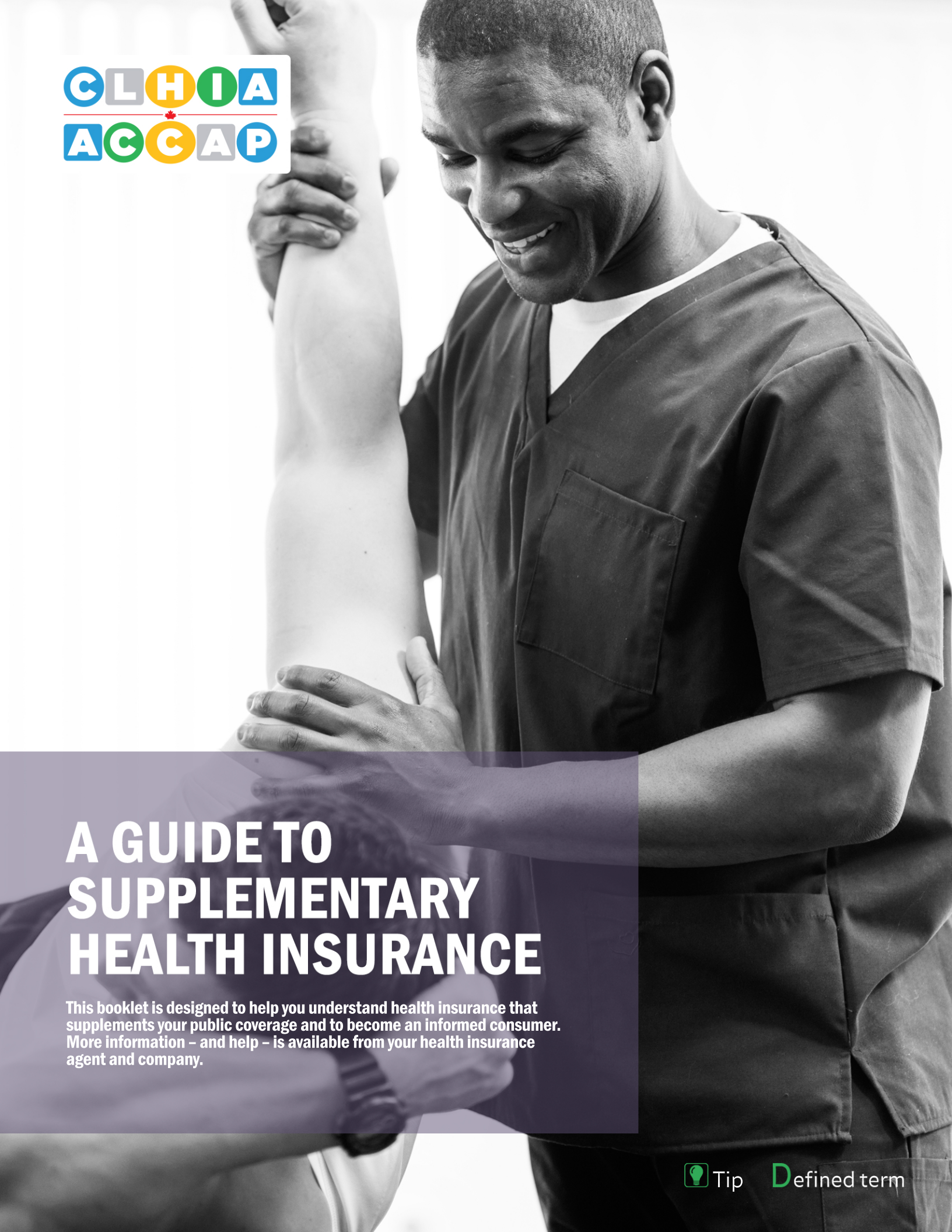

A GUIDE TO SUPPLEMENTARY HEALTH INSURANCE

This booklet is designed to help you understand health insurance that supplements your public coverage and to become an informed consumer. More information – and help – is available from your health insurance agent and company.

Tip Defined term

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You Told Us What You Want To Know About Supplementary Health Insurance

This booklet brings together the answers to many of the questions Canadians ask about supplementary health insurance.

