EXTENDED HEALTH CARE INSURANCE PLAN FOR BC PUBLIC SECTOR RETIREES

Certificate of Insurance

Desjardins Financial Security

Program Administered By:

Johnson
CERTIFICATE OF INSURANCE

BC PUBLIC SECTOR RETIREE EXTENDED HEALTH CARE INSURANCE PLAN
insuring Members of the

BRITISH COLUMBIA GOVERNMENT RETIRED EMPLOYEES’ ASSOCIATION
(called the Policyholder)

Group Master Policy No. 644453 has been issued to the British Columbia Government Retired Employees’ Association hereinafter called the “Policyholder”. An Insured Member of the Organization is referred to as the “Member.” Desjardins Financial Security is referred to as “Desjardins Financial Security” or “the Company”.

The Group Policy is administered on behalf of Desjardins Financial Security by the “Administrator” Johnson Inc.

All transactions between the Policyholder, Member and Desjardins Financial Security will be made through the Administrator.

The Group Policy was delivered in the province of British Columbia, Canada, and is governed by the laws thereof.

The Group Policy Year is September 1 through August 31. The Group Policy is renewable on each anniversary of the Policy Effective Date, subject to the policy terms and conditions.

This Certificate is issued as evidence of a Member's personal insurance under the Group Policy and is subject to the terms, conditions, limitations of liability and exclusions stated in the Group Policy. If for any reason there is a discrepancy between this certificate and the Group Policy, the provisions of the Group Policy shall prevail. The Group Policy is on file with the Policyholder, and upon request, it may be examined by the Member or the Member's personal representative at any reasonable time.

Only Desjardins Financial Security is authorized to make changes to the Group Policy or this Certificate. Any changes to these documents will be made in writing over the signature of an executive officer of Desjardins Financial Security Financial.

This Certificate becomes effective on the later of May 1, 2012 or the effective date of the Member's insurance. It replaces all other Certificates and Certificate Riders, if any, previously issued to the Member under the Group Policy.

30 DAY RIGHT TO RETURN THIS CERTIFICATE

If for any reason the Member is not satisfied with this Certificate, the Member may return it to the Administrator within 30 days after the Member receives it. The Administrator will refund any premium paid and the Certificate will be deemed void, just as though it had not been issued.

PLEASE READ YOUR CERTIFICATE CAREFULLY.
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BENEFIT SCHEDULE

Policyholder: British Columbia Government Retired Employees’ Association

Policy Number: 644453
Effective Date: May 1, 2012
Policy Renewal Date: September 1

EXTENDED HEALTH PLAN: Policy 644453

Deductible Amount: No Deductible

Benefit Reimbursement Percentages
a) Type “A” Eligible Expenses (In-Province Benefits)
   80% reimbursement for coverage of Type “A” expenses, unless otherwise noted.

b) Type “B” Eligible Expenses (Emergency Travel Benefits)
   100% reimbursement for coverage of Type “B” expenses.

Maximum Benefits Payable
a) Type “A” Eligible Expenses (In-Province Benefits)
   $250,000 per insured person during his/her lifetime
   (specified maximum per category also apply)

b) Type “B” Eligible Expenses (Emergency Travel Benefits)
   $2,000,000 per insured person during his/her lifetime.
   (Canadian Funds)

Other Extended Health Eligible Expenses
As specified below and in the Description of Benefits Section

a) TYPE “A” Eligible Expenses

Direct Pay Drug Maximum Options for Members with Subsidized Benefits through the Pension Plan

- For member: 100% coverage to a calendar year maximum of $850
- For spouse and eligible dependents: 80% coverage, to your choice of two annual calendar year maximums:
  - PLAN 1: If either you or your spouse was born in 1939 or earlier:
    - Drug Option A: $1,200 per household
    - Drug Option B: $2,500 per household
  - PLAN 2: If you and your spouse were born in 1940 or later:
    - Drug Option A: $1,500 per household
    - Drug Option B: $3,500 per household

Covers all prescription drugs included in the BC Provincial Formulary – to the least cost alternative (LCA) price for brand-name drugs which are interchangeable with generics, and to the reference-based price for drugs which are not interchangeable, with a $10 dispensing fee cap and 8% mark-up limit.
Direct Pay Drug Maximum Options for Members without Subsidized Benefits through the Pension Plan

- 80% of the first $1,500 of your household’s out-of-pocket costs, then 100% coverage, to your choice of two annual calendar year maximums:
  - **PLAN 1**: If either you or your spouse was born in 1939 or earlier:
    - Drug Option A: $1,200 per household
    - Drug Option B: $2,500 per household
  - **PLAN 2**: If you and your spouse were born in 1940 or later:
    - Drug Option A: $1,500 per household
    - Drug Option B: $3,500 per household

Covers all prescription drugs included in the BC Provincial Formulary – to the least cost alternative (LCA) price for brand-name drugs which are interchangeable with generics, and to the reference-based price for drugs which are not interchangeable, with a $10 dispensing fee cap and 8% mark-up limit.

**Accidental Dental**

- 80% Reimbursement to a Maximum of $1,000 per Calendar Year

**Ambulance**

- 80% Reimbursement to a Maximum of Ground Ambulance (when medically necessary for emergency treatment).
  - Any public Emergency Transportation, including air ambulance, within the province, limited to one (1) return trip per Calendar Year.

**Hearing Aids**

- 80% Reimbursement to a Maximum of $1,000 per 5 Consecutive Calendar Years.

**Medical Aids and Appliances**

- 80% Reimbursement for eligible expenses. Maximums are as specified in Description of Benefits section.
a) **TYPE “A” Eligible Expenses** (continued)

**Paramedical Services**
80% Reimbursement to a Combined Maximum of $1,000 per Calendar Year for Chiropractor, Physiotherapist, Athletic Therapist, Psychologist, Speech Therapist, Naturopath, Acupuncturist, Osteopath, Podiatrist/Chiropodist and Massage Therapist.

**Private Duty Nursing**
80% Reimbursement to a Maximum of $3,000 in any 3 Consecutive Calendar Years.

**Vision Care**

i) 80% Reimbursement to a Maximum of $300 per 2 Consecutive Calendar Years for prescription lenses, eyeglasses, prescription sunglasses and contact lenses not covered in (ii).

ii) 80% Reimbursement to a Maximum of $200 per 2 Consecutive Calendar Years for contact lenses prescribed for severe corneal astigmatism, severe corneal scarring, keratoconus (conical cornea), or aphakia provided visual acuity can be improved to at least 20/40.

iii) 80% Reimbursement to a Maximum of $175 per insured person additional lifetime maximum for new lenses resulting from eye surgery.

**Prescribed Educational Program**
80% Reimbursement to a Maximum of $100 per Calendar Year

**Hospital Accommodation**
100% Reimbursement to a Maximum of $100 per day

**Home Care Benefit**
80% Reimbursement to a Maximum of $50 per day for up to 10 days following a minimum 24 hour hospital stay.

b) **TYPE “B” Eligible Expenses**

**Emergency Travel Benefits (Canadian Funds)**

**Lifetime Maximum**
100% Reimbursement to a Maximum of $2,000,000 per insured person (Canadian Funds)

**Private Duty Nursing**
100% Reimbursement to a Maximum of $5,000 per Calendar Year

**Accidental Dental**
100% Reimbursement to a Maximum of $1,000 per Calendar Year

**Paramedical Services**
100% Reimbursement to a Maximum of $225 per Calendar Year per Specialty for Chiropractor, Podiatrist/Chiropodist and Physiotherapist. Requires doctor referral and prior approval from Sigma Assistel.

**Trip Cancellation**
100% Reimbursement to a Maximum of $6,000 per Insured Person per Trip for the Non-refundable portion of pre-paid travel arrangements.
<table>
<thead>
<tr>
<th>Benefit Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trip Interruption/Delay</td>
<td>100% Reimbursement to a Maximum of $6,000 per Insured Person per Trip for the extra cost of a one-way economy airfare to the departure or destination point and any unused non-refundable land arrangements.</td>
</tr>
<tr>
<td>Additional Expenses</td>
<td>100% Reimbursement to a Maximum of $150 per day up to 10 days upon trip delay due to hospitalization</td>
</tr>
<tr>
<td>Vehicle Return</td>
<td>100% Reimbursement to a Maximum of $2,000 per Calendar Year</td>
</tr>
<tr>
<td>Repatriation</td>
<td>100% Reimbursement to a Maximum of $5,000</td>
</tr>
<tr>
<td><strong>Base Plan</strong></td>
<td>The Base Plan is a continuous plan that provides Emergency medical travel coverage for an unlimited number of Trips, up to a maximum of 62 days duration for each Trip. Proof of Departure from your province or territory of residence is required if a claim occurs.</td>
</tr>
<tr>
<td><strong>Supplemental Plan</strong></td>
<td>The Insured Person may elect coverage under the Supplemental Plan for trips of longer than 62 days. This plan provides coverage for a single Trip occurring between the Effective Date and the Trip Termination Date as noted on the enrolment form or as subsequently advised to, and confirmed by, the plan administrator.</td>
</tr>
</tbody>
</table>

The Insured Person must purchase a Supplemental policy in addition to the Base Plan to cover the entire length of his/her trip.
DEFINITIONS

“Plan Administrator” means Johnson Inc. All transactions between the policyholder and the Insured Person and/or a provider of service must be made through the Plan Administrator.

