

Program Effective January 1, 2024
Version ORWP202401-A

The Ontario REALTOR® Wellness Program

Member Benefit Booklet

Active OREA Members



ONTARIO
REALTOR®
WELLNESS
PROGRAM

Your Member Benefit Booklet

This booklet has been prepared to help you better understand the coverage provided under the Ontario REALTOR® Wellness Program (ORWP). It gives you the information you will generally require regarding your benefits.

Separate sections for each component of the program allow you to quickly access relevant benefit information. If changes are made to your benefits, an updated booklet will be made available to you on the Member Portal website.

This booklet is not an agreement, and it does not create nor confer any contractual or other rights. The terms and conditions governing your benefit plans are set out in the official contracts between the insurers, CBS, OREA, and in compliance with the Canadian Life and Health Insurance Association (CLHIA).

As the policyholder, OREA acts as the Plan Sponsor of the Ontario REALTOR® Wellness Program (ORWP) on behalf of the Individual Members of all Ontario Real Estate Boards. Member Board and Plan Administrator responsibilities are outlined within this booklet.

Every effort has been made to ensure that the information in this booklet is accurate. However, if any questions should arise, a decision will be made by reference to the official plan contracts and texts.

Effective Date: January 1, 2024

Contact Sheet

Accessing Your Program

Your ORWP Member Portal

You may access important information about your ORWP benefits online at: ORWP.ca.

This secure website is the central administrative hub of the ORWP. After you have registered your account, you can log in to complete your enrollment, designate and make changes to your beneficiaries, access documents and forms, report a future Life Event, and more.

Questions? Contact your Plan Administrator, Comprehensive Benefit Solutions Limited (CBS).

Your Plan Administrator



Your Plan Administrator:
Comprehensive Benefit Solutions Limited (CBS)

By Phone: 1 (855) 335-3070

By Email: ProgramAdministrator@orwp.ca

By Fax: (905) 896-2108

Online: ORWP.ca

Program Providers

Basic Life Insurance



Your Provider: The Canada Life Assurance Company

Policy: 180733

To Do: You must designate a beneficiary for this coverage online at ORWP.ca.

To Submit a Claim: Contact the Plan Administrator.

Accidental Death & Dismemberment Insurance



Your Provider: AIG Insurance Company of Canada

Policy: 9429587

To Do: You must designate a beneficiary for this coverage online at ORWP.ca.

To Submit a Claim: Contact the Plan Administrator.

Critical Illness Insurance



Your Provider: AIG Insurance Company of Canada

Policy: 9429588

To Do: Review the coverage information in this booklet. For eligibility questions, contact your Plan Administrator.

To Submit a Claim: Contact the Plan Administrator.

Health Benefits (And Dental, if Coverage Upgrade is Selected)



Your Provider: GreenShield

Client Reference Code: ORWP

Online: <https://app.greenshieldplus.ca/en/sign-up>

Mobile App: Download the GreenShield+ app for [iOS](#) or [Android](#).

To Access Your Healthcare Insurance Benefit: To download your digital ID card, submit a claim, confirm your coverage, access pre-authorization forms, log in to your GreenShield+ account. You can create an account using the instructions provided at your enrollment.

For Coverage and Claims Questions: Contact GreenShield at 1 (888) 525-7587 (8:30 AM to 8:30 PM), or submit a "Note" through GreenShield+ desktop site or Mobile App.

For Additional Support: Contact your Plan Administrator.

Travel Insurance



Your Provider: AIG Insurance Company of Canada

Policy: 9429586

Mobile App: Download the AIG Travel Assistance app for [iOS](#) or [Android](#).

Before Travel: Review the coverage information in this booklet. For eligibility questions, contact your Plan Administrator. Before your trip, download the AIG Travel Assistance App, or find your Travel Assistance Card at ORWP.ca.

If You Need Assistance While Travelling: Refer to your Travel Assistance Card and the AIG Travel Assistance App for details.

- 1 (877) 204-2017 – U.S. and Canada
- 1 (715) 295-9967 – Outside U.S. and Canada (Collect)



Your Benefit Provider: Maple

To Get Started: Visit getmaple.ca/orwp to register. You'll need your unique ORWP Certificate Number to create your secure account.

To Access This Benefit: Once you've created your account at getmaple.ca/orwp, you can access virtual care through the Maple desktop site or mobile app.

Online: getmaple.ca

Mobile App: Download the Maple app for [iOS](#) or [Android](#).

Questions? Additional information is available on the ORWP Plan Member Portal or contact your Plan Administrator.

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Benefit Summary

This summary must be read together with the benefit information further detailed within this booklet. *Benefits are included in the ORWP Standard Plan covered by OREA Dues, for the Member only. The enrollment of eligible dependents is optional, at an additional monthly cost.

Basic Life Insurance

How It Works	All eligible OREA Members are automatically enrolled in the ORWP Basic Life Insurance Program. Your coverage is outlined below. In the event of your death, provided you are up to date on OREA Dues payment at the time of your death, a tax-free, lump-sum payment will be issued to your designated beneficiary(ies). If you have not designated a beneficiary, or there is no surviving beneficiary at the time of your death, payment will be made to your Estate.
Coverage	\$100,000
Reduction	Reduces by 50% at age 65
Termination Age	No termination age. Coverage terminates on the date you are no longer an eligible Member of OREA, or the date you retire (unless you select a retirement option within 31 days of the date your retirement, if eligible for such retirement coverage).
Eligibility	OREA Members
Insurer	The Canada Life Assurance Company ("Canada Life")

Accidental Death & Dismemberment (AD&D) Insurance

How It Works	<p>All eligible OREA Members are automatically enrolled in the ORWP AD&D Insurance Program. Your coverage is outlined below. In the event of an insurer-covered accident that results in the loss of your life, provided you are up to date on OREA Dues payment at the time of your accidental death, a tax-free, lump-sum payment will be issued to your designated beneficiary(ies). If you have not designated a beneficiary or there is no surviving beneficiary at the time of your death, payment will be made to your Estate.</p> <p>For accidental dismemberment occurring while an OREA Dues-paying Member (such as the loss of limbs, speech, hearing, or sight), a percentage of the principal sum is payable to you, based on the schedule of losses. There are additional benefits available that are associated with this coverage, as outlined within this benefit booklet.</p>
Coverage	\$100,000 principal sum
Reduction	No reduction
Termination Age	No termination age. Coverage terminates on the date you are no longer an eligible Member of OREA, or the date you retire (unless you select a retirement option within 31 days of the date your retirement, if eligible for such retirement coverage).
Eligibility	OREA Members
Insurer	AIG Insurance Company of Canada (“AIG”)

Optional Life and AD&D Insurance

How It Works	During an insurer-approved Open Enrollment Period, eligible OREA Members have the option to purchase additional Life and AD&D Insurance coverage for themselves and/or their eligible dependents, at an additional cost (paid by the Member to the Plan Administrator).
Coverage Options	\$25,000 or \$50,000
Reduction	No reduction
Termination Age	Terminates at age 70
Eligibility	OREA Members and their eligible dependents (Note – if an OREA Member is insured as both a Member and a Dependent, the maximum amount of Optional Life and AD&D Insurance available to them is \$50,000)
Insurers	Optional Life: The Canada Life Assurance Company (“Canada Life”) Optional AD&D: AIG Insurance Company of Canada (“AIG”)

Critical Illness (CI) Insurance

How It Works	<p>All eligible OREA Members are automatically enrolled in the ORWP CI Insurance Program. The coverage provides a lump sum, tax-free in the event that you are diagnosed with an insured critical illness, as long as you are up to date on OREA Dues payment at the time of occurrence.</p> <p>This plan will not cover an illness that was diagnosed prior to the coverage effective date, nor will it provide coverage for any illness for which the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment within a 12-month period preceding the Insured Person's Effective Date, or an illness or condition for which the Insured Person, during 12 months prior to the Effective Date of their coverage incurred medical expenses, received medical treatment, took prescribed drugs or medicine or consulted a Medical Doctor. The insurance company will assess whether an illness is covered at the time of claim.</p>
Coverage	\$25,000
Reduction	Reduces by 50% at age 65
Termination Age	Terminates at age 70
Eligibility	OREA Members
Insurer	AIG Insurance Company of Canada ("AIG")

Optional Critical Illness (CI) Insurance

How It Works	<p>During an insurer-approved Open Enrollment Period, eligible OREA Members have the option to purchase additional CI Insurance coverage for themselves and/or their eligible dependents at an additional cost (paid by the Member to the Plan Administrator). There are claiming exclusions for pre-existing conditions for this coverage, which are further outlined within this benefit booklet. The insurer will assess whether an illness is covered at the time of claim.</p>
Coverage	\$25,000
Reduction	Reduces by 50% at age 65
Termination Age	Terminates at age 70
Eligibility	OREA Members and their eligible dependents
Insurer	AIG Insurance Company of Canada ("AIG")

Virtual Healthcare and Mental Healthcare

How It Works	All eligible OREA Members are automatically enrolled in the ORWP Virtual Healthcare and Mental Healthcare Program. Maple is a virtual healthcare platform offering fast, convenient access to Canadian general practitioners (GPs) and therapists. Maple is designed to be user-friendly and easy to navigate, making it simple for you to request a virtual healthcare visit on-demand and consult with healthcare professionals from your home or on-the-go.
Coverage	<ul style="list-style-type: none">• Unlimited on-demand access to General Practitioners, 24/7/365.• Unlimited Mental Health Counselling: On-Demand requests within 12 hours and bookable appointments available.• Headspace Plus: Meditation app access• Mind by Maple: Access to well-being and mental health educational content library
Termination Age	No termination age. Coverage terminates on the date you are no longer an eligible Member of OREA, or the date you retire (unless you select a retirement option within 31 days of the date your retirement).
Eligibility	OREA Members Note: Headspace Plus access is for OREA Members only
Provider	Maple Corporation (“Maple”)

Health: Insurance or Services

There are two Standard Plan options for OREA Members.

ORWP Standard Plan with Health Insurance (Standard Plan 1)

This option includes insured benefits that are intended to supplement the OREA Member's provincial health insurance plan. The included benefits will be eligible if medically necessary for the treatment of an illness or injury, and reimbursement will be limited to reasonable and customary charges, in addition to any specific limitations and maximums stated on the subsequent pages. Medically necessary means generally recognized by the Canadian medical profession as effective, appropriate, and required in the treatment of an illness, in accordance with Canadian medical standards. The Standard Plan 1 covers the OREA Member only. The enrollment of eligible dependents is optional during an approved Open Enrollment Period or eligible Life Event, at an additional monthly cost.

ORWP Standard Plan with Health Services (Standard Plan 2)

This option includes non-insured benefits that are intended to provide OREA Members with a variety of health resources, services, and support tools. With an emphasis on holistic well-being, OREA Members can utilize supports for their physical, mental, and financial wellness—with discount programs for health-related expenses, fitness and healthy lifestyle coaching, one-on-one advisory support with qualified professionals, self-directed therapy modules, and more. This option does not include any insured benefits such as prescription drugs, paramedical practitioners, medical services & supplies, and other benefits included under the ORWP Standard Plan with Health Insurance (Standard Plan 1). If an OREA Member elects Standard Plan 2, the OREA Member will not have access to these coverages, nor will they be able to coordinate other coverage with ORWP

How It Works

All eligible OREA Members are automatically enrolled in the ORWP Standard Plan with Health Insurance (Standard Plan 1). During an insurer-approved Open Enrollment Period, eligible OREA Members have the option to:

- (1) Select the ORWP Standard Plan with Health Services (Standard Plan Option 2), OR
- (2) Upgrade their coverage to the ORWP Enhanced Plan, ORWP Elite Plan, or ORWP Super Elite Plan. Members may also upgrade their coverage by adding eligible dependents. These enhancements are an additional cost (paid by the Member to the Plan Administrator). The OREA Member and their dependent(s) must be enrolled in the same plan option, and this option must be the same for Healthcare Insurance, Dental Care Insurance, and Travel Insurance.

Coverage

See next page and additional details within this benefit booklet

Termination Age

No termination age. Coverage terminates on the date you are no longer an eligible OREA Member, or the date you retire (unless you select a retirement option within 31 days of retirement date).

Eligibility

OREA Members (and their eligible dependents if elected)

Insurer

GreenShield ("GSC")

Health Insurance: Coverage Details for Plans with Insured Benefits

For ORWP Standard Plan with Health Insurance (Standard Plan 1), ORWP Enhanced Plan, ORWP Elite Plan, and ORWP Super Elite Plan

Reminder: These insured benefits are not available under the ORWP Standard Plan with Health Services (Standard Plan 2). For more details on Standard Plan 2, refer to the Health Services: Coverage Details for Standard Plan 2 table.

	ORWP Standard Plan with Health Insurance (Standard Plan 1) Included with OREA Dues	ORWP Enhanced Plan Optional	ORWP Elite Plan Optional	ORWP Super Elite Plan Optional
Calendar Year Deductible	No deductible	No deductible	No deductible	No deductible
Prescription Drug Coverage				
Reimbursement:	70% (30% co-pay)	70% (30% co-pay)	80% (20% co-pay)	80% (20% co-pay)
Calendar Year Maximum: (Combined for all drug-related expenses)	\$750	\$1,000	\$5,000	\$25,000
Dispensing Fee:	Member pays the full dispensing fee for all four plan options			
Drug Plan Type:	Mandatory Generic for all four plan options			
Pay Direct:	Included for all four plan options			
Smoking Cessation Program:	One course of treatment in any 12-month period for all four plan options			
Paramedical Practitioners Coverage				
Reimbursement:	70% (30% co-pay)	70% (30% co-pay)	80% (20% co-pay)	80% (20% co-pay)
Calendar Year Maximum: (Combined for all practitioners)	\$750	\$750	\$1,250	\$1,500
Practitioners Covered: (For all four plan options)	Chiropractor, Chiropracist/Podiatrist, Osteopath, Registered Massage Therapist, Naturopath, Physiotherapist, Speech Therapist, Acupuncturist, Dietitian, Homeopath, Psychologist, Counsellor/Social Worker, Master of Social Work (MSW), Psychotherapist			

Health Insurance: Coverage Details for Plans with Insured Benefits (Continued)

	ORWP Standard Plan with Health Insurance (Standard Plan 1) Included with OREA Dues	ORWP Enhanced Plan Optional	ORWP Elite Plan Optional	ORWP Super Elite Plan Optional
Medical Services & Supplies				
Reimbursement:	70% (30% co-pay)	70% (30% co-pay)	80% (20% co-pay)	80% (20% co-pay)
Calendar Year Maximum: (Combined for all services & supplies)	\$500	\$1,000	\$2,500	\$2,500
Hearing Aids: (Maximum every 60 months)	\$500 for all four plan options			
Orthotics/Orthopaedic Footwear:				
<i>Custom Boots or Shoes</i>	2 pairs every 12 months for all four plan options			
<i>Custom Orthotics</i>	1 pair every 36 months for all four plan options			
<i>Modifications and Repairs</i>	Twice every 6 months for all four plan options			
Gender Affirmation:	Included for all four plan options			
All Other Services & Supplies:	Frequency limits and eligibilities vary. More details are outlined within this benefit booklet.			
Vision Care				
Reimbursement:		70% (30% co-pay)	80% (20% co-pay)	80% (20% co-pay)
24-Month Maximum: (Combined for all vision expenses)	Vision care is not covered under the Standard Plan.	\$250	\$400	\$500
Coverage:		Eyeglasses, Contact Lenses, Laser Eye Surgery, Eye Examinations		
Pharmacogenetic Testing				
Lifetime Max:	\$800	\$800	\$800	\$800
Other Health				
Reimbursement:	70% (30% co-pay)	70% (30% co-pay)	80% (20% co-pay)	80% (20% co-pay)
Medical Transportation (Ambulance):	Unlimited for all four plan options			
Accidental Dental:	Unlimited for all four plan options			

Health Services: Coverage Details for Standard Plan 2

Programs and Services Included

The Health Depot Pharmacy:	Access to GreenShield’s virtual pharmacy, where OREA Members can access preferred dispensing fees on medication
Change4Life®:	GreenShield’s digital wellness platform that offers support tools for adopting healthier habits and living a healthier lifestyle, rewarding health behaviours along the way
KITS Eyewear Discount Program:	Discounts on prescription eyewear
Advisory Services:	Health Coaching, Career Coaching, Life Transitions, Legal Services, and Financial Services
Tranquillity by Inkblot:	Access to a digital iCBT platform that helps management of anxiety and depression

Dental Care Insurance

The ORWP Dental Care Insurance benefits will be eligible if necessary for the prevention of dental disease or treatment of dental disease or injury and reimbursement will be limited to the amount stated in the Provincial Dental Association Fee Guide indicated.

How It Works All eligible OREA Members are automatically enrolled in the ORWP Standard Plan with Health Insurance (Standard Plan 1). This plan does not include Dental Care Insurance Coverage. Dental Care Insurance coverage is only available through one of the program's three optional enhanced plans.

During an insurer-approved Open Enrollment Period, eligible OREA Members have the option to upgrade their coverage to include dental coverage by electing the Enhanced Plan, Elite Plan, or Super Elite Plan, and/or Members may add eligible dependents in the same plan option. These upgrades are an additional cost (paid by the Member to the Plan Administrator).

Coverage See next page and additional details within this benefit booklet

Termination Age No termination age. Coverage terminates on the date you are no longer an eligible Member of OREA, or the date you retire (unless you select a retirement option within 31 days of the date your retirement, if eligible for such retirement coverage).

Eligibility OREA Members and their eligible dependents

Insurer GreenShield ("GSC")

Dental Care Insurance: Coverage Details (Not included in ORWP Standard Plan)

	ORWP Enhanced Plan (Optional)	ORWP Elite Plan (Optional)	ORWP Super Elite Plan (Optional)
Calendar Year Deductible	No deductible	No deductible	No deductible
Reimbursement			
Basic Services ¹ :	50% (50% co-pay)	80% (20% co-pay)	80% (20% co-pay)
Comprehensive Basic Services ² :	50% (50% co-pay)	80% (20% co-pay)	80% (20% co-pay)
Major Services ³ :	50% (50% co-pay)	50% (50% co-pay)	50% (50% co-pay)
Fee Guide			
General Practitioners:	Current province of treatment for all three plan options		
Independent Dental Hygienists:	Current Provincial Dental Hygienists' Association Fee Guide in the province where services are rendered for all three plan options		
Calendar Year Maximum: (Combined for all dental services)	\$750	\$1,000	\$1,500

1. Basic Services include recall visits once every 9 months, fillings, and extractions.
2. Comprehensive Basic Services include root canal therapy, periodontal scaling/root planing (6 units of scaling per year), and denture relining/rebasing, repairs, or adjustments.
3. Major Services include crowns, dentures, and/or bridgework. (Replacements of each limited to once every 5 years.)

Travel Insurance

How It Works

All eligible OREA Members are automatically enrolled in the ORWP Travel Insurance Program under the Standard Plan. This benefit provides coverage for emergency medical services required as a result of an unforeseen and unexpected medical emergency while travelling, as long as you are up to date on OREA Dues payment at the time of departure.

It does not provide coverage for any treatment, investigation or surgery for a specific condition, which had caused a physician to advise you not to travel; any sickness or Injury that, at the time of departure, might reasonably be expected to require you to undergo treatment, investigation, surgery, or hospitalization; or a medical condition that had deteriorated or had to be treated or investigated in the 90 days immediately preceding your departure from the province or territory of residence. There is no coverage for trips that begin prior to the effective date of coverage.

During an insurer-approved Open Enrollment Period, eligible OREA Members have the option to upgrade their travel coverage by electing the Enhanced Plan, Elite Plan, or Super Elite Plan, and/or Members may add eligible dependents in the same plan option. These upgrades are an additional cost (paid by the Member to the Plan Administrator).

Coverage

See next page and additional details within this benefit booklet.

Termination Age

Terminates at age 80 or the date you are no longer an eligible Member of OREA, or the date you retire (unless you select a retirement option within 31 days of the date your retirement, if eligible for such retirement coverage).

Eligibility

OREA Members and their eligible dependents

Insurer

AIG Insurance Company of Canada ("AIG")

Travel Insurance Coverage Details

	ORWP Standard Plan [Options 1 and 2] (Included with OREA Dues)	ORWP Enhanced Plan (Optional)	ORWP Elite Plan (Optional)	ORWP Super Elite Plan (Optional)
Travel				
Coverage Type:	Emergency Medical for all four plan options			
Reimbursement:	100%	100%	100%	100%
Trip Duration Limit: (Consecutive days)	30 days	60 days	60 days	60 days
Lifetime Limit:	\$2,000,000	\$2,000,000	\$2,000,000	\$2,000,000
Pre-Existing Conditions Exclusion:	90 days prior to departure for all four plan options. Additional details in this benefit booklet.			
Trip Cancellation & Interruption				
Trip Cancellation:		\$5,000 per Insured	\$5,000 per Insured	\$5,000 per Insured
Trip Interruption:	Trip Cancellation & Interruption benefits are not covered under the Standard Plan.	\$5,000 combined	\$5,000 combined	\$5,000 combined
<i>Pre-Paid and Transportation Expenses</i>		\$250 per day	\$250 per day	\$250 per day
<i>Meals and Accommodations</i>		\$250 per day	\$250 per day	\$250 per day
Aggregate per Trip Limit:		\$10,000	\$10,000	\$10,000
Baggage & Personal Effects				
Loss or Damage to Baggage and Personal Effects:		\$1,000 per trip \$500 per item	\$1,000 per trip \$500 per item	\$1,000 per trip \$500 per item
Delay of Baggage and Personal Effects:	Baggage & Personal Effects benefits are not covered under the Standard Plan.	\$400	\$400	\$400
Prescription Replacement Service:		\$200	\$200	\$200
Replacement of Travel Documents:		\$200	\$200	\$200
Aggregate Limit per Family:		\$2,000 (\$250 deductible)	\$2,000 (\$250 deductible)	\$2,000 (\$250 deductible)

ORWP Eligibility and Plan Rules

Who's Eligible?

An **OREA Member** ("Member of OREA" or "Member") is a Member of a Member Board who submits a complete application in the form required by the Member Board, meets all the membership requirements set out in the Member Board By-law, including the payments of dues, fees and assessments, is duly registered under the Real Estate and Business Brokers Act, 2002 / Trust in Real Estate Services Act, and whose application for membership has been approved by the Member Board. A Member of OREA shall be effective on the date their application for membership is approved by their Member Board. Members agree to abide by the Member Board By-law, Rules and Regulations and agree to become Members of and abide by the OREA and CREA By-laws, rules and regulations and the REALTOR® Code and any amendments to these documents.

