

RBC Insurance® Newcomer Health Plan coverage

Benefits Summary



Insurance

General information

This plan is administered by Cowan Benefits Ltd. and is underwritten by Aetna International.

Notice: This material summarizes the important features of the RBC Insurance Newcomer Health Plan. It is prepared for information only and does not in itself constitute a contract. Actual benefits will be determined in accordance with the terms and conditions of the insurance contract with the insurer, which is the governing document. No typographical or mechanical error made by any parties of the insurance contract will invalidate insurance otherwise in force or continue insurance otherwise terminated under the contract's terms and conditions.

The information contained in this booklet is important, and we suggest it be kept in a safe place.

Eligibility

The Newcomer Health Plan provides coverage for necessary hospital and medical services for those eligible employees under 75 years of age and their dependents who are not eligible for coverage under a Government Health Insurance Plan (GHIP).

Eligible dependents are those persons who reside in Canada and are:

- a) your legally married spouse, or your common-law spouse who has continuously cohabited with you for not less than one full year
- b) unmarried, unemployed children under the age of 21 years; coverage will continue up to age 26 if the child is enrolled in and in full-time attendance at an accredited educational institution
- c) unmarried, unemployed dependent children of any age who are incapable of self-sustaining support or employment by reason of mental or physical disability and have been continuously so disabled since the age of 21

Enrolment

You may enrol for coverage by completing the enrolment form available from your employer. Upon enrolment you will receive an identification certificate indicating your



group and identification number. This certificate along with proof of identification must be presented to the healthcare provider before services are rendered.

If you choose to terminate coverage under this plan and later reapply for coverage, you will be required to submit satisfactory medical evidence of insurability before an approval of your re-enrolment will be considered.

Claiming benefits

As a general rule, claims are paid directly to the provider of the healthcare service. Present your Cowan Benefits Card to your service provider. In some cases, you may have to pay the provider and claim reimbursement from the plan. Send your completed claim forms and receipts to:

Cowan Benefits Ltd.
Plan Administrator

700-1420 Blair Towers Place
Ottawa, ON K1J 9L8
Phone: 613-741-3313
Toll Free: 1-888-509-7797
Fax: 613-741-7771
clients@cowangroup.ca

Submit your claims online via the Cowan Member Portal at clients.cowangroup.ca

Select **Submit a claim**.

Proof of claim

Claims should be submitted within 90 days following the date the expense was incurred. In no event will the insurer be liable for expenses that are submitted more than six months after the services or supplies are provided. If it is anticipated that a person's claims will exceed \$50,000 per year, the claimant may be directed to a qualified healthcare provider chosen by the insurer. All eligible claims will be paid in Canadian currency.

Coordination of benefits

If you have similar benefits through any other insurer, the amount payable through this plan must be coordinated so the payments from all coverages do not exceed 100% of the allowable expenses.

Termination of benefits

Coverage for you and your dependents will cease on the earliest of:

- the day you or your dependent(s) cease(s) to be eligible due to termination of employment, attainment of age 75, retirement, leave of absence, dependent age limitation or change in classification
- the date your employer terminates the group contract

Covered services

The following benefits are covered provided the expense is incurred while the person is insured for them. Covered expenses are the lesser of the actual expenses and the customary charges set out by the Government Health Insurance Plan (GHIP). Although certain benefits are paid in accordance with the GHIP fee schedule (identified below with an asterisk (*)), the Newcomer Health Plan benefits are offered across Canada.

- **Hospital services:** When medically necessary, in-patient or out-patient services for treatment of an illness or injury: standard ward accommodation (private or semi-private accommodation will be eligible when certified in writing as necessary by the attending physician), necessary nursing services when provided by the hospital, occupational therapy, speech therapy, physiotherapy, audiology, psychological therapy (when prescribed by a physician), laboratory and X-ray diagnostic procedures, use of operating and delivery rooms, anaesthetic and surgical supplies, use of radiotherapy facilities, use of home renal dialysis equipment, use of home hyper-alimentation equipment.

A hospital is defined as an institution that is legally termed a hospital, is open at all times, offers in-patient accommodation, has a staff of one or more physicians available at all times and continuously provides 24-hour nursing by graduate registered nurses.

- **Physician's services:** Reasonable and customary charges when medically necessary: physician's services in the home, at the physician's office, at the hospital or at any other institution; diagnosis and treatment of an illness or injury; treatment of fractures and dislocations; surgery; administration of anaesthesia; obstetrical care including pre- and post-natal care. For elective surgical procedures, prior approval is required. The covered person's physician or surgeon must submit a diagnostic assessment and prognosis of the condition to be treated to the Plan Administrator.
- **Diagnostic laboratory and X-ray services:** Reasonable and customary charges when medically necessary: X-rays for diagnostic and treatment purposes, laboratory services and clinical pathology when ordered by a physician.