This guide will help you:

- decide what supplementary health insurance you need;
- understand the different types of plans and options;
- learn what happens when you apply, and when you make a claim; and
- identify questions to ask your group benefits administrator and/or agent

This booklet is not intended to be a substitute for seeking out a qualified agent. Rather, it is designed as a handy reference you will want to keep with your insurance policies. We suggest you start with the Table of Contents and look for the topics in which you're most interested.

A Guide to Supplementary Health Insurance is produced by the Canadian Life and Health Insurance Association. We do not promote any one health insurance company or any particular type of supplementary health insurance policy or plan. We leave those choices to you, the consumer.

We hope that this guide will help you make the most of your supplementary health insurance coverage.

CAUTION: This booklet presents a wide variety of general information on supplementary health insurance as simply and as accurately as possible. But it is not a legal document. Over time, new legislation and regulations and technological and competitive developments may change some of the rules, conditions and industry practices described here. If you have specific questions, check your policy details and contact your group benefits administrator and/or insurance agent or company.

1 THE BASICS

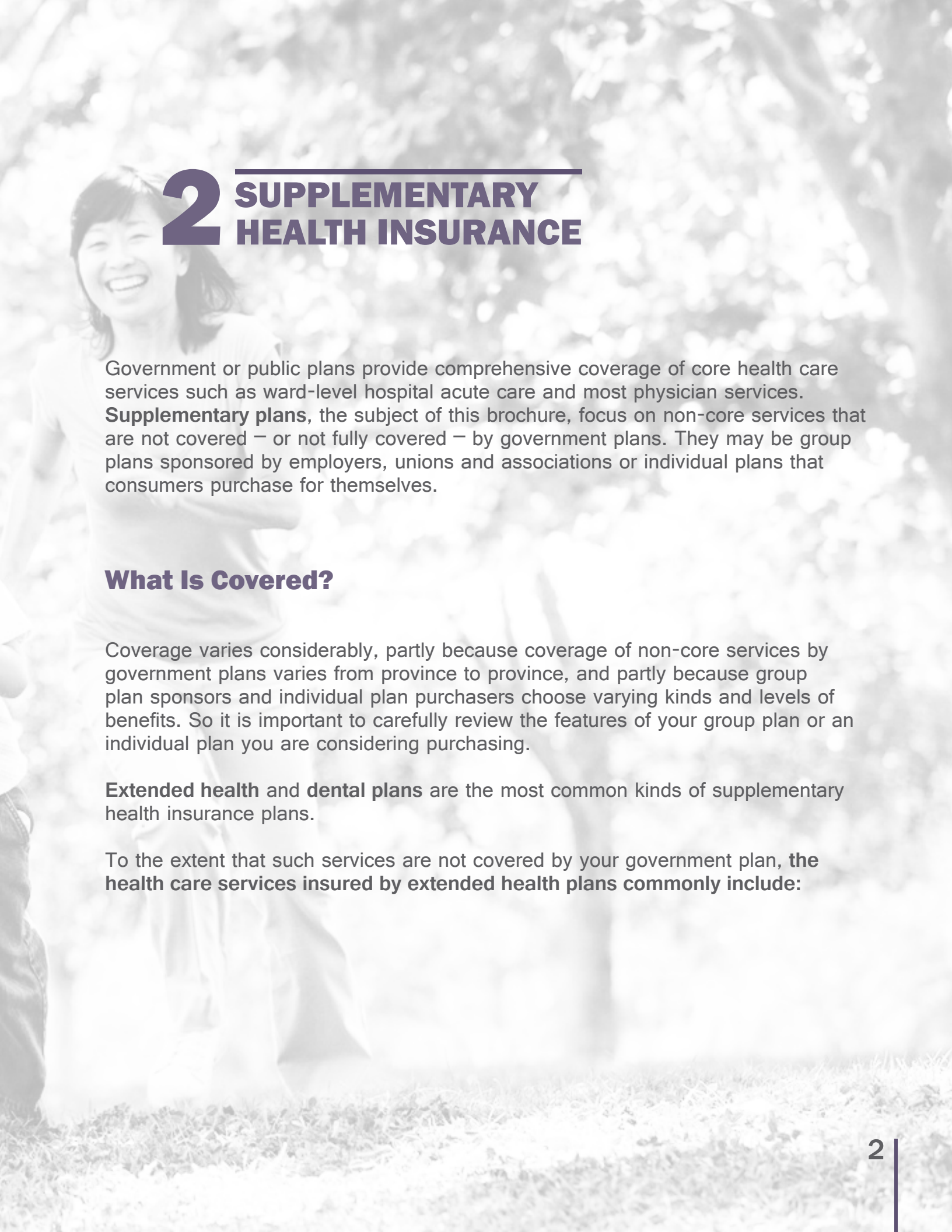
How Health Insurance Works

Insurance is a way of spreading, or sharing, financial risk. The idea of insurance dates back to the days of the Romans, but it wasn't formalized until the 18th century. It's a simple concept: a large number of people pay into a fund or pool. When one of them suffers an unexpected misfortune, he or she is compensated by the fund. The payout is called a **benefit**.

Health insurance pays part or all of your expenses when you see a health care professional, spend time in a hospital or purchase covered health care services and products.

Health Insurance Providers

Canadians have access to both **public and private health insurance plans**. These plans are provided by provincial and territorial governments and insurance companies that sell policies to individuals and to employers, unions and associations that act as group insurance sponsors.



2 SUPPLEMENTARY HEALTH INSURANCE

Government or public plans provide comprehensive coverage of core health care services such as ward-level hospital acute care and most physician services. **Supplementary plans**, the subject of this brochure, focus on non-core services that are not covered – or not fully covered – by government plans. They may be group plans sponsored by employers, unions and associations or individual plans that consumers purchase for themselves.

What Is Covered?

