# NORTH WEST COLLEGE

MEDICAL BENEFITS
PRESCRIPTION DRUG BENEFITS
CIGNA VISION
CIGNA DENTAL PREFERRED
PROVIDER BENEFITS
ACCIDENT INSURANCE

**EFFECTIVE DATE: August 1, 2023**

This Certificate contains important information. You should keep it in a safe place.

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This document printed in August 2023 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.

These materials are being made available electronically for your convenience. Cigna has provided the final documents to your Group. Care should be taken to ensure you are reviewing the most complete, accurate and up to date version. Any questions regarding content may be directed to your Group or Cigna.

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***Home Office: Scarborough, Ontario***

***Mailing Address: 100 Consilium Place, Suite 301***

***Scarborough, Ontario Canada***

## CIGNA LIFE INSURANCE COMPANY OF CANADA

(herein called Cigna) certifies that it insures certain Members for the benefits provided by the following policy(s):

**NORTH WEST COLLEGE**

**GROUP POLICY(S)** — COVERAGE

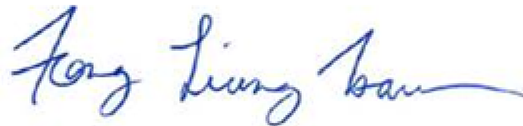
MEDICAL BENEFITS
PRESCRIPTION DRUG BENEFITS
CIGNA VISION
CIGNA DENTAL PREFERRED PROVIDER BENEFITS

**EFFECTIVE DATE:** August 1, 2023

This certificate describes the main features of the insurance. It does not waive or alter any of the terms of the policy(s). If questions arise, the policy(s) will govern.

This certificate takes the place of any other issued to you on a prior date which described the insurance.

All benefits payable under this Policy will be made in Canadian Dollars.



Fong Liang Tsaur

President and Chief Executive Officer

## Explanation of Terms

You will find terms starting with capital letters throughout your certificate. To help you understand your benefits, most of these terms are defined in the Definitions section of your certificate.

## The Schedule

**The Schedule is a brief outline of your maximum benefits which may be payable under your insurance. For a full description of each benefit, refer to the appropriate section listed in the Table of Contents.**

## Special Plan Provisions

**Emergency Procedures**

For 24 hour toll-free emergency assistance contact:

- Inside Canada – Cowan Service Center **1-888-509-7797**
- Inside United States and all other countries Cigna **toll-free number** shown on your ID card.

1. within 24 hours of admission to hospital, or if incapacitated, as soon as reasonably possible;
2. for any benefit where prior approval is required;

**Timely Filing of Claims**

Cigna will consider claims for coverage under our plans when proof of loss (a claim) is submitted within one year (365 days) after services are rendered. If services are rendered on consecutive days, such as for a Hospital Confinement, the limit will be counted from the last date of service. If claims are not submitted within one year the claim will not be considered valid and will be denied.

**WARNING**: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information; or conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act.

## Eligibility - Effective Date

### Member Insurance

This plan is offered to you as a Member.

**Eligibility for Insurance**

You will become eligible for insurance:

- the date and time the required premium is paid; or
- the date You request as the start date on Your application; or
- the date You leave Your Home Country;

**Eligibility for Dependent Insurance**

You will become eligible for Dependent insurance on the later of:

- the day you become eligible for yourself; or
- the day your Dependent arrives in Canada

### Waiting Period

None.

**Classes of Eligibilty**

The following Classes are eligible for this insurance:

- a student; or person as identified as eligible per Educational Institution; and
- under 65 years of age; and
- enrolled at participating Canadian institution

Members may opt to not enroll in provincial plan and remain on enhanced or basic plan and top-ups but if they enroll, they are no longer eligible to have enhanced or basic coverage.

All benefits, Exclusions and General Limitations are applicable to all plans unless otherwise noted.

Coverage is also available for Your spouse and Your dependent children over the age of 15 days and under age 21, or age 26 if enrolled in full-time accredited educational institution.

Persons for whom coverage is prohibited under applicable law or sanctions rules will not be considered eligible under this plan.

**Effective Date of Member Insurance**

You will become insured on the date you elect the insurance by signing an enrollment form, or are enrolled automatically by your institution as applicable, but no earlier than the date you become eligible.

You will become insured on your first day of eligibility, following your election.

**Late Entrant - Member**

You are a Late Entrant if:

- you elect the insurance more than 30 days after you become eligible; or

### Dependent Insurance

For your Dependents to be insured, you will have to pay the required contribution, if any, toward the cost of Dependent Insurance.

**Effective Date of Dependent Insurance**

Insurance for your Dependents will become effective on the date you you become eligible for Dependent Insurance. All of your Dependents as defined will be included.

Your Dependents will be insured only if you are insured.

**Late Entrant – Dependent**

You are a Late Entrant for Dependent Insurance if:

- you elect that insurance more than 30 days after you become eligible for it; or

A Dependent spouse or minor child enrolled within 30 days following a court order of such coverage will not be considered a Late Entrant.

**Exception for Newborns**

Any Dependent child born while you are insured will become insured on the date of their birth if you elect Dependent Insurance no later than 31 days after their birth. If you do not elect to insure your newborn child within such 31 days, coverage for that child will end on the 31st day. No benefits for expenses incurred beyond the 31st day will be payable.

# Medical Benefits

## The Schedule

**For You and Your Dependents**

To receive Medical Benefits, you and your Dependents may be required to pay a portion of the Covered Expenses for services and supplies. That portion is the Coinsurance.

**Coinsurance**

The term Coinsurance means the percentage of charges for Covered Expenses that an insured person is required to pay under the plan.

**Multiple Surgical Reduction** ***(applicable to services in the United States only)***

Multiple surgeries performed during one operating session result in payment reduction of 50% to the surgery of lesser charge. The most expensive procedure is paid as any other surgery.

**Assistant Surgeon and Co-Surgeon Charges** ***(applicable to services in the United States only)***

**Assistant Surgeon**

The maximum amount payable will be limited to charges made by an assistant surgeon that do not exceed a percentage of the surgeon's allowable charge as specified in Cigna Reimbursement Policies. (For purposes of this limitation, allowable charge means the amount payable to the surgeon prior to any reductions due to coinsurance or deductible amounts.)

**Co-Surgeon**

The maximum amount payable for charges made by co-surgeons will be limited to the amount specified in Cigna Reimbursement Policies.

**U.S. Out-of-Network Emergency Services Charges**

1. Emergency Services are covered at the U.S. In-Network cost-sharing level if services are received from a non-participating (U.S. Out-of-Network) provider.
2. The allowable amount used to determine the Plan's benefit payment for covered Emergency Services rendered in a U.S. Out-of-Network Hospital, or by a U.S. Out-of-Network provider in a U.S. In-Network Hospital, is the amount agreed to by the U.S. Out-of-Network and Cigna, or if no amount is agreed to, the greater of the following: (i) the median amount negotiated with U.S. In-Network providers for the Emergency Service, excluding any U.S. In-Network copay or coinsurance; (ii) the Maximum Reimbursable Charge; or (iii) the amount payable under the Medicare program, not to exceed the provider's billed charges.

The member is responsible for applicable U.S. In-Network cost-sharing amounts (any deductible, copay or coinsurance). The member is also responsible for all charges that may be made in excess of the allowable amount. If the U.S. Out-of-Network provider bills you for an amount higher than the amount you owe as indicated on the Explanation of Benefits (EOB), contact Cigna Customer Service at the phone number on your ID card.

| BENEFIT HIGHLIGHTS | |
|---|---|
| **Policy Year Maximum** | $5,000,000 |
| **The Percentage of Covered Expenses the Plan Pays -** Eligible services will be reimbursed at 100% of the reasonable and customary charge for such service as defined below: | 100% |
| **Maximum Reimbursable Charge**<br>**Services Inside the United States**<br>Maximum Reimbursable Charge is determined based on the lesser of the provider's normal charge for a similar service or supply; or<br>A percentage of a schedule Cigna has developed that is based upon a methodology similar to a methodology utilized by Medicare to determine the allowable fee for the same or similar services within the geographic market. In some cases, a Medicare based schedule will not be used and the Maximum Reimbursable Charge for covered services is determined based on the lesser of:<br>the provider's normal charge for a similar service or supply; or<br>the 80th percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by Cigna.<br>If sufficient charge data is unavailable in the database for that geographic area to determine the Maximum Reimbursable Charge, then data in the database for similar services may be used.<br>Note:<br>The provider may bill you for the difference between the provider's normal charge and the Maximum Reimbursable Charge, in addition to applicable deductibles, copayments and coinsurance. | 300% |

| BENEFIT HIGHLIGHTS | |
|---|---|
| **Maximum Reimbursable Charge**<br>**Services Outside the United States and Canada**<br>Maximum Reimbursable Charge for services outside the United States is determined based on the lesser of:<br>• the charges contracted or otherwise agreed between the provider and Cigna; or<br>• the charge that a provider most often charges patients for the service or procedure; or<br>• the customary charge for the service or procedure as determined by Cigna based upon the range of charges made for the service or procedure by most providers in the general geographic area where the service is rendered or the procedure performed. Cigna is not obligated to pay excessive charges.<br>**Note:**<br>The provider may bill you for the difference between the provider's normal charge and the Maximum Reimbursable Charge, in addition to applicable Coinsurance. | 100% |
| **Reasonable and Customary for services in Canada**<br>Eligible services inside Canada will be based on the region where the service is performed. | 100% |

| BENEFIT HIGHLIGHTS | |
|---|---|
| **Physician's Services**<br>Physician's Office visit<br>Wart Treatment<br>Benefit maximum:<br>$500 per policy year | <br>100%<br>100% |
| **Preventive Care**<br>Annual Physical<br>Immunizations<br>Benefit Maximum:<br>$100 per Immunization<br>Travel Immunizations are not covered | <br>100%<br>100% |
| **Ongoing/Non-emergent Care**<br>Benefit Maximum:<br>$5,000 per policy year | 100% |
| **Repatriation & Related Expenses**<br>Benefit Maximums:<br>Per covered person<br>Return of Body - $20,000 per policy year<br>Sickness or Injury Return - $20,000 per policy year,<br>Burial/Cremation - $20,000 per policy year,<br>Family member travel to bedside – $5,000 per policy year<br>Additional expenses for family travel - $1,500 per policy year | 100% |

| BENEFIT HIGHLIGHTS | |
|---|---|
| Prescription Drugs<br>Benefit Maximums:<br>Outpatient if related to initial emergency or acute condition<br>60 day supply<br>Diabetic Supplies - $500 per policy year<br>Asthma Supplies - $500 per policy year | 100% |
| **Travel**<br>Outside Canada – Worldwide incl US – school & leisure<br>Home Country – school related activity only<br>Travel outside Canada (other than to home country) is covered subject to the following conditions:<br>(a) More than 50% of the total coverage period must be spent in Canada<br>(b) Travel to the US is limited to 30 days per trip<br>Expenses will not be paid when incurred in home country except where the trip to home country is expressly taken in order to participate in a school-organized sporting or extra-curricular event | 100% |
| **Inpatient Hospital - Facility Services**<br>Semi-Private Room and Board<br>Private Room up to a of maximum of resonable and customary charges. | 100%<br>Limited to the semi-private room rate<br>(private room where medically required) |
| **Outpatient Facility Services**<br>Operating Room, Recovery Room, Procedures Room, Treatment Room and Observation Room | 100% |
| **Inpatient Hospital Physician's Visits/Consultations** | 100% |
| **Inpatient Hospital Professional Services**<br>Includes all specialists, as medically necessary | 100% |
| **Educational Services while hospitalized**<br>Benefit Maximum:<br>Per covered person<br>$20 per hour, to $400 per policy year | 100% |
| **Outpatient Professional Services**<br>Includes all specialists, as medically necessary | 100% |

| BENEFIT HIGHLIGHTS | |
|---|---|
| **Emergency Services** | |
| Physician's Office Visit | 100% |
| Hospital Emergency Room | 100% |
| Outpatient Professional services (radiology, pathology and ER Physician) | 100% |
| X-ray and/or Lab performed at the Emergency Room (billed by the facility as part of the ER visit) | 100% |
| Independent x-ray and/or Lab Facility in conjunction with an ER visit | 100% |
| Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans etc.) | 100% |
| **U.S. Urgent Care Services** | |
| Urgent Care Facility | 100% |
| X-ray and/or Lab performed at the Urgent Care Facility (billed by the facility as part of the UC visit) | 100% |
| Services billed as Emergency Services by an Urgent Care provider will be payable at the In-Network level. | |
| Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans etc.) | 100% |
| **Ambulance**<br>Benefit Maximums:<br>Per covered person<br>Ground Ambulance - $ 10,000 per policy year<br>Taxi - $125 per policy year | 100% |
| **Air Transportation**<br>Airfare, stretcher if required, medical attendant<br>Benefit Maximum:<br>Per covered person<br>$300,000 per policy year | 100% |

