

# HOUR BANK BENEFIT PLAN

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# Schedule of Benefits

## Employee Life Insurance page 21

Benefit \$100,000

## Accidental Death & Dismemberment page 23

Principal Sum \$100,000

## Dependent Life Insurance page 33

Spousal Benefit \$10,000

Child Benefit \$5,000

## Extended Health Care for Employees & Dependents page 34

Prescription Drugs 80%

All Other Covered Health Expenses 100% (to specified limits excluding paramedicals)

Vision Care Maximum \$350

Prescription Safety Glasses \$150 (employees only)

## Dental Care for Employees & Dependents page 59

Basic Services 80%

Major Services 50%

Maximum for Basic & Major Services \$2,500

Combined

Orthodontic Services 50%

Maximum for Orthodontic Services \$2,500 lifetime

Fee Guide Current general practitioner or specialist

## Long Term Disability Insurance\* page 67

Monthly Benefit \$3,500 per month

*\*Eligibility for benefit payment is subject to age restrictions, see page 67 for details.*

## Short Term Disability Insurance\* page 73

Weekly Benefit \$800

*\*Eligibility for benefit payment is subject to age restrictions, see page 73 for details.*

## Employee Family Assistance Program page 78

### Telemedicine page 82

### Medical Second Opinion page 83



# General Information

## Your Plan Information

### Benefit Plan Administrator

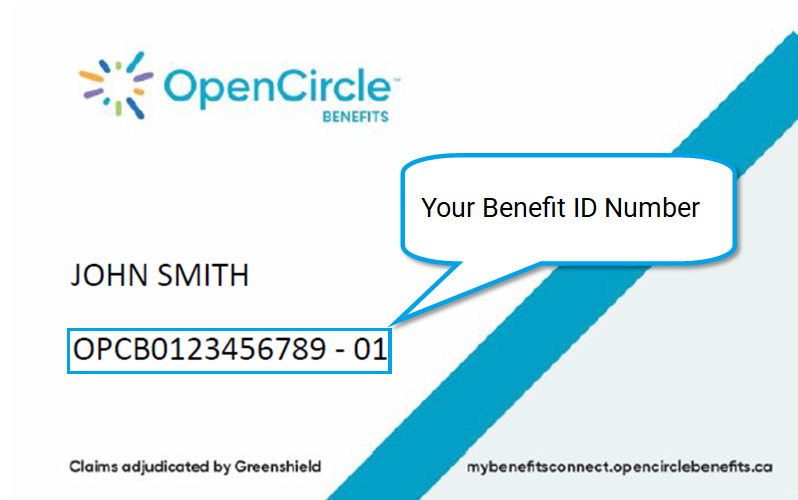
OpenCircle Benefits is the administrator of your benefit plan. OpenCircle Benefits' staff can answer your questions, help you complete claim forms, find your claims status, help with changes to your account, and help with any problems that may arise.

### Contact information for OpenCircle Benefits

**Phone:** 780.455.5845  
**Toll-free:** 1.877.263.7266  
**Email:** [inquiries@opencirclebenefits.ca](mailto:inquiries@opencirclebenefits.ca)  
**Website:** [www.opencirclebenefits.ca](http://www.opencirclebenefits.ca)  
**Mail:** OpenCircle Benefits  
104-13025 St. Albert Trail  
Edmonton AB T5L 4H5

### Client Reference Code and Benefit ID Numbers

Your **Client Reference Code** for health and dental benefits is OPCB. Your **Benefit ID Number** is on your OpenCircle Benefits ID Card



### About This Booklet

This booklet outlines your plan in general terms. If the booklet is different from the contracts and agreements with GreenShield Health, Sun Life, and iA Financial Group, the contracts/agreements will prevail to the extent permitted by law. GreenShield Health

adjudicates claims on behalf of the OpenCircle Benefit Plan for the extended health and dental portions of the benefit plan, which are self-insured.

### Access to Documents

We will provide, when asked, a copy of the policy, your application, and other records you have provided to the insurer, subject to certain limitations.

### Protecting Your Personal Information

We recognize and respect the importance of privacy. Personal information about you is kept in a confidential file at the OpenCircle Benefits office or the offices of an organization authorized by OpenCircle Benefits. Your personal information may be subject to disclosure to those authorized under applicable law within or outside Canada.

### Appeals

If you are denied all or part of a benefits claim, you or your employer may appeal within one year, in writing with additional supporting documents if applicable and with reasons that you believe the denial is incorrect. If you have questions regarding a declined claim, or you wish to file a complaint, please contact OpenCircle Benefits in writing at:

**Mail:** OpenCircle Benefits  
104-13025 St. Albert Trail  
Edmonton AB T5L 4H5

**Fax:** 780.455.6068

**Email:** [inquiries@opencirclebenefits.ca](mailto:inquiries@opencirclebenefits.ca)

### Legal Action

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the *Insurance Act* (for actions or proceedings governed by the laws of Alberta and British Columbia), *The Insurance Act* (for actions or proceedings governed by the laws of Manitoba), the *Limitations Act, 2002* (for actions or proceedings governed by the laws of Ontario), or other applicable legislation. For those actions or proceedings governed by the laws of Quebec, the prescriptive period is set out in the Quebec Civil Code.

In no case can legal action to recover non-insured benefits under this plan be introduced 60 days after notice of claim is submitted, or two years after a benefit has been denied.

### Enrolment

It is your responsibility to complete enrolment in full, and to update your information with OpenCircle Benefits if it changes. Changes can be made on the MyBenefitsConnect app, or by contacting OpenCircle Benefits. You must be enrolled to access benefits; you may be denied benefits if your information is not accurate and current.

The Employee Life Insurance beneficiary form can be signed in ink and returned to OpenCircle Benefits. You may also submit a Beneficiary form signed using a stylus or touchscreen. You may also use an I.P. tracking, audit trail and timestamping approved signing program life Docusign to submit it to OpenCircle. You may also sign electronically in your MyBenefitsConnect member portal. If you do not, death benefits will be paid to your estate.

**Residency Requirement**

You and your dependents must live in Canada year-round to be covered by this plan.

**Apprenticeship Training Hours**

For questions regarding continuation of benefits during your apprenticeship, please contact OpenCircle Benefits.

**Hour Bank**

**Initial Eligibility**

Your employer will report your hours worked and remit payment for those hours to OpenCircle Benefits. Your benefit plan starts on the 1st day of the 2<sup>nd</sup> month after your hour bank account has accumulated 300 hours. Please see the example below:

**Example:** You begin work for ABC Company in January and work 160 each month. On February 28, you have accumulated over 300 hours.

Working Month	Opening Balance	Hours Reported	Hours Deducted	Hours Remaining	Month of Benefit Coverage
January	0	160	0	160	N/A
February	160	160	150	170	<b>April</b>

**You are eligible for benefits on April 1.**

You have 8 months to build up 300 hours, if you do not build 300 hours in 8 months, your hours will be forfeited, and your account will go to zero hours.

**Deduction of Hours for Coverage**

For each month of benefit coverage, 150 hours are deducted from your Hour Bank account.

**Example:** You continue to work for ABC Company and work 160 hours monthly. On February 28, you have accumulated over 300 hours and begin coverage in April. Your coverage continues – 150 hours are deducted each month, and the remaining hours are banked for future use.

Working Month	Opening Balance	Hours Reported	Hours Deducted	Hours Remaining	Month of Benefit Coverage
January	0	160	0	160	N/A
February	160	160	150	170	April
March	170	160	150	180	May

**The maximum number of hours that can be in your account at a given time is 1,200.** Hours over 1,200 are forfeited. As long as you work for a company participating in the OpenCircle Hour Bank Plan, your hours will continue to build up in your account.

### Termination of Coverage

Your coverage under the benefit plan will terminate on the last day of the month after the balance of your account falls below 150 hours. Disability benefits terminate when hours stop being reported for you.

**Example:** You continue to work for ABC Company and your hours of work vary for the year.

Working Month	Opening Balance	Hours Reported	Hours Deducted	Hours Remaining	Month of Benefit Coverage
April	180	160	150	190	June
May	190	145	150	185	July
June	185	200	150	235	August
July	235	190	150	275	September
August	275	120	150	245	October
September	245	80	150	175	November
October	175	50	150	75	December
November	75	40	0	115	N/A
December	115	0	0	115	N/A

**On December 31, your coverage will terminate because you had less than 150 hours remaining in your bank for coverage in January. Your disability benefits will end in December as no hours were reported for you.** You cannot receive a refund for any paid hours.

### Self-Pay Option

When you fall out of benefit, you may be able to extend your benefits by self-paying, as set out below. Your disability benefits cannot continue through self-payment (except for Maternity/Parental Leave Self-Pay, as outlined below).

The self-pay option is a flat rate per month – you cannot purchase hours to top up your remaining Hour Bank balance.

Please contact OpenCircle Benefits for information.

**Self-Pay Option – Hours below 150**

If your balance falls below 150 hours, you may pay to extend your benefits (except disability benefits) for up to 6 months. Details of the price and deadlines will be in the letter that you receive advising of your last day of benefits.

**Self-Pay Option – Continued Benefits while Disabled**

If you become disabled while eligible for benefits under this plan, you may pay to continue your benefits (except disability benefits), for up to 24 months from the date you become disabled.

**Self-Pay Option – Continued Benefits while on a Maternity/Parental Leave of Absence**

You may pay to continue your benefits under this plan (including disability benefits) for up to 78 weeks (total extension) during a scheduled Maternity or Parental Leave of Absence.

**Reinstatement**

If your benefits end because you have less than 150 hours in your account, your benefits will be reinstated if your hour bank account reaches at least 150 hours (including hours on hand at the time your benefits terminated) within 8 months. Your benefits will be reinstated the 1st day of the 2<sup>nd</sup> month after the 150<sup>th</sup> hour is recorded in your account.

**Example:** Your hours are reduced working for ABC Company in September, and you stop working in December. You resume working regular hours with ABC Company in January.

Working Month	Opening Balance	Hours Reported	Hours Deducted	Hours Remaining	Month of Benefit Coverage
September	245	80	150	175	November
October	175	50	150	75	December
November	75	40	0	115	N/A
December	115	0	0	115	N/A
January	115	160	150	125	March

**On December 31, your coverage terminated due to less than 150 hours in your account. Your coverage resumes March 1 due to hours reported for January.**

If you do not build up 150 hours in 8 months of your coverage terminating, your hours will be forfeited. You will then have to build up 300 hours to have your benefits reinstated.

### Benefit Limitation for Overpayment

If benefits are paid that were not payable under the policy, you are responsible for repayment within 30 days of the insurer sending you a notice of the overpayment, or within a longer period if agreed to in writing by the insurer. If you fail to fulfil this responsibility, no further benefits are payable under the policy until the overpayment is recovered. This does not limit the insurer's right to use other legal means to recover the overpayment.

## Who is Covered?

### My Eligible Dependents

**Eligible dependents** have coverage for the same benefits as you, except for disability and Accidental Death & Dismemberment.

To be covered, your **eligible dependents** must:

- a. live in Canada; and
- b. must be listed on your enrolment form.

A **dependent spouse** includes either:

- a. a person to whom you are **legally married**, or
- b. a person **continuously living with you** for a period of at least one year and who is represented by you publicly as your spouse.

**Only one spouse** will be eligible for benefits, as indicated on your enrolment form.

A **dependent child** is eligible if he or she is:

- a. a natural child, stepchild, or legally adopted child of you or your covered spouse,
- b. unmarried and fully dependent on you for support, and
- c. under the age of 21 or under the age of 25 if a **full-time student** (with satisfactory proof of attendance).

If you are living in a common-law relationship, the **child of the common-law spouse** will be eligible for benefits if he/she is in the care and custody of both you and your spouse and living with you.

If you are in possession of **legal guardianship** papers for a dependent child under the age of 18, that child will also be eligible for dependent benefits. In certain cases, children who are

dependent because of a **mental or physical disability** may also be entitled to coverage outside the age limits.

If you have question about eligible dependents, contact OpenCircle Benefits.

## **Membership and Portability**

An “OpenCircle Member” owns a share of OpenCircle and is entitled to all of the services, privileges, and benefits of membership. Employees of Members are entitled to Hour Bank portability between OpenCircle Members as well as a suite of member benefits and services.

# Claims Instructions

If you have any questions regarding the information provided in this section, please contact OpenCircle Benefits.

## Extended Health and Dental Claims

**All Extended Health and Dental claims for a calendar year must be submitted no later than June 30th of the following year to be eligible for reimbursement.**

### Pay-Direct at Provider

All claims for eligible drugs can be made directly by your pharmacist at the time that you fill your prescription, just present your ID Card issued by OpenCircle Benefits. You will not have to pay any amount of the prescription that is covered by the plan, but you will have to pay any amounts that are not covered by the plan.

For certain other providers (dentists, massage therapists, etc.), your provider may be able to submit the claim on your behalf via direct billing. If your provider can direct bill, you will not have to pay any amount that is covered by the plan, but you will have to pay any amount that is not covered by the plan. Please consult your provider to see if they direct bill.

If you are required to pay for the claim in full, and submit it to your MyBenefitsConnect app, please see the **Online Health and Dental Claims Submissions** section for assistance with online claims. For assistance with paper claim forms, see the **Paper Claim Form Submissions** section. Paper claim forms may be printed by going to [www.opencirclebenefits.ca](http://www.opencirclebenefits.ca), or by contacting OpenCircle Benefits.

### Online Health and Dental Claim Submissions

To submit Health and Dental claims online, you register for [www.mybenefitsconnect.opencirclebenefits.ca](http://www.mybenefitsconnect.opencirclebenefits.ca) website, or download the MyBenefitsConnect app.

Once registration is completed, online claims processing will be enabled. To submit an online claim, sign into [www.mybenefitsconnect.opencirclebenefits.ca](http://www.mybenefitsconnect.opencirclebenefits.ca). You will be required to enter the type of claim, the service provider, the patient's name, and expense details. You will also be required to upload a picture of your receipt. Claims are normally processed in a few days, at which time payment for approved claims will be deposited into your bank account.

Once you have set up direct deposit, any future paper claims submitted (where benefits are to be paid to you and not the provider) will be paid via direct deposit.

GreenShield Health has extensive safeguards in place to protect you and the OpenCircle Benefit Plan from fraud or misuse. Online claims will be selected randomly for audit, where additional information may be requested. Failure to provide the requested information may result in withdrawal of online claims access. **All receipts must be retained for a minimum of 12 months in the event of an audit.**

### [Paper Claim Form Submissions](#)

This section is a step-by-step outline of the procedure you should follow for all paper extended health and dental claims. Please send completed paper claim forms directly to the appropriate address below:

#### **Medical Items**

P.O. BOX 1623  
Windsor,ON  
N9A 7B3

#### **Vision & Accommodation**

P.O. BOX 1615  
Windsor,ON  
N9A 7J3

#### **Drug**

P.O. BOX 1652  
Windsor,ON  
N9A 7G5

#### **Dental**

P.O. Box 1608  
Windsor,ON  
N9A 7G1

#### **Professional Services**

P.O. BOX 1699  
Windsor,ON  
N9A 7G6

If your Health or Dental claim is sent to OpenCircle Benefits or one of the OpenCircle offices, it will be forwarded the appropriate mailing address outlined above by regular mail, adding to the time you will have to wait for reimbursement.