Coverage varies considerably, partly because coverage of non-core services by government plans varies from province to province, and partly because group plan sponsors and individual plan purchasers choose varying kinds and levels of benefits. So it is important to carefully review the features of your group plan or an individual plan you are considering purchasing.

Extended health and **dental plans** are the most common kinds of supplementary health insurance plans.

To the extent that such services are not covered by your government plan, **the health care services insured by extended health plans commonly include:**

- prescription drugs/medicines;
- semi-private or private hospital accommodation;
- special nursing services;
- ambulance services;
- hospital and medical expenses incurred outside Canada;
- artificial limbs, prostheses and medical appliances;
- wheel chairs and other durable equipment;
- specified medical or paramedical services that fall outside government plans (e .g., services from chiropractors, physiotherapists, podiatrists, osteopaths and optometrists); and
- vision care (eyeglasses and contact lenses).

Expenses for dental services are often covered under a separate supplementary insurance plan. Coverage depends on the plan that is purchased.

Typically, **dental plans cover expenses for:**

- basic preventive and maintenance services such as regular checkups or examinations, cleaning, fillings, extractions and x-rays; and
- root canals, periodontal cleanings and scaling.

Your dental plan may also pay for major restorative work, such as inlays and crowns, bridgework and dentures, as well as orthodontic treatments.

Other kinds of supplementary health insurance are available. Please see Section 4, Individual Plans, for descriptions of other kinds of plans and the benefits they provide.

Who Is Covered?

Supplementary plans typically provide coverage for the individual who is a member, along with eligible dependents such as his/her spouse or partner and children under 19 (or older if they are full-time students or disabled). Eligibility criteria vary, so check your plan for details.

Deductibles, Coinsurance and Maximums

Supplementary plans typically do not pay 100 per cent of eligible expenses. You may have to pay for a small amount of your expenses and those of any covered dependents at the beginning of each plan year, called a **deductible**. Common deductible amounts are $25 or $50 per covered person. Alternatively, you may pay a family deductible, which might be the first $75 in eligible expenses incurred by any two covered members of your family at the beginning of each year. Some plans also include a per service deductible (e.g., $5 per drug prescription).

If your plan has a coinsurance feature, you will also be required to coinsure, or pay, a percentage of your eligible expenses in excess of your deductible. The coinsurance percentage is typically 10 per cent or 20 per cent of an eligible expense, but may be higher for certain types of services (e.g., 50 per cent for major restorative dental services or orthodontic treatments).