| BENEFIT HIGHLIGHTS | |
|---|---|
| **Private Nursing and Home Health Care**<br>Benefit Maximum:<br>Per covered person<br>$15,000 per policy year | 100% |
| **Laboratory and Radiology Services (includes pre-admission testing)** | |
| Physician's Office Visit | 100% |
| Inpatient Facility | 100% |
| Outpatient Facility | 100% |
| Independent X-ray and/or Lab Facility | 100% |
| **Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans and PET Scans)** | |
| Physician's Office Visit | 100% |
| Inpatient Facility | 100% |
| Outpatient Facility | 100% |
| Independent X-ray Facility | 100% |
| **Bereavement Counseling**<br>Inpatient<br>Outpatient<br>Services provided by Mental Health Professional | 100%<br>100% |

| BENEFIT HIGHLIGHTS | |
|---|---|
| **Paramedical Services** | 100% |
| Claim must be as a result of accident or injury for all paramedical practitioners | |
| Benefit Maximum:<br>Per covered person<br>$1000 per policy year per practitioners | |
| Includes:<br>Acupuncture<br>Chiropractic Care<br>Massage Therapy<br>Naturopathy<br>Occupational Therapy<br>Osteopathy<br>Podiatrist<br>Chiropodist<br>Physiotherapy<br>Speech Therapy | |
| **Maternity Care Services**<br>**Routine Care & Complication**<br>Benefit Maximum:<br>Per covered person<br>$25,000 per policy year | |
| Initial Visit to Confirm Pregnancy | 100% |
| All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee) | 100% |
| Physician's Office Visits in addition to the global maternity fee when performed by an OB/GYN or Specialist | 100% |
| Delivery - Facility<br>(Inpatient Hospital, Birthing Center) | 100% |
| **Abortion/Termination** | |
| Elective termination | |
| Benefit Maximum:<br>1 per policy year | |
| Spontaneous/Non-induced termination<br>Benefit Maximum:<br>Unlimited | |
| Physician's Office Visit | 100% |
| Inpatient Facility | 100% |
| Outpatient Facility | 100% |
| Physician's Services | 100% |

| BENEFIT HIGHLIGHTS | |
|---|---|
| **Family Planning Services**<br><br>Office Visits and Birth Control Counseling | <br><br>100% |
| **Durable Medical Equipment**<br>Benefit Maximums up to overall maximum except for:<br>Orthotics due to injury - $400 per policy year<br>Leg brace due to injury - $ 1,000 per policy year | 100% |
| **External Prosthetic Appliances** | 100% |
| **Hearing Aid due to injury**<br>Benefit Maximum:<br>Per covered person<br>$400 per policy year | 100% |
| **Corrective device defect, theft or malfunction**<br>Benefit Maximum:<br>Per covered person<br>$1,000 per policy year | 100% |
| **Accidental Dental Care**<br>Benefit Maximums:<br>Per covered person<br>Emergency & Accidental Dental - $4,000 per policy year<br>Emergency pain relief - $1,000 per policy year<br>Wisdom Teeth Extractions - $100 per tooth | <br><br><br>100%<br><br>100%<br>100% |

| BENEFIT HIGHLIGHTS | |
|---|---|
| **Mental Health** | |
| **Inpatient Facility**<br>Includes Acute Inpatient and Residential Treatment<br>Lifetime Benefit Maximum:<br>$60,000<br>**Inpatient Psychiatrist**<br>Lifetime Benefit Maximum:<br>$60,000 | 100% |
| **Outpatient Psychiatrist or Psychologist**<br>Includes Individual, Family and Group Psychotherapy; Medication Management, etc.<br>Lifetime Benefit Maximum:<br>$10,000 | 100% |
| **All Other Services**<br>Benefit Maximums:<br>Social Worker - $500 per policy year<br>Trauma Counseling – Covered. | 100% |

## Covered Expenses

The term Covered Expenses means the expenses incurred by or on behalf of a person for the charges listed below if they are incurred after they become insured for these benefits. Expenses incurred for such charges are considered Covered Expenses to the extent that the services or supplies provided are recommended by a Physician, and are Medically Necessary for the care and treatment of an Injury or a Sickness, as determined by Cigna. **Any applicable limits are shown in The Schedule.**

**Covered Expenses Emergency Medical Benefits**

**Hospital services**

charges for Treatment provided on an Emergency in-patient or out-patient basis as follows:

a) Hospital room and board charges up to the semi-private room rate (private room where medically required); and

b) drugs administered while confined to a Hospital; and

c) any other services or supplies;

**Physician fees**

charges made by a Physician for professional services or Treatment including all Medically Necessary follow up care until the initial Emergency has resolved and the condition has stabilized.

(Physician Services includes treatment for ADD/ADHD Consultants and Acne Consultations with a Dermatologist)

**Laboratory & diagnostic testing**

charges for technical and interpretive services. Any major diagnostic procedure including but not limited to computerized axial tomography (CAT scan), magnetic resonance imaging (MRI), cardiac catheterizations, scopes, etc.

**Private duty nursing**

when ordered by the attending Physician, charges made by a registered nurse, registered nurse assistant or home care worker up to the maximum shown in the Schedule. Services performed by You, a Family Member (even if a registered nurse, registered nurse assistant or home care worker) or someone who normally resides with You are not covered.

**Prescription medication**

when prescribed by a Physician and dispensed by a licensed pharmacist to Treat any Emergency Medical Condition or Injury. Medication is limited to a 60 day supply of any one type unless prescribed while a Hospital in-patient.

**Psychiatric hospitalization**

charges for admittance to Hospital for suicide, attempted suicide, self-inflicted injuries, mental or emotional disorders (including by not limited to stress, anxiety, panic attacks, depression, eating disorders/weight problems), or psychiatric Treatment, Cigna will pay up to the Maximum shown in the Schedule

for medical and/or psychiatric Treatment received while You are in Hospital resulting from one or more of these causes.

**Psychiatrist fees**

charges separately billed by a Psychiatrist for in-patient services up to maximum shown in the Schedule.

**Ground ambulance transportation**

charges for transportation by licensed ambulance service to the nearest Hospital, including transfers between Hospitals when ordered by the attending Physician. If a local taxi/commercial car service is required to get You to and from a Hospital, medical clinic or pharmacy for eligible Treatment We will reimburse up to a maximum shown in the Schedule.

**Pregnancy – serious complications**

charges related to serious complications of pregnancy, including newborn care (up to 15 days), are covered to a combined maximum shown in the Schedule.

• Serious complications include miscarriage, stillbirth, infection, threat of life to mother or baby, preeclampsia/ eclampsia, incompetent cervix, and hemorrhage, and do not include normal conditions of pregnancy including but not limited to morning sickness, spotting, ultrasounds, blood and urine testing including testing for gestational diabetes.

**Medical equipment and supplies**

charges for medical supplies if required as a result of a covered Sickness or Injury, such as dressings and prosthetic appliances and including rental charges for wheelchairs, crutches, Hospital type beds or other appliances not to to exceed the purchase price. Limits are shown in the Schedule.

**Emergency dental care**

charges made by a licensed Dentist or dental surgeon for Emergency Treatment for the immediate relief of pain and suffering, including wisdom teeth up to the maximum shown in the Schedule.

**Covered Expenses Non-Emergency Medical Benefits**

**Pregnancy**
charges for pre-natal, childbirth and newborn care (up to 15 days) are covered to the maximum shown in the Schedule.

**Paramedical fees**
when prescribed by a Physician, charges made by a chiropractor, osteopath, naturopath, acupuncturist, chiropodist, podiatrist, physiotherapist, speech therapist, massage therapist and occupational therapist are covered up to maximum shown in the Schedule.
Services performed by You, a Family Member or someone who normally resides with You are not covered.

**Psychotherapy**
charges for out-patient care including psychiatric and psychological counselling up to the maximum shown in the Schedule .

**Immunizations**
if required by Your course of studies, or recommended by a Public Health Authority (i.e. flu shot) charges for immunizations, including tuberculosis (TB) testing, are covered to the maximum shown in the Schedule.

**Annual physician visit**
charges for one visit to a Physician in Canada for a non-emergency exam and associated tests are covered.

**Wart treatment**
charges for Treatment of any type of warts up to maximum shown in the Schedule.

**Diabetic supplies**
charges for diabetic supplies including syringes, test strips and insulin are covered to the maximum shown in the Schedule.

**STD-STI testing**
charges for consultation, screening or testing for sexually transmitted diseases or sexually transmitted infections performed in Canada are covered.

**Educational Services**
if confined to a Hospital, rehabilitation facility or Your home within 100 days of, and as a result of, a covered Sickness or Injury, and the confinement continues for at least 30 consecutive school days, the insurance company will pay, from the first day of confinement, the actual expenses incurred for the private educational service of aqualified provider to the maximum shown in the Schedule.

**Corrective Device defect, malfunction and theft protection**
if a required corrective device is stolen and not recovered, or suffers a malfunction or defect which renders the device unusable, the insurance company will pay the maximum shown in the schedule to replace or repair the Corrective Device. The insurance company will not pay for defects or malfunctions which are covered by the manufacturer's warranty.
• This benefit requires prior written approval from the Administrator.

**Prescription Drug Benefits**

If you or any one of your Dependents, while insured for Prescription Drug Benefits, incurs expenses for charges made by a Pharmacy, for Medically Necessary Prescription Drugs or Related Supplies ordered by a Physician outside the United States, Cigna will provide coverage for those expenses as shown in the Medical Schedule. Coverage also includes Medically Necessary Prescription Drugs and Related Supplies dispensed for a prescription issued to you or your Dependents by a licensed dentist for the prevention of infection or pain in conjunction with a dental procedure.

Coverage for Prescription Drugs and Related Supplies purchased at a Pharmacy is subject to the Coinsurance shown in the Schedule. Please refer to the Schedule for any required Maximums if applicable.

**Exclusions**:

No payment will be made for the following expenses:

- drugs available over the counter that do not require a prescription by applicable law;
- any drug that is a pharmaceutical alternative to an over-the-counter drug other than insulin;
- a drug class in which at least one of the drugs is available over the counter and the drugs in the class are deemed to be therapeutically equivalent as determined by the P&T Committee;
- injectable infertility drugs and any injectable drugs that require Physician supervision and are not typically considered self-administered drugs. The following are examples of Physician supervised drugs: Injectables used to treat hemophilia and RSV (respiratory syncytial virus), chemotherapy injectables and endocrine and metabolic agents;
- Health Canada or Food and Drug Administration (FDA) approved drugs used for purposes other than those approved by Health Canada or the FDA unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia (The United States Pharmacopeia Drug Information, The American Medical Association Drug Evaluations; or The American Hospital Formulary Service Drug Information) or in medical literature. Medical literature means scientific studies published in a peer-reviewed national professional medical journal;
- prescription vitamins (other than prenatal vitamins), and dietary supplements;

- anabolic steroids;
- diet pills or appetite suppressants (anorectics);
- prescription smoking cessation products;
- biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications;
- drugs used for cosmetic purposes such as drugs used to reduce wrinkles, drugs to promote hair growth as well as drugs used to control perspiration and fade cream products;
- replacement of Prescription Drugs and Related Supplies due to loss or theft;
- drugs used to enhance athletic performance;
- drugs which are to be taken by or administered to you while you are a patient in a licensed Hospital, Skilled Nursing Facility, rest home or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals;
- prescriptions more than one year from the original date of issue.

## Emergency Evacuation

If you suffer a life-threatening/limb-threatening medical condition, and Cigna, and/or its designee, determines that adequate medical facilities are not available locally, Cigna, or its designee, will arrange for an emergency evacuation to the nearest facility capable of providing adequate care. You must contact Cigna at the phone number indicated on your identification card to begin this process.