Some providers may allow for an Assignment of Benefits. This means the provider will be paid by the OpenCircle Benefit Plan directly once the claim has been. If you require assistance

completing your claim form, or to request an Assignment of Benefits form, please contact OpenCircle Benefits.

### **Extended Health Care Expenses:**

To submit an extended health claim by paper, please follow the directions below:

1. Obtain a "Health Claim form".
2. Itemize the expenses for covered services and supplies for each family member (which can all be put on the same form).
3. Keep a copy of the statement and receipts for your records.
4. Attach original paid-in-full receipts (or invoices if an Assignment of Benefits is in place) and to the appropriate mailing address above.
5. A cheque for the eligible expenses, where applicable, will be mailed to you, unless you have enabled direct deposit claim payments, in which eligible expenses will be paid to you by direct deposit.
6. If you have made a claim under another plan first (e.g., through your spouse) you must also attach a copy of the Explanation of Benefits showing any amounts that have been paid by the other plan, or if the claim has been denied by the other plan.

### **Dental Expenses:**

To submit a dental claim by paper, please follow the directions below:

1. Obtain a "Dental Claim form" and have your dentist complete his/her portion (many dentists also now have these forms available online and may be able to complete and submit them electronically).
  - o A separate claim form must be used for each individual.
2. Complete your portion of the form and send directly to the appropriate mailing address above.
3. A cheque for the eligible expenses, where applicable, will be mailed to you or to your dentist (if you assigned payment of your dental expenses directly to your dentist by signing the top right-hand corner of the claim form).
4. If you have made a claim under another plan first (e.g., through your spouse) you must also attach a copy of the Explanation of Benefits showing any amounts that have been paid by the other plan, or if the claim has been denied by the other plan.

### **Out-of-Province/Canada Expenses:**

To submit an out-of-province/Canada expense, please follow the directions below:

1. Obtain a "Out of Country Medical Emergency Form" and the appropriate form that allows the OpenCircle Benefit Plan to co-ordinate your benefits with the applicable provincial medical plan (available by contacting OpenCircle Benefits).
2. Itemize the expenses for covered services and supplies on the form.
3. Keep a copy of the statement and receipts for your records.
4. Attach original paid-in-full receipts (or invoices if an Assignment of Benefits is in place) and send to the appropriate mailing address above.

5. A cheque for the eligible expenses, where applicable, will be mailed to you or will pay the health care provider(s) directly, if an Assignment of Benefits is in place.

Your benefit payments will be coordinated directly with your provincial health care plan (provided you have completed the appropriate form).

If you have made a claim under another plan first (e.g. through your spouse) you must also attach a copy of the Explanation of Benefits showing any amounts that have been paid by the other plan, or if the claim has been denied by the other plan.

## **Life Insurance and Accidental Death and Dismemberment (AD&D) Claims**

Life Insurance and Accidental Death and Dismemberment claim forms should be returned to OpenCircle Benefits, who will submit them to the appropriate Insurer. Sun Life is the Insurer for Employee and Dependent Life Insurance, and iA Financial Group is the Insurer for AD&D.

### **Employee and Dependent Life Insurance**

To submit a Life Insurance claim, please follow the directions below:

1. Notify OpenCircle Benefits as soon as possible, and we will provide you with the necessary claim forms.
2. Obtain an original death certificate or funeral directors statement.
3. Send the completed forms and documents to OpenCircle Benefits.
4. The benefit will be paid as soon as eligibility has been confirmed and satisfactory proof of death and beneficiary designations have been verified by Sun Life.

### **Accidental Death and Dismemberment (AD&D) Insurance**

To submit an AD&D claim, please follow the directions below:

1. Within 30 days of the accident, notify OpenCircle Benefits, who will provide you with the necessary claim forms.
2. Obtain an original death certificate, medical examiner's report or other proof of loss.
3. Send the completed forms and documents to OpenCircle Benefits no later than 90 days from the date of the accident, OpenCircle Benefits will send the forms to iA Financial Group.
4. Failure to furnish proof of claim within the time prescribed may not invalidate the claim if the notice or proof is given or furnished as soon as reasonably possible and if it is shown that it was not reasonably possible to give notice or furnish proof within the time so prescribed, in no event will the Insurer accept notice of claim beyond one year.
5. The AD&D benefits will be paid as soon as eligibility has been confirmed and proof of death or loss has been verified by iA Financial Group.

## **Disability and Waiver of Premium Claims**

Sun Life is the Insurer for disability benefits and provides assessment of waiver of premium. The claims should be submitted to Sun Life directly at the address, fax or email on the forms. Claims can also be submitted online through the Sun Life app.

Disability and waiver forms, as well as instructions on how to log into the Sun Life app, can be obtained by contacting OpenCircle Benefits.

### **Disability**

To submit a Long Term Disability (LTD) or Short Term Disability (STD) claim, where applicable, please follow the directions below:

1. Notify OpenCircle Benefits of your disability as soon as possible.
2. Notice of all LTD and STD claims must be provided to Sun Life within 90 days after the end of the Elimination Period.
3. OpenCircle Benefits will provide the necessary forms for completion by you, your employer, and your doctor.
4. Submit your claim to Sun Life directly.
5. The disability benefit will be paid as soon as eligibility has been confirmed and satisfactory proof of your disability claim has been provided to Sun Life.

### **Waiver of Premium for Life Insurance Benefits Due to Disability**

If you are receiving benefit payments for a workplace accident through Worker's Compensation, you may qualify to maintain your Life and AD&D benefits with no further premiums while you remain disabled (up to age 65). To apply for waiver of premium, please follow the directions below:

1. Notify OpenCircle Benefits of your disability as soon as possible.
2. Notice of all waiver of premium claims must be provided to Sun Life within 29 weeks of the onset of your disability.
3. OpenCircle Benefits will provide the necessary forms for completion by you, your employer, and your doctor.
4. Waiver of premium will be approved as soon as satisfactory proof of your disability has been provided to Sun Life.

# Employee Life Insurance

If you have any questions regarding the benefits outlined in this section, please contact OpenCircle Benefits.

## Benefit

You are eligible for \$100,000 of Employee Life Insurance. The policy insures you for death from any cause.

## Beneficiary

If you die while insured, the Benefit is payable to your beneficiary. You designate a beneficiary at the time you complete enrolment. You can designate your beneficiary by one of three methods: through your MyBenefitsConnect app, through completion of an Enrolment Card, or through completion of a Beneficiary Designation Form.

If designating a beneficiary outside of the MyBenefitsConnect app, your beneficiary designation must have a valid ink or e-signature to be accepted. If the beneficiary designation form is not signed by you in ink or using a valid e-signature, it will be invalid, and the Benefit will be payable to your estate. A valid e-signature is considered either:

- One created using a program (e.g., DocuSign) that embeds all signatures, IP addresses, timestamping and audit trails within the document.
- One created using an electronic stylus or touchscreen.

You may make, alter, or revoke a designation of beneficiary as permitted by law. Any designation of beneficiary you made under your employer's previous policy prior to the effective date of this policy applies to this policy until you make a change to that designation. You should review your beneficiary designation from time to time to ensure that it reflects your current intentions.

You can change your beneficiary any time by completing a new beneficiary designation form.

## Waiver of Premium Due to Disability

If you become disabled, you may be eligible to waive your Life Insurance premiums. You must apply for the waiver of premiums and submit proof of total disability within 12 months of the date the member is no longer working. Sun Life may require proof that said member is still total disabled. You must be under age 65. You are automatically approved for waiver of premium if you are on an approved Long Term Disability claim with Sun Life.

Please contact OpenCircle Benefits to apply.

## **Conversion of Benefit**

If your Employee Life Insurance terminates, you may be able to convert the amount of insurance that you had to an individual policy without evidence of insurability. Your application for an individual policy must be made within 31 days after your insurance coverage terminates.

If you die within 31 days of the date your Employee Life Insurance has terminated, the amount that could have been converted to an individual policy will be paid to your beneficiary. For complete details of the conversion option, contact OpenCircle Benefits.

# Accidental Death and Dismemberment (AD&D)

If you have any questions regarding the benefits outlined in this section, please contact OpenCircle Benefits.

## Provisions

### Coverage

This coverage provides you with 24-hour protection against on or off-the-job accidents, whether on business, vacation, or at home.

### Effective Date of Insurance

You are eligible for coverage under this policy while you are in benefit under the OpenCircle Benefit Plan.

### Waiver of Premium Due to Disability

If premiums for your basic life insurance are being waived, then premiums for the AD&D benefit will also be waived. Please contact OpenCircle Benefits to apply.

### Benefit Amount

The amount of AD&D Insurance for which you are covered (the Principal Sum) is equal to your Employee Life Insurance benefit.

### Notice Periods

Notice of a claim must be given within **30 days** from the date of the Accident, or **30 days** from the date of diagnosis in the case of the Critical Disease benefit. There are various important timelines and notice periods.

**Please contact OpenCircle Benefits as soon as possible after any accident or diagnosed covered condition (see the Critical Disease section below) to start the process.**

### Exposure & Disappearance

If, due to a covered accident, you are unavoidably exposed to the elements and such exposure, within 12 months of the date of the accident, results in a loss for which benefits would have been payable under the policy, such loss will be deemed as a result of the injury. Where, due to the accidental wrecking, sinking or disappearance of a conveyance in which you were riding, you disappear, and your body is not found within 12 months after the date of the wrecking, sinking or disappearance, it will be presumed, subject to no evidence of the contrary, that you suffered loss of life as a result of the injury.

## Schedule of Losses

If, within 12 months of the date of the accident, injury results in any of the following losses (including permanent and total loss of use), the Insurer will pay the following, subject to limitations:

<b>Two Times the Principal Sum:</b>	Loss of both arms Loss of both hands Loss of both legs Loss of both feet
<b>Two Times the Principal Sum:</b>	Loss of one arm and one leg on same side of body Quadriplegia (total paralysis of both upper and lower limbs) Paraplegia (total paralysis of both lower limbs) Hemiplegia (total paralysis of upper and lower limbs on one side of the body)
<b>One Times the Principal Sum:</b>	Loss of life Brain death Loss of entire sight of both eyes Loss of one hand and one leg Loss of one arm and one leg Loss of one hand and one foot Loss of one hand and entire sight of one eye Loss of one foot and entire sight of one eye Loss of speech and hearing in both ears
<b>Portion of the Principal Sum: Varies per type of loss</b>	Loss of one arm Loss of one leg Loss of one hand Loss of one foot Loss of entire sight of one eye Loss of speech or hearing in both ears Loss of thumb and index finger of either hand Loss of four fingers of either hand Loss of hearing in one ear Loss of all toes on one foot

### Limitations

Covered losses are subject to AD&D definitions outlined by the Insurer.

In no event will the Benefit Amount payable as the result of any single or multiple losses exceed the Principal Sum (except for those losses specified as payable at “**Two Times the Benefit Amount**”).

For losses payable at two times the Principal Sum, if loss of life occurs within 90 days following the date of accident, the loss will be payable at one times the Principal Sum.

### Aggregate Limit of Indemnity

The policy is subject to an Aggregate Limit of Indemnity of \$10,000,000 for all losses resulting from any one Accident. This means that in the event of an Accident that results in an accumulation of losses exceeding \$10,000,000, the amount payable with respect to each Insured Person will be reduced proportionately.

## Other Benefits

### Air Bag Benefit

If, due to vehicular Accident, Injury results in a loss covered by the policy, your Principal Sum will be increased by five percent if, at the time of the Accident, you were driving or riding in a vehicle equipped with one or more air bags and you were wearing a properly fastened seat belt. The driver of the vehicle must hold a current and valid driver's license authorizing him to operate such vehicle and neither be intoxicated nor under the influence of drugs at the time of the Accident. Due proof of seat belt use must be provided as part of the written proof of loss.

### Bereavement Benefit

If injury results in your loss of life and indemnity becomes payable under this policy, the Insurer will pay the reasonable and necessary expenses actually incurred by your spouse and dependent children for up to six sessions of grief counselling by a professional counselor, subject to a maximum of \$2,500.

### Brain Damage Benefit

If you, your insured spouse or insured dependent children sustain an Injury which results in Brain Damage, the insurer will pay the Principal Sum, less any amount paid or payable under "Accidental Death, Dismemberment and Specific Loss Indemnity" of the policy as the result of the same Accident, provided that:

- you, your insured spouse or insured dependent children incur Brain Damage within 120 days from the date of the Accident; and
- you, your insured spouse or insured dependent children are hospitalized as a result of Brain Damage at least seven of the first 120 days of the Injury; and
- a physician determines and the insurer is satisfied that you, your insured spouse or insured dependent children have evidence of Brain Damage for at least six consecutive months.

"Brain Damage" whenever used in the policy means irreversible physical damage to the brain causing complete incapacity of performing all the substantial and material functions and activities normal to everyday life.

### Carjacking Benefit

If Injury results in a Loss covered by the policy, your Principal Sum will be increased by 10% to a maximum of \$10,000.00, if the Injury occurs during a carjacking of an automobile that you were operating, getting into or out of, or riding as a passenger.

### Comatose Benefit

If Injury results in you being in a coma or comatose state within 12 months of the date of the Accident, the insurer will pay one percent of the Principal Sum, less any amount paid under "Accidental Death, Dismemberment and Specific Loss Indemnity" of the policy, for each month your coma or comatose state continues, subject to an overall maximum of \$50,000.00 and 100 consecutive months.

### Common Disaster Benefit

If Injury results in the loss of life of you and your insured spouse, and provided (a) indemnity becomes payable under the policy as a result of the same Accident, and (b) both deaths occur within 90 days after the date of the Accident, your insured spouse's Principal Sum will be increased to the amount of your Principal Sum, but in no event will the amount payable exceed \$1,000,000.00.

### Cosmetic Disfigurement Benefit

When, as a result of a non-occupational injury, you suffer cosmetic disfigurement due to a third-degree burn, the Insurer will pay a percentage of the Principal Sum based on the amount of body surface burned as determined by the attending physician.

If you suffer burns in more than one area as a result of any one accident, benefits will not exceed a maximum of \$25,000.

### Critical Disease Benefit

If, prior to age 65, you are diagnosed by a specialist with a Covered Disease while the policy is in force and you are totally disabled from that Covered Disease for at least nine months following the date of diagnosis, the Insurer will pay 10% of the Principal Sum to a maximum of \$50,000. This benefit is payable only if investigations leading to the diagnosis of a Covered Disease are initiated more than 90 days following the effective date of your insurance. Payment of the Critical Disease Benefit is limited to only the first Covered Disease to occur.

Covered Diseases are: Alzheimer's Disease, Amyotrophic Lateral Sclerosis (ALS), Huntington's Chorea, Multiple Sclerosis, Necrotizing Fasciitis, Parkinson's Disease, Peripheral Vascular Disease, Poliomyelitis and Type 1 Diabetes (insulin dependent).

