# Olympia Catastrophic Drug Insurance

# Booklet

## Master Policy # OLY1001

THIS BOOKLET IS AN IMPORTANT DOCUMENT
PLEASE KEEP IN A SAFE PLACE

**WAWANESA LIFE INSURANCE COMPANY**

Administrative Office: 400 - 200 Main Street, Winnipeg MB R3C 1A8
Toll Free: 888-647-5433

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**Wawanesa Life Insurance Company**
400 200 Main Street,
Winnipeg, MB R3C 1A8
(Hereinafter called the Insurer)

Hereby certifies that the bearer of this booklet, being an active, permanent Employee of a Participating Member Client of the Administrator and who has satisfied their Employer's Waiting Period, is insured, provided application has been made and the applicable premium is paid. Insured Persons must be full time residents of Canada and be covered under their Provincial Government Health care plans. In the event that two (2) Insured Employees are Spouses of each other and eligible for insurance under this policy, one (1) of the two (2) may choose to be insured as an Insured Spouse of the other in which case they will not be considered to be an Insured Employee or both may choose to be covered as an Insured Employee in which case neither will be eligible as a Spouse.

## SCHEDULE

Waiting Period for Employees: the waiting period for Employee coverage will be the period stated for their health insurance coverage under the benefit plan they are insured under to which this Policy is attached.

| Coverage A: Excess Medical | Benefit Maximum |
|---|---|
| **Lifetime Maximums** | |
| Benefits Lifetime, per listed expense item | $ 100,000 |
| **Yearly Maximums** | |
| Expense item a), Drugs | $ 25,000 |

Coverage A Deductible: $2,500 per person per calendar year

## SECTION 1 - DEFINITIONS

*The male pronoun will be construed as the feminine when the person is a female.*

**"Accident"** *means* a single sudden and unexpected event, which:

a) occurs at an identifiable time and place;

b) causes unexpected bodily Injury at the time it occurs; and

c) arises from an external source to the Insured Person

**"Actively at Work"** *means* the Employee capable of working and present at the place of work to carry out normal duties in accordance with the Employee's regular work schedule, on vacation or on a leave approved by the Employer.

**"Administrator"** *means* Olympia Benefits Inc.

**"Age"** *means* the attained age of the Insured Person (last birthday).

**"Dependent Child(ren)"** *means* all unmarried children of the Insured Employee, of the Spouse or of both, including the legally adopted children or those for whom the Insured Employee or the Spouse exercises or would exercise, in the case of a minor, parental authority and whom the Insured Employee or the Spouse supports and who is:

a) under age twenty-one (21); or

b) age twenty-one (21) and over but under age twenty-five (25), being a full-time student in an accredited educational institution, subject to proof of registration to the satisfaction of the Insurer; or

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

The Dependent Child will be covered from birth provided such child is born alive.

A Dependent Child will only be considered an Insured Dependent Child once under this policy.

**"Dependents"** *means* collectively, an Insured Spouse and/or an Insured Dependent Child, if applicable, eligible for insurance under a particular provision of this contract.

**"Disease"** *means* any unhealthy condition of the body or any part thereof occurring while this policy is in force with respect to the Insured Person whose disease is the basis of claim and for which expenses are incurred as described in the Description of Coverage section(s) of this policy.

**"Employee"** *means* a person who is under age seventy (70) and who is

a) employed on a full-time, part-time or permanent basis by the Employer; or

b) a sole proprietor, partner or shareholder of the Employer; and

c) a Canadian citizen or landed immigrant; and

d) residing in Canada.

Partners, proprietors, corporation officers or directors, or Dependents will be considered as Employees only if they are Actively at Work.

A person insured as an Employee will not be eligible to be insured again as a Spouse or Dependent Child.

**"Employer"** *means* the Policyholder or any Employer whose Employees or a category of Employees are represented by the Policyholder of this policy.

**"Illness"** *means* a Disease, mental infirmity or Sickness. Any surgery needed to donate a body part to another person, which causes Total Disability, will be considered an illness. "Total Disability" as used herein means the Employee is unable, because of Injury or Sickness to engage in *any* occupation for wage or profit.