In making their determinations, Cigna, and/or its designee, will consider the nature of the emergency, your condition and ability to travel, as well as other relevant circumstances including airport availability, weather conditions, and distance to be covered. Your medical condition must require the accompaniment of a qualified healthcare professional during the entire course of your evacuation to be considered an emergency and requiring emergency evacuation. Transportation will be provided by medically equipped specialty aircraft, commercial airline, train or ambulance depending upon the medical needs and available transportation specific to each case. **Any applicable limits are shown in The Medical Schedule.**

**Repatriation**

Following any covered emergency evacuation, Cigna will pay for **one** of the following:

(1) If it is deemed Medically Necessary and appropriate by the Cigna medical director, you will be transferred to your permanent residence via a one-way economy airfare or;

(2) You will be transferred back to your original study location or the location from which you were evacuated via a one-way economy airfare.

If your transportation needs to be medically supervised a qualified medical attendant will escort you. Additionally, if Cigna and/or its designee, determines a mode of transport other than economy class seating on a commercial aircraft is required, Cigna or its designee will arrange accordingly and such will be covered by Cigna.

**Burial at host country**

if death occurs Cigna will pay the costs for the cremation or burial of Your remains at the location where death occurs.
• if this benefit is selected Repatriation of remains cannot be elected.
• benefit requires prior written approval from the Administrator.

**Notification**

Expenses incurred for your evacuation or repatriation without the approval and authorization of Cigna and/or its designee will not be Covered Expenses. Only those expenses approved by Cigna will be eligible for coverage and/or reimbursement under the terms of your plan.

**Emergency Family Travel Arrangements and Confinement Visitation**

If Cigna determines that you are expected to require hospitalization in excess of 7 days at the location to which you are to be evacuated, an economy round-trip airfare will be provided to the place of hospitalization for an individual chosen by you. If your Dependent Child is evacuated, one economy round-trip airfare will be provided to a parent or legal guardian regardless of the number of days that the Dependent child is hospitalized.

**Return of Dependent Children**

If Dependent child(ren) are left unattended by virtue of the evacuee's absence alone following a covered evacuation, a one-way economy airfare will be provided to their place of residence.

**Repatriation of Mortal Remains**

The costs associated with the transportation of mortal remains from the place of death to the home country will be covered. In addition, assistance will be provided by Cigna or its designee for organizing or obtaining the necessary clearances for the repatriation of mortal remains.

**Air transportation**

charges in response to an Emergency Sickness or Injury to transport You to the nearest or most appropriate Hospital up to a maximum maximum shown in the Schedule as follows.

a) the extra cost of a one-way fare on a commercial airline; or

b) the cost to accommodate a stretcher to transport You on a commercial airline if a stretcher is Medically

Necessary plus the cost of a round-trip fare, reasonable meal and overnight accommodation expenses

and professional fees for the services of a qualified medical attendant (other than a Family Member) to

accompany You, when an attendant is Medically Necessary or required by the airline; or

c) the cost for air ambulance transporation when Medically Necessary.

• Land ambulance costs at each end of the flight or connecting flights are included if Medically Necessary.

• The attending Physician must certify that You are medically fit for the type of transfer selected.

• This benefit requires prior approval from the Administrator.

**General Limitations/ Exclusions for Evacuation Benefits**

No payment will be made for charges for:

- services rendered without the authorization or intervention of Cigna or its designee;
- non emergency, routine or minor medical problems, tests and exams where there is no clear or significant risk of death or imminent serious Injury or harm to you;
- a condition which would allow for treatment at a future date convenient to you and which does not require emergency evacuation or repatriation;
- medical care or services scheduled for member or provider's convenience which are not considered an emergency;
- expenses incurred if the original or ancillary purpose of your trip is to obtain medical treatment;
- services provided for which no charge is normally made;
- expenses incurred while serving in the armed forces of another country;
- transportation for your vehicle and/or other personal belongings involving intercontinental and/or marine transportation;
- service provided other than those indicated in this certificate;
- injury or sickness caused by war, or an act of war, whether declared or undeclared, riot, civil commotion or police action;
- death caused by war, or an act of war, whether declared or undeclared, riot, civil commotion or police action; or
- for claim payments that are illegal under applicable law.

# Cigna Vision

## The Schedule

| BENEFIT HIGHLIGHTS | |
|---|---|
| | **The plan will reimburse you at 100%, subject to any maximum shown below** |
| **Examinations**<br>One Eye Exam every Policy Year | $100 |
| **Frames/Lenses including contacts**<br>(Only covered if required as a result of injury)<br>One pair per Policy Year | $400 |

# Vision Benefits

**For You and Your Dependents**

## Covered Expenses

**Benefits Include:**

**Examinations** – one vision and eye health evaluation including but not limited to eye health examination, dilation, refraction and prescription for glasses.

**Hardware -** lenses, frames and contacts required as a result of an injury

## Expenses Not Covered

Covered Expenses will not include, and no payment will be made for:

- Orthoptic or vision training and any associated supplemental testing.
- Spectacle lens treatments, “add ons”, or lens coatings not shown as covered in the Schedule.
- Two pair of glasses, in lieu of bifocals or trifocals.
- Prescription sunglasses.
- Medical or surgical treatment of the eyes.
- Any eye examination, or any corrective eyewear, required by a group as a condition of employment.
- Magnification or low vision aids.
- Any non-prescription eyeglasses, lenses, or contact lenses.
- Safety glasses or lenses required for employment.
- VDT (video display terminal)/computer eyeglass benefit.
- Charges in excess of the usual and customary charge or Maximum Reimbursable Charge for the service or materials.
- Charges incurred after the Policy ends or the Insured's coverage under the Policy ends, except as stated in the Policy.
- Experimental or non-conventional treatment or device.
- High Index lenses of any material type.
- Lens treatments or “add-ons”, except rose tints (#1 & #2), and oversize lenses.
- For or in connection with experimental procedures or treatment methods not approved by the appropriate vision specialty society.
- Claims submitted and received in-excess of one year (365 days) from the original Date of Service.

Other Limitations are shown in the Exclusions and General Limitations section.

# Cigna Dental Insurance

## The Schedule

**For You and Your Dependents**
*(applicable to Enhanced Plan only)*

| BENEFIT HIGHLIGHTS | |
|---|---|
| **Classes I, II, III Combined Policy Year Maximum** | $600 |
| **Class I**<br>Preventive Care | 100% |
| **Class II**<br>Basic Restorative | 80% |
| **Class III**<br>Major Restorative | 80% |

## Covered Dental Expense

Covered Dental Expense means that portion of a Dentist's charge that is payable for a service delivered to a covered person provided:

- the service is ordered or prescribed by a Dentist;
- is essential for the Necessary care of teeth;
- the service is within the scope of coverage limitations;
- the maximum benefit in The Schedule has not been exceeded;
- the charge does not exceed the amount allowed under the Alternate Benefit Provision;
- for Class I, II or III the service is started and completed while coverage is in effect, except for services described in the "Benefits Extension" section.

**Alternate Benefit Provision**

If more than one covered service will treat a dental condition, payment is limited to the least costly service provided it is a professionally accepted, necessary and appropriate treatment.

If the covered person requests or accepts a more costly covered service, they are responsible for expenses that exceed the amount covered for the least costly service. Therefore, Cigna recommends Predetermination of Benefits before major treatment begins.

**Predetermination of Benefits**

Predetermination of Benefits is a voluntary review of a Dentist's proposed treatment plan and expected charges. It is not preauthorization of service and is not required.

The treatment plan should include supporting pre-operative x-rays and other diagnostic materials as requested by Cigna's dental consultant. If there is a change in the treatment plan, a revised plan should be submitted.

Cigna will determine covered dental expenses for the proposed treatment plan. If there is no Predetermination of Benefits, Cigna will determine covered dental expenses when it receives a claim.

Review of proposed treatment is advised whenever extensive dental work is recommended when charges exceed $300.

Predetermination of Benefits is not a guarantee of a set payment. Payment is based on the services that are actually delivered and the coverage in force at the time services are completed.

**Covered Services**

The following section lists covered dental services. Cigna may agree to cover expenses for a service not listed. To be considered the service should be identified using the appropriate dental association of Dental Procedures and Nomenclature, or by description and then submitted to Cigna.

**Class I Services – Diagnostic and Preventive**

Clinical oral examination – Only 1 per person per Policy Year.

Palliative (emergency) treatment of dental pain, minor procedures, when no other definitive Dental Services are performed. (Any x-ray taken in connection with such treatment is a separate Dental Service.)

X-rays – Complete series or Panoramic (Panorex) – Only one per person, including panoramic film, in any 3 Policy Years.

Bitewing x-rays – Only 2 charges per person per Policy Year.

Prophylaxis (Cleaning), including Periodontal maintenance procedures (following active therapy) – Only 2 per person per Policy Year.

Topical application of fluoride (excluding prophylaxis) – Limited to persons less than 19 years old. Only 1 per person per Policy Year.

Topical application of sealant, per tooth, on a posterior tooth – Only 1 treatment per tooth in any 3 Policy Years.

Space Maintainers, fixed unilateral – Limited to nonorthodontic treatment.

**Class II Services – Basic Restorations, Endodontics, Periodontics, Prosthodontic Maintenance and Oral Surgery**

Amalgam Filling

Composite/Resin Filling

Root Canal Therapy – Any x-ray, test, laboratory exam or follow-up care is part of the allowance for root canal therapy and not a separate Dental Service.

Osseous Surgery – Flap entry and closure is part of the allowance for osseous surgery and not a separate Dental Service.

Periodontal Scaling and Root Planing – Entire Mouth

Adjustments – Complete Denture

Any adjustment of or repair to a denture within 6 months of its installation is not a separate Dental Service.

Recement Bridge

Routine Extractions

Surgical Removal of Erupted Tooth Requiring Elevation of Mucoperiosteal Flap and Removal of Bone and/or Section of Tooth

Removal of Impacted Tooth, Soft Tissue

Removal of Impacted Tooth, Partially Bony

Removal of Impacted Tooth, Completely Bony

Local anesthetic, analgesic and routine postoperative care for extractions and other oral surgery procedures are not separately reimbursed but are considered as part of the submitted fee for the global surgical procedure.

General Anesthesia – Paid as a separate benefit only when Medically or Dentally Necessary, as determined by Cigna, and when administered in conjunction with complex oral surgical procedures which are covered under this plan.

I. V. Sedation – Paid as a separate benefit only when Medically or Dentally Necessary, as determined by Cigna, and when administered in conjunction with complex oral surgical procedures which are covered under this plan.

**Class III Services - Major Restorations, Dentures and Bridgework**

Crowns

Note: Crown restorations are Dental Services only when the tooth, as a result of extensive caries or fracture, cannot be restored with amalgam, composite/resin, silicate, acrylic or plastic restoration.

Porcelain Fused to High Noble Metal

Full Cast, High Noble Metal

Three-Fourths Cast, Metallic

Removable Appliances

Complete (Full) Dentures, Upper or Lower

Partial Dentures

Lower, Cast Metal Base with Resin Saddles (including any conventional clasps, rests and teeth)

Upper, Cast Metal Base with Resin Saddles (including any conventional clasps rests and teeth)

Fixed Appliances

Bridge Pontics - Cast High Noble Metal

Bridge Pontics - Porcelain Fused to High Noble Metal

Bridge Pontics - Resin with High Noble Metal

Retainer Crowns - Resin with High Noble Metal

Retainer Crowns - Porcelain Fused to High Noble Metal

Retainer Crowns - Full Cast High Noble Metal

Prosthesis Over Implant – A prosthetic device, supported by an implant or implant abutment is a Covered Expense. Replacement of any type of prosthesis with a prosthesis supported by an implant or implant abutment is only payable if the existing prosthesis is at least 5 Policy Years old, is not serviceable and cannot be repaired.

## Dental Expenses Not Covered

Covered Expenses will not include, and no payment will be made for:

- services performed solely for cosmetic reasons;
- replacement of a lost or stolen appliance;
- replacement of a bridge, crown or denture within 5 years after the date it was originally installed unless: the replacement is made necessary by the placement of an original opposing full denture or the necessary extraction of natural teeth; or the bridge, crown or denture, while in the mouth, has been damaged beyond repair as a result of an injury received while a person is insured for these benefits;
- any replacement of a bridge, crown or denture which is or can be made useable according to common dental standards;
- procedures, appliances or restorations (except full dentures) whose main purpose is to: change vertical dimension; diagnose or treat conditions or dysfunction of the temporomandibular joint; stabilize periodontally involved teeth; or restore occlusion;
- porcelain or acrylic veneers of crowns or pontics on, or replacing the upper and lower first, second and third molars;
- bite registrations; precision or semiprecision attachments; or splinting;
- instruction for plaque control, oral hygiene and diet;
- dental services that do not meet common dental standards;
- services that are deemed to be medical services;
- services and supplies received from a Hospital;
- orthodontic treatment;
- the surgical placement of an implant body or framework of any type; surgical procedures in anticipation of implant placement; any device, index, or surgical template guide used for implant surgery; treatment or repair of an existing implant; prefabricated or custom implant abutments; removal of an existing implant;
- for or in connection with experimental procedures or treatment methods not approved by the appropriate dental specialty society.
- services for which benefits are not payable according to the “General Limitations” section.