### Day Care Benefit

If a covered injury results in loss of life within 12 months of the date of the accident, the Insurer will pay the reasonable and necessary expenses actually incurred, subject to 5% of the Principal Sum to a maximum of \$5,000 for each of your dependent children under age 13 who are:

- Enrolled in a legally licensed Day Care centre on the date of your passing, or
- Enroll in a legally licensed Day Care centre within 12 months of the date of your passing.

The benefit will be paid each year immediately upon receipt of satisfactory proof that the dependent child is enrolled in a legally licensed day care centre. Benefit payments will not exceed four years, which must run consecutively, with respect to any one dependent child, subject to an overall maximum of \$20,000.00. Expenses incurred prior to your passing and expenses for room, board or ordinary living, travel or clothing are not payable under this benefit.

### Education Benefit

If a covered injury results in loss of life within 12 months of the date of the accident, the Insurer will pay the reasonable and necessary expenses actually incurred, subject to 5% of the Principal Sum to a maximum of \$10,000, for each of your dependent children who are enrolled as full-time students:

- In a school for higher learning above the secondary school level as defined in the province or territory of residence, or
- At the secondary school level, but who enroll as full-time students in a school for higher learning within 12 months of the date of your passing.

The benefit will be paid each year upon receipt of satisfactory proof that the dependent child is enrolled as a full-time student in a school for higher learning. Benefit payments will not exceed four consecutive annual payments with respect to one dependent child. If, at the time of loss, none of your dependent children are eligible for the Education Benefit, the Insurer shall pay an additional amount of \$2,500 to your designated beneficiary.

Expenses incurred prior to your passing and expenses for room, board or ordinary living, travel or clothing are not payable under this benefit.

### Extended Family Benefit

If your spouse and dependent children are insured under the policy on the date of your death due to an Injury for which benefits are payable, their insurance may be continued for a period of twelve months without payment of premiums.

### Family Transport Benefit

If, following a covered injury, you are confined as an in-patient in a hospital located from a point of not less than 150 kilometres from your normal place of residence, the Insurer will pay the reasonable and necessary expenses actually incurred by any one immediate family member for hotel accommodations and transportation by the most direct route to you, subject to a maximum of \$20,000 for all such expenses.

Payment will not be made for board or other ordinary living, travel or clothing expenses. If transportation is by a vehicle, reimbursement of transportation will be limited to \$0.35 per kilometre travelled.

### Felonious Assault Benefit

If, following an Injury which results in a Loss covered by the policy, the benefit amount payable will be increased by 10% of your Principal Sum, subject to an overall maximum of \$50,000.00 provided that the loss occurred:

- as a result of Criminal Act of Violence; and
- while you are engaged in the business of the Policyholder, whether on or off the premises of the Policyholder.

### Funeral Expense Benefit

If a covered injury results in your loss of life, the Insurer will pay the reasonable and necessary expenses actually incurred for your funeral, subject to a maximum of \$5,000.

### Home Alteration and Vehicle Modification Benefit

If, following a covered injury, you are required to use a wheelchair to be ambulatory, the Insurer will pay the reasonable and necessary expenses actually incurred within three years of the date of the accident causing such loss for:

- The cost of alterations on your principal residence, and/or
- The cost of modifications to one motor vehicle utilized by you, where such modifications are approved by the provincial vehicle licensing authorities.

In such cases, modifications must be required for the purpose of making the residence/vehicle wheelchair accessible. Costs are subject to a maximum of \$50,000 as the result of any one Accident.

### Hospital Indemnity Expense

A daily benefit of one-thirtieth of 1% of your Principal Sum, to a maximum monthly benefit of \$2,500 will be payable when you are in a hospital and under the regular care and attendance of a physician, but only if such period of hospitalization is necessary for the treatment of a covered injury and begins while insurance under this policy is in force as to that Insured

Person. Such daily benefit will be paid from the first day of a necessary period of hospitalization as an in-patient, for which a full day's room and board is charged, but in no event for more than 12 months per accident.

A period of hospitalization which becomes necessary for the treatment of an injury other than for a Loss covered by the policy will be covered in accordance with the above terms, and the daily benefit will be paid from the first day of hospitalization of at least a four-day period of hospitalization.

If a particular condition causes more than one period of hospitalization due to the same or related causes, then the maximum benefit (12 months in a hospital) will be reinstated, provided a period of six months has elapsed between periods of hospitalization.

#### Identification Benefit

If a covered injury results in your loss of life and provided identification of your body is required by the police or similar law enforcement agency, the Insurer will pay the reasonable and necessary expenses actually incurred by a member of your immediate family for lodging and board (not to exceed a maximum of three consecutive nights) and transportation by the most direct route to and from the location of the body.

The body's location must not be less than 150 kilometres from the immediate family member's normal place of residence. Benefits payable are subject to a maximum of \$20,000.

#### Parental Care Benefit

If Injury results in your loss of life, the insurer will pay 5% of your Principal Sum, to a maximum of \$5,000.00, to any eligible dependent parent who, at the time of the Accident, is a resident in a licensed nursing care facility, or enrolled in a home health care program, or living in your residence, or receiving support and care provided by you.

#### Permanent Total Disability

If, following an Injury and within 12 months of the date of the Accident, you are totally and permanently disabled while under age 65 and prevented from engaging in any and every occupation or employment for compensation or profit, the insurer will pay, provided such disability has continued for a period of 12 consecutive months and is total, continuous and permanent at the end of this period, the Principal Sum less any amount paid or payable under "Accidental Death, Dismemberment and Specific Loss Indemnity" as the result of the same Accident.

#### Psychological Therapy Benefit

If, following a covered loss, you require psychological therapy as prescribed by a physician, the Insurer will pay the reasonable and necessary expenses actually incurred, subject to a

maximum of \$5,000. Benefits will be payable until the earlier of the maximum has been paid, two years from the date of the injury has elapsed, or you die.

#### Public Transportation Benefit

If, following an Injury which results in a Loss covered by the policy, the insurer will pay an additional amount equal to 100% of the Principal Sum if, at the time of the Accident, you were riding as a passenger in a regularly scheduled public land, air or water conveyance licensed to carry Fare-paying passengers, including a train, subway, tramway, boat or commercial airplane.

#### Rehabilitation Benefit

If, following a covered injury, you require special training in order to be qualified to engage in a special occupation in which you would not have engaged except for such injury, the Insurer will pay the reasonable and customary expense incurred for training within three years of the date of the accident, subject to a maximum of \$20,000 as the result of any one accident.

#### Repatriation Benefit

If an injury results in loss of life covered under this policy, the Insurer will pay the reasonable and necessary expenses actually incurred for the preparation and transportation of your body to your city of residence, subject to a maximum of \$20,000.

#### Seat Belt Benefit

If a covered injury is due to a vehicular accident, the benefit payable under the schedule of losses will be increased by 10% to a maximum of \$50,000 if, at the time of the accident, you were driving or riding in a vehicle and wearing a properly fastened seat belt. The driver must hold a current and valid driver's license authorizing them to operate such a vehicle and could not have been intoxicated or under the influence of drugs at the time of the accident. Due proof of seat belt use must be provided as part of the written proof of loss.

#### Spousal Training Benefit

If an injury results in loss of life covered under this policy, the Insurer will pay the reasonable and necessary expenses actually incurred by your spouse who engages in a formal occupational training program in order to become specifically qualified for active employment in an occupation which they would not otherwise have sufficient qualifications.

Expenses must be incurred within three years of the date of the accident and are subject to a maximum of \$20,000 for all such expenses. Expenses incurred for room, board or ordinary living, travel or clothing are not payable under this benefit.

#### Survivor Benefit

If Injury results in your or your spouse's loss of life and indemnity becomes payable under the policy, the insurer will pay a monthly benefit of one percent of your Principal Sum to the

surviving spouse or divide it equally between the surviving dependent children if there is no spouse, subject to a monthly maximum of \$5,000.00.

Payments will commence on the date the loss of life benefit is paid and will continue for each subsequent month, to an overall maximum of six months.

#### Workplace Modification and Accommodation Benefit

If, following a covered injury, you require special adaptive equipment and/or workplace modification in order to reasonably accommodate your return to fulltime employment with your current OpenCircle employer, the insurer will pay the reasonable and necessary expenses actually incurred by your employer subject to a maximum of \$5,000 as the result of any one accident. Your employer must agree to provide the required equipment and/or make modifications to your workplace and acknowledge performance of the essential duties of your occupation may be altered. All required equipment and/or workplace modification must have prior approval from the Insurer.

## Exclusions and Termination of Coverage

### Exclusions

The plan does not cover any loss, which is the result of:

- Intentionally self-inflicted injuries, suicide or any attempt thereof, while sane or insane.
- Declared or undeclared war or any act thereof.
- Travel or flying in an aircraft owned, operated, leased or chartered by your employer.
- Losses occurring while you are serving on full-time active duty in the Armed Forces of any country or international authority.
- Flying as a pilot or crew member in any aircraft (owned by your employer or otherwise)
- physical or mental illness or disease or treatment for the illness or disease, except as provided in the part titled "Critical Disease Benefit".

Please contact OpenCircle Benefits for information about other air travel related exclusions.

### Change in Information, Coverage or Benefit Continuation

Please contact OpenCircle Benefits for information about and change in coverage, change in beneficiary or continuation of coverage if your coverage terminates.

### Termination of Policy

Insurance will immediately terminate on the earliest of:

- The date the policy is terminated,
- The date the Employer or Policyholder fails to pay the premiums for you,
- The date you cease to be in benefit under the OpenCircle Benefit Plan,

- The date you reach 65 years of age with respect to the “Permanent Total Disability” benefit, or
- With respect to other benefits, the premium due date coinciding with or immediately following the date you retire.

## Dependent Life Insurance

If you have any questions regarding the benefits outlined in this section, please contact OpenCircle Benefits.

### Benefit

Your spouse (if any) is covered for \$10,000 of Dependent Life Insurance. Each of your eligible children (if any) is covered for \$5,000 of Dependent Life Insurance. Your eligible spouse and children are covered for this benefit during the same period that you are covered for Employee Life Insurance. Note that your dependents will be covered under the Dependent Life Insurance benefit only if they are listed as dependents on your enrolment form.

In the event your spouse or an eligible child dies from any cause, the benefit will be paid to you. If you should die prior to the benefit being paid, the benefit will be paid to your estate.

### Waiver of Premium Due to Disability

If premiums for your basic life insurance are being waived, then premiums for the Dependent Life Insurance will also be waived. Please contact OpenCircle Benefits to apply.

### Conversion of Benefit

If your coverage terminates, your spouse may be able to convert the amount of insurance that he/she had to an individual policy without proof of insurability. If your spouse dies within 31 days of the date your Employee Life Insurance has terminated, the amount that could have been converted to an individual policy will be paid to you.

For complete details of the conversion option, contact OpenCircle Benefits.

# Extended Health Care for Employees & Dependents

The extended health care benefits are self-insured under the OpenCircle Benefit Plan.

If you have any questions regarding the benefits outlined in this section, please contact OpenCircle Benefits.

## Provisions

### Benefit Coverage

This section outlines the details of your extended health care benefits. The payment of any extended health care expense is subject to reasonable and customary pricing, any benefit levels and maximum benefit amounts indicated.

### Eligible Expenses

Eligible expenses are generally charges for services and supplies that are medically necessary and customarily provided in relation to the nature and severity of the illness.

Eligible expenses are generally included to the extent that:

- All expenses must occur and be paid for while you and your dependents are eligible for benefits
- They are reasonable and customary, professionally recognized and medically necessary
- Except where otherwise indicated, they are prescribed by a physician
- They exceed the amount payable under any other provision of the plan document or, subject to the Co-ordination of Benefits provision, any other plan that provides similar benefits

### Coordination of Benefits

If you are also eligible for benefits under another extended health care plan, any claim under this plan will be coordinated and limited to the extent that benefits payable from all plans do not exceed 100% of eligible expenses.

### Survivor Benefit

If you die while covered for benefits, extended health care coverage will be continued for your eligible dependents without any further payment of contributions. This extension will terminate 24 months from the date of your death.

## Prescription Drug Benefit

The OpenCircle Benefit Plan will provide coverage for 80% of the Eligible Drugs and 80% of the Eligible Dispensing Fee in Canada. When an individual has incurred \$5,000 or more in eligible prescription drug claims in a calendar year, prescription drug coverage will increase to 90%

for that individual only for the remainder of the calendar year. Coverage will revert back to 80% every January 1st.

All claims for Eligible Drugs and certain diabetes supplies can be made directly by your pharmacist at the time that you fill your prescription by presenting your OpenCircle Benefits ID Card. You will not have to pay any amount of the prescription that is covered by the plan, but you will have to pay any amounts that are not covered by the plan. Alternatively, you can pay for the drugs at the time you receive them from your pharmacist and submit your paid receipt for reimbursement.

### Eligible Drugs

The following are considered Eligible Drugs under the OpenCircle Plan:

- Drugs which by law may only be obtained with a prescription and are dispensed by a licensed pharmacist
- Smoking cessation aids are covered to a lifetime maximum of \$500 per person (includes drugs, gum, patches, lozenges and inhalers)
- Fertility drugs are covered to a lifetime maximum of \$2,500

The plan will cover only the cost of the lowest-priced equivalent generic drug unless medical evidence is provided by the prescribing physician that a brand name drug cannot be substituted.

There is a maximum limit of a 100-day supply for each prescription, subject to certain exceptions.

Some specific drugs may require prior authorization by OpenCircle Benefits to determine whether they meet clinical criteria for the particular health condition.

OpenCircle has partnered with Reformulary Group to give our members tools to help them understand the medications applicable to their needs while maximizing the value of their benefit plan.

OpenCircle plan members can use the easy online tool DrugFinder®. This database shows medications that work well, and provide good value as '**preferred drugs**'. Drugs that provide less benefit, or cost more without providing better results, are considered '**non-preferred**'.

To help you understand what this means for your own prescriptions, get started by visiting [www.drugfinder.ca](http://www.drugfinder.ca). You can create an account and then use the access code:

**OpenCircle@Reformulary** to complete your registration. You will then be able to see your coverage level and explore information tailored to your plan.

### **Eligible Dispensing Fee**

The plan will allow a maximum dispensing fee of \$9.00 for most prescriptions. Dispensing fees will vary between pharmacies.

The plan covers a maximum of five dispensing fees per maintenance medication per year where the drug is not legally limited in quantity. To maximize your amount of coverage, we recommend filling maintenance medication in 90-day quantities. There is no annual dispensing fee limit on acute medications or medications legally limited in quantity.

### **Diabetic Supplies**

The following diabetic supplies are covered at 100%: insulin syringes, disposable needles for use with non-disposable insulin injection devices, test strips, sensors for flash glucose monitoring machines, lancets.

### **Exclusions**

The following will not be considered eligible drug expenses, whether prescribed or not:

- Drugs dispensed during treatment as an in-patient or as an out-patient in a hospital
- Any drugs not approved for sale in Canada
- Charges for the administration of drugs, serums or vaccines
- Vitamins
- Proteins and dietary or food supplements
- Erectile dysfunction drugs
- Drugs that are considered cosmetic, whether or not prescribed for a medical reason

This list of exclusions is not exclusive, please contact OpenCircle Benefits if you have questions regarding your drug coverage.

