Frontier Power Products Ltd.

Policy #811843

Class B

Equitable Life of Canada®

Frontier Power Products Ltd.

Policy #811843

Class B

Through **EQUITABLE LIFE OF CANADA®**, your Employer is providing you with the Group Benefits Plan outlined in this booklet.

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

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

We welcome you as a member of this Equitable Life Group Benefits Plan.

Group Department

How to contact Equitable Life:
For services in English or French, 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.

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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 1-800-265-4556
Facsimile (519) 883-7425
Email: privacyofficer@equitable.ca

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THIS GROUP INSURANCE PLAN HAS BEEN ARRANGED BY

Perlinger Financial Services
105, 7710 – 5th Street SE
Calgary, AB T2H 2L9
Phone #(403) 217-5560

Equitable Life Group Benefits

Department Contact List

Group Benefits Administration *General Policy Inquiries, Personal Information Changes & Web Support t* Hours of Operation: 8:15AM – 8:00PM EST 6:15AM – 6:00PM MST 5:15AM – 5:00PM PST	Email: groupbenefitsadmin@equitable.ca Phone: 1 (800) 265-4556 x 283 Toll Free Fax: 1 (888) 878-7747
Dental Claims *Dental Claim Inquiries* Hours of Operation: 8:15AM – 7:00PM EST 6:15AM – 5:00PM MST 5:15AM – 4:00PM PST	Email: group-dental-claims@equitable.ca Phone: 1 (800) 265-4556 Toll Free Fax: 1 (888) 505-4373
Health Claims *Health Claim Inquiries* Hours of Operation: 8:15AM – 7:00PM EST 6:15AM – 5:00PM MST 5:15AM – 4:00PM PST	Email: group-health-claims@equitable.ca Phone: 1 (800) 265-4556 Toll Free Fax: 1 (888) 505-4373
Group Disability Claims *Short Term (STD) and Long Term Disability (LTD) Claim Inquiries* Hours of Operation: 8:15AM – 5:00PM EST 6:15AM – 3:00PM MST 5:15AM – 2:00PM PST	Email: group-disability-claims@equitable.ca Phone: 1 (800) 265-4556 Toll Free Fax: 1 (888) 505-4373
Group Life Claims *Life and AD&D Claim Inquiries* Hours of Operation: 8:15AM – 5:00PM EST 6:15AM – 3:00PM MST 5:15AM – 2:00PM PST	Email: group-life-claims@equitable.ca Phone: 1 (800) 265-4556 Toll Free Fax: 1 (888) 505-4373
Travel Assist 24 Hour Helpline *(Allianz Global Assistance I.D. #9089)*	Within Canada & U.S.A: 1-800-321-9998 Elsewhere Call Collect: 519-742-3287
Equitable Life of Canada 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 LifeWorks® Online.

HealthConnector – Supporting your Health:
Whether you need help knowing what questions to ask your doctor, are dealing with a family or personal medical issue, or are looking for available health resources where you live, the Equitable HealthConnector is there to support you. Go online or phone your personal HealthConnector Information Specialist at 1-888-344-5658 and connect with the support and information you need to navigate the Canadian healthcare system and make more informed health decisions.

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

LifeWorks Online – Balance and Understanding:
An important part of being truly healthy is recognizing and understanding the non-medical factors that can impact your daily life. LifeWorks allows you to browse articles and other resources that can help you better cope with everyday issues ranging from work-life balance and parenting concerns, financial and legal issues to dealing with aging loved ones. You can also download relevant printed and recorded information and tools directly to your computer that can help you lead a balanced, productive life.

Innovations Plan Member Web Services through EquitableHealth.ca

Innovations is the fast, convenient online way to access information about your Group Benefits whenever you need to. Innovations will help you understand and manage your Group Benefits more effectively and saves valuable time and effort by allowing you to:

- Get real time Health and Dental 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.

Get your claim payments faster with Electronic EOB and Direct Deposit payment E-Solutions through EquitableHealth.ca

These E-Solutions reduce the amount of paper we produce when paying claims and give you access to your benefit information in a secure, online environment.