Many plans also place dollar limits, called **maximums**, on the amount of benefits that will be paid for certain services, such as eyeglasses or orthodontic treatments, in a specified period. Sometimes a maximum applies to the total benefits that will be paid during a year or during the covered person's lifetime.

It is very important to know what deductibles, coinsurance percentages and maximums apply to your eligible expenses. Check your plan literature carefully.

Predetermination of Benefits

For large expenses, such as major dental restorations, your plan may ask you to obtain a predetermination or estimate of the benefits payable from the insurer before you receive treatment. The **predetermination** of benefits will tell you how much the plan will pay and how much of the expense of a specific course of treatment you will be responsible for. It will allow you to budget for your share of the expenses, and to see if you can cover more of the cost by coordinating your benefits with those of your spouse/partner (see below).

Claims

Claims are simple to file, but the procedure varies from one plan to another. Some plans require you to pay the health care providers and submit your receipts with a paper or electronic claim form to the insurer for reimbursement. Other plans provide you with a drug card or dental identification card, which allows the pharmacist or dentist to submit the bill to the insurer electronically and receive payment directly. In either case, the confidentiality of your information is protected .

Typically, you must file claims within one year after you incur the eligible expenses, although the filing period may vary. Life and health insurance companies are committed to considerate and prompt payment of claims and they continually make changes to speed up the process. A straightforward health or dental claim may be processed within a week or two; more complicated claims, such as claims for disability benefits, may take longer.

Generally, the insurance company deposits payment in your bank account or sends you a cheque, along with an explanation of the amount paid, once your claim is approved. It will note, for example, whether the deductible has been paid or you have reached the maximum amount allowed for a particular kind of expense under your plan or policy.

If you need help making a claim to a group insurance plan, call your benefits administrator or human resources officer. For help with a claim to an individual plan or policy, call your agent, the insurance company's nearest branch office or toll-free line.

TIP: Be sure to complete claims forms completely and clearly. Your claims will be processed faster if the insurer doesn't have to contact you for clarifications and more information

3 GROUP PLANS

Supplementary health insurance coverage is most commonly available under **group insurance plans**. Group plans cover all members of a specific group and their eligible dependents. If you or your spouse/partner are employed, you probably have an insurance plan sponsored by your employer or your union as part of your **employee benefits** program. Alternatively, you may be able to purchase group insurance through a professional association or group such as an alumni association.

Under employer- and union-sponsored plans, the employer or union typically pays all or part of the cost of the premiums. Under an association plan, though, the members pay the full cost. Nevertheless, the cost of such coverage is usually lower than it would be if purchased under an individual contract, because administration costs are less for group plans.

TIP: Extended health and dental insurance for which your employer pays are non-taxable benefits, except in Québec • If you are self-employed, you can deduct part of your group or individual health, dental and drug plan premiums – and, under some circumstances, premiums you pay for your employees

What Is Covered?

Your group insurance plan will provide you with a **certificate and/or a booklet** that outline the key features of your coverage, including covered expenses, eligible dependents, deductibles and coinsurance, limits and exclusions, and claim procedures. Your human resources officer and/or benefits administrator can help you obtain additional information. The complete details of the plan are contained in the master contract that is issued to the plan sponsor by the insurer.

For a list of typical benefits provided by group extended health and dental plans, please see pages 2 and 3. Bear in mind that benefits vary widely from one plan to another.

For a description of other kinds of health-related coverage your employer may provide, such as disability, travel, critical illness and long-term care benefits, please see Section 4, Individual Plans.

Who Is Covered?

To be **eligible** for coverage you typically must be a member of the sponsoring association or union, or – in the case of employer-sponsored plans – a permanent, full-time employee. Under some employer-sponsored plans, you must also have been at work for a specified period such as one month or three months. Check your plan to find out what the enrolment requirements are, for yourself and your dependents.