## **Medical Services and Supplies**

The OpenCircle Benefit Plan will provide for 100% of the following eligible medical services and supplies, subject to reasonable and customary pricing limitations.

### **Hospital**

The difference between the charges for a standard ward and a semi-private room in an active treatment hospital in Canada. For out-of-province hospital accommodation, any difference between the charges for the standard ward and the government authorized allowance in the person's home province.

### **Convalescent Care**

The charge for a standard ward or semi-private room for convalescent care for a condition that is likely to improve as a result of the care, where the eligible person is admitted within 24 days of being hospitalized for acute care. There is a maximum of 180 days per illness.

### **Home Care Nursing**

The charges for nursing services provided in the patient's home when certified in writing by the attending physician as medically necessary for the condition of the patient. A registered nurse, licensed practical nurse or registered nursing assistant must provide the nursing services. A relative of the patient or a resident in the patient's home must not provide the nursing services. To establish the amount of coverage available before home nursing begins, you should apply for a pre-care assessment. The maximum amount of expenses that will be paid is \$10,000 during any one calendar year per person.

Charges for custodial care or any service within the capabilities and competence of a member of the household are not eligible.

### **Ambulance**

Ambulance services, including air ambulance services, are covered if they are provided by a licensed ambulance company. Transportation must be to the nearest centre where essential treatment is available. If transportation is to a further centre, the plan provides alternative benefits based on coverage for transportation to the nearest centre where essential treatment is available. Alternative benefits are available on the same basis as they are for ambulance services provided in Canada.

### **Dexcom Diabetic System**

GreenShield's partnership with Dexcom Canada gives medically eligible plan members and dependents convenient access to the Dexcom G7 CGM system. With this system, users can access the "Digital Diabetes Care Program" from GreenShield Pharmacy.

This program provides personalized glucose data insights and expert guidance from the "Dexcom Clarity" platform. It also provides preferred pricing for Dexcom G7 supplies with the option to Direct Bill for said supplies with a reduced Copay, and Automated Shipments for G7 supplies every 3 months to your door.

If you do not have a compatible Smart Device for use with the Dexcom G7, one free receiver is provided upon request.

### **Hearing Aids**

The plan covers hearing aids, including tubing and ear molds provided at the time the hearing aid is purchased. The maximum amount payable is \$1,000 every 5 calendar years.

### **Orthopedic Footwear and Orthotics**

The plan covers:

- The cost of custom fitted orthopedic footwear, including orthopedic alteration to standard footwear. Must be prescribed by a physician, podiatrist or chiropodist. Up to a maximum of \$400 per person per calendar year.

- The cost of custom-made foot orthotics up to a maximum of \$350 per person per calendar year. To be eligible, the orthotics must be prescribed by a physician, podiatrist or chiroprapist.

### **Braces**

The purchase or replacement of custom braces which incorporate a rigid support of metal or plastic, prescribed by a physician. The repair of a custom fitted brace does not require a prescription.

### **Prosthetics**

Where prescribed by a physician, and reasonable for the diagnosed condition, the following prosthetics are covered:

- Charges for artificial limbs, artificial eyes, artificial nose or artificial larynx
- Myoelectric arms including repairs to a maximum of \$10,000 per prostheses (charges for duplicate prostheses are not eligible)
- Charges for external prostheses following a mastectomy (to a maximum of \$400 every two calendar years)

### **Medical Aids**

***It is recommended that you verify the reasonable and customary maximum allowed prior to purchasing covered items.***

Where prescribed by an authorized medical professional, charges for the following medical aids, subject to reasonable and customary pricing and any maximums indicated:

- Continuous or Automatic Positive Airway Pressure (CPAP/APAP) machines
- Splints, trusses, crutches, casts, canes, walkers, cervical collars, parapodiums, ileostomy and colostomy supplies, urinary kits and catheterization supplies
- Rental or purchase (at the discretion of the plan) of manual wheelchairs, hospital beds, iron lungs or oxygen
- Purchase of an electric wheelchair to a lifetime maximum of \$4,000 per person
- Rental or purchase (at the discretion of the plan) of medical durable equipment and supplies
- Diaphragms (whether or not prescribed by a doctor); intra-uterine devices, if inserted by a physician
- Up to three mastectomy bras per person every 6 months based on first paid claim or claims and mastectomy bra pads, when used in conjunction with an external mastectomy prosthesis (no prescription required)
- Up to two pairs of custom-fitted graduated compression hose per every 4 months based on first paid claim or claims and reimbursement amount is dependent upon the compression factor and whether hose are stock items or custom-made
- An aerochamber device, once every two calendar years
- Wigs required as a result of a medical condition, 1 per calendar year (lifetime max \$500)

- Laboratory services, diagnostic services, blood and blood plasma, x-rays, oxygen and the administration
- Blood testing monitors, to a lifetime maximum of \$700
- Insulin pumps when recommended by a physician once every five calendar years
- Allergy testing materials, provided the testing is performed by a physician, to a maximum of \$40 per test and a lifetime maximum of \$200 per person
- Blood pressure monitors, to a maximum of \$150 per person in any three consecutive calendar year period
- Intra-venous supplies

This list is not exclusive. If you have questions on coverage for a particular medical device, and for assistance submitting an estimate for applicable coverage, please contact OpenCircle Benefits.

## Paramedical Practitioners

Charges for the services are covered to the calendar year maximum outlined below per practitioner per person, subject to reasonable and customary pricing limitations. To be eligible, services:

- Must be provided by a practitioner who is registered/licensed with the appropriate provincial regulatory body in the specialty matching the service provided,
- Must be provided in the province where the practitioner is registered/licensed in that specialty,
- Must be provided by an eligible practitioner, as outlined below:
  - **Acupuncturist** \$500 per person per calendar year reimbursed at 80% of reasonable and customary costs
  - **Chiropracist or Podiatrist\*** \$500 per person per calendar year reimbursed at 80% of reasonable and customary costs
  - **Chiropractor** \$750 per person per calendar year reimbursed at 80% of reasonable and customary costs
  - **Dietician** \$500 per person per calendar year reimbursed at 80% of reasonable and customary costs
  - **Massage Therapist** \$750 per person per calendar year reimbursed at 80% of reasonable and customary costs
  - **Naturopath** \$500 per person per calendar year reimbursed at 80% of reasonable and customary costs
  - **Osteopath** \$500 per person per calendar year reimbursed at 80% of reasonable and customary costs
  - **Psychologist or Social Worker** \$1,000 per person per calendar year reimbursed at 80% of reasonable and customary costs

- **Physiotherapist/Athletic Therapist** \$750 per person per calendar year reimbursed at 80% of reasonable and customary costs
- **Speech Therapist** \$500 per person per calendar year reimbursed at 80% of reasonable and customary costs

### **Diagnostic X-Rays**

Maximum of one x-ray in each calendar year for each eligible person, per specialty, where applicable (chiropractor, chiropodist/podiatrist, osteopath)

*\*Excludes coverage for surgical tray fees and facility fees.*

*\*Hourly maximums also apply. Please contact OpenCircle Benefits to verify amounts.*

## **Vision Care Expenses**

### **General Expenses**

The following expenses are covered under the Vision Care benefit:

- Eye exams by a licensed ophthalmologist or optometrist where not covered by a provincial plan
- Eyeglass lenses and frames for you and your dependents (including tinting, anti-reflective or anti-scratch coating of prescribed lenses), prescription sunglasses, contact lenses, prescription safety glasses or laser eye surgery, when prescribed by a doctor, ophthalmologist or optometrist, which are purchased while eligible for benefits.

These benefits are provided every two calendar years for participants age 19 and over (every calendar year for participants under age 19), to a maximum of \$75 per person for eye exams, and \$350 per person for eyewear.

### **Special Benefits**

The benefits indicated below are in addition to the benefit maximum indicated in **General Expenses** above.

- Prescription safety glasses for you (dependents are not eligible) when prescribed by a doctor, an ophthalmologist or optometrist, which are purchased while eligible for benefits, to a maximum of \$150 every two calendar years.
- Visual training for you and your dependents, prescribed by a doctor, an ophthalmologist or optometrist, to a lifetime maximum of \$200 per person.
- Contact lenses for you and your dependents, prescribed by a doctor, an ophthalmologist or optometrist if considered to be medically necessary (e.g., for severe corneal astigmatism, severe corneal scarring, keratoconus or aphakia) and required to improve vision in the better eye to at least 20/40 if this is not possible to do with conventional glasses, to a lifetime maximum of \$500 per person.

## Out-of-Province/Canada Medical Benefits

### Medical Emergency Benefits

The OpenCircle Extended Health Plan provides for 100% of the following expenses when you or your eligible dependents are traveling outside of your province of residence or outside of Canada, to a maximum of \$2,000,000 in Canadian funds. To be eligible, the person must be covered by the government health plan in his or her home province.

This coverage is for **medical emergencies only** arising while you or your dependent are travelling for vacation, business or education, and is limited to coverage for 60 days of travel per trip. Coverage for travel within Canada is limited to emergencies arising more than 500 kilometres from the person's home. If you will be working outside of Canada or have an eligible dependent that will be studying outside of Canada, you should consider purchasing additional non-emergency medical coverage. A **medical emergency** is either a sudden, unexpected emergency or a sudden, unexpected illness or acute episode of disease that could not have been reasonably anticipated based on the person's prior medical condition.

There are limitations to this benefit, please contact OpenCircle Benefits for more information on your situation. **Claim forms must be completed for any out-of-country expenses.**

The following expenses for emergency medical treatment are covered:

- Hospital accommodation in a standard or semi-private ward or intensive care unit, if the confinement begins while you or your dependent is covered
- Medical services and supplies provided during a covered hospital confinement
- Physician services
- Hospital out-patient services and supplies
- Provided during a covered hospital confinement

If your medical condition permits you to return to Canada, benefits will be limited to the amount payable under this plan for continued treatment outside Canada or the amount payable under this plan for comparable treatment in Canada, plus return transportation, whichever is less. No benefits are paid for expenses incurred more than 60 days after the date of departure from Canada. If you or your dependent is hospital confined at the end of the 60-day period, benefits will be extended to the end of the confinement.

### Accidental Dental

Coverage for 100% of the charges for the repair, extraction or replacement of natural teeth damaged by a direct accidental external blow to the mouth. The accidental injury and the expense for the repair, extraction or replacement must occur while the individual is eligible for this benefit. The expense for the repair, extraction or replacement must occur within 12 months from the date the dental accident occurred. This 12-month limit should be taken into consideration if choosing a treatment plan that requires multiple procedures with healing

time between them. The maximum payable is \$10,000 per person per accident. There are limitations to this coverage, contact OpenCircle Benefits for more information.

## GreenShield Travel Assistance

### Travel Eligibility

#### For You

To be eligible for travel coverage, you must be a plan member who:

- a) has satisfied all the requirements for coverage under your employer's health benefit plan
- b) is enrolled in your employer's group health benefit plan
- c) is a resident of Canada, and
- d) is covered under your provincial/territorial health insurance plan.

#### For Your Dependents

To be eligible for travel coverage:

- a) you and your dependents must be enrolled in the same coverage under your employer's group benefit plan,
- b) you must be covered under this plan, and
- c) each dependent must be covered under a provincial/territorial health insurance plan.

#### Termination

Your coverage will end on the earliest of the following dates:

- the date your employment ends;
- the date you are no longer actively working;
- the date you attain age 71;
- the end of the period for which rates have been paid to GreenShield for your coverage;
- the date the group contract terminates.

Dependent coverage will end on the earliest of the following dates:

- the date your coverage terminates;
- the date your dependent is no longer an eligible dependent;
- the date on which your dependent child attains the age limit specified in the definition of Dependent;
- the end of the period for which rates have been paid for dependent coverage;
- the date the group contract terminates.

### Travel Summary

The travel benefits are intended to **supplement** provincial/territorial health insurance plans if you experience a medical emergency while travelling outside of your province/territory of residence or Canada. If your provincial/territorial health insurance plan includes out-of-Canada benefits, hospital and medical services are eligible only if your provincial/territorial health insurance plan provides payment toward the cost of incurred services. The benefits

shown below will be eligible if they are medically necessary for the emergency treatment of a sudden and unforeseen illness or injury and reimbursement will be limited to reasonable and customary charges for the area in which they are incurred.

<b>Calendar Year Deductible (per person/per family):</b>	No deductible
<b>Your Co-pay:</b>	0%
<b>Maximum Number of Days per Trip:</b>	60
<b>Your Plan Covers</b>	<b>Maximum Plan Pays</b>
Emergency Services:	\$2,000,000 per incident
Referral Services	\$75,000 per calendar year

**Before you travel, visit [greenshield.ca](http://greenshield.ca) for important information you will need to know if you experience a medical emergency while you are travelling.**

## TRAVEL

**Important: This Travel benefit includes requirements, limitations, and exclusions that can affect eligibility and/or reimbursement of incurred expenses. You must be accurate and complete in your dealings with GreenShield at all times. Please take the time to read through this benefit before you travel to ensure you are aware of the terms and conditions, making note of the following:**

- With the exception of the “**Referral Services**”, this Travel benefit is an **emergency** medical benefit only and provides coverage while you are temporarily outside of your regular province/territory of residence for vacation, education, or business reasons. It does not cover any non-emergency, elective, cosmetic, or experimental treatment, surgery, procedure, or any other service a covered person chooses to have performed outside of their home province/territory – whether pre-planned or not.
- GreenShield reserves the right to review your medical information at the time of claim. Any invasive or investigative procedures must be pre-approved by GreenShield Travel Assistance. If the covered person is the patient and it is medically impossible for the covered person to call prior to obtaining emergency treatment, it is extremely important to have someone call GreenShield Travel Assistance on the covered person’s behalf within 48 hours. If GreenShield Travel Assistance is not notified within the first 48 hours, reimbursement of incurred expenses may be limited to **the lesser of** the amount of only those expenses incurred within the first 48 hours of any and each treatment/incident **or** the plan maximum. This means the covered person will be responsible for all expenses thereafter.

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

**Co-pay** means the eligible allowed amount that must be paid by you or your dependent before reimbursement of an expense will be made.

**Covered person** means the plan member who has been enrolled in the plan or their enrolled dependents.

**Deductible** is the amount that must be paid by or on behalf of you and your dependent in any year (as defined above) before reimbursement of an eligible expense will be made.

**Dependent** means

- your spouse, if you are legally married or if not legally married, you have lived in a common-law relationship for more than 12 continuous months. Only one spouse will be considered at any time as being covered under the group contract;
- your unmarried child who:
  - is under age 21;
  - is under age 25 (age 26 for RAMQ drugs for Quebec residents) and is enrolled and in full-time attendance at an accredited college, university or educational institute;
  - regardless of age became totally disabled while eligible and enrolled in this plan, and who has been continuously so disabled since that time, also qualify as a dependent;

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

**Note:** A legally adopted child cannot be added to the benefit plan until the adoption has been finalized and permanent custody awarded.

Children who are in full-time attendance at an accredited school do not have to reside with you or attend school in your province. If the school is in another province or country, you must apply to your provincial/territorial health insurance plan for an extension of coverage to ensure your child continues to be covered under a provincial health insurance plan.