# Exclusions, Expenses Not Covered and General Limitations

## Exclusions and Expenses Not Covered

**Additional coverage limitations determined by plan or provider type are shown in the Schedule. Payment for the following is specifically excluded from this plan:**

- care for health conditions that are required by provincial or federal law to be supplied by or covered by a public program.
- care required by provincial or federal law to be supplied by a public school system or school district.
- care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
- for or in connection with an Injury or Sickness which is due to war, declared or undeclared, riot, civil commotion or police action.
- Covered Services to the extent that payment is prohibited by applicable law including but not limited to sanctions rules imposed by the United Nations, the European Commission, the United States, and Canada.
- charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this plan. For example, if Cigna determines that a provider or Pharmacy is or has waived, reduced, or forgiven any portion of its charges and/or any portion of Copayment, Deductible, and/or Coinsurance amount(s) you are required to pay for a Covered Service (as shown on The Schedule) without Cigna's express consent, then Cigna in its sole discretion shall have the right to deny the payment of benefits in connection with the Covered Service, or reduce the benefits in proportion to the amount of the Copayment, Deductible, and/or Coinsurance amounts waived, forgiven or reduced, regardless of whether the provider or Pharmacy represents that you remain responsible for any amounts that your plan does not cover. In the exercise of that discretion, Cigna shall have the right to require you to provide proof sufficient to Cigna that you have made your required cost share payment(s) prior to the payment of any benefits by Cigna. This exclusion includes, but is not limited to, charges of a non-Participating Provider who has agreed to charge you or charged you at an in-network benefits level or some other benefits level not otherwise applicable to the services received.
- charges arising out of or relating to any violation of a healthcare-related provincial, state or federal law or which themselves are a violation of a healthcare-related state or federal law.
- assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- for or in connection with experimental, investigational or unproven services.

  Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance use disorder or other health care technologies, supplies, treatments, procedures, drug or Biologic therapies or devices that are determined by the utilization review Physician to be:

  - not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed;
  - not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or Sickness for which its use is proposed;
  - the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" sections of this plan; or
  - the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the "Clinical Trials" sections of this plan.

In determining whether drug or Biologic therapies are experimental, investigational and unproven, the utilization review Physician may review, without limitation, U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature.

- cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem.
- The following services are excluded from coverage regardless of clinical indications: Macromastia or Gynecomastia Surgeries; Abdominoplasty; Panniculectomy; Rhinoplasty; Blepharoplasty; Redundant skin surgery; Removal of skin tags; Acupressure; Craniosacral/cranial therapy; Dance therapy, Movement therapy; Applied kinesiology; Rolfing; Prolotherapy; and Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- medical and surgical services, initial and repeat, intended for the treatment or control of obesity, except for treatment of clinically severe (morbid) obesity as shown in Covered Expenses, including: medical and surgical services to alter appearance or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.

- unless otherwise covered in this plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.
- court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.
- infertility services including infertility drugs, surgical or medical treatment programs for infertility, including in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs are also excluded from coverage.
- reversal of male or female voluntary sterilization procedures.
- gender affirming surgery including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.
- any services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmy, and premature ejaculation.
- genetic Counseling
- hospice Facility and Care
- nutritional Evaluation
- nutritional Formulas
- obesity/Bariatric Surgery
- occupational Cover
- organ Transplants
- TMJ treatment
- medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.
- non-medical counseling and/or ancillary services, including but not limited to, Custodial Services, vocational counseling, training and rehabilitation services, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, return to work services, work hardening programs and driver safety courses.
- therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
- consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Home Health Services" or "Breast Reconstruction and Breast Prostheses" sections of this plan.
- private hospital rooms and/or private duty nursing except as provided under the Home Health Services provision.
- personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
- artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.
- hearing aids unless due to injury. A hearing aid is any device that amplifies sound.
- hearing exam.
- aids or devices that assist with nonverbal communications, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- eyeglass lenses and frames and contact lenses (unless due to Injury).
- eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- all noninjectable prescription drugs, injectable prescription drugs that do not require Physician supervision and are typically considered self-administered drugs, nonprescription drugs, and investigational and experimental drugs, except as provided in this plan.
- routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
- membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
- genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- dental implants for any condition.
- fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood

loss is such that transfusion is an expected adjunct to surgery.

- blood administration for the purpose of general improvement in physical condition.
- cosmetics, dietary supplements and health and beauty aids.
- all nutritional supplements and formulae except for infant formula needed for the treatment of inborn errors of metabolism.
- for or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.

**General Limitations**

No payment will be made for expenses incurred for you or any one of your Dependents:

- for charges made by a Hospital owned or operated by or which provides care or performs services for, the Canadian government, if such charges are directly related to a military-service-connected Injury or Sickness.
- to the extent that you or any one of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program.
- to the extent that payment is unlawful or prohibited by applicable sanctions rules;
- for elective or pre-scheduled treatment in sanctioned countries;
- for any Members whom the Insurance Company considers to be ordinarily resident in a sanctioned country. Members are considered ordinarily resident if they visit a sanctioned country for a period of longer than 6 weeks over the course of any 12 month period.for charges which would not have been made if the person had no insurance.
- to the extent that they are more than Maximum Reimbursable Charges.
- to the extent of the exclusions imposed by any certification requirement shown in this plan.
- expenses for supplies, care, treatment, or surgery that are not Medically Necessary.
- charges made by any covered provider who is a member of your family or your Dependent's Family.

## Coordination of Benefits

This section applies if you or any one of your Dependents is covered under more than one Plan and determines how benefits payable from all such Plans will be coordinated. You should file all claims with each Plan. For claims incurred within Canada, you should file all claims under each Plan. For claims incurred outside Canada, if you file claims with more than one Plan, you must indicate, at the time of filing a claim under this Plan, that you also have or will be filing your claim under another Plan.

**Definitions**

For the purposes of this section, the following terms have the meanings set forth below:

**Plan**

Any of the following that provides benefits or services for medical, dental or vision care or treatment:

- Group insurance and/or group-type coverage, whether insured or self-insured which neither can be purchased by the general public, nor is individually underwritten, including closed panel coverage.
- Coverage under any government health insurance plan.
- Medical benefits coverage of group, group-type, and individual automobile contracts.

Each Plan or part of a Plan which has the right to coordinate benefits will be considered a separate Plan.

**Closed Panel Plan**

A Plan that provides medical or dental benefits primarily in the form of services through a panel of employed or contracted providers, and that limits or excludes benefits provided by providers outside of the panel, except in the case of emergency or if referred by a provider within the panel.

**Primary Plan**

The Plan that determines and provides or pays benefits without taking into consideration the existence of any other Plan.

**Secondary Plan**

A Plan that determines, and may reduce its benefits after taking into consideration, the benefits provided or paid by the Primary Plan. A Secondary Plan may also recover from the Primary Plan the Reasonable Cash Value of any services it provided to you.

**Allowable Expense**

A necessary, reasonable and customary service or expense, including deductibles, coinsurance or copayments, that is covered in full or in part by any Plan covering you. When a Plan provides benefits in the form of services, the Reasonable Cash Value of each service is the Allowable Expense and is a paid benefit.

Examples of expenses or services that are not Allowable Expenses include, but are not limited to the following:

- An expense or service or a portion of an expense or service that is not covered by any of the Plans is not an Allowable Expense.
- If you are confined to a private Hospital room and no Plan provides coverage for more than a semiprivate room, the difference in cost between a private and semiprivate room is not an Allowable Expense.
- If you are covered by two or more Plans that provide services or supplies on the basis of reasonable and customary fees, any amount in excess of the highest reasonable and customary fee is not an Allowable Expense.
- If you are covered by one Plan that provides services or supplies on the basis of reasonable and customary fees and one Plan that provides services and supplies on the basis of negotiated fees, the Primary Plan's fee arrangement shall be the Allowable Expense.
- If your benefits are reduced under the Primary Plan (through the imposition of a higher copayment amount, higher coinsurance percentage, a deductible and/or a penalty) because you did not comply with Plan provisions or because you did not use a preferred provider, the amount of the reduction is not an Allowable Expense. Such Plan provisions include second surgical opinions and precertification of admissions or services.

**Reasonable Cash Value**

An amount which a duly licensed provider of health care services usually charges patients and which is within the range of fees usually charged for the same service by other health care providers located within the immediate geographic area where the health care service is rendered under similar or comparable circumstances.

**Order of Benefit Determination Rules**

A Plan that does not have a coordination of benefits rule consistent with this section shall always be the Primary Plan. If the Plan does have a coordination of benefits rule consistent with this section, the first of the following rules that applies to the situation is the one to use:

- The Plan that covers you as an enrollee or a Member shall be the Primary Plan and the Plan that covers you as a Dependent shall be the Secondary Plan;
- If you are a Dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the Plan which covers the parent whose birthday falls first in the Policy Year as an enrollee or Member;
- If you are the Dependent of divorced or separated parents, benefits for the Dependent shall be determined in the following order:
  - first, if a court decree states that one parent is responsible for the child's healthcare expenses or health coverage and

the Plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;
  - then, the Plan of the parent with custody of the child;
  - then, the Plan of the spouse of the parent with custody of the child;
  - then, the Plan of the parent not having custody of the child, and
  - finally, the Plan of the spouse of the parent not having custody of the child.
- The Plan that covers you as an active Member (or as that Member's Dependent) shall be the Primary Plan and the Plan that covers you as laid-off or retired Member (or as that Member's Dependent) shall be the secondary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- The Plan that covers you under a right of continuation which is provided by federal or provincial law shall be the Secondary Plan and the Plan that covers you as an active Member or retiree (or as that Member's Dependent) shall be the Primary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- If one of the Plans that covers you is issued out of the province whose laws govern this Policy, and determines the order of benefits based upon the gender of a parent, and as a result, the Plans do not agree on the order of benefit determination, the Plan with the gender rules shall determine the order of benefits.

If none of the above rules determines the order of benefits, the Plan that has covered you for the longer period of time shall be primary.

**Effect on the Benefits of This Plan**

If this Plan is the Secondary Plan, this Plan may reduce benefits so that the total benefits paid by all Plans are not more than 100% of the total of all Allowable Expenses.

**Recovery of Excess Benefits**

If Cigna pays charges for benefits that should have been paid by the Primary Plan, or if Cigna pays charges in excess of those for which we are obligated to provide under the Policy, Cigna will have the right to recover the actual payment made or the Reasonable Cash Value of any services.

Cigna will have sole discretion to seek such recovery from any person to, or for whom, or with respect to whom, such services were provided or such payments made by any insurance company, healthcare plan or other organization. If we request, you must execute and deliver to us such instruments and documents as we determine are necessary to secure the right of recovery.

**Right to Receive and Release Information**

Cigna, without consent or notice to you, may obtain information from and release information to any other Plan with respect to you in order to coordinate your benefits pursuant to this section. You must provide us with any information we request in order to coordinate your benefits pursuant to this section. This request may occur in connection with a submitted claim; if so, you will be advised that the "other coverage" information, (including an Explanation of Benefits paid under the Primary Plan) is required before the claim will be processed for payment. If no response is received within 90 days of the request, the claim will be denied. If the requested information is subsequently received, the claim will be processed.

## Expenses For Which A Third Party May Be Responsible

This plan does not cover:

- Expenses incurred by you or your Dependent (hereinafter individually and collectively referred to as a "Participant,") for which another party may be responsible as a result of having caused or contributed to an Injury or Sickness.
- Expenses incurred by a Participant to the extent any payment is received for them either directly or indirectly from a third party tortfeasor or as a result of a settlement, judgment or arbitration award in connection with any automobile medical, automobile no-fault, uninsured or underinsured motorist, homeowners, workers' compensation, government insurance, or similar type of insurance or coverage. The coverage under this plan is secondary to any automobile no-fault or similar coverage.