“Age Limit” is not included except as it applies to the definition of dependents.

“Annual” shall mean a calendar year.

“Brace” shall mean a rigid or semi-rigid supporting device or appliance which fits on and is attached to the body or any part of the body, excluding any dental brace which is used to correct a dental defect, deficiency or injury.

“Calendar Year” shall mean the period starting January 1 and ending on December 31.

“Common Carrier” is any land, air or water conveyance, which is licensed to carry passengers for compensation and is for hire.

“Company” shall mean Desjardins Financial Security.

“Confinement” or “Confined” shall mean hospital confinement.

“Contributory” shall mean the member has to pay part or all of the insurance premium.

“Couple Coverage” shall mean coverage for two eligible family members, including the member and one eligible dependent.

“Currency” shall mean Canadian currency unless otherwise stated.

“Day of Departure” shall mean the date that the Insured Person exits their province or territory of residence in Canada.

“Day of Return” shall mean the date that the Insured Person returns to their province or territory of residence in Canada.

“Dentist” shall mean a person who is legally qualified and licensed to practice dentistry in the jurisdiction where the services are rendered for which the charges are incurred.

“Dependent” refer to definition of “Eligible Dependent”.

“Dependent Unit” shall consist of all eligible dependents of a member.

“Drugs and Medicines” shall mean medical preparations approved for use by Health Canada (Food and Drug Act), and which by law must require written prescription by a physician and which have been approved by the Company for reimbursement under this Plan.

“Due Proof” shall mean written evidence of loss satisfactory to the Insurer.
“Eligible Dependent” shall mean and include:

**Dependent Children:**

1) Natural children, legally adopted children or children living with the adopting parents during period of probation, stepchildren, children under legal guardianship, and foster children of the member or the member’s spouse. To be considered a dependent, the child must be unmarried, not employed on a regular and full-time basis, and under 21 years of age. A child up to age 25 will be considered a dependent if in full-time attendance at an accredited school, college or university and dependent on the member for support, including students attending school outside their normal Province of Residence.

2) Mentally or physically handicapped children beyond any limiting age for dependent children provided the child is incapable of self-sustaining employment and is wholly dependent upon the member for support and maintenance.

**Spouse / Surviving Spouse:**

1) a person married to the member as a result of a valid civil or religious ceremony, including a person divorced or separated from the member; or

2) a person, who although not legally married to the member, cohabits with the member in a conjugal (including same sex) relationship that has been recognized as such in the community in which they reside.

*Only one person at a time may be covered as a spouse.*

No person shall be eligible for coverage or covered under this agreement simultaneously as a member and a dependent of more than one insured member.

“Eligible Expenses for Students Living Away from Home” shall mean expenses for eligible dependents studying outside their normal province of residence will be considered under Type “A”, Extended Health Care, Eligible Expenses on the same basis as if expenses were incurred in their province of residence. Expenses incurred by students travelling 500 kilometres or more away from their student residence and outside their normal province of residence will be considered under Type “B”, Emergency Travel Benefits, Eligible Expenses.

“Eligible Expenses” shall mean any expense incurred after the person’s effective date of coverage under the Policy for any medically necessary, reasonable and customary item of expense listed in the Policy, of which by law can be covered in whole or in part and for which the Insured Person has made application, been approved by the Insurer and paid the premium.

When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service provide shall be considered to be both an eligible expense and a benefit.

“Eligibility Period” shall mean a period 60 days following the later of:

1) loss of employer benefits at retirement; or

2) loss of benefits from a spousal group plan or any other group plan.
DEFINITIONS

“Emergency” shall mean any sudden and unexpected illness or injury which takes place during an insured trip and which requires immediate medical treatment by a licensed Physician, Nurse Practitioner, Dentist or Dental Surgeon.

“Evidence of Insurability” means evidence of the person’s health that must be included with an Extended Health Care application when an application is submitted after the eligibility period or any other circumstance determined by the Company and which require approval by the Company to provide coverage to the applicant.

“Extended Family Member” shall mean an Insured Person’s spouse, parent, stepparent, child, guardian, grandparent, brother, sister, brother-in-law, sister-in-law, grandchild, parent-in-law, step-child, step-brother, step-sister, aunt, uncle, nephew, or niece. (This is applicable to the transportation benefit under the emergency medical travel plan).

“Family coverage” shall mean coverage for three or more family members, including the member and two or more eligible dependents.

“Government Plan” shall mean any plan or arrangement provided by or under the administrative supervision of any government or agency thereof, which provides coverage or reimbursement for any health care service or supply and without restricting the generality of the foregoing. This includes any Provincial Government Health Insurance Plan (GHIP), and comparable legislation in other jurisdictions.

“Grace Period” shall be the period that starts on the premium due date and continues for 31 consecutive days.

“Hospital” shall mean an institution operated pursuant to law for the care and treatment of sick and injured persons on an in-patient, outpatient and emergency basis. While in Canada, this includes convalescent and rehabilitative hospitals (not homes). The hospital must be continuously staffed and supervised by licensed physicians and registered graduate nurses. Such institution must have facilities both for diagnosis and for major surgery. The term hospital shall not include a rest home, nursing home, convalescent home, health spa, a place for custodial care, a home for the aged, and a chronic care facility or facilities.

“Hospital charges” shall mean charges made by a hospital for room and board plus charges made by the hospital for other necessary services and supplies furnished to the member or dependent for his/her use while he/she is confined. Hospital charges shall not include charges for special nursing services or for services of physicians and surgeons, or chronic care services within a hospital.

“Illness” shall mean any disorder of the body or mind, including pregnancy related disorders.

“Immediate Family Member” shall mean a spouse or dependent as defined in the section “Eligible Dependent” in the Definitions section.

“Injury” shall mean bodily injury caused by external, violent and accidental means.

“Injury” (emergency medical travel coverage) shall mean any bodily injury caused by an accident which occurs during a Trip and which results in a loss while the coverage is in force and which is serious enough to require the Insured Person to seek the attention of a licensed physician (other than an Immediate Family Member).

“In-province” means in the Insured Person’s province of residence in Canada.
“Insured Person” shall include a member, spouse or dependent, as defined in this section, who is insured under this plan and for whom premium has been paid.

“Insurer” shall mean Desjardins Financial Security.

“Late Applicant” means a Member who applies for coverage after the Eligibility Period.

“Licensed, Certified or Registered” means licensed, certified or registered to practice the profession by the appropriate authority in the jurisdiction in which the care or services are rendered; or where no such authority exist, having a certificate of competency from the professional body which regulates the particular profession.

“Medically necessary” shall mean broadly accepted by the medical profession as effective, appropriate and essential in the diagnosis and/or treatment of a sickness or injury, and based on generally recognized and accepted standards of health care.

“Medical emergency” (as used with regard to emergency medical travel coverage Eligible Expenses under the Extended Health Care Plan Benefits section) shall mean an emergency service rendered for the sudden onset of a medical condition, manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could result in:

1) permanently placing the individual’s health in jeopardy;
2) serious impairment to bodily functions;
3) serious impairment and dysfunction of any bodily organ or part; or
4) other serious medical consequences.

“Member” shall mean an individual in good standing with the British Columbia Government Retired Employees’ Association (BCGREA), who is

1) a permanent resident of Canada;
2) covered by the Provincial Health Care Plan;
3) covered by the BC Fair PharmaCare Plan;
4) “Active Member” of the British Columbia Government Retired Employees’ Association (BCGREA) is an individual receiving a pension from the Public Service Pension Plan administered by the British Columbia Pension Corporation and/or their spouse. or
5) “Associate Member” of the British Columbia Government Retired Employees’ Association (BCGREA) is an individual, or their spouse, receiving a pension from a plan administered by the British Columbia Pension Corporation other than the Public Service Pension Plan.

* An Associate Member also includes a surviving spouse who is receiving a spousal pension.

“Non-contributory” shall mean the Policyholder pays all of the insurance premium.

“Ongoing Medical Treatment” (as mentioned in the emergency medical travel coverage) shall mean any treatment, service or consultation which is deemed to be a continuation of, or provided subsequent to, Emergency medical treatment of a Sickness or Injury for which a claim was incurred.

“Out-of-Province” means outside the Insured Person’s province of residence.

“Policyholder” shall mean British Columbia Government Retired Employees’ Association.

“Policy year” shall mean the period of time between any two Policy Anniversaries.
“Practitioner or Physician” shall mean a person who is qualified and licensed to practice medicine or perform surgery within the scope and limitations of that license in the jurisdiction where the services are performed. The Practitioner/Physician will not include the member, nor the member's spouse, children, brothers, sisters, or parents, nor any person residing in the Insured Member's household.

“Provincial government plan” shall mean the body of provincially enacted laws, as amended from time to time, governing provincial health insurance plans, provincial hospital insurance plans, provincial Medicare plans, provincial medical care and service acts, and other provincial government sponsored hospitalization, Medicare, drug, or dental insurance plans which provide health insurance to residents of Canada.

“Reasonable and customary charge” shall mean a charge made by the provider of health care, services or supplies that does not exceed the general level of charges made by other providers of similar standing in the locality or geographical area where the charge is incurred, when furnishing like or comparable treatment, services or supplies to individuals.