**"Immediate Family Member"** *means* a person at least eighteen (18) years of age, who is the son, daughter, father, mother, brother, sister, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, sister-in-law, (all of the above include natural, adopted or step relationships), Spouse, grandson, granddaughter, grandfather or grandmother of the Employee.

**"Injury"** *means* bodily injury caused by an Accident occurring while this policy is in force as to the Insured Person whose injury is the basis of claim and resulting directly and independently of all other causes in loss covered by this policy, twenty-four (24) hours a day, anywhere in the world but in no event shall Injury mean Sickness or Disease howsoever caused unless caused by an Accident.

**"Insured Person"** *means* collectively, an Insured Employee, an Insured Spouse or an Insured Dependent Child, if applicable, eligible for insurance under a particular provision of this policy.

**"Medically Necessary"** in reference to a given service or supply*, means* such service or supply:

a) is appropriate and consistent with the diagnosis according to accepted community standard of medical treatment;

b) is not experimental or investigative in nature; and

c) cannot be omitted without adversely affecting the condition or quality of medical care.

**"Month"** *means* a period starting at 12:01 A.M. on the first (1st) day in a given calendar month, and ending at 12:01 A.M. on the first (1st) day in the next calendar month.

**"Nurse"** *means* a graduate registered nurse (R.N.) or nurse who is licensed to practise nursing services by a governmental agency having jurisdiction over such licensing. Nurse is neither the Insured Person himself nor an Immediate Family Member.

**"Physician"** *means* a doctor of medicine, (other than the Insured Person or an Immediate Family Member) who is licensed to practise medicine by:

a) a recognized medical licensing organization in the locale where the treatment is rendered, provided he is a member in good standing of such licensing body, or

b) a governmental agency having jurisdiction over such licensing in the locale where the treatment is rendered.

**"Residence"** *means* the primary dwelling in Canada of which the Employee is an occupant and the premises on which it is situated.

**"Sickness"** *means* an impairment of a normal physiological function and includes infections occurring while this policy is in force as the Insured Person whose sickness is the basis of claim and for which expenses are incurred as described in the Description of Coverage sections of this policy.

**"Spouse"** *means* an individual under the age of seventy (70) who is:

a) the person the Employee is legally married to; or

b) person of the opposite sex or the same sex who is publicly represented as the Employee's Spouse.

Only one (1) person at a time can be insured as an Employee's spouse under this contract.

Anyone who is insured as a Spouse will not also be eligible as an Employee or Dependent Child.

# GENERAL POLICY PROVISIONS

## SECTION 2 - EFFECTIVE DATE OF INDIVIDUAL INSURANCE

### 2.1 Employee's Insurance

The Employee's insurance shall become effective on the date he becomes eligible provided the Employee has been enrolled in the Employer's Health Plan.

### 2.2 Spouse and Dependent Children

Coverage for the Spouse and Dependent Children shall become effective on the date on which they become eligible provided the Spouse and Dependent children have been enrolled in a participating client's group health plan.

Coverage for the Spouse and Dependent Children can, at no time, become effective before the Effective Date of Individual Insurance for the Employee.

### 2.3 Actively at Work

If an Employee is not Actively at Work on the date his insurance would otherwise become effective or on the effective date of an increase in benefits, the insurance or increase will become effective on the date he returns to being Actively at Work.

## SECTION 3 - TERMINATION OF INDIVIDUAL INSURANCE

### 3.1 Employee

The insurance of an Insured Employee shall terminate on the earliest of:

a) the Employee's seventieth (70th) birthday;

b) the date the policy terminates;

c) the date the participating group/association terminates;

d) the date the Insured Employee ceases to be eligible for insurance;

e) the premium due date required for an Insured Employee in accordance with the conditions of this policy if such premiums are not paid to the Insurer prior to the expiration of the Grace Period;

f) the date on which the Employee collects or allows to be collected, as a result of false claims or misrepresentations originating from the Insured Person or a third party, benefit payments which are not provided by the policy, irrespective of the compulsory character of the coverage and of any other recourse which could be exercised by the Insurer;

g) the date the Employee ceases to be a Canadian resident;

h) the date the Employee ceases to be covered by a Provincial Health insurance plan.