Dependents of a covered Member are also eligible for all coverage provided under this agreement, subject to existing plan provisions and except for access to Headspace Premium App, which is limited to the covered Member only.

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 1 year. Only one spouse will be considered at any time as being covered under the group contract.
- Your unmarried natural, adopted, or step child of the Individual Member or the insured spouse; or any other unmarried child for whom the Individual Member or the insured spouse has been appointed guardian for all purposes by a court of competent jurisdiction 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 and is considered a dependent as defined under the Income Tax Act, 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 (a child under age 21 must not be working more than 30 hours a week, unless he is a full-time student).

A child of the insured spouse is not insurable unless:

- he is also the Individual Member's child; or
- the spouse is living with the Individual Member or Staff Participant and has custody of the child.

A child for whom the Individual Member or the insured spouse has been appointed guardian is not insurable unless:

- The insurer(s) have received satisfactory proof of guardianship; and
- if the insured spouse is the guardian, the spouse is living with the Individual Member.

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 health insurance plan for an extension of coverage to ensure your child continues to be covered under a provincial health insurance plan.

When Coverage Begins

An OREA Member's coverage begins on the date their application for membership is approved by their Member Board, provided they:

- submit a complete application in the form required by the Member Board,
- meet all the membership requirements set out in the Member Board By-law, including the payment of dues, fees, and assessments, AND
- are duly registered under the Real Estate and Business Brokers Act, 2002 / Trust in Real Estate Services Act.

Members agree to abide by the Member Board By-law, Rules and Regulations and agree to become Members of and abide by the OREA and CREA By-laws, rules and regulations and the REALTOR® Code and any amendments to these documents.

When Coverage Terminates

A Member's coverage terminates on:

- The last day of the membership year (December 31st) following the date on which the Member no longer qualifies as an active OREA Member, if membership dues are billed and collected in advance on an annual basis; or
- The last day of the month for which membership dues have been collected for, if membership dues are billed and collected in advance on a monthly basis; or
- The last day of the quarter for which membership dues have been collected for if membership dues are billed and collected in advance on a quarterly basis; or
- The date you reach the maximum age for coverage eligibility of a benefit that has a termination age.

Reinstatement of Insurance

Insurance will be automatically reinstated if:

- an individual Member who terminated in any calendar year rejoins OREA within the same calendar year; and
- if during the membership year, membership is terminated for any reason, reinstatement requires the payment of all arrears.

Insurance will be reinstated without interruption subject to the following:

- should an individual Member die during the period they are not covered, they cannot be reinstated in the Plan.
- the individual Member must be living on the date the arrears payment is received by the Member Board.
- should an individual Member be diagnosed with a Critical Illness during the period they are not covered, it would not be considered eligible under the Plan. Further, the Member will need to re-satisfy any pre-existing condition clauses associated with this coverage upon their reinstatement.
- Claims occurring within the period they are not covered will not be eligible.

If reinstatement does not occur within the same membership year in which membership is terminated, for insurance purposes, the Member will be deemed a NEW Member, on the date they re-join the Member Board. If a Member does not qualify for automatic reinstatement, they will be treated as a new Member.

Beneficiary Designations

You may make, alter, or revoke a designation of beneficiary as permitted by law. You should review any beneficiary designation made under this policy from time to time to ensure that it reflects your current intentions. You may change the designation online through your ORWP Plan Member Portal, or by completing a form available from your Plan Administrator. Subject to legal provisions, a Plan Member may designate or revoke, at any time, one or several beneficiaries of the insurance on written notice to the Plan Administrator. The rights of a beneficiary who dies before the Plan Member revert to the latter. The Administrator and the Insurer assume no responsibility with respect to the validity of any beneficiary designation or revocation.

Making Your Benefit Selections – Enrollment Periods

All eligible OREA Members are automatically enrolled in the ORWP Standard Plan with Health Insurance (Standard Plan 1). All eligible OREA Members may enhance their Standard Plan coverage on a guaranteed issue basis during an insurer-approved Enrollment Period, or within 31 days of eligibility.

Eligible Members may choose to enhance any one or combination of the following personal coverages:

- Optional Life Insurance and Accidental Death & Dismemberment Insurance
- Critical Illness Insurance
- Healthcare, Dental Care, and Travel Insurance

Eligible Members may also choose to enhance coverage through the addition of eligible dependent(s) to any one or combination of the following coverages:

- Optional Life Insurance and Accidental Death & Dismemberment Insurance
- Critical Illness Insurance
- Healthcare, Dental Care, and Travel Insurance

Enrollment Periods will be communicated to Members at least 60 days in advance. Enrollment Periods will be available no less than once every 24 months.

After a Member has made their initial benefit selections, they cannot make any changes to their coverage until the next Enrollment Period, with two exceptions:

- (1) **New OREA Members:** Any new OREA Member will have 31 days from their Date of New Membership to enhance coverage beyond the Standard Plan.
- (2) **Life Event:** A Member may terminate, change, or obtain coverage for themselves and/or eligible dependent(s) within 31 days of the insurer-approved life event.

A Life Event refers to a change in life situation that makes a person eligible to enroll in or change their health insurance outside of the Open Enrollment Periods. The insurer-approved events include:

- Death of spouse / child
- Marriage or Common-Law Union / divorce / legal separation
- Birth / adoption of a child
- Loss or gain of coverage under spouse's plan.

The insured person must report the Life Event within 31 days of occurrence and report the event online via the ORWP Plan Member Portal or directly to the Plan Administrator should they wish to change their benefit selections.

Members cannot increase or decrease their coverage by more than one coverage level during any Enrollment Period.

Enhancements to coverage are paid for by the OREA Member directly to the Plan Administrator, CBS, on a monthly basis for the upcoming month. Costs vary depending on the coverages selected. Monthly premiums include applicable taxation. If a Member fails to pay for their upgraded coverage on the date charged, the Member will have 15 days to complete missed or ineligible or incomplete payment, upon which, failing to pay, the Member's enhanced coverage will be terminated and the Member will be placed back into the ORWP Standard Plan with Health Insurance (Member only). If a Member fails to pay for options beyond Standard Plan, they will not be able to participate in any enhanced options until the next Open Enrollment Period, which cannot occur sooner than January 1st of the year following two years from date of ineligible payment.

Definitions

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

Aircraft means a vehicle used for aerial navigation which has a valid certificate of airworthiness and is being flown by a pilot with a valid license to operate the Aircraft.

Air transportation means any land, water or air conveyance required in connection with the transport of the Insured Person by air.

Allowed amount (for Healthcare Insurance and Dental Care Insurance expenses) means, as determined by the insurer, GreenShield (GSC):

- Drugs – the GSC National Pricing Policy and/or the reasonable and customary charge.
- Extended Health Services – the reasonable and customary charge for the service or supply but not more than the prevailing charge in the area in which the charge is made for a like service or supply.
- Dental – the provincial fee guide as specified in the Benefit Summary.

Biologic drug means a drug that is produced using living cells or microorganisms (e.g., bacteria) and are often manufactured using a specific process known as DNA technology.

Biosimilar drug means a biologic drug demonstrated to be similar to a reference biologic drug already authorized for sale by Health Canada.

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

Charter flight means air travel that is chartered for a specific trip, or part of a trip, and the air travel is not part of an airline's regularly scheduled flight.

Change in Treatment includes any new Treatment or medication, stopped Treatment or medication, increase, or decrease in Treatment or medication, but does not include transition between generic and brand name versions of drugs with the same active ingredient and dosage or the routine adjustment of dosage within prescribed parameters when taking insulin or oral diabetes medication.

Coinsurance means the percentage of the eligible expenses reimbursed that are in excess of those reimbursable by any other insurance contract or health plan (group or individual), up to the Maximum Per Insured Person and Aggregate Limits.

Commercial accommodation means an establishment providing short-term accommodation for paying guests, licensed under the law of its jurisdiction, which provides proof of commercial transaction. This includes accommodation booked through an online marketplace or homestay network.

Common carrier means any land, water or air conveyance operated under the license for the transportation of passengers for hire. Common carrier does not include any conveyance that is hired or used for a sport, gamesmanship, contest, sightseeing, taxi, commuting, observatory and/or recreational activity, regardless of whether such conveyance is licensed.

Co-pay means:

- Prescription Drugs – the rendered amount that must be paid by you or your dependent before reimbursement of an expense will be made.
- All other Health Care Insurance and Dental Care Insurance benefits – the eligible allowed amount that must be paid by you or your dependent before reimbursement of an expense will be made.

Covered expenses (for Travel Insurance coverage) means those Reasonable and Customary expenses, up to the maximum specified, for transportation, medical services and medical supplies which are Medically Necessary and incurred in connection with the Air Transportation of the Insured Person. All transportation arrangements made for transporting the Insured Person must be by the most direct and economical route. Expenses for Special Transportation must be recommended by the attending Physician or surgeon or required by the standard regulations of the conveyance transporting the Insured Person. Expenses for medical supplies and services must be recommended by the attending Physician.

Deductible means the amount that must be paid by or on behalf of you and your dependent in any calendar year before reimbursement of an eligible expense will be made.

Departure date means the date upon which an Insured Person leaves their province / country of residence on a trip, a date which must occur while this policy is in effect and while the Insured Person is eligible.

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 1 year. Only one spouse will be considered at any time as being covered under the group contract.
- Your unmarried child, who:
 - is under age 21, or
 - 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, or
 - regardless of age became totally disabled while eligible and enrolled in this plan, and who has been continuously so disabled since that time and is considered a dependent as defined under the Income Tax Act, 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 (not having full-time employment with their own benefit plan).

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 health insurance plan for an extension of coverage to ensure your child continues to be covered under a provincial health insurance plan.

Effective date means the date when coverage begins, as stipulated within the Plan Rules as the date from which coverage begins under this policy.

Expiration date means the date when coverage terminates within the Plan Rules as the date from which coverage ends under this policy.

Fee guide means the list of dental procedure codes developed by and maintained by the Canadian Dental Association, adopted by the provincial or territorial dental association of the province or territory in which the service is provided (or your province of residence if any dental service is provided outside Canada) and in effect at the time the service is provided.

GHIP (Government Health Insurance Plan) means the health insurance coverage that Canadian provincial or territorial governments provide for their residents.

Hospital means an establishment which:

- holds a license as a Hospital (if licensing is required in the jurisdiction).
- operates primarily for the reception, care, and treatment of sick, ailing, or injured persons as inpatients.
- provides twenty-four (24) hour a day nursing service by registered or graduate nurses.
- has a staff of one (1) or more licensed Physicians available at all times.
- provides organized facilities for diagnosis, and major medical surgical facilities.
- is not primarily a clinic, nursing, rest or convalescent home or similar establishment; and
- is not, other than incidentally, a place for the treatment of alcohol or drug addiction.

Immediate family means a person who is related to the Insured Person in any of the following ways: a spouse, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister), or child (including legally adopted or stepchild).

Injury means bodily injury which is sustained by an Insured Person as a direct result of an unintended unanticipated accident, provided such accident is external to the body and occurs while the Insured Person's insurance under this contract is in force.

Injury or Injuries (for Travel Insurance benefit) means bodily injury which is sustained by an Insured Person as a direct result of an unintended unanticipated accident, occurring anywhere in the world outside their province / country of residence, provided such accident is external to the body and occurs while the Insured Person's insurance under this policy is in force and while the Insured Person is outside their province / country of residence.

Institution of higher learning includes, but is not limited to, any university, private post-secondary college, or trade school, and any College of General and Vocational Education/ Collège d'enseignement général et professionnel (CÉGEP).

Insured Member's effective date means the effective date of an individual person's coverage under this Group Policy.

Insured Person (may also be "**Covered Person**") means the Plan Member who has been enrolled in the plan or their enrolled Dependents.

Insurer means:

- for Accidental Death & Dismemberment Insurance, Critical Illness Insurance, and Emergency Out of Country Travel Insurance - AIG Insurance Company of Canada (AIG)
- for Health and Dental Insurance - GreenShield (GSC, GreenShield Canada)
- for Life Insurance – The Canada Life Assurance Company (Canada Life)

Irreversible means the medical condition/limitations cannot be materially improved by medical or surgical treatment at the time of Diagnosis. The medical or surgical treatment need not be undertaken if it is experimental or would involve undue risk to the Insured Person's health.

Key employee is a business partner or employee whose continued presence is critical to the ongoing affairs of the business during an Insured Person's or Travel Companion's absence.

Leased aircraft means an aircraft owned by a person other than the Insured Person's Employer (or a related company, subsidiary, affiliate, parent company, principal, officer or employee or family member of an officer or employee of the Policyholder, the Employer, or such entity) that is used by the Policyholder or such Employer under the terms of a fixed agreement for a specified duration of time.

Life support means when the Insured Person is under the regular care of a licensed Physician for nutritional, respiratory and/or cardiovascular support when irreversible cessation of all functions of the brain has occurred.

Loss when used with reference to:

- **“Quadriplegia”, “Paraplegia”, and “Hemiplegia”** means the complete and irreversible paralysis of such limbs.
- **“Hand” or “Foot”** means the complete severance through or above the wrist or ankle joint, but below the elbow or knee joint.
- **“Arm” or “Leg”** means the complete severance through or above the elbow or knee joint.
- **“Thumb and Index Finger”** means the complete severance through or above the first (1st) phalange.
- **“Fingers”** means the complete severance through or above the first (1st) phalange of all four (4) Fingers of One (1) Hand.
- **“Toes”** means the complete severance of both phalanges of all the Toes of One (1) Foot.
- **“The Entire Sight of One (1) Eye”** means the total and irrecoverable Loss of Sight such that corrected visual acuity must be 20/200 or less in such eye.
- **“The Entire Sight of Both Eyes”** means the total and irrecoverable Loss of Sight in both eyes such that corrected visual acuity must be 20/200 or less and the field of vision must be less than twenty (20) degrees in both eyes. A Physician certified in Ophthalmology must clinically confirm the diagnosis in writing.
- **“Hearing in One (1) Ear”** means the diagnosis of permanent Loss of Hearing in One (1) Ear, with an auditory threshold of more than ninety (90) decibels. A Physician certified in Otolaryngology must confirm the diagnosis in writing.
- **“Hearing”** means the diagnosis of permanent Loss of Hearing in Both Ears, with an auditory threshold of more than ninety (90) decibels in each ear. A Physician certified in Otolaryngology must confirm the diagnosis in writing.
- **“Speech”** means complete and irrecoverable Loss of the ability to utter intelligible sounds; and
- **“Loss of Use”** means the total and irrecoverable Loss of use provided the Loss is continuous for twelve (12) consecutive months and such Loss of use is determined to be permanent.

Loss when used herein may also include “Loss of Life.”

Malignant Melanoma means a type of skin cancer that is 0.75 mm or less in depth when measured under a microscope.

Medical condition means the onset of sickness or disease requiring medical advice, consultation, investigation, Treatment, care, service, or diagnosis by a Physician.

Medical emergency means a condition caused by an Injury or Sickness which meets all of the following criteria:

- there is present a severe or acute symptom requiring immediate care and the failure to obtain such care could reasonably result in serious deterioration of the Insured Person's condition or place their life in jeopardy.
- the severe or acute symptom occurs suddenly and unexpectedly; and
- the severe or acute symptom occurs while the policy is in force.

Medically necessary means the services or supplies provided by a Hospital or Physician, licenced dentist or other licenced provider that are required to identify or treat an Insured Person's Sickness or Injury and that are defined as follows:

- Consistent with the symptom or diagnosis and Treatment of the Insured Person's Sickness or Injury.
- Appropriate with regard to standards of good medical practices.
- Not solely for the convenience of the Insured Person or a Physician or other licenced provider; and
- When applied to the care of a Hospital in-patient, it further means that the Insured Person's medical symptoms or conditions require that the services cannot be safely provided as a Hospital out-patient.

Metastasized means the spread of cancer from one part of the body where it started (the primary site) to another part(s) of the body.

Minor ailment means any Injury or Sickness which does not require:

- the use of medication for a period of greater than 15 days
- more than one follow-up visits to a Physician
- hospitalization of surgical intervention
- referral to a specialist; and which ends at least 30 consecutive dates prior to the Insured Person's Departure Date of a Trip
- A chronic condition or any complication of a chronic condition is not considered a minor ailment.

Off-label use means using a drug for a purpose or to treat a condition other than what Health Canada has approved that drug to be used.

Owned aircraft means an aircraft to which the Policyholder or the Employer (or a related company, subsidiary, affiliate, parent company, principal, officer or employee or family member of an officer or employee of the Policyholder, the Employer, or such entity) holds legal or equitable title such that the Policyholder, Employer or such entity or person can use, alter, or sell the aircraft as they wish.

Pharmacogenetic testing means a type of genetic testing that determines whether the covered person has genetic mutations known to influence the way the covered person responds to certain drugs. Based on that information, their health care provider could choose medications better suited to them.

Plan Administrator means the company appointed by and acting on behalf of the Plan Sponsor for purposes of providing administrative services in respect to the insurance provided under this policy.

Plan Member means an **OREA Member** ("Member of OREA" or "Member"), that is, a Member of a Member Board who submits a complete application in the form required by the Member Board, meets all the membership requirements set out in the Member Board By-law, including the payments of dues, fees and assessments, is duly registered under the Real Estate and Business Brokers Act, 2002 / Trust in Real Estate Services Act, and whose application for membership has been approved by the Member Board. A Member of OREA shall be effective on the date their application for membership is approved by their Member Board. Members agree to abide by the Member Board By-law, Rules and Regulations and agree to become Members of and abide by the OREA and CREA By-laws, rules and regulations and the REALTOR® Code and any amendments to these documents.

Physician means a medical doctor, other than the Insured Member or the Insured Member's immediate family, who is licenced to administer medical treatment and prescribe drugs in the place where the physician provides medical services. The following are not considered to be Physicians: naturopath, herbalist, and homeopath.

Policyholder means The Ontario Real Estate Association (OREA).

Pre-existing condition (for Critical Illness Insurance coverage) means:

- (a) the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment within 12 months preceding their effective date under this policy (Insured Person's Effective Date); or
- (b) an illness or condition for which, during the 12 months, prior to your effective date of coverage, incurred medical expenses, received medical treatment, took prescribed drugs or medicine, or consulted a Physician.

Pre-existing condition (for Travel Insurance coverage) means any medical or physical condition, symptom, illness, or disease for which Treatment was received or for which an ordinarily prudent person would have sought Treatment within 90 days immediately prior to the Insured Person's Departure Date unless such condition was Stable and Controlled.

Private passenger type automobile means any means of transportation not operated for commercial purposes, designed to carry passengers and that is pulled, propelled, or fueled in any way, including cars, trucks, motorcycles, mopeds, snowmobiles, or boats.

Reasonable and Customary (for Healthcare and Dental Care Insurance coverage) 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.

Reasonable and Customary (for Travel Insurance coverage) means in the opinion of AIG, the amount usually charged for Treatment, services or supplies to provide an appropriate level of care given the severity of the Sickness or Injury being treated, in the geographical location where the Treatment, services or supplies are being provided.

Reasonable and necessary means the expenditures that, in nature and amount, do not exceed what the Insured Person would incur for a similar kind, quality and value of an item.

Reference biologic drug means a biologic drug that is first authorized for sale by Health Canada.

Reimbursement means the amount of the allowable expense the insurer will pay.

Rendered amount means the amount charged by a provider for a service and submitted for payment of a claim.

Return date means the travel date, as indicated on the ticket or in the travel itinerary, upon which the Insured Person is scheduled to return from a Trip to their place of ordinary residence.

Sickness means the onset of sickness or disease requiring medical Treatment, care, or advice while the Insured Person is travelling anywhere in the world outside their province / country of residence while the Insured Person's coverage under this Policy is in force.

Special transportation includes, but is not limited to, air ambulances, land ambulances, commercial airlines, and private motor vehicles.

Specialist means a licensed medical practitioner who has been trained in the specific area of medicine relevant to the Critical Illness condition for which benefit is being claimed, and who has been certified by a specialty examining board. In the absence or unavailability of a Specialist, and as approved by AIG, a condition may be Diagnosed by a qualified medical practitioner practicing in Canada or the United States of America. Specialist includes, but is not limited to, cardiologist, neurologist, nephrologist, oncologist, ophthalmologist, burn specialist and internist. The Specialist must not be the Policyholder, the Insured Member, a relative of or business associate of the Policyholder or of the Insured Member.

Stable and controlled means any medical condition (whether or not the diagnosis has been determined), other than a Minor Ailment, for which there has been:

- no hospitalization; and
- no new diagnosis, Treatment, or prescribed medication; and
- no Change in Treatment; and
- no new, more frequent, or more severe symptoms; and
- no new test results showing deterioration; and
- no referral to a specialist (made or recommended) and the Insured Person is not awaiting surgery or results of further investigations performed by a Physician.

Squamous Cell Carcinoma means a type of skin cancer that arises from the squamous cells that make up the epidermis, or the outermost layer of the skin.

Survival period means the minimum number of consecutive days (excluding the number of days on Life Support), immediately following the date of Diagnosis or surgery, which the Insured Member must survive before a Critical Illness benefit amount may become payable. The Survival Period for this policy is 30 days.

Table of Losses means the table set out in the Accidental Death & Dismemberment (AD&D) Insurance section of this benefit booklet.

Travel arrangements means any non-refundable, non-transferrable or non-recoverable prepaid expenses for the Insured Person's Trip, including but not limited to hotel, rental car, or any land, air, or water conveyance. Travel Arrangements will not include any registration fees paid to the Policyholder, or any insurance premiums.

Travel companion means the person with whom an Insured Person is sharing travel arrangements and prepaid accommodations on a Trip.

Treatment means any medical, therapeutic, or diagnostic procedure, service or supply that is prescribed, performed, or recommended by a Physician, including but not limited to prescribed medication, investigative testing, and surgery.

Trip means travel by an Insured Person outside their province / country of residence which commences on such Insured Person's Departure Date which must commence after this policy Effective Date and before this policy Expiration Date.

Basic Life Insurance

The Basic Life Insurance coverage provided under the Ontario REALTOR® Wellness Program (ORWP) is outlined in the **Benefit Summary** (page 5) section of this booklet.