- **Ambulance services*:** Reasonable and customary charges for emergency ground ambulance service to the nearest available hospital where essential treatment is available when a physician or designated hospital official confirms the treatment is medically required. With prior approval, the plan also covers the cost of medically necessary in-province air ambulance. Reimbursement is limited to the maximum specified in the Government Health Insurance Schedule of Benefits and is subject to a user fee.

In either case, if transportation is to a further centre, the insurer will provide alternative benefits based on the coverage for transportation to the nearest centre where essential treatment is available.

- **Vision benefit:** One eye examination performed by a licensed physician, ophthalmologist or optometrist in any 12 consecutive months.
- **Out-of-province or out-of-Canada benefits:** Benefits are payable for services provided outside the province or Canada only when the services are obtained due to an emergency illness or accident. Charges will be paid up to a maximum equal to the amount that would have been allowed by GHIP.

A medical emergency is defined as a sudden, unexpected injury or an acute episode of disease.

- **Paramedical services:** Charges for treatment for the following paramedical services will be covered up to the following maximums identified per practitioner per calendar year: osteopath: \$155, podiatrist: \$135, chiropractor: \$500 and physiotherapist: \$500.

- **Nursing homes, chronic hospital care and home care*:** Nursing home expenses are eligible only when the covered person needs 24-hour medical supervision as well as nursing and personal care. In such cases, the plan will pay up to the maximum allowed under GHIP.

Chronic care is available in a hospital for those who have long-term illnesses or disabilities that cannot be treated at home, subject to a maximum of 60 days per covered person. Chronic care is covered if it starts while the person is insured under this benefit provision.

Home care services are eligible only when the recipient requires the skills and training of a professional, the professional is not a member of the patient's family and:

- a) the physician certifies the services are required
- b) the needs cannot be met on an out-patient basis, and
- c) the results show progress towards rehabilitation

With prior approval, the services include nursing, physiotherapy, occupational therapy, speech pathology, social worker services, nutritionist services and homemaker services. Other conditions apply, as per GHIP.

- **In-hospital dental care*:** Dentist fees are covered if the patient is at risk medically, the services are performed in a hospital by a dental surgeon who is a member of the hospital's staff and the services provide treatment that is recognized and eligible under GHIP.
- **Assistive Device Program*:** With prior approval, durable equipment/specialized aids and supplies required by persons with disabilities are covered to the same level and under the same conditions as GHIP including under its adjunctive Assistive Device Program.
- **Medical evacuation/repatriation:** If the insured is diagnosed as terminally ill (with 12 months or less to live), is gravely ill or is seriously injured and the medical condition is stable, or if a covered person dies, the plan will cover the cost of returning the covered person or their remains by the most direct route to the air terminal nearest the covered person's residence in the home country, to a maximum of \$10,000 (expenses must be considered reasonable by the insurer compared to prices generally charged for such services). Eligible expenses include economy airfare for the insured (or stretcher, if required) and return airfare for a qualified medical attendant (if certified necessary by an attending physician) including, if required, overnight hotel and meal expenses for the medical attendant. In the event of death, preparation and transportation of the remains, including the cost of the casket and specialized equipment, will also be covered within the overall \$10,000 maximum.

Limitations and exclusions

Benefits are payable up to a calendar-year maximum of \$500,000 per person and a lifetime maximum of \$1,000,000 per person. No benefits are payable for:

- Hospital charges above the non-resident ward rate
- Hospital visits solely for the administration of drugs
- Eyeglasses, crutches, casts or other such aids
- Private-duty nursing fees
- Drugs prescribed and taken at home on discharge from a hospital
- Transportation charges other than approved ambulance services
- Medical examinations or certificates required for applications for employment or the continuance of employment, life insurance or admission to camps, recreational activities, or immigration purposes
- Cosmetic surgery and services or supplies associated with treatment for cosmetic purposes only
- Acupuncture
- Pre-natal classes
- Fertility or weight control treatments or related drugs
- Psychological testing (unless performed in a hospital)
- Any health services other than those provided by approved hospitals or practitioners as specified herein
- Group examinations, immunizations or inoculations
- Expenses involving the commission or attempted commission of a criminal offence
- Services or supplies associated with professional sports
- Expenses arising from war, insurrection or voluntary participation in a riot or while serving in the armed forces of any country
- Charges incurred by a covered person for which they are entitled to obtain benefits or reimbursement under any other plan, or which would be provided without charge in the absence of coverage under this agreement
- Charges in excess of the amount payable to residents under GHIP, except where expressly stated herein
- Benefits no longer covered under GHIP as of the date of their deletion, except where expressly stated herein
- Private clinics and hospitals

If you have questions or need more information,
please contact Cowan Benefits Ltd. at
1-888-509-7797 or clients@cowangroup.ca



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