller is not obligated to pay hospital charges or medical fees by:
    i) co-ordinating payment (where possible) directly by the appropriate provincial health care plan and the Company, or
        I. making payment to the medical provider with funds provided by the Company and then recovering the expenses payable by the provincial health care plan and forwarding such funds to the Company
        II. arranging all aspects of transporting the insured traveller if the Travel assist provider's medical staff and the attending physician decide it's medically necessary to transport the person to the nearest appropriate medical facility or to Canada for treatment (including ground transport to and from the hospital and airport at the points of departure and arrival and medical accompaniment deemed necessary by the Travel assist provider's medical staff); these costs are a covered expense
    j) in the event of the death of an insured traveller, obtaining all necessary authorizations and making arrangements for the return of the remains to the place of its former residence; reasonable and necessary expenses of shipping the body back to the province of residence is covered by the Company, up to a maximum of $5,000 (excluding the cost of any casket other than the minimum necessary to transport the body).

2. FAMILY BENEFITS

    The family benefits outlined below are included, provided the insured traveller incurs a medical emergency outside their province of residence, subject to a maximum of $5,000 for all such expenses for any one trip.

    a) If an insured traveller is travelling alone and is hospitalized for more than 7 days outside their province of residence, the Travel assist provider will arrange, and the Company will reimburse, for the round-trip economy class transportation of one family member from the patient’s immediate family (spouse, parent, child, brother or sister). This includes transportation from the family member’s place of residence in Canada to the place where the insured traveller is hospitalized, including reimbursement for expenses of up to $150 per day for the family member’s room and meals.

b) If the insured traveller requires hospitalization and any dependent child(ren) under age 16 travelling with him/her are left unattended by an adult, arrangement may be made for transportation of such child(ren) to their place of residence in Canada including, where necessary, escort for the child(ren).

c) If an insured traveller requires hospitalization, the Travel assist provider will arrange and the Company will reimburse for the cost of upgrading the transportation for the insured traveller (and any insured dependents travelling with him) to the one-way economy class fare of a regularly scheduled airline if their original tickets can't be used due to the necessity of rescheduling the return trip to adapt to the hospitalization.

Covered expenses will also include up to $500 towards the cost of returning a private vehicle owned or rented and being driven by the insured traveller to the location from which the insured traveller began driving it, provided that person is unable to continue because of a medical emergency that prevents them from travelling by vehicle.

3. LIMITATIONS

The following limitations shall apply:

a) Circumstances (such as war, insurrection, epidemic, military operations, political conditions, local laws or orders of local legal and administrative agencies, strikes, flight conditions, severe weather, the geographical inaccessibility of health care providers) may delay, interfere or prevent the Travel assist provider from providing some or all of the services described.

b) The Travel assist provider and Equitable Life are not responsible in any way for the availability, quantity, quality or results of any medical treatment or other assistance received by the insured traveller or failure to receive medical services or other assistance for any reason.

c) Travel assist services are not available in all countries and availability may change from time to time. To ensure availability and access based on the location you are travelling to, contact the Travel assist provider prior to leaving Canada.

Covered expenses are processed through an arrangement between the Company and the Travel assist provider (subject to change without notice). Travel assist services automatically terminate if this arrangement terminates and is not replaced by a similar arrangement.

Eligible expenses must be specifically listed as such under the Extended health insurance in this booklet or in the policy. If it's determined that an amount paid by the Travel assist provider or the Company is not eligible under the policy, the Company can take action to recover such amount (plus expenses) from the plan member or other person who received the payment.

4. CONTACT THE TRAVEL ASSIST PROVIDER

Call their hotline:

- in Canada or the U.S.A.: 1.800.321.9998
- elsewhere: call collect at 519.742.3287.

Give the Travel assist provider:

- your name
- your group policy number
- your certificate number
- your government health insurance plan number.

You must contact the Travel assist provider to verify coverages. Once coverage has been verified, the Travel assist provider will assist you in obtaining any of the above services that you need.

Vision care services

1. EYE GLASSES OR CONTACT LENSES OR LASER EYE SURGERY

   Charges incurred for:

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

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

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

   Example: If Vision care is payable in any period of 24 months and the patient had paid for the services on October 5, 2023, the next time a claim will be eligible is October 6, 2025.