Electronic EOB will send an automatically generated email notification telling you that your most recent Health or Dental claim has been processed and that you can go to EquitableHealth.ca to view the details of your claim.

Direct Deposit Payment allows you to add or update personal banking information which enables us to deposit the claim payment directly to your bank account, meaning you get your money faster.

Links and instructions for these E-Solutions are available at the top of your Innovations Plan Member Web Services Welcome Page.

If you require any assistance in signing up for or accessing EquitableHealth.ca, please contact Group Administration at: 1-800-265-4556 ext. 283 or by email at groupbenefitsadmin@equitable.ca.

SCHEDULE OF INSURED BENEFITS

The Plan described in this booklet is effective as of March 1, 2012.

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

IMPORTANT NOTE

The information in the Schedule of Insured Benefits and Summary of Health Benefit Maximums in this booklet is only a brief summary of your Group Plan. These pages outline the benefits, schedules, deductibles, reimbursement percentages and most of the maximums that apply to your Plan.

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

Protecting You From Fraud

Fraudulent claims can result in additional insurance costs for you and your Employer. Equitable Life wants to protect you from the negative results of such criminal activity. To do this, we focus on all means necessary to support the detection, investigation and prosecution of false, incomplete or misleading information. Such criminal actions will result in the claim being denied and coverage being removed.
If you believe someone is involved in fraudulent claims, you can call our anonymous HOTLINE at 1-800-265-8899.

CLASSIFICATION(S)

Class B: All Eligible Retired Employees

GENERAL INFORMATION

Maximum Age for Dependent Children
Maximum age for dependent children who are not in school full-time: under age 21
Maximum age for dependent children who are in full-time attendance at school: under age 25
(See the General Provisions for Dependents section in this booklet for more information on coverage for your eligible dependents, including the requirements for continuing coverage for disabled children.)

Co-Habitation Requirement for Partners *(see the General Provisions for Dependents section in this booklet for more information on coverage for your eligible dependents)***:**
12 consecutive months

Maximum Age for Coverage *(also refer to 5. "When Does Your Insurance Terminate" in the General Provisions)***:**
All benefits terminate on your 80th birthday.

Minimum Number of Hours Per Week employees must work to be eligible for coverage:
Not applicable.

Waiting Period: *(see the General Provisions in this booklet for more important information)*
none

SCHEDULE OF INSURED BENEFITS

EMPLOYEE LIFE INSURANCE

A flat amount of $25,000

No-Evidence Limit:
Evidence of insurability is not required.

EMPLOYEE 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:

Drug Plan:	100%
Major Services:	100%
Travel Assist:	100%
Hospital Services:	100%

Benefits:
Pay-Direct Drug Plan #88

Note: This is a Generic Drug Plan and the maximum that will be eligible is an amount equal to the lowest priced substitutable drug as provided for in the Provincial Drug Benefit Formulary, except where the physician or dentist indicates on the prescription “no substitution”.

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

Major Services, including Travel Assist.

Private Hospital

Lifetime Maximum Amount for eligible Retired Employees and each of their eligible dependents:
Unlimited, except there is a $1,000,000 lifetime maximum for services received outside the retiree's province of residence.

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 and who reside in the province of Quebec will be administered in accordance with la Régie de l'Assurance Maladie du Québec (RAMQ).

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 "lifestyle" drugs (such as drugs to treat erectile dysfunction or for weight loss): not eligible

Maximum for Vaccines and Immunizations: not eligible

THE FOLLOWING MAXIMUMS APPLY TO ITEMS COVERED UNDER MAJOR SERVICES:

Note: 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: (includes over-the-counter braces with rigid supports)	reasonable and customary charges
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 48 consecutive months
Hearing aid batteries are not eligible.