Upon the death of an eligible OREA Member, The Canada Life Assurance Company (Canada Life) will pay the life insurance proceeds to the OREA Member's named beneficiary or beneficiaries. If the Insured OREA Member has not named a beneficiary or there is no surviving beneficiary at the time of the insured person's death, payment will be made to the insured person's Estate.

For information on Claims Submission, refer to page 91 of this booklet.

Optional Life Insurance

The Optional Life Insurance coverage available under the Ontario REALTOR® Wellness Program (ORWP) is outlined in the **Benefit Summary** (page 6) section of this booklet.

Optional Life Insurance allows the OREA Member to purchase additional coverage for themselves, their spouse, and/or their eligible dependent children.

Upon the death of the insured person, Canada Life will pay the life insurance proceeds to the insured person's named beneficiary or beneficiaries. If the insured person has not named a beneficiary or there is no surviving beneficiary at the time of the insured person's death, payment will be made to the insured person's Estate. If the OREA Member's spouse and/or eligible dependent children die, the OREA Member will be paid the amount for which the spouse and/or child(ren) was insured.

If Optional Life Insurance coverage for the Member, the Member's spouse, or the Member's eligible dependent children terminates, the Member, the spouse, and/or the dependent children may be eligible to apply for an individual conversion policy without providing proof of insurability. Application and payment of the first premium must be made no later than 31 days after the group insurance terminates.

Limitation

No benefit is paid for suicide within the first two years of initial or increased Optional Life Insurance coverage. In such a situation, Canada Life refunds the premiums that have been received.

Converting to an Individual Insurance Policy

OREA Members (and/or spouses and children enrolled in Optional Life Insurance) are entitled to “convert” their Life Insurance coverage to an individual insurance policy without evidence of insurability, provided they meet the following conditions:

- All or part of the life insurance for the person under this policy terminates on or before the person’s 65th birthday; and
- The person applies for the individual policy in writing and pays the first premium within 31 days after the insurance terminates.

The conversion privilege is not available if the insurance terminates because of age.

The conversion privilege is not available to a Spouse or Child for whom insurance terminates because:

- They cease to be an insurable spouse or Child; or
- The Member chooses to insure a different spouse.

The conversion privilege is not available to non-residents of Canada.

The individual policy will be one of the standard life insurance conversion forms made available by Canada Life or any of its affiliates. The premium for the individual policy will be based on current individual insurance rates.

The amount of the individual policy will not exceed the lesser of:

- The total amount of the terminated life insurance under the group policy on the date of conversion less the amount of any group term life insurance for which the person becomes eligible within the 31 days allowed for conversion; and
- \$200,000.

This is the combined maximum that can be converted under all group life plans issued to the employer by Canada Life (including Basic Term Life and Optional Life Insurance).

A person can convert less than the maximum individual policy amount but, if he does, he cannot convert an amount less than the minimum issued for the type of policy chosen.

The individual policy takes effect at the end of the 31 days allowed for conversion.

If a person dies within the 31 days allowed for conversion—and would otherwise have been eligible to convert their Life Insurance (based on age and eligibility requirements)—the lesser of the following amounts is payable under the death benefit provision of this policy’s life insurance benefit as if the death occurred while the insurance was still in force:

- the total amount of terminated life insurance; and
- \$200,000.

Contact your Plan Administrator for more information.

Accidental Death & Dismemberment (AD&D) Insurance

The Accidental Death & Dismemberment (AD&D) Insurance coverage provided under the Ontario REALTOR® Wellness Program (ORWP) is outlined in the **Benefit Summary** (page 6) section of this booklet.

The Insurer, AIG Insurance Company of Canada (AIG) shall pay the amount specified in the Table of Losses (on the following page), if the Insured Person sustains a Loss stated therein resulting from Injury, provided that:

- (a) the accident occurred while the Member was insured as an eligible Member of this program.
- (b) such Loss occurs within three hundred and sixty-five (365) days after the date of the accident causing such Loss.
- (c) the amount of the benefit payable for any such Loss shall be the amount set out in the Table of Losses, for that specific Loss.
- (d) if more than one (1) Loss is sustained as the result of any accident, only one (1) benefit shall be payable, the largest.

Table of Losses

Loss	Benefit Amount
Loss of Life	The Principal Sum
Loss of Both Hands or Both Feet	The Principal Sum
Loss of Entire Sight of Both Eyes	The Principal Sum
Loss of One Hand and One Foot	The Principal Sum
Loss of One Hand and the Entire Sight of One Eye	The Principal Sum
Loss of One Foot and the Entire Sight of One Eye	The Principal Sum
Loss of One Arm or One Leg	Four-Fifths of The Principal Sum
Loss of One Hand or One Foot	Three-Quarters of The Principal Sum
Loss of The Entire Sight of One Eye	Three-Quarters of The Principal Sum
Loss of Thumb and Index Finger of the Same Hand	One-Third of The Principal Sum
Loss of Speech and Hearing	The Principal Sum
Brain Death	The Principal Sum
Loss of Speech or Hearing	Three-Quarters of The Principal Sum
Loss of Hearing in One Ear	Two-Thirds of The Principal Sum
Loss of Four Fingers of One Hand	One-Third of The Principal Sum
Loss of All Toes of One Foot	One-Quarter of The Principal Sum
Loss of Use	Benefit Amount
Loss of Use of Both Arms or Both Hands	The Principal Sum
Loss of Use of One Hand or One Foot	Three-Quarters of The Principal Sum
Loss of Use of One Arm or One Leg	Four-Fifths of The Principal Sum
Paralysis	Benefit Amount
Quadriplegia (Total paralysis of both upper and lower limbs)	Two Times the Principal Sum
Paraplegia (Total paralysis of both lower limbs)	Two Times the Principal Sum
Hemiplegia (Total paralysis of upper and lower limbs of one side of the body)	Two Times the Principal Sum

Disappearance

If the body of the Insured Person has not been found within one (1) year of the forced landing, stranding, sinking, or wrecking of a conveyance in which such person was an occupant, then, for the purposes of this contract, such Insured Person shall, in the absence of any evidence to the contrary, be deemed to have suffered Loss of Life.

Additional AD&D Benefits

Subject to the conditions applicable to each of the additional benefits set out below, AIG shall pay additional benefits, up to the maximum amount specified for each such benefit, if an Insured Person suffers an Injury.

On-Premises Benefit

If an accidental bodily injury causes the Insured Person to suffer a covered loss while the Insured Person was on the premises of a property that was being viewed and/or shown to a prospective buyer, this benefit pays an additional amount equal to 10%.

Rehabilitation Benefit

If the Insured Person suffers Injury resulting in a Loss (other than Loss of Life) for which AIG has paid a benefit set out in the Table of Losses (page 32), AIG shall pay the reasonable and necessary expenses actually incurred for the occupational training of the Insured Person, provided that:

- (a) such training is required because of such Injury and in order for the Insured Person to be qualified to engage in an occupation in which the Insured Person would not have been engaged except for having suffered such Injury.
- (b) the training expenses are incurred within two (2) years from the date of the accident causing such Injury; and
- (c) no payment shall be made for ordinary living, travelling, or clothing expenses.

The maximum amount payable for this benefit for all Injuries resulting from any one (1) accident is fifteen thousand dollars (\$15,000.00) per Insured Person.

Home Alteration and Vehicle Modification

If the Insured Person suffers Injury resulting in a Loss (other than Loss of Life) for which AIG has paid a benefit set out in the Table of Losses (page 33) and which Loss results in and necessitates the use of a wheelchair in order for the Insured Person to be ambulatory, AIG shall pay the reasonable and necessary expenses actually incurred for:

- (a) the one-time cost of alterations to the injured Insured Person's residence to make the residence wheel-chair accessible and habitable; and
- (b) the lesser of:
 - (i) the one-time cost of modifications necessary to a motor vehicle, owned by the injured Insured Person, to make the vehicle accessible or drivable for the Insured Person; and
 - (ii) the one-time cost to purchase a wheelchair accessible specially modified vehicle, with the prior approval of AIG.

This benefit is payable only if:

- (a) home alterations are made on behalf of the Insured Person and carried out by an experienced individual in such alterations and recommended by a recognized organization, providing support and assistance to wheel-chair users; and
- (b) vehicle modifications are made on behalf of the Insured Person and carried out by an experienced individual in such matters and modifications are approved by the Provincial vehicle licensing authorities in the Insured Person's province of residence.

The maximum amount payable for this benefit for all Injuries resulting from any one (1) accident is fifteen thousand dollars (\$15,000.00) per Insured Person.

Psychological Therapy

If the Insured Person sustains Injury which results in a Loss payable under the Table of Losses (page 32) other than Loss of Life, and subsequently as a result of such Injury and Loss, the Insured Person requires, within two (2) years from the date of such Injury, Psychological Therapy as prescribed by a Physician, AIG will pay the reasonable and customary expenses for Psychological Therapy.

"Reasonable and Customary" means the lesser of:

- (a) the usual charge made by Physicians or other health care providers for a given service or supply; or
- (b) the charge determined to be the prevailing charge made by Physicians or other health care providers for a given service or supply in the geographical area where it is furnished; or
- (c) the amount negotiated by AIG and the health care provider.

"Psychological Therapy" means treatment or counselling by a therapist or counsellor, who is licensed, registered, or certified to provide such treatment, whether such treatment is on an out-patient basis or provided while a patient at a medical facility licensed to provide such treatment.

The maximum amount payable for this benefit for all Injuries resulting from any one (1) accident per Insured Person is five thousand dollars (\$5,000.00).

In-Hospital Benefit

If the Insured Person suffers Injury resulting in a Loss (other than Loss of Life) for which AIG has paid a benefit set out in the Table of Losses (page 33), and as a consequence of such Loss the Insured Person is, pursuant to the instructions of a Physician, confined to a Hospital for more than five (5) consecutive overnight stays, AIG will pay:

- (a) for a period of confinement in Hospital of more than thirty (30) consecutive overnight stays, 1% of the Insured Person's Principal Sum; or
- (b) for a period of confinement of thirty (30) consecutive overnight stays or less, one thirtieth (1/30) of the amount determined in accordance with Section A (immediately above) for each overnight stay in Hospital.

AIG will pay this benefit monthly, retroactive to the first (1st) overnight stay of confinement in Hospital.

The maximum amount payable for this benefit for all Injuries resulting from any one (1) accident per Insured Person is two thousand five hundred dollars (\$2,500.00) per month.

Benefits are not payable for more than a total of twelve (12) months of confinement for any one (1) accident-causing Injury.

Successive periods of confinement to Hospital for Injury resulting from the same accident, if separated by a period of less than three (3) months, are considered one (1) period of confinement to Hospital for the purposes of calculating this benefit.

Family Transportation

If the Insured Person suffers Injury resulting in a Loss (other than Loss of Life) set out in the Table of Losses (page 33) and if such Loss requires that the Insured Person be confined to a Hospital located more than one hundred (100) kilometres from his or her permanent place of residence, AIG shall pay the reasonable and necessary expenses actually incurred for the transportation of one (1) Immediate Family member to such Hospital. This benefit is only payable if:

- (a) confinement to Hospital occurs within three hundred and sixty-five (365) days of the accident-causing Injury; and
- (b) reimbursement of expenses is limited to the cost of one (1) economy class return airfare via the most direct route, or the equivalent amount toward another type of common carrier transportation for such Immediate Family member.

The maximum amount payable for this benefit for all Injuries resulting from any one (1) accident is fifteen thousand dollars (\$15,000.00) per Insured Person.

Repatriation Benefit

If the Insured Person suffers Injury causing Loss of Life and:

- (a) such Loss of Life occurs more than fifty (50) kilometres from the Insured Person's permanent city of residence; and
- (b) such Loss of Life occurs within three hundred and sixty-five (365) days of the date of the accident causing the Injury,

AIG shall pay the actual expenses incurred for preparing the deceased Insured Person for burial or cremation and shipment of the body to the city of residence of the deceased Insured Person.

The maximum amount payable for this benefit for all Injuries resulting from any one (1) accident is fifteen thousand dollars (\$15,000.00) per Insured Person.

Identification Benefit

If the Insured Person suffers Injury causing Loss of Life for which a benefit is paid or payable hereunder and the Insured Person's body requires identification, AIG will pay to one Immediate Family member of the Insured Person, the reasonable and necessary expenses actually incurred by such Immediate Family member for:

- (a) commercial lodging and board while en route and/or during the stay in the city or town where the body is located (not to exceed a maximum duration of three (3) consecutive nights); and
- (b) transportation by the most direct route to such location.

This benefit is payable by AIG only if the body of the Insured Person is located not less than one hundred and fifty (150) kilometres from the said Immediate Family member's normal place of residence and the identification of the body is requested by the police or a similar law enforcement agency having authority over such matters.

Payment will not be made for ordinary living, travelling, or clothing expenses, other than as specifically stated above. If transportation occurs in a vehicle or device other than one (1) operated under the license for the conveyance of passengers for hire, the reimbursement of transportation expenses will be limited to a maximum of twenty cents (\$0.20) per kilometre travelled.

This benefit is payable only once in connection with Injuries and Losses suffered by any one (1) Insured Person, regardless of the number of policies providing coverage for this benefit for such Insured Person, that may be issued by AIG.

The maximum amount payable for this benefit is five thousand dollars (\$5,000.00) per Insured Person.

Seat Belt and Air Bag Benefit

If an Insured Person suffers Injury resulting in Loss of Life for which the Company has paid a benefit set out in the Table of Losses, the Company shall pay an additional amount equal to 10% of the Insured Person's Principal Sum if Injury causing the Loss of Life results while they are a passenger or driver of a Private Passenger Type Automobile and his or her seat belt is properly fastened.

The Company will pay an additional benefit if a Seat Belt Benefit is payable and if the Insured Person is positioned in a seat protected by a properly functioning, original, factory-installed Supplemental Restraint System that inflates on impact. The additional amount payable is equal to 10% of the Insured Person's Principal Sum.

Verification of the actual use of the seat belt, at the time of the accident, and that the Supplemental Restraint System inflated properly upon impact must be a part of an official report of the accident or be certified, in writing, by the investigating officer(s).

The maximum amount payable for this benefit is fifty thousand dollars (\$50,000.00) per Insured Person.

Day Care Benefit

If the Insured Person suffers Injury resulting in Loss of Life for which AIG has paid the benefit set out in the Table of Losses (page 33), AIG will pay to the legal guardian of any surviving Dependent Child of the Insured Person, an amount equal to the lesser of the following:

- (a) the actual annual cost charged by a commercial and licensed day care centre; or
- (b) 5% of the Insured Person's Principal Sum; or
- (c) five thousand dollars (\$5,000.00) per year.

This benefit is payable annually for a maximum of four (4) consecutive payments per Dependent Child:

- (a) and only for such Dependent Child who at the date of the Insured Person's Loss of Life is under age thirteen (13).
- (b) provided such Dependent Child is enrolled in a commercial and licensed day care centre no later than ninety (90) days following the Insured Person's Loss of Life; and
- (c) provided that the Dependent Child continues enrollment in a commercial and licensed day care centre.

Dependent Child Educational Benefit

If the Insured Person suffers Injury resulting in Loss of Life for which AIG has paid the benefit set out in the Table of Losses (page 33), AIG will reimburse the annual tuition, not including room and board, charged by an Institution of Higher Learning per school year for each Dependent Child of such Insured Person up to the lesser of the following amounts:

- (a) five thousand dollars (\$5,000.00) per school year; or
- (b) 5% of such Insured Person's Principal Sum.

This benefit is payable annually up to a maximum of four (4) consecutive payments per Dependent Child:

- (a) only for such Dependent Child who is, at the time of such Insured Person's Loss of Life, enrolled as a full-time student in an Institution of Higher Learning beyond the twelfth (12th) grade level; and
- (b) only while such Dependent Child continues their continuous enrollment in an Institution of Higher Learning.

AIG will reimburse the person who has incurred the actual tuition expenses.

Spousal Education Benefit

If the Insured Person suffers Injury resulting in Loss of Life, for which AIG has paid the benefit set out in the Table of Losses (page 33), AIG will pay to the Insured Person's Spouse the actual cost incurred for a professional or trades training program in which such Spouse enrolls for the purpose of obtaining an independent source of support and maintenance provided such cost is incurred not later than thirty (30) months after the Insured Person's Loss of Life.

The maximum amount payable for this benefit is fifteen thousand dollars (\$15,000.00) per Insured Person.

Funeral Expense

If the Insured Person suffers Injury resulting in Loss of Life for which AIG has paid the benefit set out in the Table of Losses (page 33), AIG will reimburse the person who has incurred the actual expenses pertaining to the cremation, burial, or funeral expenses of the Insured Person.

The maximum amount payable for this benefit is five thousand dollars (\$5,000.00) per Insured Person.

Bereavement Benefit

If the Insured Person suffers Injury which results in Loss of Life for which AIG has paid the benefit set out in the Table of Losses (page 33), AIG will pay the reasonable and necessary expenses actually incurred for grief counselling provided that:

- (a) the counselling is for the Spouse and/or Dependent Children.
- (b) such expenses are incurred within 365 days of the date of the accident-causing Loss of Life; and
- (c) such grief counselling is provided by a therapist or counsellor who is licensed, registered, or certified to provide such treatment and who is not a member of the Immediate Family of the Insured Person.

AIG will pay the person who has incurred the actual expense.

The maximum amount payable for this benefit, is one thousand dollars (\$1,000.00).

Coma Benefit

If the Insured Person suffers Injury resulting in Loss (other than Loss of Life), and within ninety (90) days of the date of the accident causing Injury the Insured Person is disabled by coma, which coma is continuous and persistent for a period of six (6) consecutive months at which point the coma is determined by a Physician to be permanent, AIG shall pay 1% of the amount that is:

- (a) the Principal Sum.
- (b) less any other amount paid or payable under this contract in connection with the same accident, Injury or Loss.

This benefit is payable monthly, retroactive to the first complete day of coma, to a maximum of one hundred (100) payments per Insured Person for all Injuries resulting from any one (1) accident.

Limitations

The maximum amount payable per Insured Person under this contract for Losses sustained by any one (1) Insured Person as the result of any one (1) accident is the Principal Sum, except where a Loss is Quadriplegia, Paraplegia or Hemiplegia, in which case the maximum amount payable per Insured Person is the amount indicated for such Loss in the Table of Losses (page 32). This limitation does not apply to the additional benefits set out in the preceding section which are subject to their own specific limits.

Aggregate Limit Per Accident

The maximum amount payable by AIG under this contract for two (2) or more Insured Persons who suffer an Injury in any one (1) accident is the amount which is the Aggregate Limit per Accident set out in the Declarations. If the total of the benefits which would be paid by AIG would exceed the Aggregate Limit per Accident, AIG shall not be liable to any one (1) Insured Person for any amount in excess of the Aggregate Limit per Accident. Each injured Insured Person's benefits shall be a portion of the benefits to which they otherwise would have been entitled hereunder. That portion shall be the proportion of what AIG would have paid hereunder to the Insured Person relative to what AIG would have paid hereunder to all Insured Persons who suffered an Injury in such accident but for the Aggregate Limit per Accident.

Exclusions

No coverage shall be provided under this contract and no payment shall be made for any Loss or claim resulting in whole or in part from, or contributed to by, or as a natural and probable consequence of any of the following excluded risks even if the proximate or precipitating cause of the Loss or claim is an accidental Injury:

- (a) suicide or any attempt thereat by the Insured Person.
- (b) self-inflicted Injury or any attempt thereat by the Insured Person.
- (c) declared or undeclared war or any act thereof.
- (d) sickness, disease, or bodily infirmity whether the Loss or claim results directly or indirectly from any of these.
- (e) injury sustained while the Insured Person is undergoing the medical or surgical treatment of sickness, disease, or bodily or mental infirmity.
- (f) stroke or cerebrovascular accident or event, cardiovascular accident or event, myocardial infarction or heart attack, coronary thrombosis, aneurysm.
- (g) travel or flight in or on (including getting in or out of, or on or off of) any Aircraft, if the Insured Employee is:
 - i. riding as a passenger in any Aircraft not intended or licensed for the transportation of passengers; or
 - ii. performing, learning to perform, or instructing others to perform as a pilot or crew member of any Aircraft; or
 - iii. riding as a passenger in an Owned Aircraft, Leased Aircraft or on a Charter Flight.

- (h) travel or flight in or on (including getting in or out of, or on or off of) any Aircraft or any craft designed to fly or glide above the Earth's surface:
 - i. except as a passenger on a regularly scheduled commercial airline; or
 - ii. being used for crop dusting, spraying, or seeding, firefighting, traffic patrol, air ambulance, pipeline or power line inspection, aerial photography or exploration, racing, endurance tests, stunt, or acrobatic flying; or
 - iii. operating to or from offshore landing sites; or
 - iv. used in any operation that requires a special permit from the Civil Aviation Branch of Transport Canada, even if it is granted (this does not apply if the permit is required only because of the territory flown over or landed on).
- (i) infections of any kind regardless of how contracted, except bacterial infections that are directly caused by botulism, ptomaine poisoning or an accidental cut or wound independent and in the absence of any underlying sickness, disease or condition including but not limited to diabetes.
- (j) injury or Loss sustained while the Insured Person is on full-time active duty in the armed forces or organized reserve corps of any country or international authority. (Unearned premium for any period for which the Insured Person is on full-time active duty shall, upon application to AIG by the Policyholder, be refunded).
- (k) injury or Loss sustained while the Insured Person is under the influence of alcohol and operating any vehicle or means of transportation or conveyance while the Insured Person's blood alcohol is over eighty (80) milligrams in one hundred (100) millilitres of blood.
- (l) injury or Loss sustained while the Insured Person is under the influence of a drug or substance which is controlled as specified under the Controlled Drug and Substances Act (Canada) unless taken pursuant to the advice of and in strict accordance with the instructions of a duly licensed Physician.
- (m) the commission or attempted commission by an Insured Person or Injury incurred while an Insured Person is in the course of committing or attempting to commit any act which if adjudicated by a court would be an indictable offence under the laws of the jurisdiction where the act was committed.
- (n) an act, attempted act or omission taken or made by the Insured Person, or an act, attempted act or omission taken or made with the Insured Person's consent, for the purposes of interrupting the blood flow to the Insured Person's brain or to cause asphyxiation to the Insured Person whether with intent to cause harm or not.
- (o) natural causes.

The Insurer will not be liable to provide any coverage or make any payment hereunder if to do so would be in violation of any sanctions law or regulation which would expose the insurer, its parent company, or its ultimate controlling entity to any penalty under any sanctions law or regulation.