“Registered Nurse (R.N.)”, “Registered Nursing Assistant (R.N.A.)”, “Licensed Practical Nurse (L.P.N.)”, or a member of “The Victorian Order of Nurses (V.O.N.)” shall mean a person who is licensed and qualified to perform nursing services within the scope of their license excluding a person who is a relative of the Insured Person, a homemaker, or a babysitter.

“Remarriage” means either of the following arrangements entered into by the surviving spouse of a deceased member:

1) marriage by a valid civil or religious ceremony; or
2) a “common-law marriage” in which the surviving spouse, who although not legally married to a person, cohabits with the person in a conjugal (including same sex) relationship which is recognized as such in the community where they reside.

“Reimbursement” shall mean the portion of the charge of an eligible expense that will be reimbursed by the plan.

“Sickness” (as mentioned in the emergency medical travel coverage) means any sudden illness or disease which occurs during a Trip, while the insurance is in force and which is serious enough to require the Insured Person to seek the attention of a licensed physician (other than an Immediate Family Member).

“Single coverage” shall mean coverage for the member.

“Spouse” refers to definition of “Eligible Dependent”.

“Terrorism” shall mean a violent act done in order to intimidate or terrorize the general public in the course of their daily lives for political ends, and does not include any act of war, civil commotion or civil unrest.

“Travel Supplier” (As mentioned in the emergency medical travel coverage) shall mean a company in the business of providing transportation and accommodation arrangements to the public. This does not include a travel agent, agency, travel broker or tour company.

“Travel Companion” (As mentioned in the emergency medical travel coverage) shall mean a person who accompanies an Insured Person on an insured trip and who has prepaid accommodation and/or transportation arrangements with the Insured Person for the same insured trip.
“Trip(s)” means travel outside the Insured Person’s province or territory of residence during which coverage is in effect.

“Two Consecutive Calendar Years” means two calendar years beginning with the calendar year of your last incurred claim.

“Two Consecutive Years” means a 24-month period beginning from the date of your last incurred claim and “three consecutive years” means a 36-month period, etc.

“Vehicle” (As mentioned in the vehicle return benefit) means a private automobile, motorcycle, van, trailer or self-propelled recreational vehicle either owned or rented by the Insured Person.

All transactions between the Policyholder, the Insured Person and/or a provider of service must be made through the Plan Administrator.
GENERAL PROVISIONS

1. **Member Plan Eligibility**
   An Active or Associate Member of BRITISH COLUMBIA GOVERNMENT RETIRED EMPLOYEES’ ASSOCIATION becomes eligible to be insured under this Plan on the date:
   
   a) he/she becomes an Active or Associate Member of BRITISH COLUMBIA GOVERNMENT RETIRED EMPLOYEES’ ASSOCIATION; and
   
   b) his/her coverage under a Public Service Group Insurance Plan terminates; or
   
   c) his/her coverage under his/her spouse’s Group Insurance Plan terminates, or
   
   d) his/her coverage under a Group Insurance Plan, other than those plans mentioned in a), b) and c) above, terminates; or
   
   e) if maintaining his/her Public Service Group Insurance the member will be eligible under the Subsidized Plan and coverage will be effective the date the completed application is received by the administrator.

   Application must be made on, before or within 60 days of the preceding dates and prior to the Day of Departure from the Insured Person’s province of residence, otherwise the applicant will be deemed a “late applicant” and eligibility will be contingent upon medical evidence of insurability.

2. **Dependent Eligibility**
   The insurance of an eligible dependent shall become effective on the later of:

   a) the date the member is first eligible;
   
   b) the date the member first makes written application for this insurance;
   
   c) the date the dependent’s evidence of insurability is approved by the Insurer; or
   
   d) the date the dependent is no longer confined (excluding newborns).

   If a still actively working British Columbia public sector employee dies, the dependents of such employee will be eligible to participate in this Plan and the insurance of such eligible dependents shall become effective on the later of:

   a) the date the dependent(s) first makes written application for this insurance;
   
   b) the date a dependent’s evidence of insurability is approved by the Insurer; or
   
   c) the date a dependent is no longer confined (excluding newborns).

   If a member has one dependent insured under the policy, the member is not required to make written application to insure additional dependents if no additional premium is required. If evidence of insurability is required and/or the dependent is confined, the effective date of insurance shall be the first date the dependent is not confined or the date insurance coverage is approved by the Insurer. In no event, will the dependent's insurance become effective before the member’s insurance becomes effective.
Evidence of Insurability is required if the dependent is a late applicant. If evidence of Insurability is required and/or the dependent is confined to a hospital, the effective date of insurance shall be the first date the dependent is not confined to a hospital or the date insurance coverage is approved by the Insurer. In no event, will the dependent’s insurance become effective before the member’s insurance becomes effective.

Confinement in a hospital shall not postpone the effective date for:

a) a child born while the member’s dependents are insured; or
b) a mentally or physically handicapped child of any age.

3. **Effective Date of Coverage**

The insurance of eligible member shall become effective on the later of:

a) If applying during the **Eligibility Period**, within 60 days of losing coverage under an employer group plan, spouses’ group plan or other group Extended Health plan, on the date the prior coverage terminated; or
b) If applying after the **Eligibility Period**, after 60 days of losing coverage under an employer group plan, spouses’ group plan or other group Extended Health plan, on the date the completed application is approved by the Insurer.

c) If maintaining his/her Public Service Group Insurance the member will be eligible under the Subsidized Plan and coverage will be effective the date the completed application is received by the administrator.

Application must be received prior to the Day of Departure from the Insured Person’s province of residence.

4. **Late Applicant**

A late applicant, who applies after the **Eligibility Period**, for Extended Health will be required to provide medical evidence satisfactory to the Insurer and must be approved by the Insurer for coverage.

5. **Extended Coverage for Dependents**

a) **Coverage for Dependents of a Deceased Member**

Coverage for eligible dependents shall continue following the death of the member, provided premiums continue to be paid, until:

i) the date the policy terminates; or
ii) the dependent’s coverage otherwise would terminate under the other provisions of the policy.

b) **Coverage upon Remarriage of a Deceased Member’s Surviving Spouse**

Upon Remarriage of a Deceased Member’s Surviving Spouse, the new spouse and any dependent children acquired, resulting from the remarriage will be eligible for coverage, subject to the Eligibility provisions for dependents.
6. **Participation Requirements**

**Subsidized Plan Members**

Direct Pay Drug Maximum Options for Members **with** Subsidized Benefits through the Pension Plan

A Member can choose between two calendar year maximums for prescription drug coverage:

- **PLAN 1:** If either you or your spouse was born in 1939 or earlier:
  - Drug Option A: $1,200 per household
  - Drug Option B: $2,500 per household
- **PLAN 2:** If you and your spouse were born in 1940 or later:
  - Drug Option A: $1,500 per household
  - Drug Option B: $3,500 per household

100% Reimbursement to a Calendar Year maximum of $850 is covered for the Member (included in the household Calendar Year maximum).

**Non-Subsidized Plan Members:**

Direct Pay Drug Maximum Options for Members **without** Subsidized Benefits through the Pension Plan

A Member can choose between two calendar year maximums for prescription drug coverage: 80% of the first $1,500 of your household’s out-of-pocket costs, then 100% coverage, to your choice of two annual calendar year maximums:

- **PLAN 1:** If either you or your spouse was born in 1939 or earlier:
  - Drug Option A: $1,200 per household
  - Drug Option B: $2,500 per household
- **PLAN 2:** If you and your spouse were born in 1940 or later:
  - Drug Option A: $1,500 per household
  - Drug Option B: $3,500 per household

Regardless of subsidy status this plan shall cover all prescription drugs included in the BC Provincial Formulary – to the least cost alternative (LCA) price for brand-name drugs which are interchangeable with generics, and to the reference-based price for drugs which are not interchangeable, with a $10 dispensing fee cap and 8% mark-up limit.

Regardless of subsidy status an Insured Person under Drug Option B is required to remain covered for a minimum period of 24 months from the effective date of coverage before lowering the drug maximum option to Drug Option A.
7. **Premium Payments**

The premiums applicable to this insurance are payable in advance on each premium due date. Premiums are paid by regular, interest-free monthly deductions as authorized on the application for benefits.

To request a cancellation and/or refund of premium, the following provisions apply. All requests must be made in writing to the Administrator:

A refund and/or adjustment of premium is available under the Supplemental Plan providing no Emergency Medical or Trip Interruption & Delay insurance claims have been made or are pending:

a) in the event of an early return from a trip, proof of early return must be provided in the form of a stamped passport, airline ticket or boarding pass, credit card receipt, border crossing slip, or any signed and dated document that proves you have returned to your province or territory of residence; and

b) in the event that a situation covered under this insurance occurs which necessitates Trip Cancellation before your day of departure, you may request a refund of premium or alternatively, a change in your Supplemental Plan trip dates.

In the event of an early return from a trip, no downgrade in coverage or refund of premium is permitted under the Supplemental Plan if a claim has been incurred during the supplemental portion of your trip.

8. **Grace Period**

After the initial premium payment, each subsequent payment must be received within thirty-one (31) days after the premium due date, otherwise the Insured Person’s coverage will be automatically terminated at the end of the grace period.

9. **Termination of a Member’s Insurance**

Coverage for a member under this plan shall terminate on the earliest of the following dates:

a) the date the plan is terminated by the Insurer or Policyholder;

b) the date the member requests in writing to terminate coverage;

c) the date the member no longer makes premium payments, following the 31 day grace period;

d) the date the member is no longer eligible for coverage;

e) the date the member enters the Armed Forces of any country, state or international organization on a full-time basis; or

f) the date the member dies.