#4(f) **Maximum Amount for Orthopaedic Shoes and Other Orthotics**:
(Note: To be eligible, orthopaedic shoes and other orthotics must be specially constructed for the patient and prescribed by a physician, chiropractor, podiatrist or chiropodist.)
$350 per insured person per calendar year for orthopaedic shoes and all other orthotics combined

SUMMARY OF HEALTH BENEFIT MAXIMUMS

MAXIMUMS THAT APPLY TO ITEMS COVERED UNDER MAJOR SERVICES (Continued):

#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 every 48 consecutive months

#4 (j) **Maximum for Diagnostic Laboratory Procedures**:
$250 per insured person per calendar year

#6 **Maximums per insured person per calendar year for Paramedical Services**:

Chiropractor (including x-rays)	$500
Registered Massage Therapist	$500
Naturopath (including x-rays but not tests or supplements)	$500
Osteopath (including x-rays)	$500
Physiotherapist	$1,000
Podiatrist/Chiropodist (including x-rays)	$500
Psychologist (including MSW / Clinical Counsellors)	$500
Specialist in Acupuncture	$500
Speech Therapist	$1,000

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

SCHEDULE OF INSURED BENEFITS

SURVIVOR BENEFIT

For the following benefits only: Health
Maximum Period for Survivor Benefit: 24 months

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 and work in Canada as a permanent employee for this Employer, and
* have provincial health care coverage in your province of residence, and
* actively and regularly work "full-time" for this Employer ("full-time" means working the **Minimum Number of Hours Per Week** shown in the Schedule of Insured Benefits), and
* belong in one of the Classifications shown in the Schedule of Insured Benefits.

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'll be a "**late applicant**". You must then provide **satisfactory evidence of insurability**. Your benefits will become effective on the date the evidence is approved by the Company. Some or all of your benefits could be declined or restricted.

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.

If you're not actively at work on the date your benefits should take effect, your coverage will become effective on the date you return to active work. You must also be actively at work for any future increases in your coverage to be effective.

You must be insured under this Group Plan to be eligible for any benefits.

5. **WHEN DOES YOUR INSURANCE TERMINATE?**

Your insurance terminates on the earlier of the following dates:

* on the date of your retirement, unless this Group Plan provides any benefits for retirees.
* on the date you are no longer employed by the Employer
* on the date your Employer terminates your coverage
* 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.

6. **EVIDENCE OF INSURABILITY**

The Schedule of Insured Benefits tells you if evidence of insurability is required for any amounts of insurance coverage. If the amount available without evidence (the **No-Evidence Limit**) changes under this Group Plan, the amount of coverage you're eligible for will be determined by the Company according to the terms of the Master Policy.

GENERAL PROVISIONS FOR DEPENDENTS

1. **WHO ARE ELIGIBLE DEPENDENTS?**

Eligible dependents must 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 **natural child, adopted child, stepchild, child you have been granted final guardianship or custody of by an order of the Court, or child of your spouse**.

To be eligible, the child must not have a spouse or partner, be supported by you, and not be working on a full-time basis. Look in the Schedule of Insured Benefits to see the **Maximum Age for Dependent Children**.
Note: If dependent children must be in school full-time to be eligible for coverage, proof of this will be required.

Your **permanently developmentally or physically disabled child**. This means
* Your developmentally or physically disabled natural child, adopted child, stepchild or child of your spouse.

To be eligible, the child must not have a spouse or partner and we must have a Doctor's certificate stating he/she is incapable of self-sustaining employment and chiefly dependent upon you for support. This child must have been insured under this Group Policy before reaching the Maximum Age for Dependent Children in the Schedule of Insured Benefits.

2. **HOW TO APPLY TO COVER YOUR DEPENDENTS**

If you have any eligible dependents when you complete the required application form:
* Fill in the "Number of your Dependent Children" box.
* Fill in the name of your spouse.
* Check off the box marked "Family" in the Health and/or Dental sections if the Group Plan includes these benefits and you wish to cover your eligible dependents.

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

If you want to cover your partner, look under **Co-Habitation Requirement for Partners** in the Schedule of Insured Benefits to see if there's any minimum period that you and your partner must live together before your partner and his/her children become eligible for coverage.