**Emergency** means a sudden and unforeseen Medical Condition that requires Treatment. An emergency no longer exists when the evidence reviewed by GreenShield Travel Assistance indicates that no further Treatment is required at your destination or you are able to return to your province/territory of residence for further Treatment. If GreenShield Travel Assistance determines that you transfer to another facility or return to your home province/territory of residence, and you choose not to, the benefits will not be paid for further medical treatment, and coverage will be limited for unrelated events.

Emergency excludes Treatment of a **Pre-existing Condition** that was not completely **Stable** for the 90-day period immediately preceding the covered person's departure.

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

**GreenShield Travel Assistance** means Green Shield Canada Insurance or CanAssistance, providing Travel Assistance and Claims Services on behalf of Green Shield Canada Insurance.

**Pre-existing Condition** means any Medical Condition that exists prior to the date of the covered person's departure.

**Medical Condition** means any disease, illness or injury (including symptoms of undiagnosed conditions).

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

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

A Medical Condition is considered **Stable** when all of the following statements are true during the 90-day period immediately preceding the date of the covered person's departure.

- a) There has not been any new Treatment prescribed or recommended, or change(s) to existing Treatment (including stoppage in Treatment), and
- b) The Medical Condition has not become worse, and
- c) There has not been any new, more frequent, or more severe symptoms, and
- d) There has been no hospitalization or referral to a specialist, and
- e) There have not been any tests, investigation or Treatment recommended, but not yet complete, nor any outstanding test results, and
- f) There is no planned or pending treatment, and
- g) There has not been any change to an existing prescribed drug (including an increase, decrease, or stoppage to prescribed dosage), or any recommendation or starting of a new prescription drug. The following are not considered changes to existing prescribed drug Treatment.
  - i. Routine dosage adjustments of Coumadin, Warfarin, or insulin, as long as these medications have not been newly prescribed or stopped;
  - ii. A change from a brand name to a generic equivalent product as long as the dosage is the same – including a transition from a biologic to a biosimilar product;
  - iii. A decrease in the dosage of a medication due to the improvement of a condition.

**All of the above conditions must be met during the 90-day period prior to the covered person's departure in order for a Medical Condition to be considered Stable.**

**Travelling Companion** means any person who has prepaid accommodation and/or transportation with the Covered Person for the same covered trip.

**Treat, Treated, Treatment** means a procedure prescribed, performed, or recommended by a Physician for a Medical Condition. This includes but is not limited to prescribed medication, investigative testing, and surgery.

**We, us, or our** means Green Shield Canada Insurance or CanAssistance.

- To qualify for benefits, the claimants must be covered by their respective provincial/territorial government health plan or equivalent at the time the expenses are incurred; otherwise, there is no coverage under this benefit.
- Eligible travel benefits will be considered based on the reasonable and customary charges in the area where they were received, less the amount payable by your provincial/territorial health insurance plan, if your province/territory provides such coverage.
- All dollar maximums and limitations are stated in Canadian currency. Reimbursement will be made in Canadian funds or U.S. funds for both providers and plan members, based on the country of the payee. For payments that require currency conversion, the rate of exchange used will be the rate in effect on the date of service of the claim.
- Eligible benefits are limited to the maximum days per trip shown in the Summary of Benefits commencing with the date of departure from your province/territory of residence. If you are hospitalized on the last day shown in the Summary of Benefits, your benefits will be extended until the date of discharge.

Eligible travel expenses include the following:

**Hospital services and accommodation**

- up to a standard ward rate in a public general hospital;
- up to \$350 for out-of-pocket expenses such as telephone, television rental, and parking.

**Medical/surgical services** rendered by a legally qualified physician or surgeon to relieve the symptoms of, or to cure an unforeseen illness or injury;

**Emergency Transportation**

- **Land ambulance** to the nearest qualified medical facility;
- **Air ambulance** – the cost of air evacuation (including a medical attendant when necessary) between hospitals and for hospital admission into Canada when approved in advance by your provincial/territorial health insurance plan or to the nearest qualified medical facility.

**Referral services** – Reasonable and customary hospital, medical, surgical, and transportation expenses in excess of those expenses covered by your provincial/territorial health insurance plan for you and an approved escort;

- **Prior to the commencement of any referral treatment, written pre-authorization** from your provincial/territorial health insurance plan and GreenShield **must be obtained**. Your provincial/territorial health insurance plan may cover this referral benefit entirely. You must provide GreenShield with a letter from your attending physician stating the reason for the referral, and a letter from your provincial/territorial health insurance plan outlining their liability. **Failure to obtain pre-authorization will result in non-payment.**

**Services of a registered private nurse** up to a maximum of \$10,000 per calendar year, at the reasonable and customary rate charged by a qualified nurse registered and licensed in the jurisdiction in which treatment is provided. You must contact GreenShield Travel Assistance for pre-approval;

**Diagnostic laboratory tests and X-rays** when prescribed by the attending physician. Except in emergency situations, GreenShield Travel Assistance must pre-approve these services (i.e. cardiac catheterization or angiogram, angioplasty and bypass surgery);

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

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

**Treatment by a dentist** only when required on an emergency basis for:

- Services and treatment of a direct accidental blow to the mouth up to a maximum of \$2,500. Treatments (prior to and after return) must be provided within 90 days of the accident. Details of the accident must be provided to GreenShield Travel Assistance along with dental X-rays;
- Treatment to relieve dental pain up to a maximum of \$500 per trip.

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

- GreenShield Travel Assistance specifies in writing that you should immediately return to your province/territory of residence for immediate medical attention, reimbursement will be made for the extra cost incurred for the purchase of a one-way economy airfare, plus the additional economy airfare if required to accommodate a stretcher, to return

you and a Travelling Companion by the most direct route to the major air terminal nearest the departure point in your province/territory of residence.

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

This Coming Home benefit assumes that you are not holding a valid open-return air ticket. Charges for upgrading, departure taxes, or cancellation penalties are not included.

**Cost of returning your personal use motor vehicle** to your residence or nearest appropriate vehicle rental agency when you are unable to do so due to sickness, physical injury or death, up to a maximum of \$10,000 per trip. GreenShield Travel Assistance requires original receipts for costs incurred, i.e. gasoline, accommodation and airfares;

**Meals and accommodation** up to a maximum of \$250 per day to a maximum of \$5,000 per family per trip will be reimbursed for the extra costs of commercial hotel accommodation and meals incurred by you or a covered dependent when the trip is delayed or interrupted due to an illness, accidental injury to or death of a Travelling Companion and the covered person remains until they or their Travelling Companion is fit to travel. This must be verified in writing by the attending legally qualified physician or surgeon and supported with original receipts from commercial organization;

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

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

**Return airfare** if the personal use motor vehicle of you or your covered dependent is stolen or rendered inoperable due to an accident, reimbursement will be made for the cost of a one-way economy airfare to return you and your covered dependents travelling with you, or a

Travelling Companion by the most direct route to the major airport nearest your departure point in your province/territory of residence. An official report of the loss or accident is required;

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

**Paramedical Practitioners** up to a maximum of \$500 per practitioner per Emergency (including x-rays) for the services of a licensed chiropractor, physiotherapist, podiatrist/chiropractist, or osteopath in conjunction with treatment for an Emergency;

**Child Care** when pre-approved by GreenShield Travel Assistance, up to \$5,000 for one of the following benefits for dependent children under the age of 16 in the event of an Emergency involving you or your spouse while travelling:

- Additional cost of one-way economy airfare for the return home of accompanying dependent children when you or your spouse are hospitalized, plus the cost of an escort if required;
- The cost of services of a caregiver (who is not a relative) in the location where you or your spouse is hospitalized;
- The cost of services of a caregiver (who is not a relative) in your home province/territory when the children are left unattended due to the delayed return of you or your spouse.

**Pet Return** up to a maximum of \$500 for the return of your accompanying pet(s) in the event you are hospitalized or repatriated during an Emergency.

#### **GREENSHIELD TRAVEL ASSISTANCE SERVICE**

The following services are available 24 hours per day, 7 days per week through GreenShield's international medical service organization.

#### **These services include:**

- Access to Pre-trip Assistance (prior to departure): Canada Direct Calling Codes; information about vaccinations; government issued travel advisories; and VISA/document requirements for entry into country of destination;
- Multilingual assistance;
- Assistance in locating the nearest, most appropriate medical care;
- International preferred provider networks;
- Medical consultation and monitoring to review appropriateness and quality of medical care;

- Assistance in establishing contact with family, personal physician and employer as appropriate;
- Monitoring of progress during treatment and recovery and confirming when the patient is medically fit for transportation when a transfer or repatriation is necessary;
- Emergency message transmittal services;
- Translation services and referrals to local interpreters as necessary, pertaining to the medical emergency;
- Verification of coverage facilitating entry and admissions into hospitals and other medical care providers;
- Special assistance regarding the co-ordination of direct claims payment;
- Co-ordination of embassy and consular services;
- Management, arrangement and co-ordination of emergency medical transportation and evacuation as necessary;
- Management, arrangement and co-ordination of repatriation of remains;
- Special assistance in making arrangements for interrupted and disrupted travel plans resulting from emergency situations to include:
  - the return of unaccompanied travel companions;
  - travel to the bedside of a stranded person;
  - rearrangement of ticketing due to accident or illness and other travel related emergencies;
  - the return of a stranded personal use motor vehicle and related personal items.
- Knowledgeable legal referral assistance;
- Co-ordination of securing bail bonds and other legal instruments;
- Guidance in replacing lost or stolen travel documents including passports;
- Courtesy assistance in securing incidental aid and other travel related services.

### How Travel Assistance Service Works

For assistance dial **1.800.936.6226** within Canada and the United States or call collect **519.742.3556** when traveling outside Canada and the United States. These numbers appear on your GreenShield Identification Card.

Quote your GreenShield Identification Number, found on your GreenShield Identification Card, and explain your medical emergency. **You must always be able to provide your GreenShield Identification Number and your provincial/territorial health insurance plan number.**

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

Upon admission to a hospital or when consulting a legally qualified physician or surgeon for major emergency treatment, GreenShield Travel Assistance will guarantee the provider (hospital, clinic or physician), that you have the required provincial/territorial health insurance plan coverage and GreenShield travel benefits as detailed above.

GreenShield Travel Assistance will follow your progress to ensure that you are receiving the best available medical treatment. GreenShield Travel Assistance also keeps in constant communication with your family physician and your family, depending on the severity of your condition.

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

### **Travel Limitations**

1. Coverage becomes effective at the time you or your dependent crosses the provincial/territorial border departing from their province/territory of residence and terminates upon crossing the border returning to their province/territory of residence on the return home. If traveling by air, coverage becomes effective at the time the aircraft takes off in the province/territory of residence and terminates when the aircraft lands in the province/territory of residence on the return home.
2. GreenShield Travel Assistance must be notified **before** obtaining Emergency Treatment in order for GreenShield Travel Assistance to:
  - confirm coverage; and
  - provide pre-approval of treatment.

If it is medically impossible for the covered person to call prior to obtaining Emergency Treatment, GreenShield Travel Assistance requires either the covered person or someone on behalf of the covered person to call GreenShield Travel assistance within 48 hours of commencement of treatment.

If GreenShield Travel Assistance is not notified before the Emergency Treatment was received, benefits will be limited to **the lesser of** the amount of only those expenses incurred within the first 48 hours of any and each treatment/incident **or** the plan maximum. This mean you will be responsible for all expenses thereafter.

3. After your medical emergency treatment has started, GreenShield Travel Assistance must assess and pre-approve additional medical treatment. If you undergo tests as part of a medical investigation, treatment or surgery, obtain treatment or undergo surgery that is not pre-approved, your claim will not be paid. This includes invasive testing, surgery, cardiac catheterization, other cardiac procedures, transplants, MRI.
4. Repatriation is mandatory when GreenShield Travel Assistance determines that the covered person should transfer to another facility or return to the home province/territory of residence for treatment, or at the end of the emergency. If you choose not to return:
  - no benefits will be paid for any further medical treatment;
  - no benefits will be paid for any recurrence or complications related directly or

- indirectly to the Medical Condition that caused the emergency; and
- for the remainder of the trip, coverage will be limited to Medical Conditions completely unrelated to the Medical Condition that caused the emergency.
5. Air ambulance services will only be eligible if:
    - they are pre-approved by GreenShield Travel Assistance;
    - there is a medical need for you or your dependent to be confined to a stretcher or for a medical attendant to accompany you during the journey;
    - you or your dependent are admitted directly to a hospital in your province/territory of residence, and;
    - medical reports or certificates from the dispatching and receiving legally qualified physicians are submitted to GreenShield Travel Assistance;
    - proof of payment (including air ticket vouchers or air carrier invoices) is submitted to GreenShield Travel Assistance.
  6. If planning to travel in areas of political or civil unrest, or in areas where the Canadian government has issued a formal travel warning regarding non-essential travel, contact GreenShield Travel Assistance for pre-travel advice, as we may be unable to guarantee assistance services.
  7. GreenShield Travel Assistance reserves the right, without notice, to suspend, curtail or limit its services in any area if any of the following occur:
    - political or civil unrest, rebellion, riot, or military uprising;
    - labour disturbance or strike;
    - act of God; or
    - refusal of authorities in a foreign country to permit GreenShield Travel Assistance to provide service.

This includes travel if when you booked your trip (including delay of travel), or before your departure date, the Canadian government issued a formal travel warning advising Canadians to avoid either all travel or all non-essential travel regarding the country, region, city, or other key components of your travel arrangements (e.g., cruise ship) due to a likely or actual epidemic or pandemic.

In this limitation, non-essential travel means anything other than a significant medical or family emergency, such as the death of a family member.

## Travel Exclusions

In addition to the Health Exclusions, Travel claims will not be paid for the following:

1. Any expenses incurred for the treatment related directly or indirectly to a Pre-existing Medical Condition that, at the time of your departure from your province/territory of residence and the 90-day period immediately preceding your departure from your

province/territory of residence:

- a) was not completely Stable in the professional opinion of GreenShield Travel Assistance Team;
- b) where medical evidence suggested a reasonable expectation that treatment or hospitalization could be required while traveling; or
- c) a physician advised the covered person not to travel.

GreenShield Travel Assistance reserves the right to review the covered person's medical information at the time of claim. A physician's opinion that the covered person was fit to travel does not override or eliminate the requirement for the covered person to satisfy all the conditions of Stable.

2. Any expenses submitted if the covered person or anyone acting on behalf of a covered person attempts to deceive GreenShield Travel Assistance, or makes a fraudulent, false, or exaggerated statement or claim.
3. Any expenses incurred for any services received that:
  - a) were not required to treat an Emergency;
  - b) were not recommended by a legally qualified physician or surgeon;
  - c) are not covered under your provincial/territorial health insurance plan;
  - d) are normally covered under the out-of-Canada benefits of your provincial/territorial health insurance plan's out-of-Canada coverage (where applicable), when the provincial/territorial plan has declined payment; or
  - e) are for a recurrence or complication directly or indirectly related to the emergency that GreenShield Travel Assistance determined 3.a), b), c), or d) above.
4. Any expenses incurred for services received after GreenShield Travel Assistance determined:
  - a) the covered person was to return to the province/territory of residence for treatment, but the covered person chose not to return to the province/territory of residence;
  - b) the services could be reasonably delayed until the covered person returned to the province/territory of residence;
  - c) the emergency had ended; or
  - d) the services are for a recurrence or complication directly or indirectly related to the emergency that GreenShield Travel Assistance determined 4.a), b), or c) above.
5. Any expenses incurred for services to treat a medical condition or complications of a medical condition directly or indirectly related to an epidemic or pandemic if, when the trip was booked, or before the departure date, an official travel advisory was issued by the Canadian government advising Canadians to avoid either all travel or all non-essential travel regarding any country, region, city, or other key components of your travel arrangements (e.g., cruise ship). To view the travel advisories, visit the Government of Canada Travel site.