10. **Termination of a Dependent’s Insurance**

Coverage for a dependent under this plan shall terminate on the earliest of the following dates:

a) the date the plan is terminated by the Insurer or Policyholder;

b) the date the member requests in writing to terminate dependent coverage;

c) the date of termination of the member’s coverage, except that coverage may be continued in the event of the member’s death in 5(a) of the general provisions;

d) the date the contributions to the cost of coverage are ceased;

e) the date the dependent is no longer eligible for coverage;

f) the date coverage for dependents is terminated; or

G) the date the dependent enters the Armed Forces of any country, state or international organization on a full-time basis.
11. **Automatic 72 Hour Extension of Emergency Medical Travel Coverage (Type “B” Expenses)**

An Insured Person’s Emergency Medical Travel Coverage will be automatically extended beyond the first 62 days of travel coverage by the Extended Health Plan if:

a) Insured Person, a Travelling Companion, or an Immediate Family Member travelling with the Insured Person is hospitalized due to a medical Emergency on or before the 62\textsuperscript{nd} day of travel. Coverage will remain in force for as long as Insured Person, Travelling Companion, or Immediate Family member is hospitalized plus an additional period of 72 hours following discharge from Hospital.

b) the period of insurance coverage is automatically extended for 72 hours when:
   i) the delay of a plane, bus, ship or train in which the Insured Person is a passenger causes him or her to miss his or her scheduled Date of Return to his or her province or territory of residence;
   ii) the personal means of transportation in which the Insured Person is travelling is involved in an accident or mechanical breakdown that prevents him or her from returning to his or her province or territory of residence; or
   iii) the Insured Person must delay his or her scheduled Date of Return to his or her province or territory of residence by the personal means of transportation in which he or she is travelling, due to extreme weather conditions.

12. **Incontestability**

No statement made by you in your application for insurance, except for fraudulent statements and omissions, shall be used by the Company to contest a claim after your insurance has been in force for two (2) years following the policy issue date.

13. **Applicable Law**

Any provision of this policy which is in conflict with any federal, provincial or territorial law of the Insured Person’s place of residence is amended to comply with the minimum requirements of that law. All other provisions shall remain in full force and effect.

14. **Non-waiver Provisions**

Failure by the Company or the Plan Administrator to enforce any provision of this policy in a given circumstance shall not constitute a waiver of the right to enforce the provision at any other time. No one other than the Company has the authority to change or waive any provision of the policy.

15. **Limitation of Liability**

The Company, the Plan Administrator or the Travel Assistance Company are not responsible for the availability, quality or results of any medical treatment or transportation, or the failure of an Insured Person to obtain medical treatment.

16. **Right of Examination of the Master Policy**

An Insured Person and/or his or her personal representative shall, upon request, be permitted to examine this Master Policy, at the Plan Administrator’s place of business or the head office of the British Columbia Government Retired Employees’ Association, for the purpose of ascertaining the benefits, terms and provisions of this agreement; provided that any such examination takes place during the normal business hours.
CLAIMS

1. Notice and Proof of Claim

When the Plan Administrator receives a written completed claim form and appropriate receipts, payment will be made to the Insured Person, for charges for eligible expenses, upon submission of written proof of claim, satisfactory to the Plan Administrator, and subject to the terms and conditions of the Master Policy.

An Insured Person must submit a pre-authorization form completed by the attending physician for any treatments, services or supplies which require the prior approval of the Plan Administrator, before a claim shall be paid.

Charges for eligible expenses submitted as a claim shall be considered to have been incurred on the date the person received the treatment, services or supplies, or incurred an obligation with the provider for such treatment, services or supplies.

Written proof of claim, satisfactory to the Company, must be submitted to the Plan Administrator, by the end of the Calendar Year following the year in which the claim was incurred.

On termination of an Insured Person's coverage for any reason, including as a result of termination of this policy, written proof of claim satisfactory to the Plan Administrator must be received no later than 90 days following the date of termination.

Failure to give notice of claim or furnish proof of claim within the time prescribed herein does not invalidate the claim if the notice or proof is given or furnished as soon as reasonably possible, and in no event later than one year from the date a claim arises hereunder, if it is shown that it was not reasonably possible to give notice or furnish proof within the time so prescribed.

For claims information, contact the Johnson Inc. claims department at 780-413-6599 or 1-877-413-6599.

Notice of Claim for Type “B” Expenses:

In the event of a medical emergency, Sigma Assistel will direct the Insured Person to the nearest appropriate medical facility. Sigma Assistel will pay Hospitals and other medical providers directly, wherever possible, except when the Insured Person chooses to pay the expenses or when the medical care provider refuses to accept payment directly from Sigma Assistel. To ensure expenses are covered and to benefit from the assistance services available, the Insured Person must notify Sigma Assistel when he/she has an Emergency and preferably before hospitalization, or within 48 hours after admission to a Hospital. If the Insured Person is unable to do so because he/she is medically incapacitated, someone else must do so as soon as is reasonably possible. Otherwise eligible expenses will be limited to $2,000.

To make a claim for Type “B” expenses under this policy, notice of the claim must be submitted to Sigma Assistel within thirty (30) days after the medical Emergency occurs, or as soon as is reasonably possible thereafter. A phone call to Sigma Assistel to report the claim will be considered “Notice of Claim” under the terms of the policy.
CLAIMS

Written proof of claim must be submitted within 90 days after the date of the medical Emergency, but not after the end of the Calendar Year following the year in which the Medical Emergency was incurred. Written proof of claim will include the completion of any claim forms furnished by Sigma Assistel, supported by original receipts, the attending Physician’s report or statement, and any other form of documented evidence requested by Sigma Assistel. In the event that the claim is reported to Sigma Assistel by phone, and the provider of the treatment agrees to bill directly for the eligible expenses, Sigma Assistel will, where possible, obtain the documentation necessary to process the claim. If the Insured Person arranges treatment and pays the eligible expenses, they must provide the documentation indicated.

All documents necessary to support a claim must be provided to Desjardins Financial Security and / or Sigma Assistel Canada at the Insured Person’s expense.

2. Co-ordination of Benefits Between Two Private Plans
Payment for benefits provided under the policy will be co-ordinated with other benefits or payments available to the Insured Person under any other private health insurance policy or pre-paid plan. Payments under all policies or plans, including this plan, shall be co-ordinated so that total payment does not exceed 100% of the eligible expenses incurred. This means that when the Insured Person is entitled to similar payments under one or more plans, payments under this Policy will be reduced to the extent necessary so that they do not exceed 100% of eligible expenses incurred, after taking into account payments from the other plans. This provision does not apply to any government health insurance.

Order of Benefit Determination
If a person is eligible to receive a benefit under the policy and the same or a similar benefit under any other contract, policy or plan, payment of benefits shall be decided in the following manner:

a) a plan without a Co-ordination of Benefits provision pays before a plan with a Co-ordination of Benefits provision;
b) when both plans contain a Co-ordination of Benefits provision, priority of benefit payment is attributed to the plan under which the Insured Person is entitled to receive payments in the following order:
   i) first to the plan to which the Insured Person is the insured participant or member; or
   ii) second to the plan that the Insured Person is a dependent of the insured participant or member; or
   iii) a person who is an insured dependent child under more than one plan, should submit to the plan where the parent, whose birthday is the earlier date in Calendar Year, is the insured participant or member;
   iv) if priority cannot be established in the above manner, the benefit payments shall be pro-rated between or amongst the plans in proportion to the amounts that would have been paid under each plan had there been coverage by just that plan.

The Company is entitled to make payments to, and to recover payments from, other plans, as necessary in accordance with the intentions of this provision.

The Plan Administrator may (subject to the consent of the Insured Person, if so required by law), obtain from or release to any person or corporation, any information considered necessary to implement this provision and facilitate the payment of benefits under this agreement.
3. **Right to Recover Payments**
   If after benefit payments have been made to or on behalf of any Insured Person, it is discovered that, due to clerical, electronic or administrative error, payment was made inadvertently or in excess of the amount(s) required to satisfy the terms of this policy, the Company reserves the right to recover the inadvertent or excess payment(s) from the Insured Person or to the organization to whom the payment was paid.
   If the amount of the inadvertent or excess payment(s) cannot be recovered within a reasonable time period, the Company has the right to reduce future benefit payments to or on behalf of the Insured Person until such amount(s) are recovered in full.

4. **Subrogation from a Third Party**
   If the Company pays any benefits in respect of a sickness or injury where a third party is liable, the Insured Person's right of recovery shall be subrogated to the Company to the extent of the benefits paid, and the Company may bring action in the name of the Insured Person to enforce such right where permitted by law.

   In such an event, the Insured Person and his/her legal representative shall co-operate with the Company to facilitate recovery and settlement of any payments, in order to satisfy the intent of this provision.

5. **Authorization**
   An Insured Person as a condition precedent to receiving benefits under this agreement, consents to, authorizes and directs any person or corporation to provide the Plan Administrator with any reports, records, x-rays or other information relating to the treatment, services or supplies for which the claim is made.