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

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

GENERAL PROVISIONS FOR DEPENDENTS

3. **WHEN DOES COVERAGE FOR YOUR DEPENDENTS BECOME EFFECTIVE?**

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

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

4. **WHEN DOES COVERAGE FOR YOUR DEPENDENTS TERMINATE?**

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

EMPLOYEE GROUP LIFE INSURANCE

1. DESCRIPTION OF THIS BENEFIT

If you die from any cause while insured under this Plan, the amount of Group Life Insurance you're eligible for will be paid to the beneficiary you named.

Group Life Insurance cannot be assigned (it can't be used as collateral for a loan).

2. HOW TO NAME YOUR BENEFICIARY

When you joined the Group Plan, you named a beneficiary on Form #191 - Employee Group Insurance Application. You can change your beneficiary anytime. Complete the appropriate section on **Form #438 - Employee Change Form** and have your Group Plan Administrator forward it to us.

Important: If any **beneficiary is a minor (is under age 18)**, be sure to **fill in the name of a Trustee**. If you don't, it could cause a delay in payment of the proceeds and affect who the proceeds are paid to.

3. HOW WILL YOUR LIFE INSURANCE PROCEEDS BE PAID?

Your Group Plan Administrator should notify Equitable Life when there is a claim. We'll supply the required forms to be completed and returned to us. Proceeds will be paid to your beneficiary in one lump sum (unless he/she chooses another payment option).

4. THE CONVERSION PRIVILEGE

If **you terminate from the Group Plan**, or if **the Group Policy terminates**, you can convert (change) all or part of your Group Life Insurance to an individual Life Insurance policy without having to provide evidence of insurability. If you want to convert your Group Life Insurance, request an application form from Group Accounts Service at the Head Office of Equitable Life. Please note the following conditions that apply to the conversion:

* You must **apply in writing and pay the first premium within 31 days** of terminating from the Group Plan. If you should die within that time, the Company will pay to your beneficiary the maximum amount of individual Life Insurance that you could have obtained under this Conversion Privilege (even if you hadn't applied for it).
* The premiums for the individual policy will be based on your age, sex, and whether you've smoked a cigarette in the past 12 months.
* Not all types of individual plans are available under Conversion and the individual policy wouldn't include Disability, Double Indemnity or other special features.
* The individual policy may have to be for a minimum dollar amount.
* The maximum amount of Group Life Insurance that can be converted cannot exceed the full amount of your basic Group Life Insurance less the amount of insurance you have or are eligible for under any group insurance contract issued by any insurance carrier on the date your converted policy becomes effective. However, in no event shall the amount of the individual policy exceed $200,000, or such higher amount if required by applicable provincial legislation.

5. HOW TO SEND IN A CLAIM

Your Group Plan Administrator should notify Equitable Life if there is a claim. We'll supply the required forms to be completed and returned to us.

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 #4 below) and any **Deductible Amount** (see #2 below) and **Reimbursement Percentage** (see #3 below). Eligible expenses mean reasonable and customary charges for necessary medical care or treatment (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. **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:

1. The Group Plan of the parent with custody of the Dependent Child,
2. The Group Plan of the Spouse of the parent with custody of the Dependent Child,
3. The Group Plan of the parent not having custody of the Dependent Child,
4. 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 actual expense.

5. **WHAT ARE THE OVERALL MAXIMUM AMOUNTS?**

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

Any Annual Maximum Amount is **shown in the Schedule of Insured Benefits**.

6. **DEFINITIONS**

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

Paramedical practitioners:
* "**Athletic Therapist**" means a person who is a Certified Athletic Therapist.
* "**Audiologist**" means a person who has a Masters degree specializing in hearing loss.
* "**Dietician**" means a person who is registered with the Dieticians of Canada Association.
* "**Chiropractor**", "**Naturopath**", "**Osteopath**" and "**Speech Therapist**" means a person who holds a degree from a recognized school.
* "**Registered Massage Therapist**" means a person who is a member of the applicable Provincial Association of Masseurs 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:
(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: representative fees, practices and tariffs of the particular specialty of the practitioner, supplier, or medical facility in the area in which the service is performed, excluding any charges deemed by the Company to be in excess of the general level of charges for the same or comparable services or supplies in the area.