Under most group plans, you are insured only as long as you remain part of the group. In general, **if you leave your job, or cease to be a member of the association, your coverage ends.**

However, if you are laid off or leave because of a downsizing program, your benefits may be continued for a period of a few weeks. And in some instances, replacement coverage may be available if you apply within a specified time period, such as 90 days. Your benefits administrator or the **OmbudService for Life and Health Insurance** (please see page 14) may be able to provide more information about replacement coverage and how to get it.

Flexible Plans

Some group insurance plans – usually referred to as **flexible** or **cafeteria-style** plans – give members options that allow them to tailor their coverage to meet their personal circumstances and needs, within certain limits. Each member can choose to add to a basic benefits package at his/her own expense or, in some cases, with money from an individual **health care spending account** provided by the employer.

The advantage of flexible plans is that they let you change your benefits as your situation changes. You can add orthodontic coverage to your basic dental benefits when your children are pre-teens, for instance, and drop it later when you no longer need it. Typically, you can change your coverage once a year and/or upon a major life event such as a marriage, birth or death. Make sure that you know what choices are available under your plan; review your plan booklet and discuss it with your benefits administrator.

Coordination of Benefits

If you and your spouse or partner are both group plan members, coordination of benefits permits coverage of up to 100 per cent of your eligible expenses. Industry wide procedures determine which plan considers a claim first, after which the other plan considers any amount that has not been reimbursed by the first one. Ask your benefits administrator for details.

If you and your spouse or partner both pay group plan premiums, you may be tempted to save by opting out of the plan that provides the less generous benefits. But coordinating the benefits provided by the two plans could be very useful if someone in your family needs an expensive pair of glasses or orthodontic appliance.

Administrative Services Only Plans

Most group plans are purchased from an insurance company by the plan sponsor. But some employers pay the costs of group plan benefits themselves, using an insurance company to administer the plan only. These plans are called Administrative Services Only (ASO) plans. Because these plans are not insured, the insurance company does not guarantee benefits.

4 INDIVIDUAL PLANS

Individual plans are policies that you purchase for yourself (and your dependents) from an insurance agent, broker or company. You may want to consider buying an individual plan if you are not eligible for a group plan, or need additional coverage to meet special needs – if, for example, your group plan does not include a type of coverage that is important to you.

What Kind of Coverage Is Available?

You can purchase individual plans to cover many of the same supplementary hospital and medical expenses and dental expenses that group plans pay, and to provide a number of other health-related coverages described in the following pages.

For a list of expenses typically covered by individual extended health plans, please turn to page 2. **Individual extended health plans** often **exclude** expenses incurred on account of **pre-existing conditions**, that is, injuries you sustained or illnesses you had before you applied for coverage with the company. They always exclude expenses insured by any government or group plan under which you are covered, along with those related to suicide, self-inflicted injury, war or military service, alcoholism or drug addiction. Be sure you know what is excluded so you won't be surprised if the company refuses a claim.

Individual dental insurance plans cover many of the same services as group dental plans. For a list of expenses typically covered by individual dental insurance plans, please turn to page 3.

A few insurers offer individual dental plans on a stand-alone basis. Others only offer them in conjunction or along with individual health insurance plans. Like group plans, extended health and dental plans often feature **deductibles, coinsurance and maximums** on specific expenses. Read the policies and make sure you understand these features and how they apply. If you have any questions, talk to your agent or broker.

Hospital Cash Plans

Hospital cash plans or hospital indemnity insurance plans pay you cash (typically limited to $100 a day) should you be confined to hospital. You may want to use the cash to pay for everyday living expenses such as baby-sitting and housekeeping services or for items such as travel to and from the hospital.

The cost of hospital cash plans depends on the rate per day at which you choose to be reimbursed during your hospital stay. These plans generally exclude the same claims that are disallowed by extended health plans (see page 9). They may also limit benefits based on your age.

Insurance for Visitors and Returning Canadians

A few companies sell health care policies for visitors and returning Canadians. These policies are designed for individuals who are not covered by public health insurance because they are returning to Canada after a prolonged absence, are living here temporarily or do not yet qualify for public health insurance coverage. Visitors and returning Canadians policies typically cover medically necessary doctors' services, hospital services and supplies.

Many offer coverage on an emergency-only basis. Others include semi-private hospital accommodation and pay for some additional benefits, such as an emergency return home if you are completely disabled or die. Treatments for pre-existing conditions are often excluded.