Optional Accidental Death & Dismemberment Insurance

The Optional AD&D Insurance coverage available under the Ontario REALTOR® Wellness Program (ORWP) is outlined in the **Benefit Summary** (page 6) section of this booklet.

Optional AD&D Insurance allows the OREA Member to choose additional coverage for themselves and/or their spouse.

Critical Illness (CI) Insurance

The Critical Insurance coverage provided under the Ontario REALTOR® Wellness Program (ORWP) is outlined in the **Benefit Summary** (page 7) section of this booklet.

If the Insured OREA Member is diagnosed with or undergoes any one of the twenty-six (26) Critical Illnesses listed in the Critical Illness Definitions and Diagnostic Requirements section below, AIG will pay the benefit amount listed in the **Benefit Summary** (page 6), provided that:

- (1) the illness or condition is not considered a Pre-Existing Condition unless the Insured Member was insured under a prior group policy in accordance with any Pre-Existing Condition Limitation as noted in this booklet; and
- (2) the Insured Member completes the Survival Period¹; and
- (3) the Insured Member is under the age listed under Termination Age in the **Benefit Summary** at the time of the diagnosis or procedure.

¹The Survival Period is 30 days.

Claims for subsequent Critical Illness are subject to the Multiple Event Benefit terms listed in this booklet (page 52).

Critical Illness Definitions and Diagnostic Requirements

AIG reserves the right to have any Critical Illness Diagnosis reviewed by a Specialist of its choosing. In the event of any dispute or disagreement regarding the appropriateness or correctness of the Diagnosis, AIG shall have the right to request an examination of either the Insured Member or the evidence used in arriving at such Diagnosis by an independent acknowledged expert selected by AIG in the applicable field of medicine. The opinion of such expert as to such Diagnosis shall be binding on both the Insured Member and AIG.

(1) Aortic Surgery: The undergoing of surgery for disease of the aorta requiring excision and surgical replacement of any part of the diseased aorta with a graft. Aorta means the thoracic and abdominal aorta but not its branches. The surgery must be determined to be medically necessary by a Specialist.

Exclusion: No benefit will be payable under this condition for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

(2) Aplastic Anemia: A definite Diagnosis of a chronic persistent bone marrow failure, confirmed by a biopsy, which results in anemia, neutropenia and thrombocytopenia requiring blood product transfusion and treatment with at least one of the following:

- Marrow stimulating agents.
- Immunosuppressive agents.
- Bone marrow transplantation.

The Diagnosis of Aplastic Anemia must be made by a Specialist.

(3) Bacterial Meningitis: A definite Diagnosis of meningitis, confirmed by cerebrospinal fluid showing growth of pathogenic bacteria, and resulting in neurological deficits persisting for at least 90 days from the date of Diagnosis. The presence of pathogenic bacteria must be confirmed by culture or other generally medically accepted microbiological testing.

The Diagnosis of Bacterial Meningitis must be made by a Specialist.

For greater certainty, neurological deficits must be detectable by a Specialist and may include, but are not restricted to, measurable loss of hearing, objective loss of sensation, paralysis, localized weakness, dysarthria (difficulty with pronunciation), dysphasia, (difficulty with speech) dysphagia (difficulty in swallowing), measurable visual impairment, impaired gait (difficulty walking), difficulty with balance, lack of coordination, seizures undergoing treatment or measurable changes in neuro-cognitive function. Headache or fatigue will not be considered a neurological deficit.

Exclusion: No benefit will be payable under this condition for viral meningitis.

(4) Benign Brain Tumour: A definite Diagnosis of a non-malignant tumour located in the cranial vault and limited to the brain, meninges, cranial nerves, or pituitary gland. The Benign Brain Tumour must have undergone surgical or radiation treatment or cause Irreversible objective neurological deficit(s). These deficits must be corroborated by diagnostic imaging showing changes that are consistent in character, location, and timing with the neurological deficits. For greater certainty, neurological deficits must be detectable by a Specialist and may include, but are not restricted to, measurable loss of hearing, objective loss of sensation, paralysis, localized weakness, dysarthria (difficulty with pronunciation), dysphasia, (difficulty with speech) dysphagia (difficulty in swallowing), measurable visual impairment, impaired gait (difficulty walking), difficulty with balance, lack of coordination, seizures undergoing treatment or measurable changes in neuro-cognitive function. Headache or fatigue will not be considered a neurological deficit.

The Diagnosis of Benign Brain Tumour must be made by a Specialist.

Exclusion: No benefit will be payable under this condition for pituitary adenomas less than 10 mm, vascular malformations, cholesteatomas, infectious or inflammatory tumours.

(5) Blindness: A definite Diagnosis of the total and Irreversible loss of vision in both eyes, evidenced by:

- the corrected visual acuity being 20/200 or less in both eyes; or,
- the field of vision being less than 20 degrees in both eyes.

The Diagnosis of Blindness must be made by a Specialist.

(6) Cancer (Life Threatening): A malignant tumour which is characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. Life-Threatening Cancer includes carcinoma, sarcoma, invasive Malignant Melanoma, lymphoma, and leukemia.

Life-Threatening Cancer must be positively Diagnosed by a Specialist and confirmed by a histopathology report. Clinical Diagnosis alone does not meet this standard.

The following conditions are excluded under this definition:

- Prostate cancer classified as T1a or T1b, without lymph node or distant metastasis.
- Carcinoma In Situ.
- Stage I colon cancer that is classified as T1 or T2 without lymph node or distant metastasis.
- pre-malignant lesions, benign tumours, or polyps.
- any skin cancer other than invasive Malignant Melanoma greater than 0.75 mm.
- Basal Cell or Squamous Cell Carcinoma that has spread beyond the hypodermis (the deepest layer of skin) and has not Metastasized.
- Papillary thyroid cancer or follicular thyroid cancer, or both, that is less than or equal to 4.0 cm in greatest dimension and classified as T1 or T2, without lymph node or distant metastasis.
- chronic lymphocytic leukemia classified as Rai stage 0 without enlargement of lymph nodes, spleen, or liver and with normal red blood cell and platelet counts. or any tumour in the presence of any Human Immunodeficiency Virus (HIV).

For purposes of this policy:

- T1a or T1b prostate cancer means a clinically unapparent tumour that was not palpable on digital rectal examination and was incidentally found in resected prostatic tissue.
- the terms T1a, T1b, T1, and T2 are defined in the American Joint Committee on Cancer (AJCC)cancer staging manual, 8th Edition, 2018; and
- the term Rai stage 0 is defined in KR Rai, A Sawitsky, EP Cronkite, AD Chanana, RN Levy and BS Pasternack: Clinical staging of chronic lymphocytic leukemia. Blood 46:219, 1975.

(7) Coma: A profound state of unconsciousness with no reaction to external stimuli or response to internal needs from which the individual cannot be aroused, even by powerful stimulation, which lasts for a continuous period of at least 96 hours and for which period the Glasgow coma score must be 4 or less.

The Diagnosis of Coma must be made by a Specialist and indicate that permanent neurological deficit is present.

Exclusion: No benefit will be payable under this condition for:

- medically induced coma; or,
- a coma which results directly from alcohol or drug use; or,
- a Diagnosis of brain death.

(8) Coronary Artery Bypass Surgery: Undergoing open heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass grafts.

The diagnosis of the condition that necessitates the need for a Coronary Artery Bypass Surgery must be made by a cardiologist and based on angiographic evidence of the underlying disease.

Exclusion: No benefit will be payable under this condition for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

(9) Deafness: Defined as a definite Diagnosis of the total and irreversible loss of hearing in both ears, with an auditory threshold of 90 decibels or greater within the speech threshold of 500 to 3,000 hertz.

The Diagnosis of Deafness must be made by a Specialist.

(10) Dementia, including Alzheimer's Disease: Defined as a definite Diagnosis of dementia, and which must be characterized by a progressive deterioration of memory and at least one of the following areas of cognitive function:

- aphasia (a disorder of speech).
- apraxia (difficulty performing familiar tasks).
- agnosia (difficulty recognizing objects); or
- disturbance in executive functioning (e.g. inability to think abstractly and to plan, initiate, sequence, monitor, and stop complex behaviour), which is affecting daily life.

The Insured Member must exhibit:

- dementia of at least moderate severity, which must be evidenced by a Mini Mental State Exam of 20/30 or less, or equivalent score on another generally medically accepted test or tests of cognitive function; and
- evidence of progressive worsening in cognitive and daily functioning either by serial cognitive tests or by history over at least a 6-month period.

The Diagnosis of Dementia must be made by a Specialist.

For purposes of the policy, reference to the Mini Mental State Exam is to Folstein MF, Folstein SE, McHugh PR, J Psychiatry Res. 1975;12(3):189.

(11) Heart Attack (Acute Myocardial Infarction): Defined as a definite Diagnosis of the death of heart muscle due to obstruction of blood flow, that results in a rise and fall of biochemical cardiac markers to levels considered diagnostic of Acute Myocardial Infarction, with at least one of the following:

- heart attack symptoms,
- new electrocardiogram (ECG) changes consistent with a heart attack, or
- development of new Q waves during or immediately following an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty.

The Diagnosis of Heart Attack must be made by a Specialist.

Exclusion: No benefit will be payable under this condition for:

- elevated biochemical cardiac markers as a result of an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty, in the absence of new Q waves, or
- other acute coronary syndromes, including angina pectoris and unstable angina, or
- ECG changes suggesting a prior myocardial infarction, which do not meet the Heart Attack definition as described above.

(12) Heart Valve Replacement or Repair: Defined as the undergoing of surgery to replace any heart valve with either a natural or mechanical valve or to repair heart valve defects or abnormalities. The surgery must be determined to be medically necessary by a Specialist.

Exclusion: No benefit will be payable under this condition for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

(13) Kidney Failure: A definite Diagnosis of chronic irreversible failure of both kidneys to function and as a result of which regular hemodialysis, peritoneal dialysis or renal transplantation is initiated.

The Diagnosis of Kidney Failure must be made by a Specialist.

(14) Loss of Independent Existence: Defined as a definite Diagnosis of the total loss of the ability to perform, by oneself, at least 2 of the following 6 Activities of Daily Living for a continuous period of at least 90 days with no reasonable chance of recovery. The Diagnosis of Loss of Independent Existence must be made by a Specialist.

Activities of Daily Living are:

- bathing – the ability to wash oneself in a bathtub, shower or by sponge bath, with or without the aid of assistive devices.
- dressing – the ability to put on and remove necessary clothing, braces, artificial limbs, or other surgical appliances with or without the aid of assistive devices.
- toileting – the ability to get on and off the toilet and maintain personal hygiene with or without the aid of assistive devices.
- bladder and bowel continence – the ability to manage bowel and bladder function with or without protective undergarments or surgical appliances so that a reasonable level of hygiene is maintained.
- transferring – the ability to move in and out of a bed, chair, or wheelchair, with or without the aid of assistive devices; and
- feeding – the ability to consume food or drink that already has been prepared and made available, with or without the use of assistive devices.

(15) Loss of Limbs: A definite Diagnosis of the complete severance of two or more limbs at or above the wrist or ankle joint as the result of an accident or medically required amputation.

The Diagnosis of Loss of Limbs must be made by a Specialist.

(16) Loss of Speech: A definite Diagnosis of the total and Irreversible loss of the ability to speak as the result of physical injury or disease, for a period of at least 180 days.

The Diagnosis of Loss of Speech must be made by a Specialist.

Exclusion: No benefit will be payable under this condition for all psychiatric related causes.

(17) Major Organ Failure on Waiting List: A definite Diagnosis of the Irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow and transplantation must be medically necessary.

To qualify under Major Organ Failure on Waiting List, the Insured Member must become enrolled as the recipient in a recognized transplant centre in Canada or the United States of America that performs the required form of transplant surgery. For the purposes of the Survival Period, the date of Diagnosis is the date of the Insured Member's enrollment in the transplant centre.

The diagnosis of the major organ failure must be made by a Specialist.

(18) Major Organ Transplant: A definite Diagnosis of the Irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow and transplantation must be medically necessary.

To qualify under Major Organ Transplant, the Insured Member must undergo a transplantation procedure as the recipient of a heart, lung, liver, kidney, or bone marrow, and limited to these entities.

The diagnosis of the major organ failure must be made by a Specialist.

(19) Motor Neuron Disease: A definitive Diagnosis of one of the following:

- amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease).
- primary lateral sclerosis.
- progressive spinal muscular atrophy.
- progressive bulbar palsy; or
- pseudo bulbar palsy.

A Diagnosis of Motor Neuron Disease must be made by a Neurologist.

(20) Multiple Sclerosis: A definite Diagnosis of at least one of the following:

- two or more separate clinical attacks confirmed by at least one magnetic resonance imaging (MRI) of the nervous system, showing multiple lesions of demyelination,
- well-defined neurological abnormalities lasting more than six months, confirmed by MRI of the nervous system, showing multiple lesions of demyelination, or
- a single attack, confirmed by repeated MRI of the nervous system, which shows multiple lesions of demyelination which have developed at intervals at least one month apart.

The diagnosis of definite Multiple Sclerosis must be made by a Neurologist.

Exclusion: No benefit will be payable for the following:

- solitary sclerosis.
- clinically isolated syndrome.
- neuromyelitis optical spectrum disorders; or
- "suspected" Multiple Sclerosis or "probable" Multiple Sclerosis.

(21) Muscular Dystrophy: A definite Diagnosis of muscular dystrophy where the Insured Person has well defined neurological abnormalities, confirmed by electromyography and either muscle biopsy or other testing acceptable to AIG that confirms the diagnosis.

The Diagnosis of Muscular Dystrophy must be made by a Specialist.

(22) Occupational HIV Infection: A definite Diagnosis of infection with Human Immunodeficiency Virus (HIV) resulting from accidental injury during the course of the Insured Member's normal occupation, which exposed the person to HIV contaminated body fluids. The accidental injury leading to the infection must have occurred after the Insured Member's Effective Date.

Payment under this condition requires satisfaction of all of the following:

- the accidental injury must be reported to AIG within 14 days of the accidental injury.
- a serum HIV test must be taken within 14 days of the accidental injury and the result must be negative.
- a serum HIV test must be taken between 90 days and 180 days after the accidental injury and the result must be positive.
- all HIV tests must be performed by a duly licensed laboratory in Canada or the United States of America; and
- the accidental injury must have been reported, investigated, and documented in accordance with current Canadian or United States of America workplace guidelines.
- The Diagnosis of Occupational HIV Infection must be made by a Specialist.

Exclusion: No benefit will be payable under this condition if:

- the Insured Member has elected not to take any available licensed vaccine offering protection against HIV.
- a licensed cure for HIV infection has become available prior to the accidental injury; or
- HIV infection has occurred as a result of non-accidental injury including, but not limited to, sexual transmission and intravenous (IV) drug use.

(23) Parkinson's Disease and Specified Atypical Parkinsonian Disorders: A definite Diagnosis of primary Parkinson's Disease, a permanent neurologic condition which is characterized by bradykinesia (slowness of movement) and at least one of: muscular rigidity or rest tremor. The Insured Member must exhibit objective signs of progressive deterioration in function for at least one year, for which the treating neurologist has recommended dopaminergic medication or other generally medically accepted equivalent treatment for Parkinson's Disease.

Specified Atypical Parkinsonian Disorders are defined as a definite Diagnosis of progressive supranuclear palsy, corticobasal degeneration, or multiple system atrophy.

The Diagnosis of Parkinson's Disease or a Specified Atypical Parkinsonian Disorder must be made by a Neurologist. Medical information about the diagnosis and any signs, symptoms or investigations leading to the Diagnosis must be reported to AIG within six months of the date of the Diagnosis. If this information is not provided within this period, AIG has the right to deny any claim for Parkinson's Disease or Specified Atypical Parkinsonian Disorders or, any critical illness caused by Parkinson's Disease or Specified Atypical Parkinsonian Disorders or its treatment.

Exclusion: No benefit will be payable under Parkinson's Disease and Specified Atypical Parkinsonian Disorders for any other type of parkinsonism.

(24) Quadriplegia, Paraplegia, Hemiplegia: Total and Irreversible Paralysis of:

- both upper and lower limbs (Quadriplegia).
- both lower limbs (Paraplegia).
- one side of the body (Hemiplegia).

Paralysis means the complete and Irreversible loss of muscle function of two or more limbs as a result of injury or disease to the nerve supply of those limbs, for a continuous period of 90 days or more from the date of the diagnosis to determine that the Paralysis is permanent.

If an Insured Member suffers a Loss of Life as a direct result of the Paralysis, 30 days or more after the Diagnosis of such Paralysis, the benefit will be payable in accordance with the insurer's payment of claims provisions.

The Diagnosis of Paralysis must include documented evidence of the illness or injury that caused the Paralysis.

(25) Severe Burn: A definite Diagnosis of third-degree burns over at least 20% of the body surface.

The Diagnosis of Severe Burns must be made by a Specialist.

(26) Stroke (Cerebrovascular Accident): A definite Diagnosis of an acute cerebrovascular event caused by intra-cranial thrombosis or hemorrhage, or embolism from an extra-cranial source, that results in persistent neurological deficits, with:

- acute onset of new neurological symptoms, and
- new objective neurological deficits on clinical examination, persisting for more than 30 days following the date of Diagnosis.

These new symptoms and deficits must be corroborated by diagnostic imaging testing showing changes that are consistent in character, location, and timing with the new neurological deficits.

The Diagnosis of Stroke must be made by a Specialist.

For greater certainty, neurological deficits must be detectable by a Specialist and may include, but are not restricted to, measurable loss of hearing, objective loss of sensation, paralysis, localized weakness, dysarthria (difficulty with pronunciation), dysphasia, (difficulty with speech) dysphagia (difficulty in swallowing), measurable visual impairment, impaired gait (difficulty walking), difficulty with balance, lack of coordination, seizures undergoing treatment or measurable changes in neuro-cognitive function. Headache or fatigue will not be considered a neurological deficit.

Exclusion: No benefit will be payable under this condition for:

- transient ischaemic attacks.
- intracerebral vascular events due to trauma.
- ischaemic disorders of the vestibular system; or
- lacunar infarcts which do not meet the definition of stroke as described above.

Optional Child Critical Illness – Additional Definitions and Diagnostic Requirements

If an OREA Member has elected to add optional Critical Illness Insurance coverage for their eligible dependent child(ren), five additional illnesses are covered. AIG reserves the right to have any Critical Illness Diagnosis reviewed by a Specialist of its choosing. In the event of any dispute or disagreement regarding the appropriateness or correctness of the Diagnosis, AIG shall have the right to request an examination of either the Insured Member or the evidence used in arriving at such Diagnosis by an independent acknowledged expert selected by AIG in the applicable field of medicine. The opinion of such expert as to such Diagnosis shall be binding on both the Insured Member and AIG.

(1) Cerebral Palsy: A definite Diagnosis of a non-progressive neurological defect affecting muscle control. The defect is characterized by spasticity and incoordination of movements.

The Diagnosis of Cerebral Palsy must be:

- made before the Dependent Child's 25th birthday, and
- made by a Specialist.

(2) Congenital Heart Disease: A definite Diagnosis of at least one of the covered heart conditions:

- Coarctation of the aorta
- Ebstein's anomaly
- Eisenmenger syndrome

The Diagnosis of the heart condition must be:

- made before the Dependent Child's 25th birthday.
- made by a Specialist, and
- supported by cardiac imaging acceptable to the Company.

(3) Cystic Fibrosis: A definite Diagnosis of cystic fibrosis where the insured person has chronic lung disease and pancreatic insufficient.

The Diagnosis of cystic fibrosis must be:

- made before the Dependent Child's 25th birthday, and
- made by a Specialist.

(4) Down Syndrome: A definitive Diagnosis of down syndrome supported by chromosomal evidence of trisomy 21.

The Diagnosis of Down Syndrome must be made by a Specialist.

(5) Type 1 Diabetes Mellitus: A definite Diagnosis where the Insured Person has total insulin deficiency and continuous dependence on exogenous insulin for survival. Dependence on insulin must persist for a continuous period of at least three months.

The Diagnosis of Type 1 diabetes mellitus must be:

- made before the insured person's 25th birthday, and
- made by a Specialist.

Multiple Event Benefit

If the Insured Member is Diagnosed with or undergoes a Critical Illness for which the Benefit Amount has been paid and the Insured Member has thereafter been considered Fully Recovered and is then Diagnosed with or undergoes a subsequent Critical Illness, then a Multiple Event Benefit payment equal to the Benefit Amount will be payable, subject to the following:

- the Insured Member satisfies the Survival Period for the subsequent Critical Illness; and
- the subsequent Critical Illness must be in a different Critical Illness Group than the initial Critical Illness Group for which the Benefit Amount has been paid (as determined in Multiple Event Benefit – Critical Illnesses Table below).

Multiple Event Benefit – Critical Illnesses Table

The subsequent Critical Illness must be in a different Critical Illness Group for the Benefit Amount has been paid on the initial claim.

- **GROUP 1:** Cancer (Life Threatening).
- **GROUP 2:** Aortic Surgery; Coronary Artery Bypass Surgery; Heart Attack; Heart Valve Replacement or Repair; Stroke.
- **GROUP 3:** Blindness, Deafness; Loss of Limbs; Loss of Speech; Occupational HIV Infection; Severe Burn.
- **GROUP 4:** Aplastic Anemia; Bacterial Meningitis; Benign Brain Tumor; Coma; Dementia, including Alzheimer's Disease; Kidney Failure; Loss of Independent Existence; Major Organ Failure on Waiting List; Major Organ Transplant; Motor Neuron Disease; Multiple Sclerosis; Muscular Dystrophy; Parkinson's Disease and Specified Atypical Parkinson Disorders; Quadriplegia, Paraplegia, Hemiplegia.

Exclusions and Limitations

Exclusions

The Critical Illness Benefit Amount will not be paid if a Critical Illness results directly or indirectly from any one or more of the following:

- (1) any Pre-existing Condition or any complication arising from such Pre-existing Condition (Pre-existing conditions in previous 12 months are excluded for first 12).
- (2) an intentionally self-inflicted injury or sickness.
- (3) congenital anomalies or any complications or conditions arising therefrom.
- (4) any loss resulting directly or indirectly, contributed, or aggravated or prolonged by childbirth from pregnancy.
- (5) any Critical Illness based on a Diagnosis made by the Insured Member or his/her immediate family or anyone who is living in the same household as the Insured Member or by a herbalists, acupuncturist, or other non-traditional health care provider.
- (6) any loss resulting from the abuse of alcohol.
- (7) any Critical Illness if the Insured Member does not survive the applicable Survival Period.
- (8) declared or undeclared war or any act thereof.
- (9) committing or attempting to commit a criminal offense whether inside or outside of Canada, under the laws in the jurisdiction where the offense takes place.