**Subrogation/Right of Reimbursement**

If a Participant incurs a Covered Expense for which, in the opinion of the plan or its claim administrator, another party may be responsible or for which the Participant may receive payment as described above:

- Subrogation: The plan shall, to the extent permitted by law, be subrogated to all rights, claims or interests that a Participant may have against such party and shall automatically have a lien upon the proceeds of any recovery by a Participant from such party to the extent of any benefits paid under the plan. A Participant or their representative shall execute such documents as may be required to secure the plan's subrogation rights.
- Right of Reimbursement: The plan is also granted a right of reimbursement from the proceeds of any recovery whether by settlement, judgment, or otherwise. This right of reimbursement is cumulative with and not exclusive of the subrogation right granted in paragraph 1, but only to the extent of the benefits provided by the plan.

**Lien of the Plan**

By accepting benefits under this plan, a Participant:

- grants a lien and assigns to the plan an amount equal to the benefits paid under the plan against any recovery made by or on behalf of the Participant which is binding on any attorney or other party who represents the Participant whether or not an agent of the Participant or of any insurance company or other financially responsible party against whom a Participant may have a claim provided said attorney, insurance carrier or other party has been notified by the plan or its agents;
- agrees that this lien shall constitute a charge against the proceeds of any recovery and the plan shall be entitled to assert a security interest thereon;
- agrees to hold the proceeds of any recovery in trust for the benefit of the plan to the extent of any payment made by the plan.

**Additional Terms**

- No adult Participant hereunder may assign any rights that it may have to recover medical expenses from any third party or other person or entity to any minor Dependent of said adult Participant without the prior express written consent of the plan. The plan's right to recover shall apply to decedents', minors', and incompetent or disabled persons' settlements or recoveries.
- No Participant shall make any settlement, which specifically reduces or excludes, or attempts to reduce or exclude, the benefits provided by the plan.
- The plan's right of recovery shall be a prior lien against any proceeds recovered by the Participant. This right of recovery shall not be defeated nor reduced by the application of any so-called "Made-Whole Doctrine", "Rimes Doctrine", or any other such doctrine purporting to defeat the plan's recovery rights by allocating the proceeds exclusively to non-medical expense damages.
- No Participant hereunder shall incur any expenses on behalf of the plan in pursuit of the plan's rights hereunder, specifically; no court costs, attorneys' fees or other representatives' fees may be deducted from the plan's recovery without the prior express written consent of the plan. This right shall not be defeated by any so-called "Fund Doctrine", "Common Fund Doctrine", or "Attorney's Fund Doctrine".
- The plan shall recover the full amount of benefits provided hereunder without regard to any claim of fault on the part of any Participant, whether under comparative negligence or otherwise.
- The plan hereby disavows all equitable defenses in pursuit of its right of recovery. The plan's subrogation or recovery rights are neither affected nor diminished by equitable defenses.
- In the event that a Participant shall fail or refuse to honor its obligations hereunder, then the plan shall be entitled to recover any costs incurred in enforcing the terms hereof including, but not limited to, attorney's fees, litigation, court costs, and other expenses. The plan shall also be entitled to offset the reimbursement obligation against any entitlement to future medical benefits hereunder until the Participant has fully complied with their reimbursement obligations hereunder, regardless of how those future medical benefits are incurred.
- By acceptance of benefits under the plan, the Participant agrees that a breach hereof would cause irreparable and substantial harm and that no adequate remedy at law would exist. Further, the Plan shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms

of the plan, including, but not limited to, specific performance, restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief.

- Participants must assist the plan in pursuing any subrogation or recovery rights by providing requested information.

## Payment of Benefits - Medical, Prescription Drug & Vision

**Assignment and Payment of Benefits**

You may authorize Cigna to pay any healthcare benefits under this policy to a Participating or Non-Participating Provider. When you authorize the payment of your healthcare benefits to a Participating or Non-Participating Provider, you authorize the payment of the entire amount of the benefits due on that claim. If a provider is overpaid because of accepting duplicate payments from you and Cigna, it is the provider's responsibility to reimburse the overpayment to you. Cigna may pay all healthcare benefits for Covered Services directly to a Participating Provider without your authorization. You may not interpret or rely upon this discrete authorization or permission to pay any healthcare benefits to a Participating or Non-Participating Provider as the authority to assign any other rights under this policy to any party, including, but not limited to, a provider of healthcare services/items.

Even if the payment of healthcare benefits to a Non-Participating Provider has been authorized by you, Cigna may, at its option, make payment of benefits to you. When benefits are paid to you or your Dependent, you or your Dependents are responsible for reimbursing the Non-Participating Provider.

If any person to whom benefits are payable is a minor or, in the opinion of Cigna is not able to give a valid receipt for any payment due them, such payment will be made to their legal guardian or the Office of the Public Trustee. If no request for payment has been made by their legal guardian or the Office of the Public Trustee, Cigna may, at its option, make payment to the person or institution appearing to have assumed thier custody and support.

When one of our participants passes away, Cigna may receive notice that an executor of the estate has been established. The executor has the same rights as our insured and benefit payments for unassigned claims should be made payable to the executor.

Payment as described above will release Cigna from all liability to the extent of any payment made.

**Recovery of Overpayment**

When an overpayment has been made by Cigna, Cigna will have the right at any time to: recover that overpayment from the person to whom or on whose behalf it was made; or offset the amount of that overpayment from a future claim payment.

In addition, your acceptance of benefits under this plan and/or assignment of Medical Benefits separately creates an equitable lien by agreement pursuant to which Cigna may seek recovery of any overpayment. You agree that Cigna, in seeking recovery of any overpayment as a contractual right or as an equitable lien by agreement, may pursue the general assets of the person or entity to whom or on whose behalf the overpayment was made.

**Calculation of Covered Expenses**

Cigna, in its discretion, will calculate Covered Expenses following evaluation and validation of all provider billings in accordance with:

- the methodologies in the most recent edition of the Current Procedural terminology.
- the methodologies as reported by generally recognized professionals or publications.

## Payment of Benefits - Dental

**To Whom Payable**

Dental Benefits are assignable to the provider. When you assign benefits to a provider, you have assigned the entire amount of the benefits due on that claim. If the provider is overpaid because of accepting a patient's payment on the charge, it is the provider's responsibility to reimburse the patient. Because of Cigna's contracts with providers, all claims from contracted providers should be assigned.

Cigna may, at its option, make payment to you for the cost of any Covered Expenses from a Non-Participating Provider even if benefits have been assigned. When benefits are paid to you or your Dependent, you or your Dependents are responsible for reimbursing the provider.

If any person to whom benefits are payable is a minor or, in the opinion of Cigna is not able to give a valid receipt for any payment due them, such payment will be made to theirlegal guardian or the Office of the Public Trustee. If no request for payment has been made by their legal guardian or the Office of the Public Trustee, Cigna may, at its option, make payment to the person or institution appearing to have assumed their custody and support.

When one of our participants passes away, Cigna may receive notice that an executor of the estate has been established. The executor has the same rights as our insured and benefit payments for unassigned claims should be made payable to the executor.

Payment as described above will release Cigna from all liability to the extent of any payment made.

**Recovery of Overpayment**

When an overpayment has been made by Cigna, Cigna will have the right at any time to: recover that overpayment from

the person to whom or on whose behalf it was made; or offset the amount of that overpayment from a future claim payment.

## Notice of Right to Designate Beneficiaries

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

## Termination of Insurance

### Members

Your insurance will cease on the earliest date below:

- the Termination Date as shown on Your application; or
- the Termination Date of any policy extensions; or
- 365 days after coverage begins; or
- 90 days after You return to Canada (for returning Canadians only).

Any continuation of insurance must be based on a plan which precludes individual selection.

**Temporary Layoff or Leave of Absence**

If your Active Enrollment ends due to temporary layoff or leave of absence, your insurance will be continued until the date your Group (a) stops paying premium for you; or (b) otherwise cancels your insurance. However, your insurance will not be continued for more than 60 days past the date your Active Enrollment ends.

**Injury or Sickness**

If your Active Enrollment ends due to an Injury or Sickness, your insurance will be continued while you remain totally and continuously disabled as a result of the Injury or Sickness. However, your insurance will not continue past the date your Group stops paying premium for you or otherwise cancels your insurance.

### Dependents

Your insurance for all of your Dependents will cease on the earliest date below:

- the date your insurance ceases.
- the date you cease to be eligible for Dependent Insurance.
- the last day for which you have made any required contribution for the insurance.
- the date Dependent Insurance is canceled.

The insurance for any one of your Dependents will cease on the date that Dependent no longer qualifies as a Dependent.

### Rescissions

Your coverage may not be rescinded (retroactively terminated) by Cigna or the plan sponsor unless the plan sponsor or an individual (or a person seeking coverage on behalf of the individual) performs an act, practice or omission that constitutes fraud; or the plan sponsor or individual (or a person seeking coverage on behalf of the individual) makes an intentional misrepresentation of material fact.

## Medical Benefits Extension

**During Hospital Confinement Upon Policy Cancellation**

If the Medical Benefits under this plan cease for you or your Dependent due to cancellation of the policy (except if policy is canceled for nonpayment of premiums), and you or your Dependent is Confined in a Hospital on that date, Medical Benefits will be paid for Covered Expenses incurred in connection with that Hospital Confinement. However, no benefits will be paid after the earliest of:

- the date you exceed the Maximum Benefit, if any, shown in the Schedule;
- the date you are covered for medical benefits under another group plan;
- the date you or your Dependent is no longer Hospital Confined; or
- 10 days from the date the policy is canceled.

The terms of this Medical Benefits Extension will not apply to a child born as a result of a pregnancy which exists when your Medical Benefits cease or your Dependent's Medical Benefits cease.

## Dental Benefits Extension

An expense incurred in connection with a Dental Service that is completed after a person's benefits cease will be deemed to be incurred while he is insured if:

- for fixed bridgework and full or partial dentures, the first impressions are taken and/or abutment teeth fully prepared while he is insured and the prosthesis inserted within 3 calendar months after their insurance ceases.
- for a crown, inlay or onlay, the tooth is prepared while he is insured and the crown, inlay or onlay installed within 3 calendar months after their insurance ceases.

- for root canal therapy, the pulp chamber of the tooth is opened while he is insured and the treatment is completed within 3 calendar months after their insurance ceases.

There is no extension for any Dental Service not shown above.

## When You Have A Complaint Or An Appeal

For the purposes of this section, any reference to "you", "your" or "Member" also refers to a representative or provider properly authorized by you to act on your behalf, unless otherwise noted.

We want you to be completely satisfied with the care you receive. That is why we have established a process for addressing your concerns and solving your problems.

**Start with Customer Service**

We are here to listen and help. If you have a concern regarding a person, a quality of service, the quality of care, or contractual benefits, you can call our toll-free number and explain your concern to one of our Customer Service representatives. Please call us at the Cigna Global Health Benefits Service Center at 1-800-441-2668 (inside the United States and Canada or 302-797-3100 (outside the United States, call collect). You should state the reason(s) why you feel your claim should have been approved. Please have your customer ID available to assist the representatives in expediting your inquiry.

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, but in any case within 30 days. Our representatives may provide instructions or directions to pursue your issue including, but not limited to utilization of the appeals procedure outlined below. Notwithstanding that, these representatives will remain available for continued information related to your concerns.

If you are not satisfied with the results of a coverage decision, you can start the appeals procedure.

**Appeals Procedure**

Cigna has a two-step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request for an appeal in writing, within 365 days of receipt of a denial notice, to the following address:

Cigna

Attn: Appeals Department

P.O. Box 15800

Wilmington, DE 19850

You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask to register your appeal by telephone. Call us at us at the Cigna Global Health Benefits Service Center at 1-800-441-2668 (inside the United States and Canada or 302-797-3100 (outside the United States, call collect).

**Step 1- Level One Appeal**

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional in the same or similar specialty as the care under consideration, as determined by Cigna's Physician Reviewer.

For level one appeals, we will respond in writing with a decision within fifteen calendar days after we receive an appeal for a required preservice or concurrent care coverage determination (decision). We will respond within 30 calendar days after we receive an appeal for a postservice coverage determination. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

You may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves non-authorization of an admission or continuing inpatient Hospital stay. If you request that your appeal be expedited based on (a) above, you may also ask for an expedited external Independent Review at the same time, if the time to complete an expedited level-one appeal would be detrimental to your medical condition. Cigna's Physician reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing.

**Step 2 - Level Two Appeal**

If you are dissatisfied with our level one appeal decision, you may request a second review. To start a level two appeal, follow the same process required for a level one appeal set forth above. Your level two appeal should reference the specific details or conclusions included in the decision letter you received in response to your level one appeal.