Disability Insurance

Disability insurance is designed to replace lost income while you are disabled and unable to earn enough to meet your expenses. You can buy an individual policy that is tailored to your particular needs.

TIP: Foreign students should check with the registrar of the institution they will be attending to learn if inexpensive group coverage is available through the school, college or university

Critical Illness Plans

Critical illness plans and/or riders on other types of individual or group plans pay you a cash lump sum if you are diagnosed with a life-threatening illness such as cancer, heart disease requiring surgery, heart attack or stroke. Some critical illness policies also cover kidney failure, blindness, organ transplant, paraplegia, quadriplegia, and/or dementia (including Alzheimer's disease) .

You can use the money for anything you want: to pay off debts, to finance expensive medical equipment or special home care, to pay for child care, to change careers or to start a small business.

Living Benefits

If you become terminally ill, you may need extra cash to pay medical bills and living expenses.

Many companies provide living or accelerated benefits to individual life insurance policy holders who suffer a life-threatening illness.

When you apply for living benefits from your life insurance policy, you must provide your insurance company with a medical opinion that you are in the terminal stages of an illness and have 24 months or less to live. The insurance company must also ascertain that the proceeds from your policy have not been assigned to pay off a loan or debt, or left irrevocably to someone who might sue for full benefits once you die.

TIP: Consult a lawyer or financial advisor before applying for living benefits. Although these benefits are not subject to income tax at present, they can affect your eligibility for social assistance benefits that are based on means tests

If these two conditions are met, the company typically pays you a percentage of the value of your policy, not exceeding 50 per cent. Some companies pay predetermined maximum dollar amounts in living benefits. Others treat the living benefits payment as an advance or loan and charge interest on it. Still others require you to pay regular premiums to keep your policy in force after you receive the benefits.

When you die, the amount that is left in your life insurance policy, less any interest charges, will be paid to your beneficiary or estate.

Long-Term Care Insurance

A few companies offer **individual long-term care insurance plans**, which pay for stays in nursing homes and chronic care facilities, or for the services of a caregiver in your own home.

When deciding whether to purchase such insurance you should consider your age, health and financial resources, along with any support you could expect from family and friends should you need long-term care.

There are variations among longterm care policies. Inquire about the maximum lifetime payout, inflation protection, and the length of time you must pay premiums. You should also find out whether your premiums are waived, or discontinued, when you make a claim and are receiving benefits.

Travel Insurance

If you are travelling outside Canada and have limited or no supplementary **out-of-country coverage** through a group plan or credit card, it is wise to buy an **individual travel insurance policy**.

When you need medical care while in another country, your provincial or territorial health insurance plan pays for the same services it covers when you are at home, at the same rate it pays for those services at home, and in Canadian dollars.

Moreover, if you extend your stay to more than six months, your government coverage may lapse (check with your provincial or territorial government to find out how long you can be away before losing your benefits).

If your government benefits do not cover the entire cost of the services you receive, you must pay the difference. Emergency surgery or a hospital stay could leave you with a crushing personal debt, if you do not have supplementary benefits. Individual health insurance for travellers is offered by many insurance companies, and application forms are available from many retailers of travel-related products and services.

If you are travelling within Canada, an inter-provincial agreement exists to provide coverage for you. Québec participates in this agreement for hospital fees only, so Québec residents travelling out of their home province should check with their government health insurance plan for limitations.

Where Can You Buy Individual Health Plans?