- (10) the use an illicit drug or substance which is controlled as specified under the Controlled Drug and Substances Act (Canada) unless taken pursuant to the advice of and in strict accordance with the instructions of a duly licensed Physician.
- (11) any illness or procedure that is not specifically listed as covered under Benefit Summary Covered Conditions.

Pre-Existing Condition Limitation

In addition to the exclusions noted, AIG will not pay benefits for a Critical Illness caused or contributed to by, or resulting from, a Pre-Existing Condition.

A Pre-Existing Condition can exist even though a Diagnosis has not yet been made.

This Limitation will not apply to a Critical Illness for which the date of Diagnosis occurs after the Insured Member is continuously insured under this policy for at least the Pre-Existing Condition Period (Pre-existing conditions in previous 12 months are excluded for first 12 months), after the Insured Member's Effective Date.

Optional Critical Illness Insurance

The Optional CI Insurance coverage available under the Ontario REALTOR® Wellness Program (ORWP) is outlined in the **Benefit Summary** (page 7) section of this booklet.

Optional CI Insurance allows the OREA Member to choose additional coverage for themselves, their spouse, and/or their eligible dependent child(ren.)

Health (Insurance and Services) and Dental Care Insurance

The Health (Insurance and Services) and Dental Care Insurance coverage provided under the Ontario REALTOR® Wellness Program (ORWP) is outlined in the **Benefit Summary** (pages 9-14) section of this booklet.

An OREA Member is covered for only those specific benefits for which the Member has paid and/or applied and for which the Member's Member Board has certified they are eligible. The Member must be covered in order for their dependents to be covered. The Member's coverage will terminate upon the earliest of the dates appearing in the Termination section or the date their Member Board advises OREA that the Member is no longer eligible for coverage. Coverage for the Member's dependents will terminate upon the earlier of termination of the Member's coverage or the date the dependent no longer satisfies the definition of a dependent.

Members will receive Identification Cards showing their GSC Identification Number to be used on all claims and correspondence, and for identification purposes when speaking with GreenShield's Customer Service Centre. The Member's number will appear on the front of the card and end in -00, while each of their dependents with their numbers will be shown on the back.

Healthcare Insurance

Provided Under Standard Plan with Health Insurance (Standard Plan Option 1), Enhanced Plan, Elite Plan, and Super Elite Plan

The benefits described in this section will be eligible, up to the amounts indicated in the **Benefit Summary** (pages 9-11) if they are medically necessary for the treatment of an illness or injury.

Reimbursement will be limited to reasonable and customary charges in addition to any specific limitations and maximums stated in the **Benefit Summary** and as stated in this Description of Benefits.

Prescription Drugs

The Prescription Drug benefit provides coverage, up to the amount shown in the **Benefit Summary**, for prescription drugs that:

- are prescribed by a legally qualified medical practitioner or dental practitioner as permitted by law, and
- legally require a prescription and have a Drug Identification Number (DIN), and
- are approved under GreenShield's (GSC's) drug review process, and
- are submitted on a Pay Direct basis.

GSC reserves the right to manage its drug formularies through an evidence-based review process in which drugs are evaluated based on overall value taking into account clinical efficacy, safety, unmet need, and plan affordability. Formulary management includes the right to:

- add a drug to GSC's formularies.
- exclude or remove a drug from GSC's formularies regardless of Health Canada approval and/or the existence of provincial coverage.
- place restrictions on a formulary drug as determined by GSC. Restrictions may include, but are not limited to, GSC's pre-approval of the drug before the claim can be reimbursed, requirement to obtain the drug through an approved provider, and requirement to obtain a lower cost alternative of the same treatment such as a generic or a biosimilar drug.

If approved by GSC, this plan includes drugs with a Drug Identification Number (DIN) that do not legally require a prescription, including, but not limited to nitroglycerin, insulin and all other approved injectables, as well as related supplies such as diabetic syringes, needles, lancets, and testing agents. In addition, this plan includes vaccines.

Certain drugs require prior authorization from GSC before the insured's drug claim can be reimbursed. Further, certain drugs defined by GSC as specialty drugs may be required to be purchased from an approved pharmacy that is a member of GSC's Specialty Care Program before the insured's claim can be reimbursed.

Maintenance drugs required to treat lifelong chronic conditions may be required to be purchased in a 90-day supply of a prescription at any one time. Non-maintenance drugs may be purchased in a supply not exceeding 3-months (90-day) supply of a prescription at any one time. However, for all drugs, 6 months for a vacation supply may be purchased and not more than a 13-month supply in any 12 consecutive months.

Mandatory Generic Drug Substitution

Based on specific provincial health insurance plan regulations, where a generic equivalent drug exists, reimbursement will only be made up to the cost of the lowest-priced equivalent drug.

If a medical practitioner indicates a brand name drug is medically required due to a serious medical reaction to at least two generic equivalent drugs, GSC must be provided with a copy of the "Health Canada Vigilance Adverse Reaction Reporting Form" (that can be obtained from the Health Canada website) completed by the medical practitioner, to determine eligibility for payment of the cost of the prescribed drug.

Prescription Drug Benefit Over Age 65

The Prescription Drug Benefit co-pay and the deductible (where applicable) in the insured's province of residence are eligible benefits.

Quebec residents only: Legislation requires GSC to follow the RAMQ (The Regie de l'assurance maladie du Quebec) reimbursement guidelines for all residents of Quebec. If the insured individual is younger than age 65, the insured must enroll for the GSC Prescription Drugs benefit plan and GSC will be the only payer. If the insured is age 65 or older, enrollment in RAMQ is automatic, enrollment in the GSC Prescription Drugs benefit plan is optional, and RAMQ would be first payer.

If any provisions of this plan do not meet the minimum requirements of the RAMQ plan, adjustments are automatically made to meet RAMQ requirements.

Prescription Drug Exclusions

The following are excluded, and no amount will be paid for:

- drugs for the treatment of erectile dysfunction and infertility.
- reference biologic drugs that have an approved biosimilar.
- vitamins that do not legally require a prescription.
- nicotine replacement products, such as patches, gum, lozenges, and inhalers.
- products which may lawfully be sold or offered for sale other than through retail pharmacies, and which are not normally considered by practitioners as medicines for which a prescription is necessary or required, unless specifically identified and included as eligible in "Prescription Drugs".
- ingredients or products which have not been approved by Health Canada for the treatment of a medical condition or disease and are deemed to be experimental in nature and/or may be in the testing stage.
- mixtures, compounded by a pharmacist, that do not conform to GSC's current Compound Policy, which can be found on GSC's website.

Extended Health Services

Hearing Care

Reimbursement for hearing aids, initial battery, repairs, or replacement parts, if recommended or approved by the attending legally qualified medical practitioner, up to the amount shown in the Benefit Summary. No amount will be paid for replacement batteries.

Medical Items and Services

Unless otherwise specified, the following must be prescribed by a legally qualified medical practitioner. Reimbursement is limited to the reasonable and customary charges, up to the amount stated in the **Benefit Summary**, where applicable.

- Aids for daily living such as
 - hospital-style beds including rails and mattresses.
 - bedpans, standard commodes, and urinals.
 - decubitus (bedridden) supplies, portable patient lifts (including batteries), trapezes/transfer poles, and I.V. stands.

- Footwear, when prescribed by the insured's attending physician, nurse practitioner, podiatrist, or chiropodist, and dispensed by the insured's podiatrist, chiropodist, chiropractor, orthotist, or pedorthist:
 - Custom-made foot orthotics or repairs to custom-made foot orthotics.
 - Custom-made foot orthotics means devices made from a 3-dimensional model of an individual's foot and made from raw materials. These devices are used to relieve foot pain related to biomechanical misalignment to the feet and lower limbs.
 - Custom-made boots or shoes or footwear as an integral part of a brace, or modifications and repairs to orthopedic shoes, (subject to a medical pre-authorization).
 - Custom-made boots or shoes means footwear used by an individual whose condition cannot be accommodated by existing footwear products.

The fabrication of the footwear involves making a unique cast of the covered person's feet and the use of 100% raw materials. This footwear is used to accommodate the bony and structural abnormalities of the feet and lower legs resulting from trauma, disease, or congenital deformities.

- Diabetic equipment and supplies, such as:
 - blood glucose meters.
 - glucose monitoring systems (GMS) such as continuous and flash type monitors subject to medical pre-authorization and reimbursed to the cost of a blood glucose meter. Disposable GMS supplies (used with the monitor), such as, but not limited to sensors and transmitters, are included and subject to the overall annual maximum applicable to diabetic testing and monitoring equipment and supplies.

- Medical services, such as:
 - diagnostic and laboratory tests.
 - x-rays.
 - pharmacogenetic testing only through GenXys Health Care Systems, subject to prior approval.

- Medical items such as:
 - braces and casts.
 - transcutaneous electrical nerve stimulators (TENS machine), limited to one every 60 months.
 - Incontinence/Ostomy equipment, such as catheters and ostomy supplies.

- Mobility aids, such as:
 - canes, crutches, and walkers.
 - wheelchairs and scooters (including batteries).

- Standard Prosthetics, such as:
 - arm, hand, leg, foot, eye, larynx.
 - external breast prosthesis.
 - post-mastectomy bra.

- Respiratory/Cardiology equipment, such as:
 - compressors and inhalant devices.
 - oxygen and equipment for its administration.
 - tracheotomy supplies.

- Compression stockings with a pressure measurement of 15 mmhg or higher, limited to 2 pairs every 4 months.

- Wigs for temporary or permanent hair loss as a result of a medical condition.

Some items may require pre-authorization. To confirm eligibility prior to purchasing or renting equipment, submit a Pre-Authorization Form to GreenShield via GreenShield+.

Limitations on Medical Items and Services

- The rental price of durable medical equipment will not exceed the purchase price. GSC's decision to purchase or rent will be based on the legally qualified medical practitioner's estimate of the duration of need as established by the original prescription. Rental authorization may be granted for the prescribed duration. Equipment that has been refurbished by the supplier for resale is not an eligible benefit.
- Durable medical equipment must be appropriate for use in the home, able to withstand repeated use and generally not useful in the absence of illness or injury.
- When deluxe medical equipment is a covered benefit, reimbursement will be made only when deluxe features are required in order for the covered person to effectively operate the equipment. Items that are not primarily medical in nature or that are for comfort and convenience are not eligible.

Gender Affirmation

The following services not covered by the insured's provincial/territorial health plan will be considered eligible only when a diagnosis of gender dysphoria from a legally qualified physician (M.D.), or nurse practitioner is provided to GSC. Reimbursement will be limited to reasonable and customary charges, up to the amount shown in the **Benefit Summary** (page 10):

- Foundation (core) | Transition-related genital and chest/breast surgeries not covered by the insured's provincial/territorial health plan, as well as vocal surgery, tracheal shave, chest contouring/breast construction, vaginal dilators, laser hair removal and facial feminization surgery.
- Focused | non-genital, non-breast/chest enhancement surgeries as follows: nose surgery, liposuction/lipofilling, face/eyelid lift, lip/cheek fillers, hair transplant/implants, and gluteal lifts/implants.

Emergency Transportation

Reimbursement for reasonable and customary charges for professional land or air ambulance to the nearest hospital equipped to provide the required treatment when medically required as the result of an injury, illness, or acute physical disability.

Private Duty Nursing in the Home

Reimbursement for the services of a Registered Nurse (R.N.) or Registered Practical Nurse/Licensed Practical Nurse (R.P.N./L.P.N.) in the home on a visit or shift basis. No amount will be paid for services which are custodial and/or services that do not require the skill level of a Registered Nurse (R.N.) or Registered Practical Nurse/Licensed Practical Nurse (R.P.N./L.P.N.). A Pre-Authorization Form for Private Duty Nursing must be completed by the attending physician and submitted to GSC.

Paramedical Practitioners

Reimbursement for the services of the practitioners included, up to the amount shown in the **Benefits Summary**, when the practitioner rendering the service is licensed by their provincial regulatory agency or a registered member of a professional association and that association is recognized by GSC. Please contact the GSC Customer Service Centre to confirm practitioner eligibility.

Note: Podiatry services are eligible in coordination with the insured's provincial health insurance plan.

Accidental Dental

Reimbursement for the services of a licensed dental practitioner for dental care to natural teeth when necessitated by a direct blow to the mouth and not by an object wittingly or unwittingly placed in the mouth. The accident must occur while the coverage is in force. When natural teeth have been damaged eligible services are limited to one set of artificial teeth.

The insured must notify GSC immediately following the accident and the treatment must commence within 180 days of the accident and be completed within 365 days of the date of the accident.

GSC will not be liable for any services performed after the date the insured and the insured's dependent cease to be covered under this plan.

No amount will be paid for periodontia or orthodontia treatments or the repair or replacement of artificial teeth.

Charges will be based on the current Provincial Dental Association Fee Guide for General Practitioners in the province where services are rendered. Approval will be based on the current status and/or benefit level of the covered person at the time that we are notified of the accident.

Any change in coverage will alter GSC's liability.

In the event of a dental accident, claims should be submitted under the health benefit plan before submitting them under the dental plan.

Vision Care (Not included in Standard Plan)

Vision Care is not included in the ORWP Standard Plan coverage. OREA Members must upgrade to one of the program's three enhanced plans to obtain vision care coverage. This means reimbursement for the services performed by a licensed Optometrist, Optician, Optician or Ophthalmologist, up to the amounts shown in the **Benefit Summary**, for:

- (1) Prescription eyeglasses or contact lenses.
- (2) Medically necessary contact lenses when visual acuity cannot otherwise be corrected to at least 20/40 in the better eye or when medically necessary due to keratoconus, irregular astigmatism, irregular corneal curvature, or physical deformity resulting in an inability to wear normal frames.
- (3) Optometric eye examinations for visual acuity performed by a licensed optometrist, ophthalmologist, or physician. This benefit is available only in those provinces where eye examinations are not covered by the provincial health insurance plan.
- (4) Replacement parts for prescription eyeglasses.
- (5) Laser eye surgery.
- (6) Prescription industrial safety glasses.

Eligible benefits do not include, and no amount will be paid for:

- (1) Non-prescription industrial safety eyeglasses.
- (2) Medical or surgical treatment, unless specifically identified and included as eligible in "Vision" above.
- (3) Special or unusual procedures such as, but not limited to, visual training (unless specifically identified and included as eligible in "Vision"), orthoptics, subnormal vision aids and aniseikonic lenses.
- (4) Follow-up visits associated with the dispensing and fitting of contact lenses.
- (5) Charges for eyeglass cases.

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:
 - an act of war, declared or undeclared.
 - participation in a riot or civil commotion. or
 - 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:
 - does not meet accepted standards of medical, dental, or ophthalmic practice, including charges for services or supplies which are experimental in nature.
 - is not considered to be effective (either medically or from a cost perspective) as determined by GSC's drug review process regardless if Health Canada has approved the drug.
 - is an adjunctive drug prescribed in connection with any treatment or drug that is not an eligible service.
 - is administered in a hospital or is required to be administered in a hospital in accordance with Health Canada's approved indication for use.
 - is not dispensed by the pharmacist in accordance with the payment method shown under the Prescription Drugs benefit.
 - 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:
 - are not recommended, provided by, or approved by the attending legally qualified (in the opinion of GSC) medical practitioner or dental practitioner as permitted by law.
 - are legally prohibited by the government from coverage.
 - the insured is 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 their behalf by a not-for-profit prepayment association, insurance carrier, third-party administrator, like agency or a party other than GSC, your plan sponsor or insured.
 - are provided by a health practitioner whose license by the relevant provincial regulatory and/or professional association has been suspended or revoked.

- are not provided by a designated provider of service in response to a prescription issued by a legally qualified health practitioner.
- are used solely for recreational or sporting activities and which are not medically necessary for regular activities.
- are primarily for cosmetic or aesthetic purposes or are to correct congenital malformations.
- are provided by an immediate family member related to the insured by birth, adoption, or by marriage and/or a practitioner who normally resides in the insured's home. An immediate family member includes a parent, spouse, child, or sibling.
- are provided by the plan sponsor and/or a practitioner employed by the plan sponsor, other than as part of an employee assistance plan.
- 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.
- are video instructional kits, informational manuals, or pamphlets.
- are for medical or surgical visual treatment (unless specifically identified and included as eligible under the plan) or medical or surgical audio treatment.
- are special or unusual procedures such as, but not limited to, visual training unless specifically identified and included as eligible under the plan), orthoptics, subnormal vision aids and aniseikonic lenses.
- are delivery and transportation charges.
- are for Insulin pumps and supplies (unless specifically identified and included as eligible under the plan).
- are for audiometric examinations or hearing aid evaluation tests (unless specifically identified and included as eligible under the plan), or medical examinations.
- are batteries, unless specifically included as an eligible benefit.
- are a duplicate prosthetic device or appliance.
- 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.
- 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.
- 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.
 - 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).

- 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.
- 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:

- the service or supplies being claimed is not eligible, or
- the financial commitment is complete.

A letter from the insured's automobile insurance carrier will be required.

- 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.

Health Services

Provided Under Standard Plan with Health Services (Standard Plan Option 2)

ORWP Health Option 2 includes non-insured benefits that are intended to provide Members with a variety of products and services with an emphasis on mental health and wellness, and discounts on their health-related costs. This option does not include any insured benefits; Members will not be able to coordinate other coverage with ORWP if they elect this option.

The ORWP Standard Plan with Health Services (Standard Plan 2) includes non-insured benefits that are intended to provide OREA Members with a variety of health resources, services, and support tools. With an emphasis on holistic well-being, Members can access supports for their physical, mental, and financial wellness—with discount programs for health-related expenses, fitness and healthy lifestyle coaching, one-on-one advisory support with qualified professionals, self-directed therapy modules, and more.

This option does not include any insured benefits such as prescription drugs, paramedical practitioners, medical services & supplies, and other benefits included under the ORWP Standard Plan with Health Insurance (Standard Plan 1), or in the optional enhanced plans. If a Member elects the ORWP Standard Plan 2 with Health Services, the Member will not have access to these coverages, nor will they need to coordinate existing healthcare coverage with the ORWP.

If ORWP Standard Plan with Health Services is selected during enrollment, Members will enjoy access to the following suite of five (5) benefits and services, available right from your GreenShield+ account by mobile app or desktop computer:

(1) The Health Depot Pharmacy

The ORWP Standard Plan 2 with Health Services provider, GreenShield, is pleased to provide Members enrolled in this plan option with a new digital pharmacy option. With the trust and expertise of a traditional pharmacy and the convenience of a digital platform, The Health Depot has:

- Personalized complimentary consultations with a clinical pharmacist.
- Fast & Free Delivery to your home, work, or cottage.
- The convenience of having your prescriptions delivered right to your door.

Once registered for GreenShield+ and enrolled in this option, Members can obtain a free, no-obligation consultation with a clinical pharmacist, ideal for those taking multiple medications. Additionally, the caregiver dashboard allows individuals to manage their household medications all in one place.

(2) CHANGE4LIFE®

GreenShield's Change4Life health portal is an all-in-one, online path to enrolled Members achieving better health while winning great rewards along the way.

From their account, Members can:

- **Complete an online Health Risk Assessment (HRA).**
 Completing an HRA questionnaire customizes the Change4Life portal to match the Member's health and lifestyle goals. A personalized health report card with an overall health score, as well as a recommended action plan filled with customized targeted tips, tools, and resources will help Members take a small-steps approach to adopting healthier habits and living a healthier lifestyle. Expect insights into current health and learn how to successfully improve it. And, for those with a diagnosed medical condition (like high cholesterol, hypertension, or diabetes, for example), the health portal's tools and information can make it easier to manage the condition.
- **Check out GreenShield's Mindfulness Program.**
 This six-session series focuses on mental wellness as part of overall health. The program is a valuable tool for approaching stress, low mood, and/or anxiety differently.
- **Sign up to receive Stick2It® medication reminder emails.**
 GreenShield's Stick2It medication reminder service helps Members remember to take medications as prescribed. They can set up Stick2It reminders to receive regularly scheduled emails reminders to take your medications and/or refill a prescription.
- **Sign up to receive health reminder emails.**
 Like Stick2It, Members can stay on track with health-related activities by scheduling health-reminder emails for a wide variety of health activities, such as tracking daily steps, physical activity, diet, and blood pressure.
- **Get to know the Spotlight page.**
 The Spotlight page features great resources such as a recipe library, health-related news, 30-day health challenges, and more.
- **Education on a variety of health topics.**
 The health portal's multi-media education modules help Members get the information they need. Learn about topics such as diabetes, stress, migraines, and more by reading articles, completing Learn & Earn modules, or listening to podcasts.
- **Set a S.M.A.R.T. Goal.**
 The S.M.A.R.T. Goal tool allows Members to develop a personal health plan and track progress as they work towards achieving it. Using the S (specific) M (measurable) A (achievable) R (realistic) T (timely) methodology can encourage Members to make a personal pledge towards better health.
- **Sync a wearable tracker (e.g. Fitbit, Garmin, etc.) with Change4Life.**
 Track steps automatically by syncing a compatible wearable device.

As Members use the Change4Life tools and resources, they will earn points that can be used to participate in the Change4Life Rewards Program. Expect ongoing draws for great rewards including gift cards for popular retailers of home goods, sports apparel, and more.

(3) KITS Eyewear Discount Program

GreenShield has partnered with KITS, a leading Canadian eyewear e-retailer, to bring enrolled Members exclusive savings on glasses and contact lenses.

Members can shop from the comfort of home and get doorstep delivery. KITS offers immediate access to high-quality eyecare, maintaining a large inventory of contact lenses and eyeglasses with over 700 styles and over 300,000 frames in stock. This includes the KITS premium brand, as well as top designer brands such as Tom Ford, Gucci, Prada, and Ray-Ban.

Members can expect savings of 25% off on any prescription glasses (designer brands included!) or 20% off contact lenses. They can also check out regular ongoing KITS promotions.