2. WHAT IS NOT COVERED?

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

3. "SPECIAL" CONTACT LENSES

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

4. HOW TO SEND IN A CLAIM

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

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

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

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

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

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

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

Eye examinations

1. EYE EXAMINATIONS

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

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

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

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

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

2. HOW TO SEND IN A CLAIM

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

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

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

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

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

Dental benefits

General provisions

1. DESCRIPTION OF THIS BENEFIT

   If you or your eligible dependents incur expenses described in the following pages while insured under this group plan, you'll be reimbursed for those charges.

   The amount payable is subject to the co-ordination of benefits (see #5 below) and any deductible amount and reimbursement percentage (see #3 and #4 below).

2. WHAT ARE THE ELIGIBLE EXPENSES?

   These are the reasonable and customary charges made for required dental treatment performed by a dentist or, where allowed under the legislation of the province or territory, by an Independently licensed dental hygienist, provided the Schedule of insured benefits indicates the charges are included under this group plan and they are listed in the applicable dental fee guide.

   The maximum payable is the amount shown in the dental fee guide indicated in the Schedule of insured benefits for a general practitioner.

3. WHAT IS THE "DEDUCTIBLE AMOUNT"?

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

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

   Eligible claims incurred during October, November and December of a calendar year which satisfy the deductible amount for that year will also be used towards satisfying the deductible amount for the next calendar year.

4. WHAT IS THE "REIMBURSEMENT PERCENTAGE"?

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

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

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

   Claims for your dependent children should first be submitted through the group plan of the parent with the earlier birthday (month/day) in the calendar year. Any balance is then submitted through the other parent's group plan.

   For example, if your birthday is October 10 and your spouse's birthday is May 25, claims for your dependent children should be sent to your spouse's insurance company first (because your spouse's birthday is earlier in the year). Any unpaid balance would then be submitted to Equitable Life, along with a copy of what your spouse's insurer paid. Total reimbursement for any claim cannot be more than 100% of the actual expense.

6. WHAT ARE THE MAXIMUM AMOUNTS?

The annual calendar year maximum amount is shown in the Schedule of insured benefits. This is the total amount payable for each insured person in any calendar year and is automatically reinstated each January 1st.

If there is a **lifetime maximum amount shown in the Schedule of insured benefits**, this is the maximum amount payable for each insured person for the entire time they're covered under this group plan.

Note: If you and/or any of your dependent(s) are a "late applicant" (see #3 "How do you join?" under the General provisions) and submit satisfactory evidence of insurability, dental coverage for late applicants (if insured for dental benefits) will be subject to a maximum of $250 for all dental expenses during the first 12 consecutive months of coverage under the Dental benefit.

7. PRE-DETERMINATION OF BENEFITS

If your dentist suggests a course of treatment that costs more than $300, a treatment plan and estimates of the charges should be sent to us before treatment begins. We'll then be able to tell you in advance how much will be eligible under the group plan.

8. ALTERNATE TREATMENT

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

9. WHAT IS NOT COVERED?

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

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

b) active participation in a riot, rebellion or insurrection

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

d) committing or attempting to commit a criminal offense

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

f) examinations for a third party

g) procedures that aren't approved by the Canadian dental association or that are experimental in nature

h) any condition where you or your dependents are entitled to benefits under any workers' compensation act or law or similar legislation or service, or where benefits are payable under any other insurance policy issued by the Company

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

j) cosmetic surgery or treatment

k) any expenses for on-going treatment if it started before your coverage under this plan became effective

l) treatment performed or supplies delivered after your coverage under this group plan terminates (except for covered prosthetic appliances ordered and fitted before the date of termination and delivered within 31 days after the date of termination)

m) treatment for the purpose of altering vertical dimension, restoring occlusion, splinting (unless shown in the Schedule of insured benefits) or replacing tooth structure lost because of abrasion or attrition (wearing away). Your dentist should tell you if any of these conditions apply and explain them to you.

n) treatment for disturbances of the temporomandibular joint (TMJ), unless the Dental section in the Schedule of insured benefits shows this is covered. Your dentist should tell you if this condition applies and explain it to you.