Province of Residence:
For both employees and dependents, this means the province in which the employee resides.

HEALTH BENEFITS
GENERAL PROVISIONS

7. **RECURRENT DISABILITY**

If **you** return to active work after being disabled due to illness or accident and you then become disabled again within 14 days from the same or related causes, it will be assumed that the original disability has continued. If **one of your eligible dependents** is disabled due to sickness or accident and recovers but then becomes disabled again within 90 days from the same or related causes, it will be assumed that the original disability has continued. This could apply to those Health Benefits, which include a maximum period of time during which benefits are payable for any one disability or period of disability (such as Convalescent Home Services under Major Services, if this is included in the Group Plan).

8. **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.

9. **WHAT IS NOT COVERED?**

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

(a) wilfully self-inflicted injury or any attempt at self-destruction (whether the person is sane or insane)
(b) active participation in a riot, rebellion or insurrection
(c) war or hostilities of any kind (whether or not war is declared)
(d) committing or attempting to commit a criminal offence
(e) services performed by a person who usually lives in the patient's home or is related to the patient by birth or marriage, or related to the patient through the patient's spouse
(f) services that are provided free or for a nominal (small) amount by public authorities or tax-supported agencies, by the Workers' Compensation Act or some other law, or where no charge would be made if the person didn't have any insurance
(g) charges that are covered under a Provincial Health Care Plan (whether or not the person is actually insured under it), or by any other insurance carrier, or as a result of legal action or settlement
(h) charges for un-kept appointments, telephone time, or to complete forms or reports
(i) charges for periodic or routine health examinations or examinations for a third party (for example, if you need to get a medical exam in order to get a license)
(j) costs involved if you have to move or travel for health reasons
(k) services for which it's not legal to provide insurance
(l) expenses for treatment or materials for dental care, eyeglasses, physician services, or services outside the province of residence (unless they're specifically included under this Group Plan)
(m) cosmetic surgery or treatment or medication (unless it's required as the result of accidental injuries and provided the surgery or treatment begins within 90 days of the accident)
(n) charges for lifestyle counselling (such as counselling for weight loss or to stop smoking)
(o) charges for treatment or materials, which (in the opinion of the Company's medical advisors) are experimental or illegal to use or are not a recognized form of treatment
(p) any charge related to in vitro fertilization or any other fertility programme (other than the Maximum Amount for Fertility Drugs, if any, shown in the Summary of Health Benefit Maximums)
(q) services and supplies for an out-patient at a hospital, such as anaesthesia for a surgical procedure, use of an examination or operating room, drugs administered at the hospital, bandages, dressings and casts
(r) anaesthesia, blood and blood plasma
(s) expenses that are not actually charged to you or your eligible dependent
(t) lifestyle drugs (unless shown on the Summary of Health Benefit Maximums), such as drugs to treat erectile dysfunction (such as Viagra) and for weight loss
(u) sphygmomanometer (blood pressure monitor) and insulin pumps for diabetes, unless shown as an eligible expense in the Summary of Health Benefits Maximums.

HEALTH BENEFITS
PAY-DIRECT DRUG PLAN #88

1. **WHAT IS COVERED?**

(a) **selected prescription requiring drugs and medicines** if they're dispensed by a pharmacist and which:
* have been assigned a valid Drug Identification Number (DIN) by Health Canada and are listed as "prescription requiring" in Federal or Provincial Drug Schedules (see Exclusions below)
* are injectable drugs, injectable vitamins, and non-patient specific allergy extracts which bear a valid Drug Identification Number (DIN)
* are extemporaneous preparations or compounds where one of the ingredients is an eligible benefit (see Exclusions below)

(b) **selected products** from within the following classes of non-prescription requiring drugs are eligible: potassium replacements, iron supplements, and vasodilating nitrates

(c) **insulins; insulin supplies**: disposable needles, disposable syringes, lancets and chemical reagent testing materials used for insulin administration and monitoring diabetes (see Exclusions below).