6. **Limitation of Action**
   In the event of a claims dispute, an Insured Person must bring any legal action or proceeding against the Company within 24 months of the date the charges were incurred or the date on which they return to their province or territory of residence, whichever applies. All legal actions or proceedings must be brought in the Canadian province or territory in which the Insured Person permanently resides.

7. **Duplicate Coverage**
   If there is any duplication of expenses between Both Type “A” and “Type “B” Eligible Expenses, expenses which are incurred outside the insured individual’s province of residence in the event of an emergency while travelling shall be payable as Type “B” Eligible Expense, not as Type “A” Eligible Expenses.

8. **Returning a Patient to their Province of Residence (Type “B” Expenses)**
   The Company, through Sigma Assistel, in consultation with the attending physician, reserves the right to return the sick or injured Insured Person to his or her province or territory of residence. If in consultation with the attending physician, an Insured Person is able to return to their province or territory of residence following the diagnosis of, or emergency medical treatment and / or diagnosis of a medical condition which requires continuing medical care, treatment or surgery, and the Insured Person elects to have the treatment or surgery performed outside their province of residence, no benefits shall be payable with respect to such continuing treatment or surgery. The immediate availability of treatment or surgery on return to the province of residence is not the responsibility of the Company, Sigma Assistel or the Plan Administrator.
9. **Proof of Day of Departure (Type “B” Expenses)**

In the event of a claim, the Insured Person will be required to provide proof of the Day of Departure from his / her province or territory of residence.

Proof of Day of Departure includes: a border crossing receipt, duty free receipt, airplane ticket or boarding pass, stamped passport, credit card receipt, signed and dated bank or financial institution documents, or any signed and dated document that proves the Insured Person was in his / her province of residence the day before the schedule Day of Departure.

10. **CONTACT IN THE EVENT OF A MEDICAL EMERGENCY (Type “B” Option)**

The Insured person must contact Sigma Assistel directly when a medical Emergency arises, at their 24-hour Emergency Helpline:

Sigma Assistel  
Canada/USA: 1-877-775-3695  
Other Locations (Call Collect): (514) 875-3695  
Fax: (514) 875-7729

Sigma Assistel will direct the Insured Person to the nearest appropriate medical facility. Sigma Assistel will pay Hospitals and other medical providers directly, wherever possible, except when the Insured Person chooses to pay the expenses or when the medical care provider refuses to accept payment directly from Sigma Assistel.

**IMPORTANT TO REMEMBER!**

To benefit from the assistance services available and to ensure expenses are covered, the Insured Person must notify Sigma Assistel when he / she has an Emergency and preferably before hospitalization or within 48 hours after admission to a Hospital. If the Insured Person is unable to do so because he / she is medically incapacitated, someone else must do so as soon as is reasonably possible. Otherwise eligible expenses will be limited to $2,000.
DESCRIPTION OF BENEFITS

If the Insured Person incurs charges for medically necessary treatment, services or supplies which are covered under the policy, the Company will pay benefits, subject to the terms, conditions and limitations outlined in the policy.

Benefits are payable to the extent that:

a) the charges are reasonable and customary for the services rendered and do not exceed the maximum amount specified and are paid according to the Benefit Schedule;

b) there is no law or legislation prohibiting insuring such services in the Insured Person's province or territory of residence;

c) the services were authorized in writing as medically necessary by a Practitioner operating within the scope of his or her license except as otherwise stated;

d) the amount claimed is not covered, or exceeds the amount allowed under the Government Health Insurance Plan for the services provided; and

e) the charges are for treatment of an illness or injury.

Under this policy, coverage for medical expenses is supplementary to and not a replacement for coverage under the Insured Person's Government Health Insurance Plan in their province or territory of residence.

Charges for the following services are included as Eligible Expenses for reimbursement under your policy:

**Extended Health Care Type “A” Expenses (In-Provience Expenses)**

Eligible In-Provience Expenses are reimbursed at 80% and to the specified dollar maximum (where applicable) unless otherwise noted.

1. **Direct Pay Prescription Drugs and Medicine**

   **Subsidized Plan Members**

   Direct Pay Drug Maximum Options for Members with Subsidized Benefits through the Pension Plan

   A Member can choose between two calendar year maximums for prescription drug coverage:

   - **PLAN 1**: If either you or your spouse was born in 1939 or earlier:
     - Drug Option A: $1,200 per household
     - Drug Option B: $2,500 per household
   - **PLAN 2**: If you and your spouse were born in 1940 or later:
     - Drug Option A: $1,500 per household
     - Drug Option B: $3,500 per household

   100% Reimbursement to a Calendar Year maximum of $850 is covered for the Member (included in the household Calendar Year maximum).
Non-Subsidized Plan Members:

Direct Pay Drug Maximum Options for Members without Subsidized Benefits through the Pension Plan

A Member can choose between two calendar year maximums for prescription drug coverage: 80% of the first $1,500 of your household’s out-of-pocket costs, then 100% coverage, to your choice of two annual calendar year maximums:

- **PLAN 1:** If either you or your spouse was born in 1939 or earlier:
  - Drug Option A: $1,200 per household
  - Drug Option B: $2,500 per household
- **PLAN 2:** If you and your spouse were born in 1940 or later:
  - Drug Option A: $1,500 per household
  - Drug Option B: $3,500 per household

Regardless of subsidy status this plan shall cover all prescription drugs included in the BC Provincial Formulary for eligible prescription drugs and medicines and will be reimbursed to the least cost alternative (LCA) price for brand-name drugs which are interchangeable with generics, and to the reference-based price for drugs which are not interchangeable, with a $10 dispensing fee cap and 8% mark-up limit. This includes:

a) medically necessary drugs, sera and injectables which legally require a prescription and are approved by Health Canada, or the Provincial Health Ministry, which:
   i) are prescribed by a physician or dentist for the treatment of a diagnosed illness or injury; and
   ii) are dispensed by a licensed pharmacist, physician or dentist legally authorized to dispense such drugs and medicines.
   iii) are included under the Drug Formulary.

b) drugs and medically required supplies of a non-prescription nature required as a result of a colostomy or ileostomy and/or for the treatment of cystic fibrosis, diabetes and Parkinson.

c) medically necessary drugs prescribed for the treatment of heart disease.

For Subsidized Plan Members the following non-prescription benefits are available for your covered spouse and eligible dependents only (i.e. member covered for prescription drug and emergency travel coverage only). For Non-Subsidized Plan Members the following non-prescription benefits are available to the plan member, your covered spouse and eligible dependents.

2. **Accidental Dental**

Services by a dentist or dental surgeon to repair or replace damaged natural teeth, (crowned or capped teeth are considered to be natural teeth) to set or repair a broken or dislocated jaw when the injuries are caused by an external accidental blow to the head or mouth (and not caused by any object or food intentionally placed in the mouth) subject to a $1,000 per insured person calendar year maximum. The injury must have occurred after the effective date of coverage under the plan and while coverage is in force.

Treatment must be completed within six (6) months following the date of the injury. No benefit will be payable for charges incurred for such services after the termination date of this policy or after the termination date of the Insured Person’s coverage. Chewing Accidents are not covered.
Payment for insured services will be based on the British Columbia Dental Association Fee Guide which reflects current and customary fees for General Practitioners in effect in the Insured Person's province or territory of residence on the date the charges were incurred.

The claim must be accompanied by one of the following: (i) an official police or accident report, (ii) an accidental dental claim form filled out by a licensed Dentist, Dental Surgeon, and injured Insured Member (form to be provided by the Plan Administrator), or (iii) an emergency hospital or medical facility report.

3. **Medical Aids and Appliances**

80% Reimbursement coverage for the purchase or rental of items listed below are subject to charges which are reasonable and customary for the area where incurred (as determined by the Plan Administrator’s records). Claims for the following eligible aids and appliances must include written authorization from the attending Practitioner and must be for therapeutic use only:

a) trusses, splints, braces, crutches, canes, casts, artificial limbs or eyes, or breast prosthesis, including two mastectomy bras per year;
b) surgical support stockings, subject to a maximum benefit of $200 per insured person per calendar year;
c) custom-made orthopaedic shoes, which are not part of a brace, and orthotics, including orthopaedic adjustments to stock items and excluding the cost of pre-manufactured footwear, subject to a maximum benefit of $500 per insured person every three calendar years for orthopaedic shoes and $300 per insured person every three calendar years for orthotics;
d) orthopaedic shoes that are attached to and form part of a brace;
e) incontinence supplies; subject to a maximum benefit of $200 per insured person per calendar year;
f) a medically necessary geriatric chair, subject to a lifetime maximum of $1,000 per insured person;
g) visual enhancement equipment, subject to a maximum of $200 per insured person per two (2) calendar years. The following prescribed medical devices and equipment will be covered under the vision enhancement benefit:
   1. An optical scanner or similar device, as recommended by a physician, designed to enable an individual with a severe vision impairment to read print;
   2. A device or equipment, including a synthetic speech system, Braille printer and large print-on-screen device, as recommended by a physician, designed exclusively for use by an individual who has a severe vision impairment; and
   3. Hand-held magnifiers.