### 3.2 Dependents

The insurance of an Insured Spouse or Insured Dependent Child shall terminate on the earliest of:

a) the date the Employee's insurance ceases;

b) the date the Employee ceases to be in a class of Employees eligible for Dependents insurance;

c) the date the Dependent no longer qualifies as a Dependent.

## SECTION 4 - CONTINUATION OF INDIVIDUAL COVERAGE

### 4.1 Continuation of Coverage

If an Employee is not Actively at Work due to temporary layoff or leave of absence, the insurance will be continued until the participating Employer stops paying to the Administrator the premium amount due, as may be required by the Policyholder for the Employee or otherwise terminates the insurance. However, the insurance will not continue for more than six (6) Months past the date the Employee is no longer Actively at Work.

### 4.2 Reinstatement of Individual Coverage

Wherever used throughout this policy, “Reinstatement” shall refer to this section.

If the insurance on an Employee ceased because he was no longer employed in a class of eligible Employees, he is not required to satisfy any Waiting Period if he again becomes a member of a class of eligible Employees within six (6) Months after his insurance ceased.

## SECTION 5 - CLAIMS

### 5.1 Beneficiary

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

Unless otherwise indicated, all benefits, including those benefits payable for a Dependent, will be paid to the Insured Employee.

Accrued benefits, if any, unpaid at the time of the Insured Employee’s death will be paid to his/her estate.

### 5.2 Notice of claim

The Insured Person or his/her representative or beneficiary entitled to make a claim shall give written notice of claim to the Insurer by delivery thereof, or by sending it by registered mail to the Insurers Administrative Office not later than thirty (30) days after the Accident, Injury, or Illness causing a loss and for which expenses are incurred.

### 5.3 Insurer to Furnish Forms for Proof of Claim

The Insurer shall furnish forms for proof of claim within fifteen (15) days after receiving Notice of Claim. Where the claimant has not received the forms within that time the claimant may submit his proof of claim in the form of a written statement giving rise to the claim.

### 5.4 Proof of Claim

The Insured Person or his/her representative or Beneficiary entitled to make a claim shall provide proof of claim within one hundred (100) days from the date a claim arises.

### 5.5 Failure to Give Notice or Proof

Failure to give notice of claim or furnish proof of claim within the time prescribed by the above condition does not invalidate the claim if the notice or proof is given or furnished as soon as reasonably possible, and in no event later than one (1) year from the date of death or the date a claim arises under this policy if it is shown that it was not reasonably possible to give notice or furnish proof within the time prescribed.

### 5.6 Reserving Rights

As a condition precedent to recovery of insurance money under this policy the Insurer reserves the right to:

a) examine the full details regarding the claim;

b) require the Insured Person to undergo a medical examination at the Insurer's expense;

c) examine the Insured Person when and so often as is reasonably required while the claim hereunder is pending;

d) require an autopsy to be performed on the Insured Person in the event of death, unless prohibited by law or religious belief;

e) disallow the claim based on information developed from the attending Physician's report, medical examination, payroll records, or other sources of pertinent data.

### 5.7 Fraudulent Claims

Any claim for benefits under the policy which is based on false or incorrect information on an application, claim form or other documents required to verify benefits will result in the benefits being denied or the liability assumed by the Beneficiary if the benefit has already been provided or performed.

### 5.8 Limitations of Actions

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the *Insurance Act (*Alberta and B.C.).

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in *The Insurance Act* (Manitoba).

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the *Limitations Act, 2002* (Ontario).

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

### 5.9 Subrogation

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

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

### 5.10 Recovering Overpayments

Whenever payments have been made for allowable expenses in a total amount that exceeds the maximum payment necessary, the Insurer has the right to recover by any available legal means, such benefit overpayments from any person to who or for whom payments were made or from an Insurance company or other organization.

### 5.11 Coordination of Coverage

If the Insured Person is covered under this policy and another insurance policy or plan, benefits will be co-ordinated with the other policy and/or plan following insurance industry standards. These standards determine where the claim should be sent first.