(4) Advisory Services

This benefit entitles Members to five hours of access to one-on-one live support from expert professionals in health, life, career, financial and legal advisory services. The services are provided by a network of qualified, expert practitioners on the secure, encrypted Inkblot platform. GreenShield's network includes nurses, registered dietitians, nutritionists, kinesiologists, certified fitness coaches, life coaches, career coaches and more who are all trained to provide strategies to support wellness goals.

Services include:

- **Health Coaching**
Information and counselling on adaptive and preventative health and well-being, which includes smoking cessation, eating well models/nutrition, illness/disease management, and weight management.
- **Life Transitions**
Information and support for those planning a family, parenting skills, childcare, eldercare, teen support, and life transitions such as marriage, divorce, and empty nest.
- **Career Coaching**
Coaching and guidance around career management, career transition, and retirement transition.
- **Legal Services**
Provides information and clarification on real estate, divorce, custody and child support, wills and estate planning, family matters, consumer concerns, criminal matters, and legal rights. A 1-800 number and case ID is provided for Member access.
- **Financial Services**
Provides information and clarification on credit management, budgeting, financial management, overextension, investing, retirement planning, insurance, and taxes. These services are managed by Acquaint Financial and can be scheduled for Members' convenience.

(5) Tranquility by Inkblot

Tranquility uses internet-based cognitive behavioral therapy (iCBT) to help those experiencing mild to moderate anxiety and depression take control of their mental health. Using a CBT framework, this self-guided digital program helps individuals develop positive coping strategies and reduce life-disrupting symptoms through psychoeducation, goal setting, cognitive skill building, behavioral skill building, and problem-solving.

Tranquility consists of two nine-session programs for anxiety and depression, which can be combined into one 12-session program for individuals wishing to address both. Members will begin by learning more about anxiety and depression and creating personalized goals to work towards throughout the program. They can then go through a series of modules related to learning how to challenge their thoughts and have more balanced thinking.

Through the anxiety program, Members will learn behavioral skills related to exposure therapy (or facing fears), while the depression program will help you learn activity tracking and behavioral activation skills. Members will complete the program with a module on further problem-solving skills and another module encouraging reflection and planning for the future. Members are encouraged to complete a weekly module for approximately 9-12 weeks. However, the material is designed to be flexible to accommodate everyone's unique needs and schedules.

Tranquility's self-guided program also includes digitized motivational interviewing throughout the program to help Members harness your internal motivation to continue with the program weekly.

Dental Care Insurance

Provided Under the ORWP Enhanced Plan, Elite Plan, and Super Elite Plan Only

Dental Care Insurance is not included in the ORWP Standard Plan coverage. OREA Members must upgrade to one of the program's three enhanced plans to obtain Dental Care Insurance. The benefits described in this section will be eligible, if based on the licensed dental practitioner's reasonable and customary charge and in accordance with the Fee Guide, to the maximums shown in the **Benefit Summary** (page 13 and 14).

Basic Services

Basic Diagnostic and Preventive Services

- complete oral examinations once every 3 years.
- emergency and specific oral examinations.
- full series X-rays and panoramic X-rays once every 3 years.
- bitewing X-rays once every 9 months.
- recall examinations once every 9 months.
- cleaning of teeth, up to 1 unit of polishing plus up to 1 unit of scaling once per recall period.
- topical application of fluoride once per recall period.
- denture cleaning once per recall period.
- pit and fissure sealants for covered persons under age 16, on molars only.
- space maintainers for covered persons 16 years of age and under.

Basic Restorative Services

- amalgam, tooth-coloured filling restorations and temporary sedative fillings.
- inlay restorations – these are considered basic restorations and will be paid to the equivalent non-bonded amalgam.

Basic Oral Surgery

- extractions of teeth and/or residual roots.

General anesthesia, deep sedation, and intravenous sedation in conjunction with eligible oral surgery only.

Comprehensive Basic Services

Standard Denture Services

- denture repairs and/or tooth/teeth additions.
- standard relining and rebasing of dentures once every 2 years, only after 6 months have elapsed from the installation of a denture.
- denture adjustments and remount and equilibration procedures, only after 3 months have elapsed from the installation of a denture.
- soft tissue conditioning linings for the gums to promote healing.
- remake of a partial denture using existing framework, once every 5 years.

Comprehensive Oral Surgery

- surgical exposure, repositioning, transplantation, or enucleation of teeth.
- remodeling and recontouring – shaping or restructuring of bone or gum.
- excision – removal of cysts and tumors.
- incision – drainage and/or exploration of soft or hard tissue.
- fractures including the treatment of the dislocation and/or fracture of the lower or upper jaw and repair of soft tissue lacerations.
- maxillofacial deformities – frenectomy – surgery on the fold of the tissue connecting the lip to the gum or the tongue to the floor of the mouth.

Endodontic Treatment

- root canal therapy.
- pulpotomy (removal of the pulp from the crown portion of the tooth).
- pulpectomy (removal of the pulp from the crown and root portion of the tooth).
- apical curettage, root resections and retrograde fillings (cleaning and removing diseased tissue of the root tip).
- root amputation and hemisection.
- bleaching of non-vital tooth/teeth.
- emergency procedures including opening or draining of the gum/tooth.

Periodontal Treatment

- treatment of diseased bone and gums.
- periodontal scaling and/or root planing 6-time units every 12 months.
- occlusal equilibration – selective grinding of tooth surfaces to adjust a bite 2-time units every 12 months.

The fees for periodontal treatment are based on units of time (15 minutes per unit) and/or number of teeth in a surgical site in accordance with the General Practitioners Fee Guide.

- bruxism appliance, limited to one every 24 months.

Major Services

- Standard onlays or crown restorations to restore diseased or accidentally injured natural teeth, once every 5 years.
- Standard bridges, including pontics, abutment retainers/crowns on natural teeth, once every 5 years.
- Standard dentures including complete, immediate, transitional, and partial dentures, once every 5 years.
- Standard repair or recementing of crowns, onlays and bridge work on natural teeth.

Alternate Benefit Clause

This benefit plan will reimburse the amount shown in the Fee Guide for the least expensive service or supply where two or more professionally accepted courses of treatment are a benefit under the plan. The covered person can choose to have a more expensive treatment performed; however, reimbursement will be limited to the cost of the least expensive alternative.

Predetermination

Before the insured's treatment begins, their dental practitioner must submit an estimate, including supporting materials, such as digital photos and x-rays, for any proposed treatment for which the total cost is expected to exceed \$500. Our assessment of the proposed treatment may result in a lesser benefit being payable or in benefits being denied. Failure to submit an estimate before treatment begins will delay the assessment of the claim.

Dental Limitations

- (1) Laboratory services that are in excess of 40% of the dentist's fee in the applicable Fee Guide shown in the Summary of Benefits will be reduced accordingly. Laboratory services must be completed in conjunction with other services and reimbursement is limited to the same percentage as the service for which the laboratory service was received.
- (2) Reimbursement will be made according to standard and/or basic services, supplies or treatment. Related expenses beyond the standard and/or basic services, supplies or treatment will remain the insured's responsibility.
- (3) Reimbursement will be pro-rated and reduced accordingly, when time spent by the dentist is less than the average time assigned to a dental service procedure code in the applicable Fee Guide shown in the Benefit Summary.
- (4) If this plan includes endodontic services, reimbursement for root canal therapy will be limited to payment once only per tooth. Extra charges for difficult access, exceptional anatomy, calcified canals, and retreatments are not included. The total fee for root canal therapy includes all pulpotomies and pulpectomies performed on the same tooth.
- (5) Common surfaces on the same tooth/same day will be assessed as one surface. If individual surfaces are restored on the same tooth/same day, payment will be assessed according to the procedure code representing the combined surface. Payment will be limited to a maximum of 5 surfaces in any 36-month period.
- (6) When more than one surgical procedure, including multiple periodontal surgical procedures if this plan covers periodontics, is performed during the same appointment in the same area of the mouth, only the most comprehensive procedure will be eligible for reimbursement, as the fee for each procedure is based on complete, comprehensive treatment, and is deemed part of the multiple services factor.
- (7) The multiple services factor occurs when a minimum of 6 or more restorations (fillings) or multiple periodontal services, if this plan covers periodontics, are performed at the same appointment and the full fee guide price is charged for each

restoration or periodontal service, the first service will be paid in full, and all remaining services will be reduced by 20%.

- (8) If this plan includes coverage for major services (crowns), core build-ups are eligible only for the purpose of retention and preservation of a tooth when performed with crown treatment. Necessity must be evident on mounted pre-treatment X-rays. Core build-ups to facilitate impression taking and/or block out undercuts are considered included in the cost of a crown.
- (9) If this plan includes periodontics, root planning is not eligible if done at the same time as gingival curettage.
- (10) In the event of a dental accident, claims should be submitted under the health benefit plan before submitting them under the dental plan.

Dental 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:
 - (i) an act of war, declared or undeclared.
 - (ii) participation in a riot or civil commotion. or
 - (iii) 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 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) Implants.
- (7) Any dental service that is not contained in the procedure codes developed and maintained by the Canadian Dental Association, adopted by the provincial or territorial dental association of the province or territory in which the service is provided (or the province of residence if any dental service is provided outside Canada) and in effect at the time the service is provided.
- (8) Restorations necessary for wear, acid erosion, vertical dimension and/or restoring occlusion.
- (9) Appliances related to treatment of myofascial pain syndrome including all diagnostic models, gnathological determinants, maintenance, adjustments, repairs and relines.
- (10) Posterior cantilever pontics/teeth and extra pontics/teeth to fill in diastemas/spaces.
- (11) Service and charges for sleep dentistry.

(12) Diagnostic and/or intraoral repositioning appliances including maintenance, adjustments, repairs and relines related to treatment of temporomandibular joint dysfunction.

(13) Any specific treatment or drug which:

- does not meet accepted standards of medical, dental, or ophthalmic practice, including charges for services or supplies which are experimental in nature.
- is not considered to be effective (either medically or from a cost perspective) as determined by GSC's drug review process regardless if Health Canada's approved the drug.
- is an adjunctive drug prescribed in connection with any treatment or drug that is not an eligible service.
- is administered in a hospital or is required to be administered in a hospital in accordance with Health Canada's approved indication for use.
- is not dispensed by the pharmacist in accordance with the payment method shown under the Health Benefit Plan Prescription Drugs benefit.
- 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).

(14) Services or supplies that:

- are not recommended, provided by, or approved by the attending legally qualified (in the opinion of GSC) medical practitioner or dental practitioner as permitted by law.
- are legally prohibited by the government from coverage.
- the insured is 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 their behalf by a not-for-profit prepayment association, insurance carrier, third party administrator, like agency or a party other than GSC, the plan sponsor or the insured.
- are provided by a health practitioner whose license by the relevant provincial regulatory and/or professional association has been suspended or revoked.
- are not provided by a designated provider of service in response to a prescription issued by a legally qualified health practitioner.
- are used solely for recreational or sporting activities and which are not medically necessary for regular activities.
- are primarily for cosmetic or aesthetic purposes or are to correct congenital malformations.
- are provided by an immediate family member related to the insured by birth, adoption, or by marriage and/or a practitioner who normally resides in their home. An immediate family member includes a parent, spouse, child, or sibling.
- are provided by the plan sponsor and/or a practitioner employed by the plan sponsor, other than as part of an employee assistance plan.
- 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.
- are video instructional kits, informational manuals, or pamphlets.
- are delivery and transportation charges.

- are a duplicate prosthetic device or appliance.
- 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.
- would normally be paid through any provincial health insurance plan, Workplace Safety and Insurance Board or tribunal, 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.
- 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:

- the service or supplies being claimed is not eligible, or
- the financial commitment is complete.

A letter from the insured's automobile insurance carrier will be required.

- 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.

Additional Services

The following services are included in the benefit plan but are not provided by GSC. GSC has arranged for this coverage and provides only administration on behalf of the plan sponsor.

Pharmacogenetic Testing

If specific criteria are met, the insured and their eligible dependents will be able to access pharmacogenetic testing provided through GenXys Health Care Systems. Their TreatGx^{Plus} all-in-one product includes the myPGx pharmacogenetic test and a subscription to TreatGx, a medication decision-support software that provides personalized and optimized medication options based on your pharmacogenetic insights, current drug regimen, and other health information. For details, visit: genxys.com/gsc-members

Travel Insurance

The Travel Insurance coverage provided under the Ontario REALTOR® Wellness Program (ORWP) provides emergency Out of Province / Country Medical benefits. The coverage is outlined in the **Benefit Summary** section of this booklet (page 14 and 15).

The Insurer, AIG Insurance Company of Canada (AIG), will pay for Reasonable and Customary medical expenses actually incurred by an Insured Person for those services described below and required by them outside their province/country of residence, as a result of a Medical Emergency that occurs on a Trip provided such Medical Emergency occurs while this policy is in effect for such person.

The Total Maximum Benefit Amount Payable for this benefit per Insured Person is listed in the Schedule of Benefits.

Schedule of Benefits

Coverage Type	Primary Coverage
Emergency Hospital Confinement	Included in Total Maximum Benefit Amount Payable – Out of Province/Country
Emergency Medical and Therapeutic Services	Included in Total Maximum Benefit Amount Payable – Out of Province/Country, where applicable sub limits are noted below
Services of a Physician or legally qualified surgeon	Included
Laboratory tests and X-ray examinations (not including MRI) ordered by a Physician or legally qualified surgeon for the purpose of diagnosis	Included
MRI, for diagnostic purposes when Medically Necessary	\$7,500 per Insured Person per Trip
Services of a registered graduate nurse (other than an Immediate Family Member of the Insured Person)	50 nursing shifts at a fee not to exceed \$100 per shift
Rental of crutches or a Hospital type bed, or the cost of splints, canes, slings, trusses, braces, or other prosthetic appliances approved by AIG	Included
Services of a Physician who is an anesthetist	Included
Drugs or medicines that require a Physician or legally qualified surgeon's written prescription	Included

Services of a chiropodist, chiropractor, osteopath, physiotherapist, or podiatrist	\$300 for each class of practitioner
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Expenses for accidental Injury to natural and sound teeth (capped or crowned teeth are considered whole or sound natural teeth) which require Treatment by a legally qualified dentist or dental surgeon	\$2,000 for any one accident
Out-patient services provided by a Hospital	Included
Repatriation Benefit	\$15,000
Identification Benefit	\$5,000
Automobile Return	\$1,000 per Trip
Out-of-Pocket Expense Benefit	\$150 per day up to a maximum of \$1,500
Family Transportation	\$15,000 maximum for any one accident and up to \$250/day for incidental travel expenses
Return Transportation for Travelling Companion	\$2,000 for any one Trip for the transportation of one Travel Companion
Return and Escort of Dependent Children	\$5,000 per repatriated or returned Insured Person
Ground Transportation Benefit	\$5,000
Emergency Air Transportation Benefit	\$300,000
Attaché services	Included

Primary Coverage

The Emergency Out of Province/Country Medical Benefit does not require the Insured Person to have coverage under a separate employee benefit plan. AIG will seek recoveries from the applicable Government Health Insurance Plan and will coordinate benefits with all other benefit plans according to the guidelines established by the Canadian Life and Health Insurance Association.

Emergency Hospital Confinement

AIG will pay benefits hereunder in the event of a Medical Emergency to the Insured Person which results in emergency confinement as a resident in-patient in a Hospital outside their province/country of residence. AIG shall cover only Reasonable and Customary charges made by the Hospital for services and supplies provided to the Insured Person to the extent that such are Medically Necessary, including semi-private accommodation and only if such expenses are incurred while this Policy is in effect for such person.

Emergency Medical and Therapeutic Services

AIG will pay benefits hereunder in the event the Insured Person requires emergency medical or therapeutic services outside their province/country of residence to treat a Medical Emergency to the extent that such are Medically Necessary and only if such expenses are incurred while this Policy is in effect for such person. Benefits are payable to reimburse Reasonable and Customary expenses for:

- the services of a Physician or legally qualified surgeon,
- laboratory tests and X-ray examinations (not including MRI) ordered by a Physician or legally qualified surgeon for the purpose of diagnosis,
- MRI, for diagnostic purposes when Medically Necessary up to the Maximum Amount Payable listed in the Schedule of Benefits (page 75),
- the services of a registered graduate nurse (other than an Immediate Family Member of the Insured Person), up to the Maximum Amount Payable listed in Schedule of Benefits (page 75),
- rental of crutches or a Hospital type bed, or the cost of splints, canes, slings, trusses, braces, or other prosthetic appliances approved by AIG,
- the services of a Physician who is an anesthetist,
- drugs or medicines that require a Physician or legally qualified surgeon's written prescription,
- services of a chiropodist, chiropractor, osteopath, physiotherapist, or podiatrist up to the Maximum Amount Payable listed in the Schedule of Benefits (page 75),
- expenses for accidental Injury to natural and sound teeth (capped or crowned teeth are considered whole or sound natural teeth) which requires the care of a legally qualified dentist or dental surgeon within 30 days from the date of the accident, Maximum Amount Payable listed in the Schedule of Benefits (page 75), and
- out-patient services provided by a Hospital.

Repatriation Benefit

If the Insured Person has a Medical Emergency causing loss of life while on a Trip and when this Policy is in effect for such person and:

- such loss of life occurs outside their province/country of residence; and
- such loss of life occurs within three hundred and 365 days of the date of the accident causing the injury, causing loss of life, or the date of the sickness causing loss of life,

AIG shall pay the actual expenses incurred for preparing the deceased Insured Person for burial or cremation and shipment of the body to the city of residence of the deceased Insured Person. The Maximum Amount Payable per Insured Person for this benefit is listed in the Schedule of Benefits (page 75).

Identification Benefit

If the Insured Person has a Medical Emergency causing loss of life for which a benefit is paid or payable hereunder and the Insured Person's body requires identification, AIG will pay to one Immediate Family member of the Insured Person, the reasonable and necessary expenses actually incurred by such Immediate Family member for:

- commercial lodging and board while en route and/or during the stay in the city or town where the body is located (not to exceed a maximum duration of 3 consecutive nights); and
- transportation by the most direct route to such location.

This benefit is payable by AIG only if the body of the Insured Person is located outside their province/country of residence and the identification of the body is requested by the police or a similar law enforcement agency having authority over such matters.

Payment will not be made for ordinary living, travelling, or clothing expenses, other than as specifically stated above. If transportation occurs in a vehicle or device other than one operated under the license for the conveyance of passengers for hire, the reimbursement of transportation expenses will be limited to a maximum of forty cents (\$0.40) per kilometre travelled.

This benefit is payable only once in connection with Injury, Sickness or loss suffered by any one Insured Person, regardless of the number of policies providing coverage for this benefit for such Insured Person, that may be issued by AIG.

The Maximum Amount Payable per Insured Person for this benefit is listed in the Schedule of Benefits (page 75).

Automobile Return

If as a result of a Medical Emergency the Insured Person is unable to return to Canada/their province of residence/country of residence with the vehicle used for their Trip, AIG will pay the actual expense incurred for a commercial agency to return the Insured Person's private or rental vehicle used for the Trip to the Insured Person's place of residence or nearest rental agency.

The Maximum Amount Payable per Insured Person for this benefit is listed in the Schedule of Benefits (page 75).

Out-Of-Pocket Expense Benefit

If the Insured Person or their Travel Companion is hospitalized as an inpatient during their Trip and are delayed beyond the end of their Trip AIG will pay for reasonable and necessary commercial living expenses, such as commercial accommodations and meals, incurred by any Insured Person.

The Maximum Amount Payable per Insured Person for this benefit is listed in the Schedule of Benefits (page 75).

Family Transportation Benefit

If the Insured Person experiences a Medical Emergency resulting in the Insured Person being confined to a Hospital located outside their province/country of residence, AIG shall pay the reasonable and necessary expenses actually incurred for the transportation of one Immediate Family member to such Hospital.

This benefit is only payable if:

- confinement to Hospital occurs within 365 days of the Medical Emergency; and
- reimbursement of expenses is limited to the cost of one economy class return airfare via the most direct route, or the equivalent amount toward another type of common carrier transportation for such Immediate Family member, including incidental travel expenses.

The Maximum Amount Payable per Insured Person for this benefit from any one Medical Emergency is listed in the Schedule of Benefits (page 75).

Return Transportation for Travelling Companion

If the Insured Person is repatriated to their province/country of residence in accordance with the Repatriation Benefit, or is returned to their province/country of residence in accordance with the Ground or Air Transportation Benefit, AIG will pay a benefit to such Insured Person (or the estate of such Insured Person) for the extra cost of a one-way economy air fare on a commercial flight or charter via the most cost effective itinerary to transport the Insured Person's Travel Companion to their province/country of residence.

The Maximum Amount Payable per Insured Person for this benefit is listed in the Schedule of Benefits (page 75).

Return and Escort of Dependent Children

If the Insured Person is repatriated to their province/country of residence in accordance with the Repatriation Benefit, or is returned to Canada/their country of residence in accordance with the Ground or Air Transportation Benefit, AIG will pay a benefit to such Insured Person (or the estate of such Insured Person) for the cost of a one-way economy air fare on a commercial flight or charter via the most cost effective itinerary to transport the Insured Person's Dependent Children travelling with the Insured Person on a Trip to such Dependent Children's home, plus reasonable overnight hotel accommodation and meal expenses and for the services of an attendant to escort Dependent Children under age 16, if required.

The Maximum Amount Payable per repatriated or Insured Person for this benefit listed in the Schedule of Benefits (page 75).

Ground Transportation Benefit

If a Medical Emergency during a Trip results in a Medically Necessary transportation of the Insured Person by a licensed ground ambulance, AIG will pay the expenses actually incurred for such transportation.

The Maximum Amount Payable per Insured Person for this benefit is listed in the Schedule of Benefits (page 75).

Emergency Air Transportation Benefit

If a Medical Emergency during a Trip results in a Medically Necessary Air Transportation of the Insured Person, AIG will pay benefits for Covered Expenses up to the Maximum Amount Payable per Insured Person listed in the Schedule of Benefits (page 75) for such Air Transportation. Any Air Transportation must first be approved by AIG, and it must be ordered by a Physician or licensed surgeon who certifies that the severity of the Insured Person's Medical Emergency warrants the Air Transportation of the Insured Person and that such is Medically Necessary. If due to the geographical area at the onset of the Medical Emergency an air ambulance is deemed necessary, AIG will pay the cost of a licensed air ambulance to transport the Insured Person to the nearest Hospital or medical facility where appropriate medical Treatment can be obtained.