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, thyroid agents.

3. **EXCLUSIONS**

The following are not eligible under the Drug Plan:
(a) smoking cessation products, unless specifically shown as an eligible expense in the Summary of Health Benefit Maximums
(b) drugs used to enhance fertility (even if prescription requiring)
(c) atomizers, appliances, prosthetic devices, colostomy supplies, first aid kits or equipment, electronic diagnostic monitoring or testing equipment (such as a "Glucometers"), non-disposable insulin delivery devices (such as "Novolin Pen" and "Insulin Pumps"), spring loaded devices to hold lancets, alcohol, alcohol swabs, disinfectants, cotton, bandages, delivery or extension devices for inhaled medications (such as "Diskhaler" or "Aerochamber"), or supplies and accessories for the aforementioned
(d) 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
(e) diaphragms, condoms, contraceptive jellies/foams/sponges/suppositories, non-medicinal intrauterine devices (IUD's, such as Gyne-T), contraceptive implants or appliances normally used for contraception, whether or not a prescription is given for a medical reason
(f) herbal and Homeopathic preparations, even if combined with a prescription requiring medicine or with a product considered to be an eligible benefit
(g) 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, unless otherwise approved by the Pay-Direct Drug Plan provider
(h) all preventative immunization vaccines and toxoids, unless specifically shown as an eligible expense in the Summary of Health Benefit Maximums
(i) all patient-specific allergy extracts, compounded in a lab, and not bearing a Drug Identification Number (DIN)

HEALTH BENEFITS
PAY-DIRECT DRUG PLAN #88

3. **EXCLUSIONS** (Continued)

(j) items deemed to be cosmetic or hygienic by the Pay-Direct Drug Plan provider or the Company (even if a prescription is legally required), such as topical Minoxidil, or sunscreens, or contact lens care products, whether or not a prescription is given for medical reasons
(k) any medication the person is eligible to receive under the applicable Provincial Drug Benefit Plans
(l) Meridia™ and Xenical™
(m) oral erectile dysfunction drugs
(n) consultation charges and/or Professional Fees for services rendered by a licensed physician, pharmacist (other than dispensing fees) or registered nurse
(o) selected injections normally administered to patients admitted to hospital for treatment
(p) costs of administration
(q) illegal or experimental drugs
(r) products bearing a Natural Product Number (NPN) by Health Canada.

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. **CLAIMS**

IMPORTANT: If your insurance terminates, or if the Drug Benefit under this Policy terminates, or if this Group Policy terminates, all claims incurred prior to the date of termination must be received by the Company within **90 days** of the date of termination. However, if this Group Policy terminates and the General Information box in the Schedule of Insurance indicates that the Health Benefit is Administration Services Only (ASO), no benefits (including claims incurred prior to the date the Policy terminates) are payable after the Policy terminates.

See your "Group Benefits Pay-Direct Drug Plan" brochure for more information about pay-direct drug plans, including how and where to submit paper claims if you were unable to use your drug card at the pharmacy. If you don't have a copy of this brochure, please ask your Group Plan Administration for one.

HEALTH BENEFITS
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.)

4. **APPLIANCES AND SUPPLIES** (Continued)

(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, chiropractor, podiatrist or chiropodist:

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

subject to the **Maximum for Orthopaedic Shoes and Other Orthotics** shown in the Summary of Health Benefit Maximums.

Note: Stock orthopaedic shoes that can be purchased off-the-shelf are eligible only if they have been modified for the patient and the Summary of Health Benefit Maximums specifies that they are eligible. Stock shoes that have not been modified for the patient are not eligible under any circumstances.

The following is required for proper claim review:

* Medical referral: A medical referral must be provided from a physician, chiropractor, 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 testing is excluded.

HEALTH BENEFITS
MAJOR SERVICES

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 #6 (Definitions) under the Health Benefits - General Provisions for the definition/qualifications of the various practitioners.