Reimbursement of charges, upon written recommendation of a physician and completion of an authorization form provided by the Program Administrator, for the rental (or purchase) of:

h) a manual wheelchair to a maximum of $2,000 per insured person per five (5) calendar years, or an electric wheelchair to a maximum of $5,000 per insured person per five (5) calendar years;
i) a hospital bed;
j) a respirator ventilator; or
k) a CPAP device or similar appliance for the treatment of sleep apnea to a maximum of $2,000 per insured person per five (5) calendar years.
4. **Ambulance Services**  
80% Reimbursement for eligible charges incurred for the cost of the following:  
a) licensed ground ambulance to and from a local hospital **when medically necessary for emergency treatment**; and  
b) emergency transportation inside the person’s province of residence by a licensed ambulance, air-ambulance or by any other public transportation vehicle, to the nearest hospital in which the required treatment can be provided, subject to one return trip per insured person per calendar year.

Charges for licensed ground ambulance service to and from points of departure and arrival are also covered.

Charges for non-emergency use of an ambulance used solely as a means of transportation in lieu of other forms of transportation, i.e. taxi, bus, para-transport, are not covered.

5. **Diagnostic Services**  
80% Reimbursement of expenses after the eligible portion, where applicable, has been paid by your Provincial Government Health Insurance Plan for:  

a) diagnostic procedures, radiology (when not confined to a hospital), blood transfusions; and  
b) oxygen and its administration in both province of residence and outside province of residence.

*Expenses related to maintenance of equipment are not eligible for reimbursement.*

6. **Hearings Aids**  
80% Reimbursement for charges for the purchase or repair of either a single or dual contact hearing aid(s), upon the written recommendation of the attending licensed, certified or registered audiologist, otolaryngologist, otologist or physician. The maximum benefit payable is $1,000 per insured person every five (5) consecutive calendar years.

7. **Private Duty Nursing**  
80% Reimbursement of charges to an overall maximum benefit of $3,000 per insured person in any three (3) consecutive calendar years for the professional services of a Registered Nurse (R.N.), a Licensed Practical Nurse, or a Registered Nursing Assistant upon written recommendation of a physician and completion of an authorization form provided by the Program Administrator, while the patient is not confined to a hospital or nursing home subject to the provision that such nurse does not ordinarily reside in the home of the member or any of the member’s dependents and is not related to the member by blood or marriage. **Custodial (i.e. housekeeping), homemaking and companion services are not covered.**

8. **Paramedical Services**  
80% Reimbursement of charges for the services, including laser therapy, of any of the paramedical practitioners listed below when the practitioner is:  
a) licensed, certified or registered; and  
b) providing services within his/her recognized field.
When applicable, benefits are only payable in excess of the yearly maximum benefit payable under the insured individual’s provincial plan. The maximum benefits payable for Chiropractor, Physiotherapist, Athletic Therapist, Psychologist, Speech Therapist, Naturopath, Acupuncturist, Osteopath, Podiatrist/Chiropodist and Massage Therapist expenses is $1,000 combined per insured person per calendar year. A statement of diagnosis from your physician may be required.

9. **Prescribed Health Educational Programs**
80% Reimbursement of charges for wellness, rehabilitation and other medically related educational program(s) recommended by a physician and subject to a maximum of $100 per insured person per calendar year. This does not include fitness club fees and/or memberships.

10. **Referral for Treatment Outside Canada**
80% Reimbursement for charges when the insured person is referred by a physician in Canada to a hospital outside Canada for medically necessary treatment which is unavailable in Canada and for which there is no medically sufficient alternate treatment available in Canada, and which is eligible for reimbursement in whole or in part by a provincial medical plan, the following expenses in excess of any provincial government plan allowance are covered for reimbursement.

   a) reasonable and customary hospital charges for ward accommodation and for “Special Hospital Services”, subject to a maximum payment for 31 days during any one period of disability; and
   b) reasonable and customary charges for the services of a physician.

11. **Vision Care**
80% Reimbursement of charges for the following vision care services and supplies when recommended or provided by an ophthalmologist or optometrist:

   a) prescription lenses, frames and fitting of prescription eyeglasses, including prescription sunglasses and contact lenses not covered in 2) below, up to a maximum benefit of $300 per insured person in any two (2) consecutive calendar years. If new lenses are required due to eye surgery, additional benefits in excess of those described above will be payable up to a lifetime maximum of $175 per insured person.

   b) contact lenses prescribed for severe corneal astigmatism, severe corneal scarring, keratoconus (conical cornea), or aphakia, provided visual acuity can be improved to at least the 20/40 level by contact lenses but cannot be improved to that level by eyeglasses, subject to a maximum benefit of $200 per insured person in any two (2) consecutive calendar years;

   c) visual training or remedial exercise not covered by the provincial health plan; and

   d) ocular examinations, including refraction, limited to not more than one in any calendar year for dependent children, and not more than one in any two (2) consecutive calendar years for other insured persons, up to a maximum of $100.

12. **Hospital Accommodation**
100% reimbursement of the difference between standard ward and semi-private or private hospital accommodation charges in a licensed hospital in Canada, including a convalescent or rehabilitative hospital (not homes), limited to a maximum of $100 per insured person per day (excluding charges for accommodation and care in a chronic care facility).
13. **Home Care**

80% Reimbursement for charges after a hospital stay of at least 24 hours, reimbursement of home care expenses are covered up to a maximum of $50 a day per insured person, for up to 10 days – upon written recommendation of a physician and completion of a Johnson Inc. authorization form and provided in your own home. This service may be rendered by persons without professional skills or training working under the supervision of a Home Care Agency or a Home Health Care Agency. The level of care includes assisting with:

a) activities of daily living (eating, bathing, dressing);
b) ambulation and exercise;
c) self-administered medications;
d) homemaker services or home health aide services; and
e) services needed to maintain or improve the insured's functional ability.
f) respite care to maintain your health or safety and to provide temporary relief from care giving duties to a member of your immediate family or other unpaid person who is your primary caregiver.
g) outpatient services and supplies not covered by the provincial government.

The home caretaker must not ordinarily reside in your home or any of your dependents and must not be related to you by blood or marriage.
Extended Health Care Type “B” Expenses (Emergency Travel Expenses)

This plan is administered by Johnson Inc. (Johnson). It is underwritten by Desjardins Financial Security (Desjardins Financial Security), which has appointed Sigma Assistel Canada Inc. (Sigma Assistel) as the sole provider of all assistance and claims services under this policy.

IMPORTANT: Benefits and services eligible for payment under this policy must be pre-approved and arranged in advance by Sigma Assistel. Please read this certificate of insurance carefully.

Immediate contact to Sigma Assistel is necessary to ensure expenses are covered. At first onset of symptoms of a medical emergency and before the Insured Person seeks medical attention, he / she should contact the 24-hour Sigma Assistel Assistance Centre; however if the Insured Person is unable to do so because he / she is medically incapacitated, someone else must contact Sigma Assistel as soon as is reasonably possible. Otherwise eligible expenses will be limited to $2,000.

Type “B” expenses will be considered providing:

a) the insured is covered by a provincial or territorial Government Health Insurance Plan;

b) the charges fulfill the requirements of an eligible expense as described in the Benefit Schedule;

c) the expenses were incurred as a result of:

i) a medical emergency due to an injury or sudden illness;
ii) of a medical emergency which occurs while the insured is travelling outside his/her province of residence or outside Canada;
iii) travelling for non-medical reasons (e.g. while on vacation trip or a business trip); and
iv) within 62 days of the date the insured departs on the trip, or of the Effective Date of Coverage, if later.
v) the insurance is effective on the date the insured departs on the trip.

Type “B” eligible expenses will not be reimbursed if they are incurred while an insured is referred outside his/her province of residence or Canada for medical treatment.

Any emergencies that occur while travelling in excess of 62 days but not more than 182 days of the date the insured departs on the trip (or of the Effective Date of Coverage, if later), will only be covered if Supplemental Plan (extended outside province/Canada emergency medical coverage) was purchased. For those members who purchase Supplemental coverage, the days covered between the 63rd and 182nd day will depend on the amount of Supplemental coverage purchased.

If you experience a travel delay due to weather conditions, car trouble or sudden illness, a 72-hour grace period will be in effect.
DESCRIPTION OF BENEFITS

All eligible Type “B” expenses will be reimbursed at 100%. The expenses that are covered in addition to and after any government sponsored plan, shall include:

1. **Hospital Accommodation**
   Reimbursement of:

   a) Room and board charges made by a licensed hospital up to the charge for semi-private room accommodation; and

   b) Hospital charges incurred as an outpatient for necessary medical and surgical treatment (excluding physicians’ and special nurses’ fees).

2. **Physicians’ Services**
   Reimbursement of reasonable and customary charges made for the medical, surgical or anaesthetic services of a physician or surgeon, where permitted by law.

3. **Private Duty Nursing**
   Reimbursement of charges for the professional services of a Registered Nurse (R.N.) while the patient is not confined to a hospital, subject to prior approval from Sigma Assistel Canada and to a maximum benefit of $5,000 per insured person per calendar year, provided such nurse does not ordinarily reside in the home of the member or any of the member’s dependents and is not related to the member by blood or marriage.

   *Custodial (i.e. housekeeping), homemaking and companion services are not covered.*

4. **Drugs**
   Reimbursement of charges for medically necessary drugs, sera and injectables which legally require a prescription and are approved by Health Canada, or the Provincial Health Ministry, which:

   a) are prescribed by a physician or dentist for the treatment of a diagnosed illness or injury; and

   b) are dispensed by a licensed pharmacist, physician or dentist legally authorized to dispense such drugs and medicines.