An Air Transportation is Medically Necessary if:

- the Insured Person's medical condition warrants immediate transportation from the place where the Insured Person suffers from a Medical Emergency to the nearest Hospital where appropriate medical Treatment can be obtained; and/or
- after being treated at a local Hospital, the Insured Person's medical condition warrants transportation to the place where they reside (provided such residence is located in Canada) to obtain further medical Treatment or to recover.

Emergency Medical Assistance

AIG provides worldwide emergency assistance for Insured Persons while on a Trip except where local conditions render such assistance not feasible. In the event of a Medical Emergency covered by this Policy requiring hospitalization, AIG must be notified within 48 hours from the time of incident or expense claims may be denied or only partially covered. In the event of a Medical Emergency, Insured Persons or an individual acting on their behalf must call the Assistance Company.

Refer to the Assistance Company for further details regarding the emergency assistance services available to travelling Insured Persons.

Availability and Quality of Care and Services

AIG is not responsible for, and incurs no liability for:

- the quality of any medical Treatment or services, or any facility that provides such Treatment or services.
- the availability of medical Treatment, services, or any facility to provide such Treatment or services; and
- the failure or inability of any Insured Person to obtain or seek medical Treatment.

Additional Emergency Out of Province / Country Medical Benefits Conditions

In the event of a Medical Emergency, an Insured Person which requires medical Treatment, AIG reserves the right to:

- Transfer the Insured Person to one of AIG's preferred health care providers for the medical Treatment of a Sickness and/or Injury, and/or
- Return the Insured Person to their province/country of residence, where this poses no danger to the life or health of the Insured Person.

If the Insured Person chooses to decline the transfer or return when declared medically stable by the medical director of AIG, AIG will not pay benefits for, and shall be released from any liability for, expenses incurred for such Sickness and/or Injury after the proposed date of transfer or return.

Once the Insured Person is returned to their province/country of residence (with or without medical escort) any further expenses for consultation, Treatment, recurrence, or complication related to such emergency will no longer be eligible for coverage under this policy.

Exclusions and Limitations

No coverage shall be provided, and no payment shall be made for any Medical Emergency resulting in whole or in part from, or contributed to by, or as a natural and probable consequence of, any of the following excluded risks:

- Sickness or injury sustained while the Insured Person is on full-time active duty in the armed forces or organized reserve corps of any country or international authority.
- Injury sustained while the Insured Person is under the influence of alcohol and operating any vehicle or means of transportation or conveyance while his or her blood alcohol is over 80 milligrams in 100 millilitres of blood.
- Injury sustained while the Insured Person is under the influence of a drug or substance which is controlled as specified under the Controlled Drug and Substances Act (Canada) (even if such drug or substance is taken outside Canada) unless taken pursuant to the advice of and in strict accordance with the instructions of a Physician.
- the abuse of medication or drugs or non-compliance with prescribed medical therapy or Treatment whether prior to or during the Insured Person's Trip.
- Injury incurred while an Insured Person is in the course of committing or attempting to commit, any act which if adjudicated by a court would be an indictable offence under the laws of the jurisdiction where the act was committed.
- childbirth or any unexpected pregnancy complications after 31 weeks.
- routine pre-natal care.
- voluntary termination of pregnancy.
- a child born during a Trip covered under this policy.
- Sickness or Injury where the Trip is undertaken for the purpose of securing medical Treatment or advice for such Sickness or Injury.
- Sickness or Injury due to participation in any professional sport.
- suicide or any attempt at suicide.
- intentionally self-inflicted Injury or any attempt at intentionally self-inflicted Injury.
- an act of declared or undeclared war, civil war, rebellion, revolution, or insurrection.

- repair or replacement of the following except for the purpose of modifying the item because the Injury or Sickness has caused further impairment in the underlying bodily condition:
 - existing artificial limbs, artificial eyes or other prosthetic appliances or rental of existing durable medical equipment.
 - new, or repair or replacement of, dentures, bridges, dental implants, dental bands or braces or other dental appliances, crowns, caps, inlays or onlays, fillings or any other treatment of the teeth or gums, except for repair or replacement of sound natural teeth damaged or lost.
 - new eyeglasses or contact lenses or eye examinations related to the correction of vision or related to the fitting of glasses or contact lenses.
 - new hearing aids or hearing examinations.
 - rental of durable medical equipment where the total rental expense exceeds the usual purchase expense for similar equipment in the locality where the expense is incurred (but if, in the Company's sole judgment, Emergency Medical and Therapeutic Services for rental of durable medical equipment are expected to exceed the usual purchase expense for similar equipment in the locality where the expense is incurred, the Company may, but is not required to, choose to consider such purchase expense as a Reasonable and Customary charge in lieu of such rental expense).
- Personal comfort or convenience items, such as but not limited to Hospital telephone charges, television rental, or Hospital guest meals.
- Treatment or services when reimbursement or coverage by the Company would contravene any GHIP in Canada.
- expenses incurred on an elective (non-emergency) basis.
- any Treatment, investigation or surgery for a specific condition, or a related condition, which had caused the Insured Person's Physician to advise such person not to travel.
- any services or supplies provided by an Insured Person or an Immediate Family Member of the Insured Person.
- a Sickness or Injury that, at the time of departure, might reasonably be expected to require an Insured Person to undergo Treatment, investigation, surgery, or hospitalization.
- any service, Treatment, surgery or stay in Hospital not required for the immediate relief of acute pain or suffering or which is not Medically Necessary.
- any Treatment or surgery which reasonably could be delayed until the Insured Person returns to their province/country of residence.
- anticipated medical Treatments required on an ongoing basis or for continued stabilization of a medical condition known to the Insured Person prior to departure from their province/country of residence.
- any sickness, injury or medical condition that is a Pre-Existing Condition within the number of days as specified in the Pre-Existing Condition Period in the Policy Schedule Declarations.
- that portion, if any, of any expenses for Treatment, advice or hospitalization which are not Reasonable and Customary.

Trip Cancellation / Interruption and Baggage Loss Benefits

Trip Cancellation, Trip Interruption, and Baggage Loss Benefits are not included in the ORWP Standard Plan Travel Insurance coverage. OREA Members must upgrade to one of the program’s three enhanced plans to obtain these coverages.

Subject to any exclusions and limitations provided hereafter, in the event of a Trip Cancellation Covered Risk or a Trip Interruption Covered Risk, this coverage provides payment for the eligible expenses described below. Such expenses must be in excess of those reimbursable by any other insurance contract or health plan (group or individual), under which the Insured Person is entitled to benefits.

Schedule of Benefits (Enhanced, Elite, and Super Elite Travel Plans Only)

Benefit	Maximum Per Insured Person	Primary Coverage
Trip Cancellation and Interruption	\$10,000	<p>Pays up to the maximum for Trip Cancellation and Interruption expenses.</p> <p>(a) Trip Cancellation \$5,000 per Insured Person</p> <p>(b) Trip Interruption pre-paid expenses and transportation costs \$5,000 combined</p> <p>(c) Trip Interruption meals and accommodations \$250 per day</p>
Baggage and Personal Effects	\$2,000	<p>Pays up to the maximum per family per Trip; \$250 deductible applies:</p> <p>(a) Loss of or Damage to Baggage and Personal Effects: \$1,000 per trip subject to a maximum of \$500 for any one item or set of items</p> <p>(b) Delay of Baggage and Personal Effects: \$400 towards the replacement of the necessary toiletries and clothing</p> <p>(c) Prescription Replacement Service: \$200</p> <p>(d) Replacement of Travel Documents: \$200 towards the replacement of one or more of the Insured Person driver’s license, passport, birth certificate or travel visa</p>

Trip Cancellation Benefit

The Trip Cancellation benefit reimburses up to the Trip Cancellation Coinsurance and Maximum shown in the Benefit Summary for losses incurred should an Insured Person’s Trip be cancelled before the scheduled Departure Date due to a Trip Cancellation Covered Risk. The following benefits are eligible under the policy:

- The Insured Person’s Travel Arrangements; or
- The Insured Person’s applicable change-fee to reschedule a Trip when such option is available, and the Insured Person reschedules in lieu of cancellation; or
- The single supplement charged to the Insured Person as the result of a Travel Companion being unable to travel due to a Trip Cancellation Covered Risk.

When multiple Insured Persons are scheduled to travel together on the same Trip, the maximum Trip Cancellation amount payable for all Insured Person’s will not exceed the

Aggregate Limit listed in the Benefit Summary. The amount payable will be prorated among all Insured Person's, so that the total amount paid will not exceed the Aggregate Limit.

Trip Cancellation Covered Risks

The Trip Cancellation benefits in the Benefit Summary are payable if a Trip is cancelled due to one of the following Covered Risks, provided it is unexpected and unforeseen:

- *Covered Risk 1 – Medical Condition or Injury:* Medical Condition or Injury of 1 or more of the following persons:
 - Insured Person or Travel Companion provided the Insured Person or Travel Companion is under the direct care of a Physician and the Physician has recommended in writing that the Insured Person or Travel Companion cancel the Trip due to the severity of the condition.
 - Immediate Family Member provided the Medical Condition or Injury is life-threatening and the Immediate Family Member requires the Insured Person's or Travel Companion's care.
 - Key Employee provided the Medical Condition or Injury is life-threatening.
- *Covered Risk 2 – Death:* Death of 1 or more of the following persons:
 - Insured Person or Travel Companion.
 - Immediate Family Member or Key Employee provided the death occurs within 30 days of the scheduled Trip Departure Date.
- *Covered Risk 3 – Pregnancy:* One of the following:
 - Pregnancy of the Insured Person, Travel Companion or Travel Companion's spouse that is initially confirmed after the date the Trip was booked and the Departure Date falls within 9 weeks before the expected delivery date; or
 - Pregnancy of the Insured Person, Travel Companion, or Travel Companion's spouse that results in complications of pregnancy, including early delivery, occurring within the first 31 weeks of pregnancy.

Trip Interruption Benefit

The Trip Interruption benefit reimburses up to the Trip Interruption Coinsurance and Maximum shown in the Benefit Summary for losses incurred should an Insured Person's Trip be interrupted or delayed after the scheduled Departure Date due to a Trip Interruption Covered Risk.

The following benefits are eligible under the policy:

- **Pre-paid Expenses:** The Insured Person's unused Travel Arrangements for the Trip purchased before the Departure Date (excluding partially used airline tickets).
- **Transportation Expenses:** The extra cost of economy class transportation by the Insured Person for the most cost-effective route to:
 - return the Insured Person to their ordinary province or territory of residence.
 - or continue the Trip at the next destination.

The reimbursement of any eligible Transportation Expenses is limited to the lesser of the change-fee; a one-way economy airfare; or a return economy fare by the most cost-effective route.

- *Meals & Accommodation:* If a Trip is interrupted or delayed beyond the original scheduled Return Date, AIG will reimburse up to the per day and overall maximums listed in the Benefit Summary for the additional Commercial Accommodation and meals, essential telephone calls and taxi fares. To file a claim, original receipts must be supplied.

When multiple Insured Persons are travelling together on the same Trip, the maximum Trip Interruption amount payable for all Insured Person's will not exceed the Aggregate Limit listed in the Benefit Summary. The amount payable will be prorated among all Insured Person's, so that the total amount paid will not exceed the Aggregate Limit.

Trip Interruption Covered Risks

The Trip Interruption Benefits listed above are payable if a Trip is interrupted or delayed due to one of the following Trip Interruption Covered Risks, provided the covered risk is unexpected and unforeseen:

- Covered Risk 1 – Medical Condition or Injury: Medical Condition or Injury of 1 or more of the following persons:
 - Insured Person or Travel Companion provided the Insured Person or Travel Companion is under the direct care of a Physician and the Physician has recommended in writing that the Insured Person or Travel Companion terminate the Trip early due to the severity of the condition.
 - Immediate Family Member provided the Medical Condition or Injury is life-threatening and the Immediate Family Member requires the Insured Person's or Travel Companion's care.
 - Key Employee provided the Medical Condition or Injury is life-threatening.
- Covered Risk 2 – Death: Death of 1 or more of the following persons:
 - Insured Person or Travel Companion.
 - Immediate Family Member or Key Employee provided the death occurs during the Trip.
- Covered Risk 3 – Pregnancy: Pregnancy of the Insured Person, Travel Companion, or Travel Companion's spouse that results in complications of pregnancy, including early delivery, occurring within the first 31 weeks of pregnancy and during the Trip.
- Covered Risk 4 – Automobile Accident: The Insured Person and/or Travel Companion is/are directly involved in or are delayed due to an automobile accident while on route to the Common Carrier (must be substantiated by a police report).

Exclusions

This insurance does not cover any loss or expense related in whole or in part, directly or indirectly, to any of the following:

- Pre-existing Conditions of an Insured Person, Travel Companion, Immediate Family Member or Key Employee.
- Alcohol related sickness or the abuse of medication, drugs, alcohol, or any other toxic substance prior to or during the Trip. Alcohol abuse is defined as having a blood alcohol level in excess of eighty (80) milligrams of alcohol per one hundred (100) millilitres of blood.
- Any Trip Cancellation expenses if the Insured Person or Policyholder has knowledge of any reason why the Trip might be cancelled or interrupted as of the date the initial Trip deposit was made.
- Any Trip Interruption expenses if the Insured Person or Policyholder has knowledge of any reason why the Trip may be interrupted prior to the Departure Date.
- Travel for the purpose of visiting a person suffering from a Medical Condition and the Medical Condition (or ensuing death) of that person is the cause of the Trip Cancellation or Trip Interruption.
- Suicide, or attempted suicide, or intentionally self-inflicted Injury or any attempt at intentionally self-inflicted Injury or auto eroticism by the Insured Person, Immediate Family Member, Travel Companion, or Key Employee.
- War or act of war, whether declared or not, civil commotion, insurrection, or riot.
- Any unlawful acts, committed by the Insured Person, Immediate Family Member, Travel Companion, or Key Employee, whether insured or not.
- Injury sustained while committing or attempting to commit a felony or misdemeanour or crime.
- Expenses incurred due to, contributed to by, or resulting from pregnancy or childbirth except as specified under the Trip Cancellation Pregnancy Covered Risk and Trip Interruption Complication of Pregnancy Covered Risk
- Expenses incurred due to, contributed to by, or resulting from any Medical Condition or Injury where the Trip is undertaken for the purpose of seeking medical Treatment or advice.
- Common Carrier caused delays, including an announced, organized, sanctioned union labor strike that affects public transportation.
- Travel Arrangements cancelled or changed by a Common Carrier or travel supplier.
- Changes in plans by the Insured Person, an Immediate Family Member or Travel Companion, for any reason (unless the reason is a Trip Cancellation or Trip Interruption Covered Risk under the Policy).
- Financial circumstances of the Insured Person, an Immediate Family Member, or a Travel Companion.
- Any business or contractual obligations of the Insured Person, an Immediate Family Member or Travel Companion.
- Default caused by financial insolvency of the travel supplier or travel agent from whom the Insured Person purchased their Travel Arrangements.
- A Trip for which the Insured Persons tickets do not contain specific travel dates (open tickets).
- Any government regulation or prohibition including travel advisories.

- An event or circumstance which occurs prior to the date the initial Trip deposit was made for Trip Cancellation or the Trip Departure Date for Trip Interruption.
- Inclement weather.
- Failure of any tour operator, Common Carrier, person, or agency to provide the bargained-for-travel arrangements.
- Travelling against the advice of a Physician.

Insured Risks – Baggage and Personal Effects Benefits

The Baggage and Personal Effects benefit reimburses the Reasonable and Necessary expenses up to the Baggage and Personal Effects Coinsurance and Maximums shown in the Benefit Summary which are incurred by the Insured Person due to the delay, direct physical loss of, or damage to, the baggage and personal effect the Insured Person owns and use during their trip outside the province or territory of residence. Such expenses must be in excess of those reimbursable by any other insurance contract or health plan (group or individual) under which the Insured Person is entitled to benefits.

The following benefits are eligible under the policy:

- Loss of or Damage to Baggage and Personal Effects provides reimbursement on the least of the following:
 - the cost of repair,
 - the cost of replacement or
 - the depreciated value of the lost or damaged articles.
- Reimbursements for an entire set are only made if the entire set is lost or damaged; otherwise, reimbursement is made specific to the affected article within the set.
- Delay of Baggage and Personal Effects covers the replacement of the necessary toiletries and clothing when the Insured Person's checked baggage is delayed by the common carrier for more than 12 hours while on route and before returning to the home province or territory of residence.
- Prescription Replacement Service covers medically necessary prescription drugs for the Insured that are lost, stolen, or damaged. The prescribing Physician must authorize the replacement and it must be legally permissible in the jurisdiction in which the loss or damage occurs.
- Replacement of Travel Documents covers the replacement of one or more of the Insured Person driver's licenses, passport, birth certificate or travel visa in the event any of these is lost or stolen during a Trip.

Conditions – Baggage and Personal Effects Benefit

- If any one of the above benefits is duplicated under a similar benefit or under another insurance coverage in this policy or another policy issued by AIG, the maximum the Insured Person is entitled to is the largest amount specified under any one benefit or insurance coverage. The total amount paid to the Insured Person from all sources cannot exceed the actual expense incurred.
- The Insured Person must notify the police immediately if their baggage, personal effects, or travel documents are stolen and obtain from them corroborating documentary evidence. The Insured Person must also promptly act to recover the property.

- The Insured Person must take all precautions to protect, save or recover the property immediately and advise AIG as soon as they return home. The claim will not be valid under this policy if the Insured Person does not comply with these conditions. AIG also reserves the option to repair or replace the Insured Person's property with other of a similar kind, quality, and value. AIG may also ask the Insured Person to submit damaged item for an appraisal of the damage and for sworn proof of loss as soon as possible from the date of loss, providing the amount of loss, date, time and cause of loss, and a complete list of damaged/lost items.
- All items claimed over \$250.00 must be accompanied by an original receipt.
- In the case of theft, documentation of theft of the Baggage and/or personal effects, travel documents must be part of a report by the police or other local authority or, in the case of loss or damage, documentation from the appropriate party responsible for the loss or damage.

Exclusions For Baggage and Personal Effects Benefit

This insurance does not cover any loss or expense related in whole or in part, directly or indirectly, to any of the following:

- Electronics (such as, but not limited to, mobile phones or computers) and valuables (such as, but not limited to, jewellery, cameras, or watches).
- Damage or loss resulting from wear and tear, deterioration, defect, mechanical breakdown, the Insured Person's imprudence, or omission.
- Baggage or personal property left in an unattended vehicle (unless there are visible signs of forcible entry), and which was not locked in the trunk, or baggage or personal property shipped under a freight contract.
- Theft, loss or damage of baggage or personal affects where a written report has not been obtained from the police or local or conveyance authorities to substantiate the loss.
- Wear and tear or gradual deterioration.
- Natural defect or damage sustained due to any process or repair.
- Defective materials or craftsmanship.
- Damage from animals, rodents, insects, or vermin.
- Inherent vice or damage.
- Seizure or destruction under quarantine or custom regulation.
- Radioactive contamination.
- Mysterious disappearance.
- Damage from electrical current, including electric arcing that damages or destroys electrical devices or appliances.

Virtual Healthcare and Mental Health Care

The Virtual Healthcare and Mental Health Care coverage under the Ontario REALTOR® Wellness Program (ORWP) provides OREA Members with access to Maple, a healthcare platform for fast, convenient access to Canadian General Practitioners (GPs) and Therapists. The coverage is outlined in the **Benefit Summary** section of this booklet (page 8). Maple is designed to be user-friendly and easy to navigate, making it simple for Members to request a visit on-demand, to consult with healthcare professionals, and to access their medical records. Below is a summary of the sponsored services available to OREA Members through the ORWP.

Mental Health Therapy

Available 7 days a week, Members can see a therapist 'On-Demand' (under 12 hours) if they choose or schedule an appointment that better suits their needs. Providers are Registered Social Workers and Registered Psychotherapists. Users access services by self-selecting a therapist based on determined need and readiness to access services. There is no assessment or triage process mandatory for the patient, as the user self-selects their preferred provider.

Members have the option to begin the process through well-being check-ins or connecting with Maple's Care Concierge via the Maple app for support in matching with a therapist. This is ideal for individuals needing additional guidance in understanding their needs and selecting a well-matched therapist.

There are mental health therapists on the Maple virtual platform who specialize in treating patients with different mental health concerns. Each therapist's health profile is available for patients to read and determine who would be the best match for them based on their experience and expertise.

This benefit is also available to the eligible dependent(s) of OREA Members at no additional cost.

On-Demand Access to General Practitioners, 24/7/365

Maple offers the flexibility of round-the-clock access to virtual care, ensuring that OREA Members can receive medical advice and support at any time, whether it's day or night. Maple connects Members with Canadian-licensed doctors and nurse practitioners. During a virtual visit, they'll be able to diagnose and treat common health issues, write prescriptions, issue lab requisitions, and more, if medically necessary.

This benefit is also available to the eligible dependent(s) of OREA Members at no additional cost.

Headspace

Headspace is the leading science-backed meditation app that helps people stress less and improve their overall mental well-being. With Headspace, Members will have free access to:

- Guided meditations, courses, and mindfulness exercises
- Sleepcasts, music, and nature sounds
- Quick workout videos including yoga, mindful walks, and guided cardio.

This benefit is exclusive to OREA Members.

Mind by Maple

Within the Maple mobile application or desktop interface, Members will be able to access well-being content and receive clinically validated screenings to track mental health progress over time. Maple offers access to a robust library of audio, text, and video content for self-guided learning. Mind by Maple's resource library is stocked with engaging mental health learning material to engage patients and encourage regular self-care.

This benefit is also available to the eligible dependent(s) of OREA Members at no additional cost.

Claims Submission

Life Insurance

Claims under the policy must be submitted to Comprehensive Benefit Solutions Limited on the appropriate form. The beneficiary must submit to Comprehensive Benefit Solutions and the Insurer proof of death, including a death certificate, as well as any other information deemed useful by the Insurer.

AD&D Insurance

The Insured Person or an Insured Person's beneficiary entitled to make a claim:

- shall give written notice of claim to Comprehensive Benefit Solutions AIG by delivery thereof, or by sending it by mail or email not later than thirty (30) days from the date of the accident.
- within 90 days from the date of the accident or the Injury, furnish to Comprehensive Benefit Solutions such proof of claim as is reasonably possible in the circumstances of the happening of the accident or Injury occasioned thereby; and
- if so, required by AIG, furnish a certificate as to the cause and nature of the accident or Injury caused thereby, for which the claim is made and as to the duration of the Injury or Loss, from a legally qualified medical practitioner.