The guidelines are as follows:

a) if the Employee is claiming expenses for the Insured Spouse and the Spouse is covered for those expenses under another plan, the claim should be sent to the Spouse's plan first.

b) if the Employee is claiming expenses for Insured Dependent Child(ren), and both the Employee and Spouse have coverage under different plans, the Employee must claim under the plan of the parent with the earlier birthday (month and day) in the calendar year. For example, if the Employee's birthday is May 1 and the Spouse's birthday is June 5, the Employee must claim under his plan first. If both parents have the same birthday, claim under the plan of the parent whose first name begins with the earlier letter of the alphabet.

c) the maximum amount that the Employee can receive from all plans for eligible expenses is one hundred per cent (100%) of actual expenses.

d) when submitting a claim to a second payor, include payment details provided by the first payor.

## SECTION 6 - CONTRACT

### 6.1 Clerical or Mechanical Errors

If a clerical or mechanical error by the Policyholder, Administrator or the Insurer results in a person being incorrectly classified under the policy, then such person will be classified according to the true facts.

### 6.2 Conformity to Legislation

If this policy does not conform to legislation that governs it, it is considered automatically amended to comply with the minimum requirements of that legislation.

### 6.3 Currency

All payments made under the policy, either to or by the Insurer will be in the lawful money of Canada.

### 6.4 Entire Contract

The application, this policy, any document attached to this policy when issued, and any amendment to the policy agreed upon in writing after this policy is issued, constitute the entire contract and no agent has authority to change this policy or waive any of its provisions.

### 6.5 Insured Right of Access

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

### 6.6 Material Facts

No statement made by the Insured Person at the time of application for this policy shall be used in defense of a claim under or to avoid this contract unless it is contained in the application or any other written statement or answers furnished as evidence of insurability.

### 6.7 Misrepresentation and Incontestability

The policy will be void and the Insurer's liability will be limited to the return of any premiums paid if incomplete, inaccurate, untrue or wrong information was submitted to the Insurer at any time and a claim arises under the policy during the first two (2) years from the Effective Date of Individual Insurance or two (2) years from most recent date of Reinstatement.

### 6.8 Misstatement of Age

If the age of an Insured Person has been misstated, the corrected age and facts will be used to determine whether insurance is in force under the policy and in what amount, and an equitable adjustment of premium will be made.

### 6.9 Non-Participating

This policy does not share in the Insurer's surplus earnings.

### 6.10 Replacement

This policy is considered a replacement policy if it replaces previous group coverage providing similar insurance benefits that the Employer terminated less than thirty-one (31) days prior to the Master Policy Effective Date.

If this policy is replacing previous group coverage, the Insurer will insure an Employee and his Dependents(s) who:

a) was insured under the previous policy at the date of termination and whose coverage terminated solely because the policy terminated; and

b) is not in Actively at Work on the Master Policy Effective Date; and

c) is a member of a class of eligible Employees.

While such Employee is not Actively at Work, each Employee and Dependents(s) will be insured for the lesser of:

a) the amount of coverage that they will become eligible for under this policy, and

b) the amount of coverage that were insured for under the previous policy.

However, no benefits will be payable under this policy for which benefits are payable under the previous policy.

### 6.11 Waiver

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

# COVERAGE A: EXCESS MEDICAL

## SECTION A1 - DESCRIPTION OF COVERAGE

In accordance with the provisions of this policy, the Insurer will reimburse the reasonable and necessary charges for services or supplies received by the Insured Person within two (2) years following the date the initial deductible under this plan is satisfied for such Eligible Expenses if an Insured Person requires medical or surgical treatment and incurs Eligible Expenses as described in Section A3 - Benefits as a result of Injury or Illness.

## SECTION A2 - AMOUNT OF EXCESS MEDICAL

The total amount payable for reimbursement of all expenses, which an Insured Person has incurred as the result of all Injuries caused any one (1) Accident or as the result of any one (1) Illness, will not exceed the all expense maximum per calendar year and the lifetime maximums as stated in the Schedule.