5. **Diagnostic Services**
   Reimbursement of expenses after the eligible portion, where applicable, has been paid by your Provincial Government Health Insurance Plan where applicable, for diagnostic procedures, radiology or x-ray services.

6. **Aids and Appliances**
   Reimbursement of charges for the rental of a wheelchair, crutches or canes when ordered by a physician.
7. **Accidental Dental**
Reimbursement of charges for necessary dental treatment required as the direct result of accidental injury or damage from an external blow to natural teeth or artificial teeth provided the accident occurred while insured under this coverage. The dental work must be completed within 6 months of the accident and while coverage is in effect to be a covered expense. *Chewing accidents are not covered.*

The eligible expenses for such dental treatment shall be limited to the expenses incurred only to repair the damage resulting directly from the accident, up to a maximum benefit of $1,000 per insured person per calendar year (including up to one set of artificial teeth when natural teeth have been damaged). Reimbursement will be based on the British Columbia Dental Association Fee Guide, which reflects current and customary fees for General Practitioners.

8. **Paramedical Services**
Reimbursement of charges for the services of any of the paramedical practitioners listed below when the practitioner is:

- a) licensed, certified or registered; and
- b) providing services within his/her recognized field.

These services must be medically necessary and the Insured Person’s attending physician verifies in writing that the treatment is necessary as a result of an emergency. Where applicable, benefits are only payable in excess of the yearly maximum benefit payable under the insured individual’s provincial plan. **Approval must be arranged in advance by Sigma Assistel Canada.** The maximum benefits payable under this plan are as follows:

<table>
<thead>
<tr>
<th>Paramedical Practitioner</th>
<th>Maximum Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chiropractor</td>
<td>$225 per insured person per calendar year</td>
</tr>
<tr>
<td>Podiatrist/Chiropodist</td>
<td>$225 per insured person per calendar year</td>
</tr>
<tr>
<td>Physiotherapist</td>
<td>$225 per insured person per calendar year</td>
</tr>
</tbody>
</table>

9. **Transportation**
Reimbursement of charges for:

- a) licensed ground or air ambulance to the nearest medical care facility in which the required treatment can be provided, subject to a limit of one return trip;
- b) extra costs of return economy fare by the most direct route (air, bus or train) to the insured’s normal place of residence when an insured’s illness is such that he/she must return home and be accompanied by a qualified medical attendant. Written authorization that such emergency transportation and the care of a medical attendant is required must be provided by the attending physician. Coverage includes:
  - i) one economy seat for the insured, or the number of economy seats required to accommodate the insured if the insured must be transported on a stretcher; and
  - ii) one economy round trip fare for a medical attendant who is not related to the insured by blood or marriage.
c) one round trip economy fare (air, bus or train) by the most direct route from Canada, of an insured person’s immediate family member to be with the insured, who has been confined to a hospital, when:
   i) the attendance of a family member is recommended in writing by the insured’s attending physician; and
   ii) the insured is confined to a hospital for three days or more.

d) one round trip economy fare for an immediate family member of the deceased insured person, by the most direct route (air, bus or train), when it is necessary to identify the deceased prior to the release of the body.

_All transportation must be pre-approved and arranged by Sigma Assistel Canada._

10. Trip Cancellation or Trip Interruption /Delay

_Trip Cancellation – PRIOR to Departure_

In the event the Insured Person must cancel his / her Trip, the Insured Person will be reimbursed the non-refundable portion of the pre-paid travel arrangements up to a maximum of $6,000 per Insured Person per Trip.

Note: This insurance does not cover trips within the Insured Person’s province or territory of residence and must be in effect prior to the event which necessitates a claim. When the reason for cancellation occurs prior to departure of an insured Trip, the Insured Person must cancel his / her Trip with the travel agency or Travel Supplier and notify Sigma Assistel Canada within 48 hours following the event forcing cancellation. Any issued ticket(s) must be surrendered to Sigma Assistel Canada.

_Trip Interruption and Delay – POST Departure_

In the event the Insured Person must curtail his / her Trip or delay his / her Day of Return, the Insured Person must contact Sigma Assistel Canada within 48 hours of the event forcing interruption / delay. The Insured Person will be reimbursed for the extra cost of a one-way economy airfare to the departure point or to the destination point and any unused non-refundable land arrangements up to a maximum $6,000 per Insured Person per Trip.

_Expenses will be reimbursed when the Insured Person provides, at Desjardins Financial Security’s discretion, any of the following when applicable:_

a) a statement completed by the Physician in personal attendance in the locality where the Sickness or Injury occurred stating the diagnosis and the complete reason for the necessity of delay or cancellation of the Insured Person’s Trip;

b) documentary evidence of the Emergency situation which caused the delay;

c) proof that a portion of the travel arrangement costs are non-refundable;

d) any unused transportation tickets;

e) any receipts for land arrangements and out-of-pocket expenses;

f) any tickets or receipts for any extra transportation cost incurred.
Trip Cancellation and Trip Interruption / Delay benefits are covered where applicable upon the occurrence of any of the following events:

a) Death, Injury or Sickness of an Insured Person, an Extended Family Member, a Close Business Associate, or a Travelling Companion.

b) Insured Person being called unexpectedly for jury duty or being subpoenaed as a witness in a case being heard during the Trip.

c) A transfer by employer of the Insured Person or his / her Spouse for which notice was received from the employer subsequent to the booking and prior to scheduled Day of Departure, if the date of transfer is coincident with or prior to the scheduled Day of Departure, and requires a move to a new principal residence.

d) Damage to the Insured Person’s principal residence by a disaster making it uninhabitable.

e) Hijack of a Common Carrier in which an Insured Person is travelling.

f) Terrorism in a country that an Insured Person is scheduled to visit, which leads to a recommendation by the Government of Canada that Canadians should not travel to that area due to Terrorist incidents for a period which includes the Day of Departure.

g) Death, quarantine or hospitalization for at least 48 hours, of host at destination.

h) A natural disaster at the place of destination.

i) Medical quarantine of an Insured Person for a communicable disease diagnosed by a Physician.

j) If an Insured Person is involuntarily dismissed or laid-off from his / her principal employment within 30 days of the scheduled Day of Departure, provided a letter of termination is produced, and provided the Insured Person had no knowledge of this loss on the date of application for insurance.

k) Refusal of an Insured Person’s visa, provided that documentation shows he or she was eligible to apply, that refusal is not due to a late application, and that the application is not a subsequent attempt for a visa that had been previously refused.

l) If the Insured Person misses the originating flight from the scheduled departure point or cruise due to delay of the Insured Person’s connecting carrier (plane, ship, bus, limo, taxi, train, auto) resulting from inclement weather conditions, mechanical failure, traffic accident, police-directed road closure or flight delay.

m) Cancellation of a planned business meeting due to death or hospitalization of the person with whom the Insured Person is to meet, or cancellation of a conference (for which the Insured Person has paid registration fees) due to circumstances beyond the control of the Insured Person. Benefits are only payable to the Insured Person who is attending the meeting. Proof of registration will be required in the event of a claim.

n) A call to service of the Insured Person by Government with respect to reservists, military, police or fire personnel.

11. Additional Expenses
Reimbursement of charges, when a trip is interrupted or delayed due to hospitalization of an insured person, for board, lodging or similar expenses incurred by insured persons and/or travelling companions who remain with the hospitalized person up to a combined daily limit of $150 for no more than 10 days. Receipts for all expenses must be provided.
12. **Vehicle Return**

Reimbursement of charges and arrangements, upon prior approval from Sigma Assistel Canada, if an insured individual is unable to operate his/her owned or rented vehicle due to sickness, injury or death while travelling outside his/her normal province of residence, for the return of the vehicle up to a maximum of $2,000 (Canadian). Benefits will only be payable for return of the vehicle:

a) to the insured individual’s normal place of residence; or
b) to the nearest appropriate rental agency.

Expenses incurred by anyone travelling with the person returning the vehicle are not covered.

13. **Return of Dependent Children**

Reimbursement of charges and arrangements, upon prior approval from Sigma Assistel Canada, for the return of dependent children or grandchildren by the most direct route to their normal place of residence in Canada if the dependent children are left unattended while travelling because of the hospitalization of a member or the member’s spouse, payable up to:

a) a one-way economy fare; or
b) the excess cost over and above any allowance available under pre-paid travel arrangements.

If necessary, arrangements will be made for a qualified escort to accompany the children on the return trip. Charges for the round trip economy transportation of the escort will also be payable.

14. **Repatriation**

All necessary arrangements and authorizations will be obtained for the repatriation of a deceased member’s or dependent’s body.

Reimbursement of charges for such repatriation (including cremation) and the transportation of the deceased’s body to the first resting place (including but not restricted to a funeral home or place of interment) in proximity to the deceased’s normal place of residence will be payable up to a maximum of $5,000 (Canadian).

Charges for a burial coffin will not be payable.