Failure to give notice of claim or furnish proof of claim within the time prescribed will 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 year from the date of the accident or the Injury and if it is shown that it was not reasonably possible to give notice or furnish proof within the time as prescribed.

AIG has the right, and any Insured Person making a claim shall afford to AIG an opportunity, to examine them when and as often as AIG may reasonably require while the claim hereunder is pending, and also, in the case of the Loss of Life of an Insured Person, to make an autopsy subject to any law of the Insured Person's province of residence relating to autopsies. AIG shall pay, within 60 days after it has received sufficient proof of claim and the person entitled to benefits in connection with such claim, all moneys payable under this policy.

Every action or proceeding against an insurer for the recovery of insurance money payable under the policy 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), The Limitations Act (for actions or proceedings governed by the laws of Saskatchewan) 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.

The benefit payable for Loss of Life will be payable in accordance with the AD&D Schedule of Benefits, unless otherwise specified herein:

- any accrued other benefits payable but unpaid at the Insured Person's death will be paid to the Insured Person's estate; and
- all other benefits are payable to or on behalf of the Insured Person.

Critical Illness Insurance

Claims under the policy must be submitted to Comprehensive Benefit Solutions Limited on the appropriate form. Within 90 days of a death, the beneficiary must submit to Comprehensive Benefit Solutions and the Insurer proof of death, including a death certificate, as well as any other information deemed useful by the Insurer.

Notice and proof of any claim must be received by the Insurer within the time limit, if any, specified for each Benefit. However, if the policy terminates, no payment will be made unless the notice and proof of a claim is submitted to the Insurer within 120 days of the date of termination of the policy.

Failure to submit notice or proof of claim within the prescribed time limit does not invalidate the claim, provided that the notice and proof of the claim are sent as soon as reasonably possible. However, no payment will be made if the notice and proof of claim are sent more than 12 months after the expenses were incurred.

Failure to give notice of claim or furnish proof of claim within the time prescribed in Section will 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 year from the date of the Diagnosis or procedure and if it is shown that it was not reasonably possible to give notice or furnish proof within the time as prescribed.

AIG has the right, and any Insured Member making a claim shall afford to AIG an opportunity, to examine him or her when and as often as AIG may reasonably require while the claim hereunder is pending.

AIG shall pay, within 60 days after it has received sufficient proof of claim and the person entitled to benefits in connection with such claim, all moneys payable under this policy.

Every action or proceeding against an insurer for the recovery of insurance money payable under the policy 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), The Limitations Act (for actions or proceedings governed by the laws of Saskatchewan) 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.

Health and/or Dental Insurance

Inquiries

For detailed inquiries, contact GreenShield:

- Customer Service Centre at 1 (888) 525 7587 (hours are 830 AM to 830 PM ET, Monday through Friday) to determine eligibility for a specific item or service and GSC's pre-authorization requirements, or
- Visit our website at greenshield.ca to e-mail your question.

Submitting Claims

Claim forms, including Pre-Authorization forms, and valuable claims submission information, is available at greenshield.ca.

Please note that in addition to a completed claim form, claims reimbursement requires the original itemized paid receipt (cash receipts or credit card receipts alone are not acceptable).

GSC reserves the right to request supplementary claims information. Failure to respond to such requests may result in the denial of the claim.

The intentional omission, misrepresentation or falsification of information relating to any claim constitutes fraud. Submission of a fraudulent claim is a criminal offence and will be reported to the applicable law enforcement and/or regulatory agencies and your plan sponsor. This could result in termination of your coverage under this benefit plan.

Claims Submission Period

All Health and Dental claims must be received by GSC no later than 12 months from the date the eligible benefit was incurred.

Predetermination – Dental Claims

Before your treatment begins, your dental practitioner must submit an estimate, including supporting materials, such as digital photos and x-rays, for any proposed treatment for which the total cost is expected to exceed \$500. Our assessment of the proposed treatment may result in a lesser benefit being payable or in benefits being denied. Failure to submit an estimate before treatment begins will delay the assessment of your claim.

Reimbursement

Reimbursement will be made by one of the following methods:

- Direct deposit to your personal bank account, when requested.
- A reimbursement cheque, or
- Direct payment to the provider of services, where applicable.

All dollar maximums and limitations stated are expressed in Canadian dollars. Reimbursement will be made in Canadian or U.S. funds for both providers and plan members, based on the country of the payee.

Overpayments

GSC reserves the right to recover all amounts resulting from overpaid or unsupported claims for benefits by deducting such amounts from future claims and/or by any other legal means.

Limitation on Legal Action

In Ontario, every action or proceeding against GSC for recovery of benefit payment under the plan is absolutely barred unless commenced within the time set out in the Limitations Act, 2002. In British Columbia, Alberta and Manitoba, every action or proceeding against GSC for recovery of benefit payment under the plan is absolutely barred unless commenced within the time set out in the Insurance Act.

Subrogation

GSC retains the right of subrogation of benefits. This means if GSC paid benefits on behalf of you or your dependent, but the benefits either should have been paid or are subsequently paid or provided, in whole or in part, by a third-party liability or other coverage(s), GSC has the right to recover such payment or reimbursement. In cases of third-party liability, you must advise your lawyer of our subrogation rights.

Co-ordination of Benefits (COB)

If you are covered for extended health and dental benefits under more than one plan, your benefits under this plan will be coordinated with the other plan so that you may be reimbursed up to 100% of the eligible expense incurred.

Claims must be submitted to the primary payer first. Any unpaid balances should then be submitted to the secondary plan(s). When GSC is identified as a secondary carrier, submit the original Explanation of Benefits statement from the primary carrier and a copy of the claim form in order to receive any balances owing.

Use the following guidelines to identify the primary and secondary plans:

- *GSC Plan Member*: GSC coverage for you is always primary. If you are the plan member under two group plans, priority goes in the following order:
 - The plan where you are a full-time plan member.
 - The plan where you are a part-time plan member.
 - The plan where you are a retiree.
- *Spouse*: If your spouse is a plan member under another benefit plan, this GSC coverage is always secondary. Your spouse must first submit claims to his/her benefit plan.
- *Children*: When dependent children are covered under both your GSC plan and your spouse's benefit plan, use the following order to determine where to submit the claims:
 - The plan of the parent whose birth date (month and day) occurs earliest in the calendar year.
 - The plan of the parent whose first name begins with the earlier letter of the alphabet if the parents have the same birth date.
 - In cases of separation or divorce with multiple benefit plans for the children, the following order applies:
 - The benefit plan of the parent who has custody of the dependent child.
 - The plan of the spouse of the parent who has custody of the dependent child.
 - The plan of the parent who does not have custody of the dependent child.
 - The plan of the spouse of the parent who does not have custody of the dependent child.

If the parents have joint custody and both have the children listed as dependents under their plans, claims should first be submitted to the plan of the parent whose birth date (month and day) occurs earliest in the calendar year. Balances can then be submitted to the other parent's plan.

Travel Insurance

The Insured Person or an Insured Person's beneficiary entitled to make a claim:

- shall give notice of claim to AIG not later than 30 days from the date of the Medical Emergency covered under this policy.
- within 90 days from the date of the Medical Emergency, furnish to AIG such proof of claim as is reasonably possible in the circumstances of the happening of the accident, Injury or Sickness occasioned thereby; and
- if so, required by AIG, furnish a certificate as to the cause and nature of the accident or Injury or Sickness caused thereby, for which the claim is made and as to the duration of the Injury or Sickness, from a legally qualified medical practitioner.

Failure to give notice of claim or furnish proof of claim within the time prescribed will 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 year from the date of the Medical Emergency and if it is shown that it was not reasonably possible to give notice or furnish proof within the time as prescribed.

AIG has the right, and any Insured Person making a claim shall afford to AIG an opportunity, to examine them when and as often as AIG may reasonably require while the claim hereunder is pending.

AIG shall pay, within 60 days after it has received sufficient proof of claim and the person entitled to benefits in connection with such claim, all moneys payable under this policy.

Every action or proceeding against an insurer for the recovery of insurance money payable under the policy 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), The Limitations Act (for actions or proceedings governed by the laws of Saskatchewan) 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.

The benefit payable for all benefits is payable to the Insured Member, whether for Injury or Sickness suffered by the Insured Member or another Insured Person.

ORWP Retirement Program

OREA Members retiring after January 1, 2024, shall have the option to participate in the ORWP Retirement Program. The ORWP Retirement Program consists of two Plans:

- (1) ORWP Retiree Life and Accidental Death & Dismemberment Insurance Plan
- (2) ORWP Retiree Health, Dental, Travel, Virtual Care, and Mental Health Plan

Each Plan has different qualification requirements as outlined below. Eligible Members can choose to participate in any Plans they qualify for.

(1) ORWP Retiree Life and Accidental Death & Dismemberment Insurance Plan

Qualification Requirements

To qualify for this Plan, a retiring Member must satisfy **ALL** of the following conditions:

- Has a minimum of 25 years as an OREA Member; and
- Is a Member of OREA in good standing for a minimum of 5 consecutive years immediately prior to the date of retirement; and
- Submits their application for this Plan within 31 days of their retirement date or loss of ORWP coverage, whichever is later; and
- Is no longer an OREA Member; and
- Has a minimum 3 years' participation in the ORWP or in a Qualifying Member Board Life Insurance Program¹ prior to the date of retirement.

Proof of eligibility must be confirmed by the Member Board/Association and retirement notice submitted by Member Board/Association to CBS within 31 days of retirement date. Applications received after the 31-day window to apply will not be eligible. Once enrolled, continued participation is subject to the payment of the required annual premium. Premiums are subject to change. If coverage is terminated due to non-payment, Retirees will not be eligible for reinstatement in the program.

¹Qualifying Member Board Life Insurance Programs include Member Life Insurance Programs offered by the following Boards prior to January 1, 2024:

- Brampton Real Estate Board
- Brantford Regional Real Estate Association (optional)
- Durham Region Association of REALTORS®
- London St. Thomas Association of REALTORS®
- Mississauga Real Estate Board
- Sarnia-Lambton Real Estate Board
- Toronto Regional Real Estate Board
- Windsor-Essex County Association of REALTORS®
- Woodstock-Ingersoll & District Real Estate Board

Benefit Summary

Basic Life Insurance

Coverage	\$30,000
Reduction	No reduction age
Termination Age	No termination age
Eligibility	Retirees of OREA who meet qualification requirements
Insurer	The Canada Life Assurance Company

Accidental Death & Dismemberment (AD&D) Insurance

Coverage	\$100,000 principal sum
Reduction	No reduction age
Termination Age	No termination age
Eligibility	Retirees of OREA who meet qualification requirements
Insurer	AIG Insurance Company of Canada

NOTE: The terms and provisions of coverage under the ORWP Retiree Life and Accidental Death and Dismemberment Insurance, as noted above, apply to OREA Members retiring AFTER January 1, 2024. For members who retire prior to January 1, 2024, and who are enrolled in a Retirement Life Insurance Program through WECAR, DRAR or TRREB, such coverage will be grandfathered under the ORWP Retirement Benefit Program effective January 1, 2024—with continued participation subject to the payment of the required annual premium. Premiums are subject to change. If coverage is terminated due to non-payment, you will not be eligible for reinstatement in the program.

(2) ORWP Retiree Health, Dental, Travel, Virtual Healthcare, and Mental Health Plan

Qualification Requirements

To qualify for this Plan, a retiring Member must satisfy ALL of the following conditions:

- Is a Member of OREA in good standing immediately prior to the date of retirement; and
- Submits their application for this Plan within 31 days of their retirement date or loss of ORWP coverage, whichever is later.

Benefit Summary

Healthcare and Dental Care Insurance

Coverage	Two options available to eligible Retirees of OREA, as outlined on next page
Reduction	No reduction age
Termination Age	No termination age
Eligibility	Retirees of OREA who meet qualification requirements and eligible dependents
Insurer	GreenShield

Travel Insurance

Coverage	Out-of-Province/Country Emergency Medical Travel Insurance is available as part of the two options available to eligible Retirees of OREA, as outlined on the next page
Reduction	No reduction age
Termination Age	Terminates at age 80
Eligibility	Retirees of OREA who meet qualification requirements and their eligible dependents
Insurer	AIG Insurance Company of Canada

Virtual Healthcare and Mental Health Care

Coverage	Virtual care coverage is available as part of the two options available to eligible Retirees of OREA, as outlined on the next page
Reduction	No reduction age
Termination Age	No termination age
Eligibility	Retirees of OREA who meet qualification requirements and their eligible dependents
Insurer	Maple Corporation

ORWP Retiree Health, Dental, Travel, Virtual Healthcare, and Mental Health Plan Coverage Details

	Option 1 Retiree Enhanced Plan	Option 2 Retiree Elite Plan
Healthcare Insurance Coverage		
Reimbursement:	70%	80%
Prescription Drugs Calendar Year Maximum: (Combined for all drug-related expenses)	\$750	\$5,000
Paramedical Practitioners: (Combined Annual Maximum)	\$750	\$1,250
Vision Care: (24-Month Combined Maximum)	\$250	\$400
Medical Services & Supplies: (Combined Annual Maximum)	\$1,000	\$2,500
Ambulance:	Unlimited for both plan options	
Accidental Dental:	Unlimited for both plan options	
Dental Care Insurance Coverage		
Reimbursement:	50% Basic / 50% Major	80% Basic / 50% Major
Calendar Year Maximum: (Combined for all dental services)	\$750	\$1,000
Recall:	9 months for both plan options	
Units of Scaling per Year:	6 for both plan options	
Travel Insurance Coverage		
Coverage:	Emergency Medical for both plan options	
Lifetime Maximum:	\$2,000,000 for both plan options	
Maximum Number of Days per Trip:	30 days for both plan options	
Trip Cancellation & Interruption, Baggage Loss & Delay	Not included for both plan options	
Pre-Existing Condition Exclusion	180 days before travel for both plan options	
Termination Age	80 for both plan options	
Virtual Healthcare and Mental Health Care Coverage		
General & Health Practitioner:	Unlimited, direct access to GPs 24/7/365 for both plan options	
Psychotherapy:	Unlimited (12 Hour Wait for On-Demand Requests) for both plan options	
Additional Benefits Include:	Care Navigation Service, Mental Health Tools, Meditation App for both plan options	

Insurer Profiles

Canada Life

Canada Life is a leading Canadian life and health insurer. Canada Life's financial security advisors work with our clients from coast to coast to help them secure their financial future. We provide a wide range of retirement savings and income plans, as well as life, disability and critical illness insurance for individuals and families. As a leading provider of employee benefits in Canada, we offer effective benefit solutions for large and small employee groups.

Canada Life Online

Visit our website canadalife.com for:

- information and details on Canada Life's corporate profile and our products and services
- investor information
- news releases
- contact information.
- claim forms and the ability to submit certain claims online.

Access to Documents

You have the right, upon request, to obtain a copy of the policy, your application and any written statements or other records you have provided to Canada Life as evidence of insurability, subject to certain limitations.

Legal 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 (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.

Appeals

You have the right to appeal a denial of all or part of the insurance or benefits described in the contract as long as you do so within one year of the initial denial of the insurance or a benefit. An appeal must be in writing and must include your reasons for believing the denial to be incorrect.

Benefit Limitation for Overpayment

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

Protecting Your Personal Information

At Canada Life, we recognize and respect the importance of privacy. Personal information about you is kept in a confidential file at the offices of Canada Life or the offices of an organization authorized by Canada Life. Canada Life may use service providers located within or outside Canada. We limit access to personal information in your file to Canada Life staff or persons authorized by Canada Life who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law. Your personal information may be subject to disclosure to those authorized under applicable law within or outside Canada.

We use the personal information to administer the group benefits plan under which you are covered. This includes many tasks, such as:

- determining your eligibility for coverage under the plan
- enrolling you for coverage
- investigating and assessing your claims and providing you with payment
- managing your claims
- verifying and auditing eligibility and claims
- creating and maintaining records concerning our relationship
- underwriting activities, such as determining the cost of the plan, and analyzing the design options of the plan
- preparing regulatory reports, such as tax slips

We may exchange personal information with your plan administrator, any insurance or reinsurance companies, administrators of government benefits or other benefit programs, other organizations, or service providers working with us or the above when relevant and necessary to administer the plan. You can access Canada Life's privacy policy at any time by visiting canadalife.com/privacy.html.

GreenShield

The information prepared with the support of GreenShield and contained in this booklet is intended to provide an overview of the coverage available. Detailed benefit information about your coverage, including limitations and exclusions applicable to the benefits appearing in this summary, which will form part of your Benefit Plan Booklet, will be available online at greenshield.ca.

This summary describes the deductibles, co-pays and maximums that may be applicable to your coverage if you are included in the Billing Division shown on the cover of this summary. All dollar maximums stated in this summary are expressed in Canadian dollars.

You are covered for only those specific benefits for which you have applied and for which your plan sponsor has certified you are eligible. You must be covered in order for your dependents to be covered.

Your coverage will terminate upon the earliest of the dates appearing in the Termination section or the date your plan sponsor advises GSC that you are no longer eligible for coverage. Coverage for your dependents will terminate upon the earlier of termination of your coverage or the date your dependent no longer satisfies the definition of a dependent.

You will receive Identification Cards showing your GSC Identification Number to be used on all claims and correspondence, and for identification purposes when speaking with our Customer Service Centre. Your number will appear on the front of the card and end in -00, while each of your dependents with their numbers will be shown on the back.

GreenShield+

In addition to this summary, and our Customer Service Centre, we also provide you with access to our secure website. Self-service through the GSC website makes things quick, convenient, and easy. Register with GreenShield+ to:

- View your Benefit Plan Booklet.
- Access your personal claims information, including a breakdown of how your claims were processed.
- Check your eligibility and coverage for health services or items to instantly find out what portion of a claim will be covered.
- Submit claims online (some claims can even be processed instantly if you are signed up for direct deposit).
- Search for a drug to get information specific to your own coverage (or coverage for your family).
- Search for GSC-vetted health providers in a particular location (within Canada) that will submit your claims for you.
- Arrange for claim payments to be deposited directly into your bank account.
- Print personalized claim forms and access your digital ID card.
- Print personal Explanation of Benefits statements for when you need to co-ordinate benefits.

Our Commitment to Privacy

The GSC Privacy Code balances the privacy rights of our group and benefit plan members and their dependents, and our employees, with the legitimate information requirements to provide customer service.

To read our privacy policies and procedures, please visit us at [greenshield.ca](https://www.greenshield.ca).

AIG

AIG Canada has provided insurance solutions for over 50 years and is federally licensed to operate in all provinces and territories in Canada. AIG Canada is one of the country's leading property and casualty insurance companies, providing a wide range of business and consumer products to the marketplace through a network of independent brokers.

AIG Canada enjoys strong ratings from the principal rating agencies: S&P: A+ and A.M. Best: A. In 2022, AIG Canada reported gross premiums of \$1.53 billion, assets of \$4.93 billion, and policyholder surplus of \$805 million. AIG Canada served over 20,100 policyholders, handled approximately 13,100 claims, and incurred gross claims and adjustment expenses of \$305 million in 2022.

AIG's goal is to provide customers with a broad array of insurance products that help manage virtually any risk with confidence. AIG is at its best when it empowers each and every one of its customers to be at their best as they strive to realize their dreams and find success every day. AIG Canada is part of American International Group, Inc. ("AIG"), a global insurance solutions provider. With roots that trace back to 1919, AIG is a global insurance company with operations in approximately 70 countries and jurisdictions. What unites AIG is the company's commitment to helping its clients prepare for what's next. Whether that's helping cities and communities to prepare for and recover from natural disasters, AIG has the specialist expertise to help clients better manage risk.

AIG is also committed to doing the right thing for its people and the community. It's why AIG seeks to offer what matters to its ever-diversifying team - like flexible and creative work environments, professional growth opportunities and forums to advocate for one another and incite change. AIG encourages employees to give back to the causes they care most about, supporting these efforts through the Volunteer Time Off and Matching Grants Programs. Canada Life is a leading Canadian life and health insurer. Canada Life's financial security advisors work with our clients from coast to coast to help them secure their financial future. We provide a wide range of retirement savings and income plans, as well as life, disability and critical illness insurance for individuals and families. As a leading provider of employee benefits in Canada, we offer effective benefit solutions for large and small employee groups.

AIG abides by Privacy Principles and wants applicants, policyholders, insureds, claimants, and any other individuals who provide AIG with personal information to be aware of how and why AIG handles this personal information. Learn more at [aig.ca/privacy-principles](https://www.aig.ca/privacy-principles).

Maple

About Maple

Maple is a virtual care platform founded in 2015 that provides timely and convenient access to doctors and other healthcare providers. It allows patients to connect directly with general practitioners, mental health therapists and specialists for medical care in minutes from their smartphone or computer, 24/7/365. Maple offers access to over 25 specialties, including dermatology, mole mapping, endocrinology, mental health therapy, psychotherapy, general health assessments, and much more. While you'd typically have to wait months to see a specialist in person, there's no waitlist or referral needed to speak with many of our Canadian-licensed specialists.

Vision

Maple is defined by three words — simple, connected, and human.

It should be simple to access healthcare. That's why Maple created a platform that's easy to use for Canadians of all ages, abilities, and technology education levels.

Healthcare should be connected. Maple believes that in the future, the majority of wellness and medical care interactions will occur digitally. Maple's vision is to have the Maple platform be the primary vehicle for healthcare providers to deliver patient care. Maple is on its way to becoming an open-source system to facilitate wellness and care encounters. Maple boasts a streamlined user experience, integrated digital health record keeping, and tools for continuity of care within Canada's broader healthcare system.

The human aspect of medicine should never be forgotten. Maple's healthcare providers are passionate about what they do and are dedicated to improving patients' lives with each virtual care visit.

Providers

Physicians on Maple are Canadian-licensed and practice family or emergency medicine right here in Canada. Maple has a comprehensive screening and onboarding process to onboard doctors including a review of their medical training, clinical experience, credential checks, medical license verification and proprietary virtual training program. Maple's Canadian-licensed doctors and nurse practitioners can treat many conditions online including bladder infections, UTIs, colds, flu, eye infections, sexual health issues including ED, vomiting, diarrhea, skin issues, and more. They can also provide medical advice, prescriptions, diagnostic imaging, lab requisitions, medical notes and more as medically necessary.

Privacy

Maple takes the privacy of its users seriously. Maple's privacy policy can be viewed in full at getmaple.ca/privacy.