If the appeal involves a coverage decision based on issues of Medical Necessity, clinical appropriateness or experimental treatment, a medical review will be conducted by a Physician Reviewer in the same or similar specialty as the care under consideration, as determined by Cigna's Physician Reviewer. For all other coverage plan-related appeals, a second-level review will be conducted by someone who was not involved in any previous decision related to your appeal, and not a subordinate of previous decision makers. Provide all relevant documentation with your second-level appeal request.

For required preservice and concurrent care coverage determinations, Cigna's review will be completed within 15 calendar days. For postservice claims, Cigna's review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review.

In the event any new or additional information (evidence) is considered, relied upon or generated by Cigna in connection with the level-two appeal, Cigna will provide this information to you as soon as possible and sufficiently in advance of the decision, so that you will have an opportunity to respond. Also, if any new or additional rationale is considered by Cigna, Cigna will provide the rationale to you as soon as possible and sufficiently in advance of the decision so that you will have an opportunity to respond.

You will be notified in writing of the decision within five days after the decision is made, and within the review time frames above if Cigna does not approve the requested coverage.

You may request that the appeal process be expedited if, the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or your appeal involves non-authorization of an admission or continuing inpatient Hospital stay. Cigna's Physician Reviewer, in consultation with the treating Physician will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing.

**Review of Medical Appeals – Cigna's Ombudsman**

If you are not fully satisfied with the decision of Cigna's level-two appeal review regarding your Medical Necessity or clinical appropriateness issue, you can contact Cigna's Ombudsman in writing at:

CLIC Ombudsman Liaison
100 Consilium Place, Suite 301
Scarborough, Ontario, Canada M1H 3E3
Email: ombudsmanCLICCanada@Cigna.com
Fax: 1.416.290.0732

A decision to use this level of appeal will not affect the claimant's rights to any other benefits under the plan.

To be eligible for review by Cigna's Ombudsman you must have completed Steps 1 and 2 outlined above. After Cigna's Ombudsman has reviewed your appeal, we will send you a written response within 30 days of receipt of the appeal by the Ombudsman. If more time or information is needed to make the determination, we will notify you in writing to request an extension and to specify any additional information needed to complete the review. The Ombudsman's response is considered Cigna's final position on the appeal and will not be reopened or reconsidered internally unless you provide additional information that was not previously reviewed in reaching the decision.

**Claim Appeal to the Industry OmbudService and/or The Financial Consumer Agency of Canada**

You have the right to appeal a claim denial to the OmbudService for Life and Health Insurance ("OHLI") that provides information and resources on issues that have not been resolved through Cigna's internal complete process. Information regarding this resource is available at http://olhi.ca/ or OHLI can be contacted at 1.888.295.8112 (English) or 1.866.582.2088 (French).

You may also contact the Financial Consumer Agency of Canada ("FCAC") that ensures federally regulated entities comply with consumer provision measures and raises awareness of their rights and responsibilities. FCAC can be contacted regarding your appeal through its website at www.fcac-acfc.gc.ca.

**Notice of Benefit Determination on Appeal**

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: information sufficient to identify the claim; the specific reason or reasons for the adverse determination; reference to the specific plan provisions on which the determination is based; a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access

to and copies of all documents, records, and other Relevant Information as defined; a statement describing any voluntary appeal procedures offered by the plan and the claimant's right to bring an action; upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; and information about any office of health insurance consumer assistance or ombudsman available to assist you in the appeal process. A final notice of adverse determination will include a discussion of the decision.

You also have the right to bring a civil action if you are not satisfied with the decision on review. You or your plan may have other voluntary alternative dispute resolution options such as Mediation.

**Relevant Information**

Relevant Information is any document, record, or other information which was relied upon in making the benefit determination; was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit or the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

**Action Against Cigna**

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the Insurance Act (Alberta and B.C.). Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time out in the Limitations Act (Ontario), and otherwise within such a longer period as may be required under the law applicable in the covered person’s province.

# Definitions

**Active Enrollment**

If you are a member, you are an International Student actively enrolled and attending the Participating Educational Institution.

**Bed and Board**

The term Bed and Board includes all charges made by a Hospital on its own behalf for room and meals and for all general services and activities needed for the care of registered bed patients.

**Biologic**

A virus, therapeutic serum, toxin, antitoxin, vaccine, blood, blood component or derivative, allergenic product, protein (except any chemically synthesized polypeptide), or analogous product, or arsphenamine or derivative of arsphenamine (or any other trivalent organic arsenic compound), used for the prevention, treatment, or cure of a disease or condition of human beings, as defined under Section 351(i) of the Public Health Service Act (42 USC 262(i)) (as amended by the Biologics Price Competition and Innovation Act of 2009, title VII of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 7002 (2010), and as may be amended thereafter).

**Certification**

The term Certification means a decision by a health care insurer that a health care service requested by a provider or covered person has been reviewed and, based upon the information available, meets the health care insurer's requirements for coverage and medical necessity, and the requested health care service is therefore approved.

**Charges**

The term "charges" means the actual billed charges; except when the provider has contracted directly or indirectly with Cigna for a different amount.

**Chiropodist**

See Podiatrist

**Chiropractic Care**

The term Chiropractic Care means the conservative management of neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain and improve function.

**Contracted Fee - Cigna Dental Preferred Provider**

The term Contracted Fee refers to the total compensation level that a provider has agreed to accept as payment for dental procedures and services performed on a Member or Dependent, according to the Member's dental benefit plan.

**Custodial Services**

Any services that are of a sheltering, protective, or safeguarding nature. Such services may include a stay in an institutional setting, at-home care, or nursing services to care for someone because of age or mental or physical condition. This service primarily helps the person in daily living. Custodial care also can provide medical services, given mainly to maintain the person's current state of health. These services cannot be intended to greatly improve a medical condition; they are intended to provide care while the patient cannot care for themself. Custodial Services include but are not limited to:

- Services related to watching or protecting a person;
- Services related to performing or assisting a person in performing any activities of daily living, such as: walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating, preparing foods, or taking medications that can be self administered, and
- Services not required to be performed by trained or skilled medical or paramedical personnel.

**Dentist**

The term Dentist means a person practicing dentistry or oral surgery within the scope of their license. It will also include a provider operating within the scope of their license when he performs any of the Dental Services described in the policy.

**Dependent**

Dependents are:

- your lawful spouse including someone to whom you're married or someone with whom you co-habitate in a conjugal relationship; and
- any child of yours who is
- over age 15 days and under age 21, or age 26 if enrolled in full time accredited educational institution;
    - 26 or more years old and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical handicap.

Proof of the child's condition and dependence must be submitted to Cigna within 31 days after the date the child ceases to qualify above. During the next two years Cigna may, from time to time, require proof of the continuation of such condition and dependence. After that, Cigna may require proof no more than once a year.

A child includes a legally adopted child. It also includes a stepchild.

Benefits for a Dependent child [or Member] will continue until the last day of the calendar month in which the limiting age is reached.

Anyone who is eligible as a Member will not be considered as a Dependent spouse. A child under age 26 may be covered as either a Member or as a Dependent child. You cannot be covered as a Member while also covered as a Dependent of a Member.
No one may be considered as a Dependent of more than one Member.

**Emergency Services**

Emergency services are medical, psychiatric, surgical, Hospital and related health care services and testing, including ambulance service, which are required to treat a sudden, unexpected onset of a bodily Injury or serious Sickness which could reasonably be expected by a prudent layperson to result in serious medical complications, loss of life or permanent impairment to bodily functions in the absence of immediate medical attention. Examples of emergency situations include uncontrolled bleeding, seizures or loss of consciousness, shortness of breath, chest pains or severe squeezing sensations in the chest, suspected overdose of medication or poisoning, sudden paralysis or slurred speech, burns, cuts and broken bones. The symptoms that led you to believe you needed emergency care, as coded by the provider and recorded by the Hospital on the UB92 claim form, or its successor, or the final diagnosis, whichever reasonably indicated an emergency medical condition, will be the basis for the determination of coverage, provided such symptoms reasonably indicate an emergency.

**Member**

The term Member means a Member as determined by your Group who is currently in Active Enrollment.

**Group**

The term Group means the Policyholder and all Affiliated Groups.

**Expense Incurred**

An expense is incurred when the service or the supply for which it is incurred is provided.

**Free-Standing Surgical Facility**

The term Free-standing Surgical Facility means an institution which meets all of the following requirements:

- it has a medical staff of Physicians, Nurses and licensed anesthesiologists;
- it maintains at least two operating rooms and one recovery room;
- it maintains diagnostic laboratory and x-ray facilities;
- it has equipment for emergency care;
- it has a blood supply;
- it maintains medical records;
- it has agreements with Hospitals for immediate acceptance of patients who need Hospital Confinement on an inpatient basis; and
- it is licensed in accordance with the laws of the appropriate legally authorized agency.

**Herbalist**

The term Herbalist means a non-medical practitioner who specializes in treating disorders with natural remedies derived exclusively from plant materials.

**Hospital**

The term Hospital means:

- an institution licensed as a hospital, which: maintains, on the premises, all facilities necessary for medical and surgical treatment; provides such treatment on an inpatient basis, for compensation, under the supervision of Physicians; and provides 24-hour service by Registered Graduate Nurses; or
- an institution which: specializes in treatment of Mental Health and Substance Use Disorder or other related illness; provides residential treatment programs; and is licensed in accordance with the laws of the appropriate legally authorized agency.

The term Hospital will not include an institution which is primarily a place for rest, a place for the aged, or a nursing home.

**Hospital Confinement or Confined in a Hospital**

A person will be considered Confined in a Hospital if he is:

- a registered bed patient in a Hospital upon the recommendation of a Physician;
- receiving treatment for Mental Health and Substance Use Disorder Services in a Residential Treatment Center.

**Injury**

The term Injury means an accidental bodily injury.

**Massage Therapist**

The term Massage Therapist means a person who is licensed to apply manipulation, methodical pressure, friction and kneading to the body.

**Maximum Reimbursable Charge (MRC) –Dental and Vision**

**Services in the United States**

The term Maximum Reimbursable Charge (MRC) means the charge for a covered service which is determined based on the lesser of:

- the provider's normal charge for a similar service or supply; or
- the percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by Cigna.

The percentile used to determine the Maximum Reimbursable Charge is listed in The Schedule.

The Maximum Reimbursable Charge is subject to all other benefit limitations and applicable coding and payment methodologies determined by Cigna. Additional information about how Cigna determines the Maximum Reimbursable Charge is available upon request.

**Maximum Reimbursable Charge – Medical, Dental, Vision and Pharmacy**

**Services Outside the United States**

Maximum Reimbursable Charge for services outside the United States is determined based on the lesser of:

- the charges contracted or otherwise agreed between the provider and Cigna; or
- the charge that a provider most often charges patients for the service or procedure; or
- the customary charge for the service or procedure as determined by Cigna based upon the range of charges made for the service or procedure by most providers in the general geographic area where the service is rendered or the procedure performed. Cigna is not obligated to pay excessive charges.

**Maximum Reimbursable Charge - Medical**

**Services in the United States**

The Maximum Reimbursable Charge for covered services is determined based on the lesser of:

- the provider's normal charge for a similar service or supply; or
- a percentage of a fee schedule Cigna has developed that is based upon a methodology similar to a methodology utilized by Medicare to determine the allowable fee for the same or similar service within the geographic market.

The percentage used to determine the Maximum Reimbursable Charge is listed in The Schedule.

In some cases, a Medicare based schedule will not be used and the Maximum Reimbursable Charge for covered services is determined based on the lesser of:

- the provider's normal charge for a similar service or supply; or
- the 80th percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by Cigna. If sufficient charge data is unavailable in the database for that geographic area to determine the Maximum Reimbursable Charge, then data in the database for similar services may be used.

The Maximum Reimbursable Charge is subject to all other benefit limitations and applicable coding and payment methodologies determined by Cigna. Additional information about how Cigna determines the Maximum Reimbursable Charge is available upon request.

**Medically Necessary/Medical Necessity**

Medically Necessary Covered Services and Supplies are those determined by the Medical Director to be:

- required to diagnose or treat an illness, injury, disease or its symptoms;
- in accordance with generally accepted standards of medical practice;
- clinically appropriate in terms of type, frequency, extent, site and duration;
- not primarily for the convenience of the patient, Physician or other health care provider; and
- rendered in the least intensive setting that is appropriate for the delivery of the services and supplies. Where applicable, the Medical Director may compare the cost-effectiveness of alternative services, settings or supplies when determining least intensive setting.