6. Any expenses incurred for services to treat:
  - a) any medical condition, including symptoms of withdrawal, arising from or in any way related to the chronic use of alcohol, drugs, or other intoxicants whether prior or during the trip;
  - b) any medical condition arising during the trip resulting from, or in any way related to, the abuse of alcohol that results in a blood alcohol level of more than 80 milligrams in 100 millilitres of blood, drugs or other intoxicants; or
  - c) any medical condition resulting from not following Treatment as prescribed, including prescribed or over-the-counter medication.
7. Any expenses related to pregnancy, delivery, or complications of either, arising during the 8-week period before and after the expected date of delivery.
8. Any expenses incurred for a child born during the trip within the 8-week period before and after the expected date of delivery.
9. Any expenses incurred during any trip made for the purpose of obtaining a diagnosis, Treatment, surgery, palliative care, or any alternative therapy, as well as any directly or indirectly related complication.

**GreenShield does not assume responsibility for, nor will it be liable for any medical advice given, but not limited to a physician, pharmacist or other healthcare provider or facility recommended by GreenShield Travel Assistance.**

#### Health Exclusions

Eligible benefits do not include and reimbursement will not be made for:

1. Services or supplies received as a result of disease, illness, or injury due to:
  - a) an act of war, declared or undeclared;
  - b) participation in a riot or civil commotion; or
  - c) attempting to commit or committing a criminal offence or illegal act;
2. Services or supplies provided while serving in the armed forces of any country;
3. Failure to keep a scheduled appointment with a legally qualified medical or dental practitioner;
4. Any treatment, drug, service, or supply received outside of Canada on a non-emergency basis.
5. Charges for the translation or completion of any claim forms and/or insurance reports;
6. Any form of medical cannabis for the treatment of any medical condition, regardless of whether it is authorized by way of a medical document or prescription from a legally authorized medical practitioner and obtained from a Health Canada-licensed producer

pursuant any federal or provincial legislation or regulation regarding access to and/or distribution of medical cannabis;

7. Any specific treatment or drug which:
  - a) does not meet accepted standards of medical, dental, or ophthalmic practice, including charges for services or supplies which are experimental in nature;
  - b) is not considered to be effective (either medically or from a cost perspective) as determined by GreenShield's drug review process regardless if Health Canada approved the drug;
  - c) is an adjunctive drug prescribed in connection with any treatment or drug that is not an eligible service;
  - d) is administered in a hospital or is required to be administered in a hospital in accordance with Health Canada's approved indication for use;
  - e) is not dispensed by the pharmacist in accordance with the payment method shown under the Prescription Drugs benefit;
  - f) is not being used and/or administered in accordance with Health Canada's approved indication for use, even though such drug or procedure may customarily be used in the treatment of other illnesses or injuries (i.e., off-label use);
  
8. Services or supplies that:
  - a) are not recommended, provided by, or approved by the attending legally qualified (in the opinion of GreenShield) medical practitioner or dental practitioner as permitted by law;
  - b) are legally prohibited by the government from coverage;
  - c) you are not obligated to pay for or for which no charge would be made in the absence of benefit coverage or for which payment is made on your behalf by a not-for-profit prepayment association, insurance carrier, third party administrator, like agency or a party other than GreenShield, your plan sponsor or you;
  - d) are provided by a health practitioner whose license by the relevant provincial regulatory and/or professional association has been suspended or revoked;
  - e) are not provided by a designated provider of service in response to a prescription issued by a legally qualified health practitioner;
  - f) are used solely for recreational or sporting activities and which are not medically necessary for regular activities;
  - g) are primarily for cosmetic or aesthetic purposes, or are to correct congenital malformations;
  - h) are provided by an immediate family member related to you by birth, adoption, or by marriage and/or a practitioner who normally resides in your home. An immediate family member includes a parent, spouse, child, or sibling;
  - i) are provided by your plan sponsor and/or a practitioner employed by your plan sponsor, other than as part of an employee assistance plan;
  - j) are a replacement of lost, missing, or stolen items, or items that are damaged due to negligence. Replacements are eligible when required due to natural wear, growth, or

- relevant change in your medical condition but only when the equipment/prostheses cannot be adjusted or repaired at a lesser cost and the item is still medically required;
- k) are video instructional kits, informational manuals, or pamphlets;
  - l) are for medical or surgical audio and visual treatment;
  - m) are special or unusual procedures such as, but not limited to, orthoptics, visual training, subnormal vision aids and aniseikonic lenses;
  - n) are delivery and transportation charges;
  - o) are for Insulin pumps and supplies (unless otherwise covered under the plan);
  - p) are for medical examinations, audiometric examinations or hearing aid evaluation tests;
  - q) are batteries, unless specifically included as an eligible benefit;
  - r) are a duplicate prosthetic device or appliance;
  - s) are from any governmental agency which are obtained without cost by compliance with laws or regulations enacted by a federal, provincial, municipal, or other governmental body;
  - t) would normally be paid through any provincial health insurance plan, Workplace Safety and Insurance Board or tribunal, the Assistive Devices Program, or any other government agency, or which would have been payable under such a plan had proper application for coverage been made, or had proper and timely claims submission been made;
  - u) were previously provided or paid for by any governmental body or agency, but which have been modified, suspended, or discontinued as a result of changes in provincial health plan legislation or de-listing of any provincial health plan services or supplies;
  - v) may include but are not limited to, drugs, laboratory services, diagnostic testing or any other service which is provided by and/or administered in any public or private health care clinic or like facility, medical practitioner's office, or residence, where the treatment or drug does not meet the accepted standards or is not considered to be effective (either medically or from a cost perspective, based on Health Canada's approved indication for use);
  - w) are provided by a medical practitioner who has opted out of any provincial health insurance plan and the provincial health insurance plan would have otherwise paid for such eligible service;
  - x) relates to treatment of injuries arising from a motor vehicle accident;  
 Note: Payment of benefits for claims relating to automobile accidents for which coverage is available under a motor vehicle liability policy providing no-fault benefits will be considered only if–
    - i) the service or supplies being claimed is not eligible; or
    - ii) the financial commitment is complete;
 A letter from your automobile insurance carrier will be required;
  - y) are cognitive or administrative services or other fees charged by a provider of service for services other than those directly relating to the delivery of the service or supply.

## Exclusions

No Extended Health Care Benefits will be paid for:

- Expenses that private benefit plans are not permitted to cover by law
- Service or supplies the person is entitled to without charge by law or for which a charge is made only because the person has coverage under a private benefit plan
- The portion of the expense for services or supplies that is payable by the government health plan in the person's home province, whether or not the person is actually covered under the government health plan
- Service or supplies that do not represent reasonable treatment
- Services or supplies associated with treatment performed for cosmetic purposes only, except cosmetic surgery as a result of an accidental injury
- Services or supplies associated with recreation or sports rather than with other regular daily living activities
- Services or supplies associated with the diagnosis or treatment of infertility, except as may be provided under the prescription drug provision
- Services or supplies associated with covered items, unless specifically listed as a covered expense
- Extra medical supplies that function as spares or alternates
- Services or supplies received outside Canada except as provided under the Out of Province/Canada Medical Emergency Benefits
- Services or supplies received out-of-province in Canada unless the person is covered by the government health plan in his home province or the government coverage replacement plan sponsored by the employer and this plan would have paid benefits for the same services or supplies if they had been received in the person's home province
- Expenses arising from war, insurrection or voluntary participation in a riot
- Services of physicians and surgeons (except when provided under Out of Canada Medical Emergency Benefit)
- Services provided by any other insurance or benefit plan
- Interest charges
- A service or supply which is experimental or investigative in nature
- Medical treatment not approved or recognized by the provincial government health program
- Treatment or services provided by a person who is related to or resides with the individual
- An examination by, or the services of, a physician, if required solely for third party use
- Any services or supplies to which the individual is entitled under any Workers' Compensation statute or any other legislation
- Charges for missed appointments or the completion of claim forms
- Routine examination or routine general checkup required for the use of a third party
- Stock item footwear

- Charges for the administration of injectable drugs

## Dental Care

The dental care benefits are self-insured under the OpenCircle Benefit Plan.

If you have any questions regarding the benefits outlined in this section, please contact OpenCircle Benefits.

### Provisions

#### Benefit Coverage

The OpenCircle Benefit Plan will pay up to the **lower** of the amounts specified in the current Provincial General Practitioners or Denturist Society Fee Guide where the dental service is provided, and the amount charged by your dentist/denturist. If dental services are provided by a specialist, then the applicable specialist fee guide will be used.

Some dentists may charge more while other dentists may charge less than what will be paid by the OpenCircle Benefit Plan. Therefore, you should **ask your dentist** what the charge for dental services would be prior to having any dental work done. Your dental office will also be able to tell you what portion of the dental services will be paid by the OpenCircle Benefit Plan.

The payment of any dental expenses is subject to any benefit levels and maximum benefit amounts indicated.

#### Pre-determination of Benefits

If you will be undergoing extensive dental treatment, it is recommended that your dentist submit the proposed course of treatment before treatment begins. The Plan will not determine the appropriateness of the treatment but will advise you, of the amount that is payable by the OpenCircle Benefit Plan.

#### Eligible Expenses

Eligible expenses are described in the Dental Services sections that follow. All expenses must occur while you or your eligible dependents are eligible for benefits. Only those services that are provided by a health care professional licensed, certified or registered to practice a profession by the appropriate licensing, certification or registration authority will be covered.

#### Maximum Benefit

The maximum amount that will be paid for the combination of **Basic Dental Services** and **Major Dental Services** (as outlined in the following sections), is \$2,500 per person per calendar year. per person. The total maximum lifetime amount that will be paid for Orthodontic Dental Services for each eligible participant is \$2,500.

## Alternate Courses of Treatment

When two or more courses of dental treatment are available to correct a dental condition, the OpenCircle Benefit Plan will base reimbursement on the cost of the least expensive treatment that in the opinion of the plan provides a professionally adequate result.

## Basic Dental Services

Subject to the Fee Guide and Maximum Benefit provisions outlined earlier, the OpenCircle Benefit Plan will provide coverage for 80% of the following basic dental services.

### **Routine examinations and diagnosis**

- Complete examinations, once every five calendar years
- Recall examinations, once every calendar year for participants age 19 and over, and once every six months, for participants under age 19
- Emergency examinations
- Sialography
- Radiopaque dyes used to demonstrate lesions
- Interpretation of radiographs or models from another source
- Microbiological, histological, cytological and pulp vitality tests
- Laboratory reports
- Treatment planning
- Consultations with the patient

### **Dental x-rays and interpretation**

- Full mouth or panoramic, once every two calendar years
- Bitewings, once every calendar year for participants age 19 and over, and once every six months, for participants under age 19
- Intra-oral, other than bite-wings, to a maximum of 15 films every two calendar years
- Periapical and extra-oral films

### **Oral hygiene instruction**

- Lifetime limit of one unit per person

### **Polishing of teeth**

- Once every calendar year for participants age 19 and over
- One unit every six months for participants under age 19

### **Topical fluoride treatment**

- Only for participants under age 19, once every six months

### **Habit breaking appliances**

- For the control of harmful dental habits

### **Pit and fissure sealants**

- For permanent molars only, Once per 5 year period

### **Space maintainers**

- For missing primary teeth, for participants under age 19
- Maintenance of space maintainers

### **Oral surgery**

Covered oral surgery includes but is not limited to:

- Removal of teeth
- Surgical exposure of teeth
- The following procedures for remodelling and recontouring oral tissues:
  - Minor alveoloplasty,
  - Gingivoplasty and stomatoplasty, and
  - Reconstruction of the alveolar ridge.
- Surgical incisions
- Surgical excision of tumors, cysts, and granulomas
- Treatment of fractures, including related bone grafts to the jaw
- Treatment of maxillofacial deformities, including related bone grafts to the jaw and cheiloplasty

Palatal obturators, although not listed with oral surgery in the Canadian Dental Association Uniform System of Coding and List of Services, are also covered under this provision. Cleft palate obturators are not covered.

No benefits will be paid for implantology, surgical movement of teeth, services performed to remodel or recontour oral tissues other than those listed above (services for remodeling and recontouring oral tissues are covered under Major Dental Services), or alveoloplasty or gingivoplasty performed in conjunction with extractions.

### **Fillings**

- Composite (tooth-coloured) or amalgam (silver) fillings
- Stainless steel crowns only for participants under age 19
- Replacement fillings are covered only if the existing filling is at least two years old
- Interproximal diskings
- Recontouring of teeth
- Caries, trauma and pain control
- Retentive pins and prefabricated post for fillings
- Plastic crowns

### **Endodontics**

Covered endodontic services include but are not limited to:

- Treatment of the pulp chamber

- Root canal therapy for permanent teeth, limited to one course of treatment per tooth (repeat treatment is covered only if the original therapy fails after the first 18 months)
- Apexification
- Periapical services (apicoectomies are covered for permanent teeth only)

No benefits will be paid for root canal therapy for primary teeth, isolation of teeth, enlargement of pulp chambers or endosseous intra coronal implants.

### **Periodontics**

- Limited periodontal examinations, once every calendar year for participants age 19 and over and once every six months for participants under age 19
- Occlusal adjustments to a lifetime maximum of eight units
- Root planing, to a combined maximum of eight units per year from first paid claim
- Periodontal appliances including maintenance, adjustment and repair to appliances, twice in a calendar year
- Replacement appliances are covered where the existing appliance is at least four years old
- Periodontal surgery
- Desensitization
- Periodontal re-evaluations

### **Denture services**

- Relines and rebasings, limited to once each calendar year
- Denture repairs limited to reasonable and customary frequency
- Resilient liner in relined or rebased dentures after the three-month postinsertion care period has elapsed, once every three calendar years

### **Adjunctive services**

- Minor remedies for relief of dental pain when provided on an emergency basis

## **Major Dental Services**

Subject to the Fee Guide and Maximum Benefit provisions outlined earlier, the OpenCircle plan will provide coverage for 50% of the following major dental services.