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

If your province does allow private insurers to pay the excess charged by certain practitioners over what the Provincial Health Care Plan pays, and **if your Employer has chosen to include these in your Group Plan**, this will be indicated in the Paramedical section in the Summary of Health Benefit Maximums.

7. SERVICES OUTSIDE THE PROVINCE

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

(a) The services are covered under the employee'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 employee's province of residence, or

(c) The services (or similar services) are not available in the employee'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.

7. **SERVICES OUTSIDE THE PROVINCE** (Continued)

"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 his 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 employee's province of residence.

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 issued a travel warning or restriction prior to the insured's departure from the country.

No benefit is payable for injury that results from participation in any sport as a professional athlete or participation in a dangerous activity.

"Professional athlete" is defined as someone who receives payment for their athletic performance in the form of taxable income, prizes or sponsorships.

Examples of dangerous activities include, but are not limited to: extreme sports, off-trail skiing, sky-diving, mountaineering, scuba diving (without certification) and spelunking.

If you are unsure of whether your travel plans include activities that may be considered dangerous, please contact your travel provider for travel assistance before or during your trip. The phone number is on your wallet card.

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:

(i) 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.
(ii) 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.

7. **SERVICES OUTSIDE THE PROVINCE** (Continued)

(iii) 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.
(iv) Except for drugs, the emergency services must be eligible under the Provincial Health Care Plan of the student's province of residence.
(v) 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.
(vi) The student is covered only during the school term.
(vii) Coverage is not provided during holidays or student absences during or between school terms that are longer than one month.
(viii) 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 he/she is in school (include the name of the school) or if he/she is employed full-time or part-time.

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

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

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

IMPORTANT: If your insurance terminates, or if the Major Services Benefit under this Policy terminates, or if this Group Policy terminates, all claims that were incurred prior to the date of termination must be received by the Company within **90 days** of the date of termination. However, if this Group Policy terminates and the General Information box in the Schedule of Insurance indicates that the Health Benefit is Administration Services Only (ASO), no benefits (including claims incurred prior to the date the Policy terminates) are payable after the Policy terminates.

HEALTH BENEFITS
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
    (ii) 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
(i) 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 coffin 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 his 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 his 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).

2. **Family Benefits** (Continued)

(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 him 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.

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 employee or other person who received the payment.

4. **How to 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.

HEALTH BENEFITS
PRIVATE HOSPITAL

1. **WHAT IS COVERED?**

If you or one of your eligible dependents are confined as an inpatient **in a private room** (a room with one bed, other than a suite) in a licensed hospital while insured under this Group Plan, a reimbursement will be made to the hospital for **reasonable and customary charges** made by the hospital (taking into account any Deductible Amount or Reimbursement Percentage shown in the Schedule of Insured Benefits).

Expenses are not eligible:
* if the person is confined in a special ward or unit that would qualify as a "convalescent home" under the Policy or which would otherwise not qualify as a hospital
* if the private room is the lowest level of accommodation available
* if the private room is required for medical reasons.

The maximum amount eligible is the difference between:
* the charges actually made by the hospital for private care, and
* the charges made by the hospital for standard ward care.

subject to a maximum of $50 per day over the daily semi-private care charge.

The maximum amount eligible if confined in a semi-private room is the difference between:
* the hospital charges for semi-private care

and the greater of:
* the Provincial Hospital Plan allowance, and
* the hospital charges for standard ward care.

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

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

3. **SERVICES OUTSIDE THE PROVINCE**

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

4. **HOW TO SEND IN A CLAIM**

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

IMPORTANT: If your insurance terminates, or if the Hospital Benefit under this Policy terminates, or if this Group Policy terminates, all claims incurred prior to the date of termination must be received by the Company within **90 days** of the date of termination. However, if this Group Policy terminates and the General Information box in the Schedule of Insurance indicates that the Health Benefit is Administration Services Only (ASO), no benefits (including claims incurred prior to the date the Policy terminates) are payable after the Policy terminates.

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 your spouse remarries or qualifies as the spouse of another person
* the date this Group Plan terminates.