**Naturopath**

The term Naturopath means a non-medical practitioner who specializes in treating conditions by making reforms to the diet and lifestyle of the patient.

**Necessary Services and Supplies**

The term Necessary Services and Supplies includes any charges, except charges for Bed and Board, made by a Hospital on its own behalf for medical services and supplies actually used during Hospital Confinement, any charges, by whomever made, for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided; and any charges, by whomever made, for the administration of anesthetics during Hospital Confinement.

The term Necessary Services and Supplies will not include any charges for special nursing fees, dental fees or medical fees.

**Nurse**

The term Nurse means a Registered Graduate Nurse, a Licensed Practical Nurse or a Licensed Vocational Nurse who has the right to use the abbreviation "R.N.," "L.P.N." or "L.V.N."

**Ophthalmologist**

The term Ophthalmologist means a person practicing ophthalmology within the scope of their license. It will also include a physician operating within the scope of their license when he performs any of the Vision Care services described in the policy.

**Optician**

The term Optician means a fabricator and dispenser of eyeglasses and/or contact lenses. An optician fills prescriptions for glasses and other optical aids as specified by optometrists or ophthalmologists. The state in which an optician practices may or may not require licensure for rendering of these services.

**Optometrist**

The term Optometrist means a person practicing optometry within the scope of their license. It will also include a physician operating within the scope of their license when he performs any of the Vision Care services described in the policy.

**Other Health Care Facility/Other Health Professional**

The term Other Health Care Facility means a facility other than a Hospital or hospice facility. Examples of Other Health Care Facilities include, but are not limited to, licensed skilled nursing facilities, rehabilitation Hospitals and subacute facilities. The term Other Health Professional means an individual other than a Physician who is licensed or otherwise authorized under the applicable provincial law to deliver medical services and supplies. Other Health Professionals include, but are not limited to physical therapists, registered nurses and licensed practical nurses. Other Health Professionals do not include providers such as Certified First Assistants, Certified Operating Room Technicians, Certified Surgical Assistants/Technicians, Licensed Certified Surgical Assistants/Technicians, Licensed Surgical Assistants, Orthopedic Physician Assistants and Surgical First Assistants.

**Pharmacy**

The term Pharmacy means a retail Pharmacy, or a home delivery Pharmacy.

**Physician**

The term Physician means a licensed medical practitioner who is practicing within the scope of their license and who is licensed to prescribe and administer drugs or to perform surgery. It will also include any other licensed medical practitioner whose services are required to be covered by law in the locality where the policy is issued if he is:

- operating within the scope of their license; and
- performing a service for which benefits are provided under this plan when performed by a Physician.

**Podiatrist**

The term Podiatrist means a licensed practitioner responsible for the examination, diagnosis, prevention, treatment and care of conditions and functions of the human foot. A Podiatrist performs surgical procedures, prescribes corrective devices, drugs and physical therapy.

**Prescription Drug**

Prescription Drug means; a drug which has been approved by the Food and Drug Administration for safety and efficacy; certain drugs approved under the Drug Efficacy Study Implementation review; or drugs marketed prior to 1938 and not subject to review, and which can, under provincial, federal or state law, be dispensed only pursuant to a Prescription Order.

**Prescription Drug List**

Prescription Drug List means a listing of approved Prescription Drugs and Related Supplies. The Prescription Drugs and Related Supplies included in the Prescription Drug List have been approved in accordance with parameters established by the P&T Committee. The Prescription Drug List is regularly reviewed and updated.

**Prescription Order**

Prescription Order means the lawful authorization for a Prescription Drug or Related Supply by a Physician who is duly licensed to make such authorization within the course of such Physician's professional practice or each authorized refill thereof.

**Preventive Treatment**

The term Preventive Treatment means treatment rendered to prevent disease or its recurrence.

**Psychologist**

The term Psychologist means a person who is licensed or certified as a clinical psychologist. Where no licensure or certification exists, the term Psychologist means a person who is considered qualified as a clinical psychologist by a recognized psychological association. It will also include any other licensed counseling practitioner whose services are required to be covered by law in the locality where the policy is issued if he is operating within the scope of their license and performing a service for which benefits are provided under this plan when performed by a Psychologist.

**Related Supplies**

Related Supplies means diabetic supplies (insulin needles and syringes, lancets and glucose test strips), needles and syringes for injectables covered under the pharmacy plan, and spacers for use with oral inhalers.

**Review Organization**

The term Review Organization refers to an affiliate of Cigna or another entity to which Cigna has delegated responsibility for performing utilization review services. The Review Organization is an organization with a staff of clinicians which may include Physicians, Registered Graduate Nurses, licensed mental health and substance use disorder professionals, and other trained staff members who perform utilization review services.

**Sickness – For Medical Insurance**

The term Sickness means a physical or mental illness. It also includes pregnancy. Expenses incurred for routine Hospital and pediatric care of a newborn child prior to discharge from the Hospital nursery will be considered to be incurred as a result of Sickness.

**Skilled Nursing Facility**

The term Skilled Nursing Facility means a licensed institution (other than a Hospital, as defined) which specializes in:

- physical rehabilitation on an inpatient basis; or
- skilled nursing and medical care on an inpatient basis;

but only if that institution: maintains on the premises all facilities necessary for medical treatment; provides such treatment, for compensation, under the supervision of Physicians; and provides Nurses' services.

**Stabilize**

Stabilize means, with respect to an emergency medical condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

**Terminal Illness**

A Terminal Illness will be considered to exist if a person becomes terminally ill with a prognosis of six months or less to live, as diagnosed by a Physician.

**Urgent Care**

Urgent Care is medical, surgical, Hospital or related health care services and testing which are not Emergency Services, but which are determined by Cigna, in accordance with generally accepted medical standards, to have been necessary to treat a condition requiring prompt medical attention. This does not include care that could have been foreseen before leaving the immediate area where you ordinarily receive and/or were scheduled to receive services. Such care includes, but is not limited to, dialysis, scheduled medical treatments or therapy, or care received after a Physician's recommendation that the insured should not travel due to any medical condition.

**Vision Provider**

The term Vision Provider means: an optometrist, ophthalmologist, optician or a group partnership or other legally recognized aggregation of such professionals; duly licensed and in good standing with the relevant public licensing bodies to provide covered vision services within the scope of the Vision Providers' respective licenses.

# GROUP ACCIDENT
# INSURANCE CERTIFICATE

# NORTH WEST COLLEGE

Cigna

**CIGNA LIFE INSURANCE COMPANY OF CANADA**

Home Office: Scarborough, Ontario
Mailing Address: 100 Consilium Place Suite 301
Scarborough, Ontario Canada M1H 3E3

**GROUP INSURANCE CERTIFICATE**

We, Cigna Life Insurance Company of Canada, certify that we have issued this Group Policy to your Group.

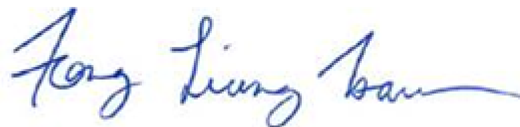
We certify that we insure all eligible persons, who are enrolled according to the terms of the Policy. Your coverage will begin and end according to the terms set forth in this certificate.

This certificate describes the benefits and basic provisions of your coverage. You should read it with care so you will understand your coverage.

This is not the insurance contract. It does not waive or alter any of the terms of the Policy. If questions arise, the Policy will govern. You may examine the Policy at the office of the Policyholder or the Administrator.

This certificate replaces any and all certificates which may have been issued to you in the past under the Policy.

**These materials are being made available electronically for your convenience. Cigna has provided the final documents to your Group. Care should be taken to ensure you are reviewing the most complete, accurate and up to date version. Any questions regarding content may be directed to your Group or Cigna.**



Fong Liang Tsaur

President and Chief Executive Officer

**SCHEDULE OF BENEFITS**

**Effective Date:** August 1, 2023

**Policy Anniversary Date:** August 1

**Policy Number:** 09388A

## ACCIDENTAL DEATH AND DISMEMBERMENT

The insurance provides benefits for accidental death and dismemberment. The amount that may be payable is based on the Amount of Principal Sum.

| | |
|---|---|
| **Amount of Principal Sum** | $0 |
| **24-hour accident** | $50,000 |
| **Common carrier** | $100,000 |
| **Aggregate limit** | $1,250,000 |

Dismemberment Scale

| **Table of Losses and Benefits** | |
|---|---|
| Loss of Life or Two or more Members | $50,000 |
| Loss of Sight of both Eyes | $50,000 |
| Loss of Sight of One Member and Sight of one Eye | $50,000 |
| Loss of One Member | $25,000 |
| Loss of Sight of One Eye | $25,000 |

Such payment shall be in addition to any other indemnity payable as of the date of loss, but only one (1) amount, the larger applicable amount, shall be payable for all such losses resulting from one accident. The "Principal Sum" is the amount specified as such in the Schedule.

"Member" means a hand, foot or the entire sight of an eye. Loss of a hand or foot means complete Severance through or above the wrist or ankle joint. Loss of sight means the total, permanent loss of sight of the eye. The loss of sight must be irrecoverable by natural, surgical or artificial means.

## WHO IS ELIGIBLE

**Classes of Eligible Persons**

A person may be insured only once under the Policy as a member, Spouse, or Dependent Child, even though they may be eligible under more than one class. Persons for whom coverage is prohibited under applicable law will not be considered eligible under this policy.

**MEMBER**

A member in one of the Classes of Eligible Members shown in the Schedule of Benefits eligible to be insured on the Policy Effective Date.

**SPOUSE**

If a member is eligible to elect Spouse coverage, the Spouse is eligible to be insured on the date the Member is eligible or the date they become a Spouse of a member, if later.
For the purposes of eligibility the Spouse must be a lawful Spouse and not legally separated from, divorced from, or widowed by the Member. A Spouse must be under age 65 to be eligible.

**DEPENDENT CHILD**

If a member is eligible to elect Dependent Child coverage, a Dependent Child is eligible to be insured on the date the Member is eligible or the date the child qualifies as a Dependent Child, if later. In no event will a Dependent Child be eligible to become insured more than once under the Policy.

## WHEN COVERAGE BEGINS

You may elect insurance for yourself, your Spouse and Dependent Children under this Policy on the later of:
- the date and time the required premium is paid; or
- the date You request as the start date on Your application; or
- the date You leave Your Home Country.

If coverage for a Dependent Child is in force and another Dependent Child becomes eligible, coverage for that child is effective on the date they qualify as a Dependent Child.

If you are not in Active Enrollment on the date insurance would otherwise go into effect, it will be effective on the date you return to Active Enrollment.

## WHEN COVERAGE ENDS

Coverage will end on the earliest of the following dates:

- the Termination Date as shown on Your application; or
- the Termination Date of any policy extensions; or
- 365 days after coverage begins.

## WHAT IS NOT COVERED

We will not pay Accident Insurance Benefits for a loss which in any way results directly or indirectly from any of the following:

1. Suicide, attempted suicide or intentionally self-inflicted injury, while sane or insane;
2. Voluntary ingestion or self-administration of any narcotic, drug, poison, gas, fumes or other chemical substance unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage. (Accidental ingestion of a poisonous substance is not excluded.)
3. Sickness, disease, bodily or mental infirmity; bacterial or viral infection or medical or surgical treatment thereof, except for any bacterial infection resulting from an accidental external cut or wound or accidental ingestion of contaminated food;
4. Travel or flight in, or getting in or out of:
   a) an aircraft being used for test or experiment;
   b) an aircraft the Insured is flying, is learning to fly, or is part of the crew of;
   c) a military aircraft, or a similar air transport service of a country;
   d) an aircraft owned or leased by or for the Insured or a member of their household;
   e) an aircraft that does not have a valid transport type certificate of airworthiness; or
   f) an aircraft that is not flown by a pilot with a valid license.
5. Commission or attempt to commit a felony or an assault.
6. No benefits are payable for war or an act of war, whether or not declared or active participation in a riot.
7. Injuries arising out of, or in the course of, any work for wage or profit.
8. No benefits are payable for an Insured on full-time active duty for more than 30 days in the Armed Forces of any nation. (If the Insured sends proof of service, we will refund any premiums paid for coverage during this time. Reserve duty or training are not excluded unless it extends beyond 31 days.)
9. No benefits are payable for claim payments that are illegal under applicable law.