### **Examinations**

- General prosthodontic exam, once every five calendar years
- Specific prosthodontic exam, once in a calendar year

### **Crowns, onlays, inlays and veneers**

Crowns, onlays, inlays and veneers are covered when a tooth has extensive structural loss that cannot be adequately restored using other procedures, when the existing restoration is at least four years old. The following crowns and related items are covered:

- Metal, plastic, porcelain, and ceramic crowns. Coverage for crowns on molars is limited to the cost of metal crowns. Coverage for complicated crowns is limited to the cost of standard crowns
- Onlays. Coverage for tooth-coloured onlays on teeth other than teeth 1-6 is limited to the cost of metal onlays
- Inlays. Coverage for tooth-coloured inlays on teeth other than teeth 1-6 is limited to the cost of metal onlays
- Veneer applications
- Posts, cores, and pins related to covered crowns
- Copings related to covered crowns
- Repairs to covered tooth-coloured materials
- Rebonding, removal and recementation of crowns, onlays and inlays

### **Dentures and bridgework**

- Standard complete dentures, standard cast or acrylic partial dentures or complete overdentures or bridgework when standard complete or partial dentures are not viable treatment options.
- Coverage for tooth-coloured retainers and pontics on teeth other than teeth 1 through 6 is limited to the cost of metal retainers and pontics.
- Replacement appliances are covered only when the existing appliance is a covered temporary appliance that was placed within the last 12 months, or the existing appliance is at least four years old and cannot be made serviceable. If the existing appliance is less than four years old, a replacement will still be covered if the existing appliance becomes unserviceable as a result of the placement of an initial opposing appliance or the extraction of additional teeth. If additional teeth are extracted but the existing appliance can be made serviceable, coverage is limited to the replacement of the additional teeth.
- Replacement dentures that are lost, stolen or broken through misuse are not covered if less than four years old.

### **Denture Related Surgery**

- Denture-related surgical services for remodelling and recontouring oral tissues

### **Appliance Maintenance**

Denture and bridgework maintenance following the three-month postinsertion period including:

- Denture remakes, once every 3 calendar years
- Denture adjustments, once every calendar year
- Tissue conditioning
- Repairs to covered bridgework
- Removal and recementation of bridgework

## Orthodontic Dental Services

Subject to the Maximum Benefit provisions outlined earlier, the OpenCircle Benefit Plan will provide coverage for 50% of the following orthodontic dental services. Only participants who are over age 6 and under age 19 are eligible for this benefit. The following services are covered under this benefit: general orthodontic exam, once every five calendar years, cephalometric, hand and wrist, and extra-oral radiographs, diagnostic photographs, orthodontic diagnostic casts, fixed and removable appliances, related charges for observations, adjustments, repairs, alterations, removal and retention.

No benefits will be paid for expenses for replacement of orthodontic applicates which have been lost, stolen, or broken, except where eligible replacement frequency is met. Expenses covered under another group plan's extension of benefits are also not covered. Coverage for services that commenced before age 19 will be covered until treatment is complete. Services rendered for comprehensive orthodontic treatment will not be covered unless a treatment plan and records are submitted for approval in writing. The treatment plan must provide the diagnosis, treatment to be rendered, appliances to be used, length of each phase of treatment, the charges, financial arrangements and commencement date of treatment.

## Dental Expenses Outside of Canada

Expenses incurred for dental services outside Canada will be eligible if:

- They represent the usual, customary and reasonable charges for the procedures in the locality where they are performed, and
- Charges for such procedures would have been paid under this plan had the procedures been performed in your province of residence.

## Coordination of Benefits

If you are also eligible for benefits under another dental plan, any claim under this plan will be coordinated and limited to the extent that benefits payable from all plans do not exceed 100% of eligible expenses.

## Survivor Benefit

If you die while covered for benefits, dental coverage will be continued for your eligible dependents without any further premium payment. This extension will terminate 24 months from the date of your death.

## Extension of Benefits

Certain benefits are extended until 31 days after coverage terminates where major dental work is in progress and cannot be safely delayed. No benefits are payable for treatment started after termination of coverage, or for continuation of basic dental services.

## Exclusions

No Dental Care Benefits will be paid for or as a result of the following:

- Duplicate x-rays, custom fluoride appliances, audio-visual oral hygiene instruction and nutritional counselling
- The following endodontic services – root canal therapy for primary teeth, isolation of teeth, enlargement of pulp chambers and endosseous intra coronal implants
- The following periodontal services – topical application of antimicrobial agents, subgingival periodontal irrigation, charges for post-surgical treatment and replacement of periodontal appliances that are less than four years old
- The following oral surgery services - implantology, surgical movement of teeth, services performed to remodel or recontour oral tissues (other than minor alveoloplasty, gingivoplasty and stomatoplasty) and alveoloplasty or gingivoplasty performed in conjunction with extractions
- Hypnosis or acupuncture
- Recontouring existing crowns and staining porcelain
- Crowns, onlays or inlays if the tooth could have been restored using other procedures. If crowns, onlays, inlays or veneers are provided, benefits will be based on coverage for fillings
- Expenses covered under another group plan's extension of benefits provision
- Replacement of dentures, devices or appliances that have been lost, stolen or broken, except where the appliance's age makes it eligible for replacement
- Accidental dental injury expenses for treatment performed more than 12 months after the accident, denture repair or replacement, or any orthodontic services
- Expenses private plans are not permitted to cover by law
- Services or supplies the person is entitled to without charge by law or for which a charge is made only because the person has coverage
- Orthodontic treatment or devices
- Services or supplies that do not represent reasonable treatment
- Treatment performed for cosmetic purposes only
- Congenital defect or developmental malformation in people 19 years of age or over
- Temporomandibular joint disorders, vertical dimension correction or myofacial pain
- Expenses arising from war, insurrection, or voluntary participation in a riot
- Services provided by a government funded program
- Charges that normally would not be made if the individual were not covered by the plan
- Services provided by any other insurance or benefit plan
- Interest charges
- A service or supply which is experimental or investigative in nature
- Treatment or services provided by a person who is related to, or resides with the individual
- Any services or supplies to which the individual is entitled under any Workers'

Compensation statute or any other legislation

- Charges for missed appointments or the completion of claim forms
- Oral appliances, other than required periodontal appliances
- Mouth guards
- Bleaching of teeth
- Recent duplication of services, whether by the same or different dentist
- Hospital charges for dental services
- Spare or duplicate dentures, devices or appliances
- In all cases in which the patient selects a more expensive plan of treatment than is customarily provided for necessary and adequate treatment, payment and coverage will be based on the lesser fee
- Where the charge for a particular service includes a fee for the diagnostic radiograph, no other radiographic charges will be covered for the diagnosis or treatment of that condition
- Fees for polishing and finishing restorations
- Payment in advance of services being rendered (payment for comprehensive cases will be amortized over the length of active treatment)
- Myofunctional therapy
- Motivation of patient
- In all cases in which a fee is charged for a complicated or difficult treatment, payment will be based on the lesser cost of an uncomplicated or standard service

# Long Term Disability

If you have any questions regarding the benefits outlined in this section, please contact OpenCircle Benefits.

## Eligibility

You are eligible for Long Term Disability (LTD) coverage when the following three conditions are met:

- You are **under age 65** following the completion of the **elimination period**,
- You are **in benefit** under the Hour Bank Benefit Plan, and
- You are **actively at work** for an OpenCircle employer who is participating in the OpenCircle LTD program.

The **elimination period** is 26 weeks of uninterrupted total disability, or the last day benefits are payable under any Short-Term disability, loss of income or other salary continuation plan, whichever is later.

You are **in benefit** if you meet the requirements of being in benefit (as set out earlier in this booklet) for the month during which you became disabled.

You are considered to be **actively at work** if you were working for your employer on your last scheduled shift prior to becoming disabled and if your employer reports the hours to OpenCircle and pays the required premiums.

The benefit is payable for until the last day of the month you turn age 65 and remain disabled under the Definition of Disability.

## Provisions

### Benefit

The LTD benefit is \$3,500 per month.

The LTD benefit is **reduced** by any benefits paid under any Workers' Compensation Act or similar law..

The benefit is payable only while you remain disabled as provided under the **Definition of Disability**. The benefit is **further reduced** if the total of your income listed under the section **Integration With Other Income** exceeds 85% of your pre-disability income. For the non-taxable plans, it is 85% of pre-disability income after income tax. If it does, your benefit is reduced by the excess amount.

Changes in other government plans and programs could lead to a reduction in the benefits that you receive.

### Pre-Disability Income

Pre-disability income is defined as the current salary paid by your employer, including commission and shift differentials, regular overtime and regular bonuses paid in the last calendar year, at the start of the disability period.

### Tax

LTD benefits are taxable if your employer pays any part of the LTD premium and non-taxable if you pay the entire premium.

### Payment Period

LTD payments **start** the later of:

- The end of the Elimination Period, or
- The date you are no longer entitled to receive any wages, short-term disability benefits.

LTD payments will **end** the earlier of:

- The date your disability ceases, or
- The last day of the month in which you turn age 65.

### Definition of Disability

To be considered totally disabled, you must be unable to perform the essential duties of your own occupation during the Qualifying Period and during the 24 months immediately following the Qualifying Period. After that, you will be considered to be totally disabled if:

- during the elimination period and the following 24 months while you are continuously unable due to an illness to perform the essential duties of your own occupation, in any workplace, including in a different department or location with the same employer or with another employer, and
- afterwards while you are continuously unable due to an illness to perform any occupation, for any employer, for which you are or may become reasonably qualified for by education, training or experience

The availability of work with any employer does not affect the determination of total disability.

A member with 35 or more years of employment with the employer is totally disabled if prevented by illness from performing the essential duties of the employee's own occupation.

A member with 35 or more years of employment with the employer is totally disabled if prevented by illness from performing the essential duties of the employee's own occupation.

If a member must hold a government permit or licence to perform the employee's own occupation and the permit or licence is withdrawn or not renewed solely for medical reasons, Sun Life will consider the member to be totally disabled for up to 12 months after the end of the elimination period. The employee cannot be working other than in a Sun Life approved partial disability or rehabilitation program.

### Benefits Are Not Payable

You are **not eligible** to receive LTD benefits during any period that you are:

- Not receiving regular, ongoing care and treatment from a physician appropriate to the disabling condition, as determined by the Insurer,
- Receiving Employment Insurance Maternity or Parental benefits,
- On a lay-off during which you become disabled,
- On a leave of absence during which you become totally disabled, unless your employer is required to pay benefits during this period as required by legislation, regulation or case law,
- Receiving benefits under an employer-sponsored salary continuance or short term wage loss replacement plan,
- Doing any work for wage or profit except as approved by Sun Life, Serving a prison sentence or is confined in a similar institution.

### Integration With Other Income

The LTD benefit is designed to supplement other benefits that may be available to you during disability. The LTD benefit is **reduced** as outlined below.

#### All Source Maximum

If your total income from the following sources, when added to the LTD benefit, exceeds an all source maximum limit of 85% of gross pre-disability income (if LTD benefit is taxable) or 85% of net pre-disability income (if LTD benefit is non-taxable), your LTD benefit payment will be reduced:

- Under a group plan which provides income replacement benefits as a result of an accident or an illness, including a multiple-employer group plan but excluding any benefits or payments provided under a Critical Illness plan or an association plan.
- Any retirement or pension plan earnings.
- Employment income (excluding severance/termination payments), disability benefits, or retirement benefits related to any employment. This excludes income from an approved rehabilitation plan, or employer sponsored short term disability or sick leave

benefits.

- Earnings from self-employment,
- Any government plan, excluding Employment Insurance Benefits,
- Earnings from Canada or Quebec Pension Plans.
- Loss of income benefits available through legislation, except for Employment Insurance benefits and automobile insurance benefits, which you are entitled to on the basis of your disability.
- The wage loss portion of any criminal injury award.

### **Offset Provision**

Your LTD benefit is reduced by the following income:

- Benefits under any Workers' Compensation Act or similar law except for:
  - Permanent partial disability awards that were payable for each of the 12 months before a disability period; and
  - Benefits related to employment with another employer.
- Loss of income benefits under an automobile insurance plan, to the extent permitted by law.

### **Recurrent Disability**

If you stop being disabled while satisfying a Elimination Period, and within 30 days become disabled again from the same or related causes, and each period of total disability is completed within 12 months after the start of the elimination period, or as approved by Sun Life in advance in cases where the elimination period is 365 days or more, the Elimination Period will be extended by the number of days during which the disability ceased.

If you stop being disabled following a disability for which benefits were paid, and within six months become disabled again from the same or related causes, that second disability is considered to be a continuation of the previous disability. If the same disability recurs more than six months after the end of the period for which benefits were paid, such disability will be considered a separate disability.

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

### **Survivor Benefits**

If you die your surviving spouse will be paid, a survivor benefit equal to three times the last monthly disability benefit payment received by you. If you have no surviving spouse, the survivor benefit will be paid to your surviving dependent children. If there are no surviving dependents, the benefit will be paid to your estate.

### Waiver of Long Term Disability Premiums

LTD premiums will be waived during any period that you are in receipt of LTD benefits.

### Exclusions/Limitations

No LTD benefit is payable for any disability directly or indirectly related to:

- Any period in which you do not participate or cooperate in a reasonable and customary treatment program,
- Any period in which you fail to participate or cooperate in a rehabilitation plan and/or medical coordination program that has been recommended or approved by Sun Life  
A scheduled duration of leave of absence or lay-off,
- Medical or surgical care which is not medically necessary,
- Intentionally self-inflicted injuries or illnesses, whether sane or insane,
- Committing or attempting to commit an assault or a criminal offense,
- War, insurrection, the hostile actions of any armed forces or participation in a riot or civil commotion, or
- A pre-existing condition which causes disability within the first 12 months from the date your coverage commences. For more information about pre-existing conditions please contact OpenCircle Benefits.

LTD benefit payments will not commence during any period of Maternity/Parental Leave or Leave of Absence.

### Subrogation (Reimbursement for Third Party Liability)

If the Insurer has paid or may be obligated to pay a benefit for an injury or disease for which a third party is or may be liable for damages either in whole or in part, the Insurer will assert their right to reimbursement, where permitted by law. Before benefit payments are made, the Insurer requires that you sign and comply with a reimbursement agreement. You are obligated to reimburse the Insurer when the amount of monthly disability benefit paid, together with the amount you recover from the third party for lost income, exceeds 100% of your lost income. If you recover less than the entire loss, the Insurer is entitled to pro-rate their subrogated recovery.

### Termination of LTD Benefit Payments

Your LTD benefit will terminate on the earliest of the following dates:

- You are no longer totally disabled,
- You fail to supply the Insurer with appropriate medical evidence,
- You do not attend a medical, psychiatric, psychological, educational and/or vocational examination or evaluation by an examiner selected by the Insurer,
- You refuse to participate in a vocational or functional capabilities assessment,
- You refuse to participate in a rehabilitation program approved by the Insurer,

- The last day of the month in which you reach age 65, or
- The last day of the month you die.

### Termination of LTD Coverage

Your LTD coverage terminates on the earliest of the following dates:

- You are no longer in benefit under the Hour Bank Benefit Plan,
- You cease to be actively at work,
- Your employer ceases to make any required premium contributions, or
- You reach age 65 less the Elimination Period.

# Short Term Disability

If you have any questions regarding the benefits outlined in this section, please contact OpenCircle Benefits.

## Eligibility

You are eligible for Short Term Disability (STD) coverage when the following three conditions are met:

- You are **under age 70** following the completion of the **Elimination period**,
- You are **in benefit** under the Hour Bank Benefit Plan, and
- You are **actively at work** for an OpenCircle employer who is participating in the OpenCircle STD program.