## SECTION A3 - BENEFITS

The eligible expenses are:

a) charges for prescription drugs, sera and vaccines, obtainable only upon a written prescription by a Physician or legally qualified dentist and dispensed by a registered pharmacist or Physician, but excluding any charges made for the administration of injectable drugs, sera and vaccines, subject to a dispensing maximum of a ninety (90) day supply and subject to the maximum stated in the Schedule, per calendar year, per Accident or Illness;

## SECTION A4 - DEDUCTIBLE

There is a deductible per calendar year in the amount stated in the Schedule. The deductible amount applies to all eligible expenses stated in Section A3 - Benefits as a result of Injury or Illness.

Reimbursement of insured expenses commences following satisfaction of the deductible amount, if any.

## SECTION A5 - RECURRENT INJURY, SICKNESS OR DISEASE

If an Injury or Illness causes the Insured Person to incur eligible expenses following which a continuous period of six (6) or more Months elapses during which the same Injury or Illness does not cause the Insured Person to incur any eligible expenses and does not require any treatment of the Insured Person by a Physician, the Insured Person will be deemed to have recovered from the Injury or Illness at the end of the period of six (6) or more Months.

Thereafter, a subsequent recurrence of the Injury or Illness, which causes the Insured Person to incur eligible expenses will be deemed to be a different Injury or Illness to which the full maximum limit of indemnity will be applicable without any reduction or variation by reason of eligible expenses incurred as a result of the Injury or Illness from which the Insured Person was deemed to have recovered.

## SECTION A6 - EXCLUSIONS, LIMITATIONS, AND SPECIAL PROVISIONS

Coverage A: Excess Medical does not cover any charges for Injury or Illness caused directly or indirectly, in whole or in part by any of the following:

a) intentionally self-inflicted Injury while sane or insane;

b) declared or undeclared war or any acts thereof;

c) perpetration of acts of terrorism;

d) participation in a riot, insurrection or civil commotion;

e) active full-time, part-time or temporary service in the armed forces of any county;

f) any treatment, surgery, care service, examination or device which:

   i) is not Medically Necessary;

   ii) is provided or required for cosmetic purposes;

   iii) is conducted as an experiment;

   iv) is provided or required for non-curative reasons; or

   v) exceeds what is ordinarily provided or required by current therapeutic practice;

g) any treatment related to or provided for drug addiction;

h) while the Insured Person is committing or attempting to commit an assault, battery or criminal offence, whether or not the Insured Person has been charged with a criminal offence;

i) operating a motorized vehicle where the Insured Person:

   i) was found to have a blood alcohol level in excess of eighty (80) milligrams of alcohol per one hundred (100) milliliters of blood; or

   ii) has been convicted of an alcohol-related offence such as driving while impaired; or

   iii) has refused to take a breathalyser test.

j) if the Insured Person was negligent or non-compliant in seeking and/or following reasonable medical treatment, consultation, care or services including diagnostic measure as prescribed by their attending Physician.

Coverage A: Excess Medical does not cover any of the following supplies or services or costs thereof:

a) expenses incurred outside of Canada;

b) therapeutic or elective abortion;

c) services or supplies associated with:

   i) erectile dysfunction;

   ii) the diagnosis or treatment of infertility;

   iii) contraception,

d) homeopathic preparations, unless federal or provincial legislation requires a prescription for their sale;

e) drugs which do not legally require a prescription and pharmaceutical supplies which are either experimental or not approved by the Canadian government or Provincial government regulatory body in the Insured Person's province of Residence.

**Exclusion for Pre-Existing Condition(s)**

Benefits are not payable as a result of any pre-existing condition unless Excess Medical costs commence after the Insured Person has been continuously insured for twenty-four (24) Months after the Effective Date of Individual Insurance or the date of their last Reinstatement.

Pre-existing conditions means any Injury, Illness, nervous disorder or any symptom or other condition for which medical advice, consultation, investigation, diagnosis or treatment, including medication, was required or recommended by a Physician, or for which a reasonable person would have sought treatment or advice, during the twenty-four (24) Month period prior to the Effective Date of insurance.