## CLAIM PROVISIONS

**Notice of Claim**
Written notice of claim, or notice by any other electronic/telephonic means authorized by us, must be given to us within 31 days after a covered loss occurs or begins or as soon as reasonably possible. If written notice, or notice by any other electronic/telephonic means authorized by us, is not given in that time, the claim will not be invalidated or reduced if it is shown that notice was given as soon as was reasonably possible. Notice can be given at our home office in Scarborough, Ontario or to our agent. Notice should include the Group's name, the Policy Number and the claimant's name and address.

**Claim Forms**
When we receive notice of claim, we will send claim forms for filing proof of loss. If we do not send claim forms within 15 days after notice is received by us, the proof requirements will be met by submitting, within the time required under the "Proof of Loss" section, written proof, or proof by any other electronic/telephonic means authorized by us, of the nature and extent of the loss.

**Claimant Cooperation Provision**
If you fail to cooperate with us in our administration of your claim, we may terminate the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

**Insurance Data**
The Group is required to cooperate with us in the review of claims and applications for coverage. Any information we provide to the Group in these areas is confidential and may not be used or released by the Group if not permitted by applicable privacy laws.

**Proof of Loss**
You must provide written proof of loss to us, or proof by any other electronic/telephonic means authorized by us, within 90 days after the date of the loss for which a claim is made. If written proof of loss, or proof by any other electronic/telephonic means authorized by us, is not given in that 90 day period, the claim will not be invalidated nor reduced if it is shown that it was given as soon as was reasonably possible. In any case, written proof of loss, or proof by any other electronic/telephonic means authorized by us, must be given not more than one year after the 90 day period. If written proof of loss, or proof by any other electronic/telephonic means authorized by us, is provided outside of these time limits, the claim will be denied. These time limits will not apply due to lack of legal capacity.

**Time of Payment**
Benefits due under the Policy for a loss, other than a loss for which the Policy provides installment payments, will be paid immediately upon receipt of due written proof of such loss.

Subject to the receipt of satisfactory written proof of loss, all accrued benefits for loss for which the Policy provides installment payments will be paid monthly; any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof, unless otherwise stated in the Description of Benefits.

**To Whom Payable**
Death Benefits will be paid to the Insured's named beneficiary, if any, on file at the time of payment or to the certificate owner if alive. If there is no named beneficiary or surviving beneficiary, Death Benefits will be paid to the first surviving class of the following living relatives: spouse; child or children; mother or father; brothers or sisters; or to the executors or administrators of the Insured's estate. We may reduce the amount payable by any indebtedness due.

**CLAIM PROVISIONS**
**(Continued)**

All other benefits unless otherwise stated in the Policy, will be payable to the Insured or the certificate owner if other than the Insured.

Any other accrued benefits which are unpaid at your death will, at our option, be paid either to your beneficiary or to the executor or administrator of your estate.

If we pay benefits to the executor or administrator of your estate or to a person who is incapable of giving a valid release, we may pay up to $1,000 to a relative by blood or marriage whom we believe is equitably entitled. This good faith payment satisfies our legal duty to the extent of that payment.

**Change of Beneficiary**
You may change your beneficiary at any time by giving written notice to the Group or to us. The beneficiary's consent is not required for this or any other change which you may make unless your designation of beneficiary is irrevocable.

No change in beneficiary will take effect until the form is received by the Group or us. When this form is received, it will take effect as of the date of the form. If you die before the form is received, we will not be liable for any payment that was made before receipt of the form.

**Physical Examination and Autopsy**
We may, at our expense, exercise the right to examine any person for whom a claim is pending as often as we may reasonably require. Also, we may, at our expense, require an autopsy unless prohibited by law.

**Legal Actions**
No action at law or in equity may be brought to recover benefits under the Policy less than 60 days after written proof of loss, or proof by any other electronic/telephonic means authorized by us, has been furnished as required by the Policy. Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the *Insurance Act* (Alberta and B.C.). Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the *Limitations Act* (Ontario), and otherwise within such longer period as may be required under the law applicable in your province. No such action shall be brought more than 3 years after the time satisfactory proof of loss is required to be furnished.

**Time Limitations**
If any time limit stated in the Policy for giving notice of claim or proof of loss, or for bringing any action at law or in equity, is less than that permitted by the law of the locale in which you live when the Policy is issued, then the time limit provided in the Policy is extended to agree with the minimum permitted by the law of that locale.

**Physician/Patient Relationship**
You have the right to choose any Physician who is practicing legally. We will in no way disturb the Physician/patient relationship.

**Recovery of Overpayment**
If benefits are overpaid, we have the right to recover the amount overpaid by either of the following methods.
1. A request for lump sum payment of the overpaid amount.
2. A reduction of any amounts payable under this Policy.
If there is an overpayment due when you die, we may recover the overpayment from your estate.

## ADMINISTRATIVE PROVISIONS

**Premiums**
The premiums for this Policy will be based on the rates currently in force, the plan and the amount of insurance in effect.

If the Insured's coverage amount is reduced due to their attained age, premium will be based on the amount of coverage in force on the day after the reduction took place.

**Reinstatement of Insurance**
Your coverage may be reinstated without satisfying the Insurability Requirement, if your insurance ends because you are on an unpaid leave of absence and you apply for Reinstatement within 31 days of your return to Active Enrollment.

After your insurance ends, it may be reinstated at any date prior to five years after the date of termination if the following conditions are met.

1. The Policy is still in force.
2. You are eligible under the Policy.
3. You send us a written request for reinstatement and a new enrollment form.
4. The required premium is paid.
5. The Insurability Requirement, if applicable, is satisfied.

## GENERAL PROVISIONS

**Incontestability**
All statements made by the Group or by an Insured are representations not warranties. No statement will be used to deny or reduce benefits or as a defense to a claim, unless a copy of the instrument containing the statement has been furnished to the claimant. In the event of death or legal incapacity, the beneficiary or representative must receive the copy.

After two years from an Insured's effective date of insurance, or from the effective date of any added or increased benefits, no such statement will cause insurance to be contested except for fraud or eligibility for insurance.

**Misstatement of Age**
If an Insured's age has been misstated, we will adjust all benefits to the amounts that would have been purchased for the correct age.

**Misstatement of Fact**
If you have misstated any fact, all amounts payable under this Policy will be such as the premium paid would have purchased had such fact been correctly stated.

**Assignment of Benefits**
We will not be affected by the assignment of your certificate until the original assignment or a certified copy of the assignment is filed with us. We will not be responsible for the validity or sufficiency of an assignment. An assignment of benefits will operate so long as the assignment remains in force provided insurance under the Policy is in effect. This insurance may not be levied on, attached, garnisheed, or otherwise taken for a person's debts. This prohibition does not apply where contrary to law.

## GENERAL PROVISIONS
## (Continued)

**Clerical Error**
A person's insurance will not be affected by error or delay in keeping records of insurance under the Policy. If such an error is found, the premium will be adjusted fairly.

**Ownership of Records**
All records maintained by the Insurance Company are, and shall remain, the property of the Insurance Company.

**Policy Changes**
We may agree with the Policyholder to modify a plan of benefits without your consent.

## DEFINITIONS

Please note, certain words used in this document have specific meanings. These terms will be capitalized throughout this document. The definition of any word, if not defined in the text where it is used, may be found either in this Definitions section or in the Schedule of Benefits.

**Accident**
The term Accident means a sudden, unforeseeable external event that causes you bodily Injury and occurs while your coverage is in force under the Policy.

**Active Enrollment**
If you are a member, you are an International Student actively enrolled and attending the Participating Educational Institution.

**Member**
For eligibility purposes, you are a member if you are in one of the "Classes of Eligible Members." Otherwise, you are a member if you are a member of the Group who is insured under the Policy.

**Group**
The Policyholder and any affiliates or subsidiaries covered under the Policy. The Group is acting as your agent for transactions relating to this insurance. You shall not consider any actions of the Group as actions of the Insurance Company.

**Injury**
Any accidental loss or bodily harm that results directly and independently from all other causes from an Accident.

**Insurance Company**
The Insurance Company underwriting the Policy is named on your certificate cover page. References to the Insurance Company have been changed to "we", "our", "ours", and "us" throughout the certificate.

## DEFINITIONS
(Continued)

**Insured**
You are an Insured if you are eligible for insurance under the Policy, insurance is elected for you, the required premium is paid and your coverage is in force under the Policy.

**Physician**
Physician means a licensed doctor practicing within the scope of their license and rendering care and treatment to an Insured that is appropriate for the condition and locality. The term does not include you, your spouse, your immediate family (including parents, children, siblings, or spouses of any of the foregoing, whether the relationship derives from blood or marriage), or a person living in your household.

**Prior Plan**
The Prior Plan refers to the plan of insurance providing similar benefits to you, sponsored by the Group and in effect directly prior to the Policy Effective Date.

**Sickness**

Sickness or impairment of normal physiological function affecting an Insured.

**Spouse**
The current lawful Spouse of a member under age 65.

**Terrorism or terrorist events**
An act or threat of violence or an act harmful to human life, property or infrastructure with the intention or effect of influencing or overthrowing any government or of putting the public or any section of the public in fear.

**War or war event**
An organized conflict (whether declared or not) including terrorism, overthrow or influencing of any government or ruling body by force, or popular or military uprising (e.g. invasion, mutiny, insurrection, rebellion, riot).

## WHAT YOUR BENEFICIARY SHOULD DO AND EXPECT IF THEY HAVE A CLAIM

When your beneficiary is eligible to receive benefits under the Plan, a request must be made for a claim form or to obtain instructions for submitting a claim telephonically or electronically, from the Plan Administrator. All claims submitted must be on the claim form or in the electronic or telephonic format provided by the Insurance Company. A claim must be completed according to directions provided by the Insurance Company. If these forms or instructions are not available, a written statement of proof of loss must be provided. After a claim form or written statement has been completed, it must be submitted to the Plan Administrator.

The Plan Administrator has appointed the Insurance Company as the named fiduciary for adjudicating claims for benefits under the Plan, and for deciding any appeals of denied claims. The Insurance Company shall have the authority, in its discretion, to interpret the terms of the Plan, to decide questions of eligibility for coverage or benefits under the Plan, and to make any related findings of fact. All decisions made by the Insurance Company shall be final and binding on Participants and Beneficiaries to the full extent permitted by law.

### Review of Claims for Benefits

The Insurance Company has 90 days from the date it receives a claim for benefits, to determine whether or not benefits are payable in accordance with the terms of the Policy. The Insurance Company may require more time to review the claim if necessary due to matters beyond its control. If this should happen, the Insurance Company must provide notice in writing that its review period has been extended for up to two more 30 day periods. If this extension is made because additional information must be furnished, these extension periods will begin when the additional information is received. The requested information must be furnished within 45 days.

During the review period, the Insurance Company may require a medical examination of the Insured, at its own expense; or additional information regarding the claim. If a medical examination is required, the Insurance Company will notify the Insured of the date and time of the examination and the physician's name and location. If additional information is required, the Insurance Company must notify the claimant, in writing, stating what information is needed and why it is needed.

If the claim is approved, the Insurance Company will pay the appropriate benefit.

If the claim is denied, in whole or in part, the Insurance Company will provide written notice within the review period. The Insurance Company's written notice will include the following information:

1. The specific reason(s) the claim was denied.
2. Specific reference to the Policy provision(s) on which the denial was based.
3. Any additional information required for the claim to be reconsidered, and the reason this information is necessary.
4. A statement regarding the right to appeal the decision, and an explanation of the appeal procedure.

**Appeal Procedure for Denied Claims**

Whenever a claim is denied, there is the right to appeal the decision. A written request for appeal must be made to the Insurance Company within 60 days from the date the denial was received. If a request is not made within that time, the right to appeal will have been waived.

Once a request has been received by the Insurance Company, a prompt and complete review of the claim will take place. This review will give no deference to the original claim decision. It will not be made by the person who made the initial claim decision, or a subordinate of that person. During the review, the claimant (or the claimant's duly authorized representative) has the right to review any documents that have a bearing on the claim, including the documents which establish and control the Plan. Any medical or vocational experts consulted by the Insurance Company will be identified. Issues and comments that might affect the outcome of the review may also be submitted.

The Insurance Company has 60 days from the date it receives a request to review the claim and provide its decision. Under special circumstances, the Insurance Company may require more time to review the claim. If this should happen, the Insurance Company must provide notice, in writing, that its review period has been extended for an additional 60 days. Once its review is complete, the Insurance Company must state, in writing, the results of the review and indicate the Plan provisions upon which it based its decision.

Cigna

UNDERWRITTEN BY:
CIGNA LIFE INSURANCE COMPANY OF CANADA

08/2023

Cigna