10. HOW TO SEND IN CLAIMS

If your dentist* uses EDI (Electronic data interchange for electronic claim submissions):

- Your dentist's* office will submit the claim electronically to Equitable Life.

If your dentist* does not use EDI:

When you go to your dentist*, take a Form 520 - Dental claim form with you or get one from your dentist's* office. The dentist* fills in Part 1 showing what was done and how much was charged. You may want to take this booklet with you when you go to the appointment in case the dentist* wants to check what's covered.

- or, where applicable, independently licensed dental hygienist

Follow the instructions on the form. Be sure each form is fully completed, including:

- the group policy number
- your certificate number
- the full birthdate (day/month/year) for your dependent, if it's a dental claim for your spouse or dependent child
- all information on a dependent child, especially if they are in school (include the name of the school) or if they are employed full-time or part-time.
- sign in Part 3 - Patient information on the back of the form.

If any of this information is missing, we'll have to return the form to you for completion and this will cause a delay in getting your payment.

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

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

Type A – Basic services

1. DIAGNOSTIC SERVICES

   Services required to evaluate existing conditions, including:

   - consultations and biopsies
   - oral examinations **
   - bitewing x-rays **
   - complete mouth x-rays or panoramic films (once in any 24 months).

2. PREVENTIVE SERVICES

   Services required to prevent dental disease, including:

   - dental cleaning **
   - oral hygiene instruction **
   - application of fluoride **
   - pit and fissure sealants for dependent children under age 18.

3. ROUTINE RESTORATIVE SERVICES

   Services required for the treatment of dental cavities, including:

   - amalgam, acrylic or composite fillings
   - prefabricated metal or plastic restorations

4. ROUTINE SURGICAL SERVICES

   Routine extractions (including wisdom teeth) and the anaesthesia required to do them are eligible.

5. WHAT IS NOT COVERED UNDER THE BASIC DENTAL SERVICES?

   - protective appliances (such as mouthguards) and space maintainers
   - all extensive restorative services
   - all major surgical services (other than the routine extractions in #4 above)
   - charges for specific and emergency examinations when performed in conjunction with any dental cleaning.

See the **recall examination period in the Schedule of insured benefits for how often a recall examination is eligible.

Type A – Basic services options

The following Type A Basic services options are eligible only if the Schedule of insured benefits indicates they are eligible.

SPACE MAINTAINERS OPTION (eligible only if shown in the Schedule of insured benefits)

This option pays for space maintainers if used as a preventative measure to maintain space. Space regainers used to move teeth or used for orthodontics are **not covered**.

MAJOR SURGICAL SERVICES OPTION (eligible only if shown in the Schedule of insured benefits)

This option covers major surgical services such as:

- major oral surgery (other than routine extractions which are covered under the routine surgical Services of the basic dental plan)
- necessary sutures (stitches)
- post-operative treatment and related general anaesthesia
- alveoloplasty, gingivoplasty, osteoplasty and frenectomy (your dentist should tell you if any of these conditions apply and explain them to you).

Surgical services to prepare for orthodontics or major restorative services (other than fillings) are **not covered** under this major surgical service option.

PERIODONTAL SERVICES OPTION (eligible only if shown in the Schedule of insured benefits)

This option pays for services required to treat the soft tissues and bone that support the teeth, including gingivectomy and osseous surgery. Periodontal scaling is subject to the maximum number of units specified in the Dental section in the Schedule of insurance.

ENDODONTIC SERVICES OPTION (eligible only if shown in the Schedule of insured benefits)

This option covers services required to diagnose or treat the following:

- root canals
- diseases of the tooth pulp
- diseases of the periapical area.

DENTURE REPAIR SERVICES OPTION (eligible only if shown in the Schedule of insured benefits)

This option pays for services that are required to:

- rebase and reline removable full or partial dentures
- repair broken dentures.
- add teeth to partial dentures (provided the natural tooth is extracted while the insured person is covered under this group plan).

The making of dentures is **not covered** under denture repair services option.

Survivor benefit

Premium waived

1. DESCRIPTION OF THIS BENEFIT

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

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

2. WHAT BENEFITS ARE INCLUDED IN THE SURVIVOR BENEFIT?

   The Schedule of insured benefits in this booklet shows:

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

3. WHEN DO THE SURVIVOR BENEFITS TERMINATE?

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

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