15. **Sigma Assistel Travel Assist Services**

In an Emergency, the Insured Person or someone on their behalf must contact Sigma Assistel to ensure the Insured Person’s expenses are covered. At the first onset of symptoms of an Emergency, and before the Insured Person seeks medical attention, he / she must contact the 24-hour Sigma Assistel Assistance Centre. If the Insured Person is unable to do so, because he / she is medically incapacitated, someone else must contact Sigma Assistel as soon as is reasonably possible. This call to the Sigma Assistel Emergency Assistance Helpline will entitle the Insured Person to receive the following services:

a) **Medical Assistance and Consultation**

   The Insured Person will be directed to the nearest appropriate medical facility. Sigma Assistel will verify coverage to ensure there are no delays in treatment.

b) **Up Front Payment**

   For eligible medical expenses, Sigma Assistel will guarantee coverage and arrange direct payment to the medical providers and the Hospital, wherever possible.
DESCRIPTION OF BENEFITS

c) Emergency Message Centre
In case of an Emergency, Sigma Assistel can help to relay important messages to or from the Insured Person’s family, business or Physician.

d) Lost Document and Ticket Replacement
Sigma Assistel will help the Insured Person replace lost or stolen travel documents. The cost of obtaining replacement documents is the Insured Person’s responsibility.

e) Legal Assistance
Sigma Assistel can direct the Insured Person to a local lawyer or assist the Insured Person to arrange for bail or for payment of legal fees. The cost of these services is the Insured Person’s responsibility.

f) Pre-Trip Planning Assistance
If the Insured Person calls 1-800-465-6390 Sigma Assistel can provide information on inoculation and visa requirements.
EXCLUSIONS AND LIMITATIONS

Benefits are not payable for Type “A” and Type “B” Expenses resulting from:

1. services which are insured by the insured person’s provincial government health plan or expenses which
   the Insurer is not permitted, by any law or regulation, to cover; or government actions implemented
   during the policy year which may impact the Plan;

2. general health examinations and examinations required for use of a third party;

3. eye examinations, except where included as an eligible expense;

4. a surgical procedure or treatment performed primarily for cosmetic reasons, or charges for hospital
   confinement for such surgical procedure or treatment unless such surgery or treatment is for accidental
   injuries and begins within 90 days of the accident;

5. medical treatment or surgical procedures by a physician other than described under Physicians’ Services
   in the Benefits Section;

6. expenses incurred by a physician, dentist or denturist expenses for travel time, broken appointments,
   transportation costs, completion of insurance forms, room rental charges or consultation received by any
   telecommunication means, other than as specifically provided under Eligible Expenses;

7. unspecified items in the foregoing lists of eligible expenses;

8. services or supplies which are furnished without the recommendation, unless specified otherwise, and
   approval of a physician acting within the scope of his/her license;

9. services or supplies which are not medically necessary to the care and treatment of any existing or
   suspected injury, disease or pregnancy;

10. services or treatment for occupational injuries or diseases covered by any Workers’ Compensation law
    or similar legislation;

11. expenses which would not normally have been incurred but for the presence of this insurance or for
    which the member or dependent is not legally obligated to pay;

12. dental work where a third party is responsible for payment of such charges;

13. services or supplies which were necessitated either wholly or partly, directly or indirectly, as the result
    of committing, attempting, or provoking an assault or criminal offence;

14. services or supplies which were necessitated either wholly or partly, directly or indirectly, as the result
    of a war or act of war (whether declared or undeclared), service in the armed forces of any country,
    insurrection or riot, or hostilities of any kind;

15. services or supplies for treatment of injuries that are intentionally self-inflicted;
16. drugs, sera, injectable drugs or supplies which are not approved by Health Canada (Food and Drug Act), or that are experimental or limited in use whether or not so approved;

17. experimental medical procedures or treatment methods not approved by the Canadian Medical Association or the appropriate medical specialty society;

18. charges for drugs that can be purchased without a physician’s or a dentist’s prescription, whether or not a physician or dentist has prescribed them;

19. accommodation in a rest home, nursing home, convalescent home, health spa, a place for custodial care, a home for the aged, or a chronic care facility;

20. nursing home services provided in a nursing home;

The foregoing list of Type “B” Eligible Expenses shall not include charges for:

Exclusions applicable to the Extended Health Care Benefit also apply to the Travel Insurance provision. Furthermore, the Insurer will not pay any of the benefits provided for under the Travel Insurance provision in the following circumstances:

1. expenses are not incurred as a result of an “Emergency” or “Medical Emergency” as defined in this certificate, while travelling outside the province of residence or outside Canada;

2. for elective, non-emergency treatment or surgery, when this service could have been provided in the province of residence of the Insured Person without endangering his life or health, even if such service is provided as a result of a sudden Illness or an Accident requiring emergency treatment;

3. if the purpose of the trip is to receive medical or paramedical treatment of hospital services, unless the Insured Person was referred to another Physician, in accordance with the provisions of the referral treatment section of this Benefit;

4. services or treatment are received as a result of routine medical care;

5. a medical Emergency no longer exists and medical evidence indicates that the Insured Person is able to return to his/her province of residence or territory of residence. Once a medical Emergency ends, no further benefits are payable for the continuing treatment, recurrence or complication arising directly or indirectly from the condition which caused the medical emergency. If the Insured person does not agree to repatriate in as recommended by Sigma Assistel, no further benefits will be payable relating to that medical emergency;

6. services or treatment were not pre-approved by Sigma Assistel where and when required. If an Insured Person fails to contact Sigma Assistel immediately when he requires Medical Emergency services that require Hospitalization outside the country, the Insurer may reduce or deny reimbursement of a portion of the incurred Eligible Expenses. It is understood that the Insurer is not responsible for the availability or quality of such services;
EXCLUSIONS AND LIMITATIONS

7. expenses are incurred as a result of an emergency while travelling outside the province of residence or outside Canada, if the application for Type “B” Base Plan coverage was not received by the insurer prior to the Day of Departure from the province of residence;

8. eye glasses, contact lenses, hearing aids or prescriptions for the same;

9. air travel, other than as a passenger in a commercial aircraft licensed to carry passengers for hire;

10. pregnancy, childbirth or miscarriage, or any complications arising from pregnancy within 8 weeks of the expected delivery date;

11. mental or emotional disorders that do not require hospitalization;

12. abuse of medication, drugs or alcohol, intentional self-injury, suicide or attempt thereat, whether sane or insane. (This exclusion does not apply to Trip Interruption and Delay claims);

13. any Emergency transplants including but not limited to organ transplants and bone marrow transplants;

14. injuries sustained by the individual while operating a motor vehicle, either while under the influence of any intoxicant or if his/her blood contained more than 80 milligrams of alcohol per 100 millilitres of blood at the time of injury.

15. if the Insured Person is not covered under government health and hospital insurance plans; or

16. illness, injury or medical condition you suffer or contract in a specific country, region or area for which the Department of Foreign Affairs and International Trade of the Canadian Government has issued a travel advisory or formal notice, before your day of departure advising Canadians not to travel to a specific country, region or area. If the Canadian Government issues a travel advisory or formal notice to leave that specific country, region or area, after your date of departure, your coverage for illness, injury or medical condition is limited to a period of 10 days from the date the advisory was issued, or to a period that is reasonably necessary to safely evacuate the country, region or area. In this exclusion, “illness, injury or medical condition” means any illness, injury or medical condition that is attributable to the reason for which the travel advisory or formal notice was issued or any complications arising therefrom.
PLAN ADMINISTRATOR
The Plan was developed by BCGREA and Johnson Inc. It is administered by Johnson Inc. and is underwritten by Desjardins Financial Security. If you require additional information, or if you have any questions concerning this BCGREA Plan, please contact the Plan Administrator, Johnson Inc.

Group Services Department
Walnut Grove Commerce Centre
Suite 201, 9440 – 202nd Street
Langley, BC  V1M 4A6
Phone: 604-881-8840
Toll-Free in North America: 1-866-799-0000 (Administration)
vancouver@johnson.ca

-or-

11120-178 Street NW
Edmonton, Alberta T5S 1P2
Phone: 780-413-6536
Toll Free in North America: 1-877-989-2600 (Administration)
Toll Free in North America: 1-877-413-6599 (In Province Claims)
edmonton@johnson.ca

Johnson Website:  www.johnson.ca
8:30 a.m. to 4:30 p.m. MST, Monday through Friday

IN THE EVENT OF A MEDICAL EMERGENCY
At the first onset of a medical emergency, the Insured Person must contact the 24-hour Sigma Assistel Assistance Center for direction to the nearest appropriate medical facility. Sigma Assistel will pay Hospitals and other medical providers directly, wherever possible, except when the Insured Person chooses to pay the expenses or when the medical care provider refuses to accept payment directly from Sigma Assistel.

Sigma Assistel
Canada/USA: 1-877-775-3695
Other Locations (Call Collect): (514) 875-3695
Fax: (514) 875-7729

IMPORTANT TO REMEMBER!
To benefit from the assistance services available and to ensure expenses are covered, the Insured Person must notify Sigma Assistel when he / she has an Emergency and preferably before hospitalization or within 48 hours after admission to a Hospital. If the Insured Person is unable to do so because he / she is medically incapacitated, someone else must do so as soon as is reasonably possible. Otherwise eligible expenses will be limited to $2,000.
PRIVACY STATEMENT
The Federal and Provincial Governments enacted legislation to protect the personal information of Canadians. This statement informs you of the steps taken to comply with the legislation. Desjardins Financial Security and Johnson Inc. may use your personal information for the following purpose: They may collect personal and other information about you to provide your requested coverage and services or to process claims. The primary sources of information are you, BCGREA and your medical advisors. To administer or otherwise provide you the coverage and services requested, Desjardins Financial Security may collect information from individuals, groups or companies from whom collection is necessary.