**Elimination Period** – you become eligible for STD benefits on the first day of an accident, on the first day of hospitalization, or on the eighth day of illness.

You are **in benefit** if you meet the requirements of being in benefit (as set out earlier in this booklet) for the month during which you became disabled.

You are considered to be **actively at work** if you were working for your employer on your last scheduled shift prior to becoming disabled and if your employer reports the hours to OpenCircle and pays the required premiums.

The benefit is payable for as long as you are:

- Under age 70,
- Remain disabled under the Definition of Disability, and

## Provisions

### Benefit

The STD benefit is \$800 per week.

The benefit is payable only while you remain disabled as provided under the **Definition of Disability**. The STD benefit is **reduced** by any benefits paid under any Workers' Compensation Act or similar law.

The benefit is **further reduced** if the total of your income listed under the section **Integration With Other Income** exceeds 85% of your pre-disability income for the taxable plan, and 85% of pre-disability income after income tax for non-taxable plan. If it does, your benefit is reduced by the excess amount.

Changes in other government plans and programs could lead to a reduction in the benefits that you receive.

### Tax

STD benefits are taxable if your employer pays any part of the STD premium and non-taxable if you pay the entire premium.

### Payment Period

STD payments start the later of:

- The end of the Elimination Period, or
- The date you are no longer entitled to receive any wages or short-term disability benefits

STD payments will end the earlier of:

- The date your disability ceases,
- Once the member has reached 26 weeks of payment, or
- When you turn age 70.

### Pre-Disability Income

Pre-disability income is defined as the current salary paid by your employer, including commission and shift differentials, regular overtime and regular bonuses paid in the last calendar year, at the start of the disability period.

### Definition of Disability

To be considered disabled, you must have a restriction or lack of ability due to an illness or injury that prevents you from performing the essential duties of your own occupation.

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

If you are required to hold a government permit or license to perform your duties, you will not be considered disabled solely because such permit or license has been withdrawn or not renewed.

### Benefits Are Not Payable

You are **not eligible** to receive STD benefits during any period that you are:

- Not receiving regular, ongoing care and treatment from a physician appropriate to the disabling condition, as determined by the Insurer,
- Receiving Employment Insurance Maternity or Parental benefits less required health-related portion due to provincial legislation,
- On a lay-off during which you become disabled,
- On a leave of absence during which you become totally disabled, unless your employer is required to pay benefits during this period as required by legislation,

regulation or case law,

- Receiving benefits under an employer-sponsored salary continuance or short term wage loss replacement plan,
- The member does any work for wage or profit, except as approved by Sun Life, or
- The member is serving a prison sentence or is confined in a similar institution.

### Integration With Other Income

The STD benefit is designed to supplement other benefits that may be available to you during disability. The STD benefit is **reduced** as outlined below.

#### All Source Maximum

If your total income from the following sources, when added to the STD benefit, exceeds an all source maximum limit of 85% of gross pre-disability income (if STD benefit is taxable) or 85% of net pre-disability income (if STD benefit is non-taxable), your STD benefit payment will be reduced:

- Under a group plan which provides income replacement benefits as a result of an accident or an illness, including a multiple-employer group plan but excluding any benefits or payments provided under a Critical Illness plan or an association plan.
- Any retirement or pension plan,
- Earnings or payments from any employer, excluding vacation pay,
- Self-employment,
- Any government plan, excluding Employment Insurance Benefits,
- Canada or Quebec Pension Plans, including dependent benefits,
- Workers' Compensation (or similar body) payments.
- Any government motor vehicle automobile insurance plan or policy, unless prohibited by law.

#### Offset Provision

Your STD benefit is reduced by the following income:

- Benefits under any Workers' Compensation Act or similar law except for:
  - Benefits related to employment with another employer.
- up to 100% of pre-disability income.

### Recurrent Disability

If you become totally disabled again from the same or related cause as those for which STD benefits have already been paid, and such disability recurs within two weeks from the end of the period for which benefits were paid, the Qualifying Period will be waived. All such recurrences will be considered a continuation of the same disability.

If the same disability recurs more than two weeks after the end of the period for which benefits were paid, such disability will be considered a separate disability.

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

### Exclusions/Limitations

No STD benefit is payable for any disability directly or indirectly related to:

- Any illness or injury which arises out of or in the course of employment, unless the claim has been denied by workers' compensation because the illness or injury is not recognized as resulting from employment,
- Any period in which you do not participate or cooperate in a reasonable and customary treatment program,
- Any period in which the person fails to participate or cooperate in a rehabilitation plan and/or medical coordination program that has been recommended or approved by Sun Life ,
- A scheduled duration of leave of absence or lay-off,
- Medical or surgical care which is not medically necessary,
- War, insurrection, the hostile actions of any armed forces or participation in a riot or civil commotion,
- Committing or attempting to commit an assault or a criminal offense,
- Intentionally self-inflicted injuries or illnesses, whether sane or insane.

STD benefit payments will not commence during any period of Maternity/Parental Leave or Leave of Absence unless there are health reasons related to birth were portions of the leave require compliance for legislation. Contact OpenCircle for more information.

### Subrogation (Reimbursement for Third Party Liability)

If the Insurer has paid or may be obligated to pay a benefit for an injury or disease for which a third party is or may be liable for damages either in whole or in part, the Insurer will assert their right to reimbursement, where permitted by law. Before benefit payments are made, the Insurer requires that you sign and comply with a reimbursement agreement. You are obligated to reimburse the Insurer when the amount of monthly disability benefit paid, together with the amount you recover from the third party for lost income, exceeds 100% of your lost income. If you recover less than the entire loss, the Insurer is entitled to pro-rate their subrogated recovery.

### Termination of STD Benefit Payments

Your STD benefit will terminate on the earliest of the following dates:

- You are no longer totally disabled,
- You fail to supply the Insurer with appropriate medical evidence,
- You do not attend a medical, psychiatric, psychological, educational and/or vocational examination or evaluation by an examiner selected by the Insurer,
- You refuse to participate in a vocational or functional capabilities assessment,

- You refuse to participate in a rehabilitation program approved by the Insurer,
- The earlier of the end of the Payment Period or the day you reach age 70,
- You retire, or
- You die.

#### Termination of STD Coverage

Your STD coverage terminates on the earliest of the following dates:

- You are no longer in benefit under the Hour Bank Benefit Plan,
- You cease to be actively at work,
- Your employer ceases to make any required premium contributions, or
- You reach age 70.

# Employee Family Assistance Program (EFAP)

If you have any questions regarding the benefits outlined in this section, please contact OpenCircle Benefits.

## Benefit Coverage

The Employee Family Assistance Program (EFAP) is available to you and your eligible dependents to manage work, health, and life issues with complete confidentiality. EFAP services include professional counselling, work/life support services, and specialized programs to assist with your everyday issues, complex concerns, and everything in between. EFAP provides expert advice, consultation, information, and resources.

The EFAP counselling services are available through your MyBenefitsConnect portal – they are provided through a network of mental health care professionals. Counsellors that specialize in certain fields are also available through your EFAP, including counsellors specializing in addictions counselling, marriage and family therapy, bereavement issues, anger management and more. In person, telephonic, online, video counselling and a variety of text-based services are available.

You can access qualified support for your mental, physical, social, and financial well-being, any time, from anywhere. The MyBenefitsConnect app is available for all smart phones, simply search 'MyBenefitsConnect' in the App Store or Google Play.

## Eligibility

You and your eligible dependents can access the EFAP when you are in benefit under the OpenCircle Benefit Plan. You are considered in benefit if you meet the requirements of being in benefit as set out earlier in this booklet.

The EFAP is available to you and your eligible dependents 24 hours, 7 days a week, 365 days a year by phone at 1.833.707.4747.

## Confidentiality

Confidentiality is the cornerstone of the EFAP and is taken very seriously. You will be able to discuss your personal problems and concerns in complete confidence, within the limits of the law, in a caring and professional environment, away from your workplace.

MyBenefitsConnect has strict guidelines in place to ensure your privacy. When you access EFAP services, only you and your counsellor will know. No personal information is ever released to your spouse, your children, your employer, OpenCircle Benefits or OpenCircle.

The commitment to confidentiality ensures you will in no way jeopardize your work situation by using the program. In fact, the program is likely to be of benefit because counselling may help resolve problems that might otherwise affect your job performance.

To further ensure confidentiality, no two employees from the same organization will be seen at the same time at the same office or have appointments back-to-back.

## Services Provided

the EFAP services provided through the MyBenefitsConnect app will provide assessment and counselling across a broad spectrum of personal, health and work-related concerns which include but are not limited to:

- Digital Cognitive Behaviour Therapy for Depression and Anxiety (In-App)
- Care Navigation (Navigational Support for Healthcare)
- Marital/relationship issues
- Bereavement
- Personal and emotional difficulties
- Personal and/or workplace stress
- Family issues including childcare and eldercare
- Interpersonal conflict
- Smoking cessation
- Alcohol/drug misuse and/or abuse
- Gambling addiction
- Work-related concerns
- Financial issues
- Violence
- Single parenting
- Nutritional
- The "Health Store" (for over-the-counter health products and supplements)
- Health coaching
- Childcare/elder care
- Career counselling and coaching
- Legal issues (*information and advice only, no legal activities such as completion of wills, etc.*)
- Indigenous and Youth Mental health
- "First Step" Mental Health discussions by Michael Landsberg
- "Mightier", a Children's Mental Health program

In addition, the MyBenefitsConnect app can match you with a counsellor that meets your needs including clinical experience, language preference, cultural fit, and more.

## Trauma Response Services

MyBenefitsConnect is available to respond immediately to traumatic events providing group and/or individual debriefings. Traumatic events include, but are not limited to:

- Accident resulting in amputation, injury or death
- Violent behavior in the workplace
- Sudden death by suicide or natural causes
- Situations of fraud
- Physical or sexual harassment at work
- Sudden death by tragedy or accident
- Major organizational restructuring
- Terrorism
- Natural disasters

## Cost of Accessing the EFAP

There is no cost to you or your eligible dependents to access the services of the EFAP. The cost of any service not supplied through the EFAP or costs associated with appointments that exceed the number of counselling sessions included in your EFAP are your responsibility. Some of these expenses may be eligible to claim under your Extended Health Care benefit plan.

## Counselling Sessions Provided

The EFAP provides short-term counselling for a variety of unique issues and concerns. Everyone's needs are different and will thus result in a varying number of counselling sessions for any given problem.

Your EFAP includes five (5) hours of in-person, talk, or online counselling per person, per issue. Free 15-minute consultations are available to help you find the right therapist. Sessions are available in 30-, 60- or 90-minute appointment blocks.

If you reach your five-appointment maximum and wish to continue with your treatment with your selected counsellor, you can do so at your own cost. OpenCircle Benefits has secured reduced rates that can be used towards extended counselling sessions with your same EFAP counsellor to ensure you have the best journey with respect to resolving your issues or concerns. These reduced-rate sessions may be claimed under your paramedical extended health benefits, where your OpenCircle Benefit Plan includes this coverage.

All it takes is filling out a short assessment, and a list of counsellors will be generated best suited to your needs, including clinical experience, language, cultural fit and more.

## **Survivor Benefit**

If you die while covered for benefits, your eligible dependents may continue to access the EFAP. This access will terminate 24 months from the date of the employee's death.

# Telemedicine

If you have any questions regarding the benefits outlined in this section, please contact OpenCircle Benefits.

## Benefit

Telemedicine offers convenient access to quality healthcare when and where you need it most. You can visit with a Canadian-licensed healthcare provider via phone or video, on-demand or by scheduling an appointment, for a broad array of episodic healthcare issues. Depending on your needs, the service includes diagnosis and treatment recommendations including medical prescriptions when necessary and appropriate. Their services can be accessed anywhere within Canada or when traveling to the United States.

## Eligibility

You and your eligible dependents are eligible for the services provided by Telemedicine coverage when you are:

- In benefit under the OpenCircle Benefit Hour Bank or Office Supervisory plans.

## How Telemedicine works

- You and your dependents can access services through Telemedicine by initiating an account with Teladoc Health at <https://member.teladoc.ca/signin> , or phone via the toll-free number 1.877.419.2378.

## Termination of Policy

Insurance will immediately terminate on the earliest of:

- The date the policy is terminated,
- The date the Employer or Policyholder fails to pay the premiums for you, or
- The date you cease to be in benefit under the OpenCircle Benefit Plan.

## Medical Second Opinion

If you have any questions regarding the benefits outlined in this section, please contact OpenCircle Benefits. This benefit is available to you, your eligible dependents, your parents and parents-in-law.

### Health Information Specialists

The Medical Second Opinion Program connects individuals with Health Information specialists from Novus Health when facing critical and serious illness and disease. When you contact the program, within 24 hours you will be set up with a Nurse Case Manager for your Clinical Evaluation to gather all of your current health and diagnosis information. This will confirm the correct diagnosis, and give possible further information, assistance and access to Canadian Medical experts to their Case Manager for applicable serious illness and diseases. They can also assist through one-on-one coaching, support and access to additional resources and navigational assistance.

Whether facing a complex medical condition, questioning an existing diagnosis, or requiring help deciding on the right treatment for a serious and/or critical disease or illness, the guidance and recommendations from their Nurse Case Manager can make all the difference. Even if your condition may not meet the criteria for Medical Second Opinion, helpful information packages can be made available to you. The steps for the Medical Second Opinion service are shown below:

#### How Medical Second Opinion Works:

- You and your dependents can access the Medical Second Opinion services through [mybenefitsconnect.opencirclebenefits.ca](https://mybenefitsconnect.opencirclebenefits.ca), or by using the MyBenefitsConnect app or by calling via the toll-free number 1.855.908.1275.
- A Health Information Specialist from Novus Health will ask for some personal and medical information. Within 24 hours you'll be set up with a telephone appointment with a Nurse Case Manager for your clinical evaluation. A mental health assessment is also available at this step.
- A 'Chart Review' using Novus' Health Specialist Network will review your file, and give Personalized treatment recommendations and treatment plan adjustments. Timelines will vary based on complexity and timely access to necessary information.
- The Nurse case manager can also provide Enhanced Navigation Support, to assist in finding Crisis resources, patient education, and Community resources.
- If your case does not qualify for the Medical Second Opinion, your Case Manager can still provide navigational support of the Canadian Healthcare system to assist and aid with your current treatment plan

Medical Second Opinion can recommend a doctor from our quality-ranked database of Canadian physicians, providing details about each specialist's preferred method of referral and information. Appointments and referrals must be made by your treating physician.

**Medical and travel expenses are not covered.**

This service empowers members to make informed decisions about their own care by helping them navigate the health care system. Your Case manager provides one-on-one support, customized health information and condition-specific content, and access to local resources. It is not only for complex illnesses but can also help all members and their dependents with any health care questions.

### **Mental Health Team**

Members will get a review of their diagnosis, treatment plan, and mental health conditions by our carefully selected expert clinicians and specialists. The expert will recommend modifications with their findings if necessary. A personalized action plan is then created for the member and ongoing support will be provided to assist members for Mental Health Diagnoses.