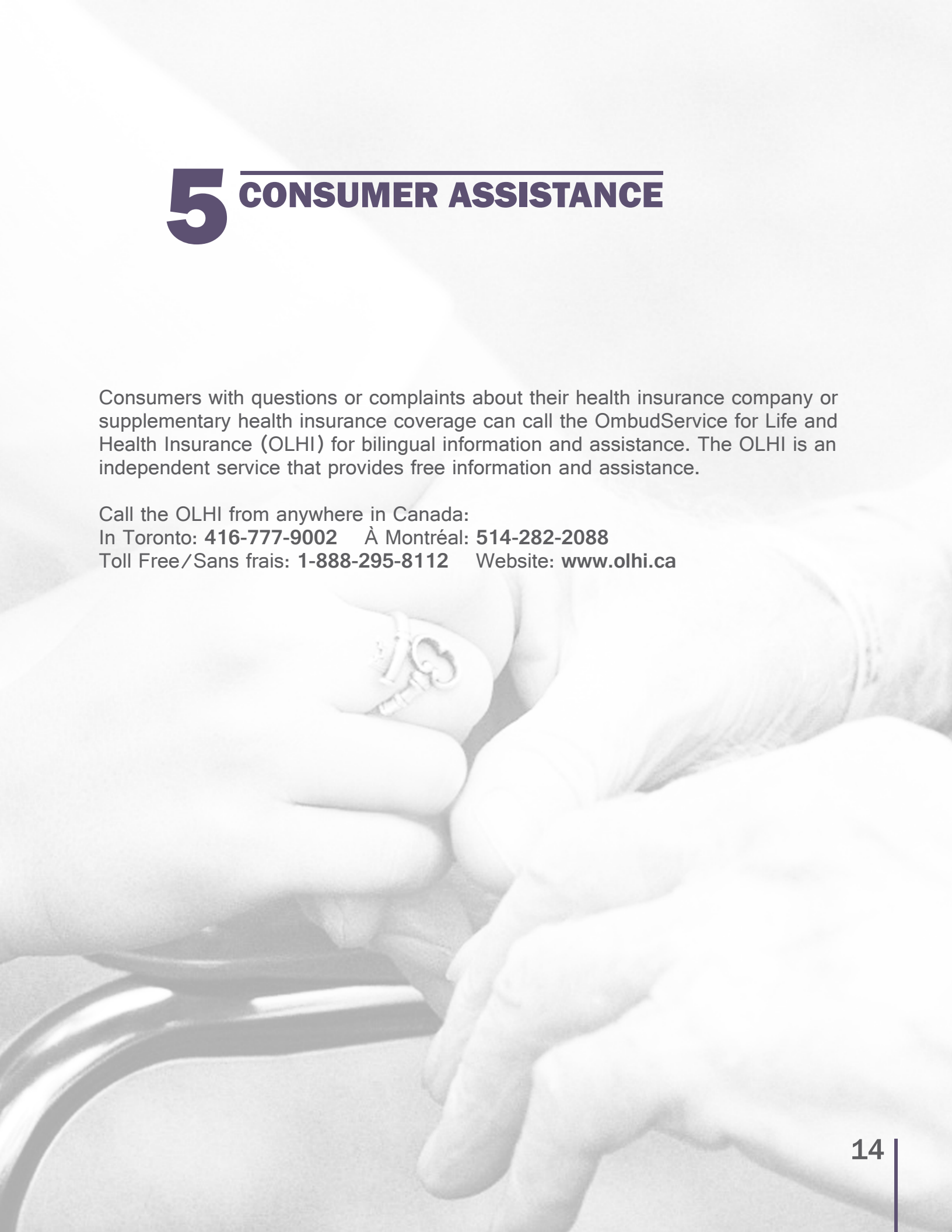
You can call the OmbudService for Life and Health Insurance's toll-free number to find the names of insurance companies that sell individual plans to Canadians.

TIP: Insurers generally provide a card that lists emergency numbers you can call in case of an accident or illness while travelling. Be sure to carry the card with you at all times. And get copies of all bills for health care expenses you incur while away

5 CONSUMER ASSISTANCE

Consumers with questions or complaints about their health insurance company or supplementary health insurance coverage can call the OmbudService for Life and Health Insurance (OLHI) for bilingual information and assistance. The OLHI is an independent service that provides free information and assistance.

Call the OLHI from anywhere in Canada:
In Toronto: **416-777-9002** À Montréal: **514-282-2088**
Toll Free/Sans frais: **1-888-295-8112** Website: **www.olhi.ca**



How Do I Choose an Insurance Company?

If you belong to a group plan that provides health coverage, the group sponsor (typically an employer, union or association) chooses your insurer.

If you decide to buy individual health coverage, there are many sources of information about companies that offer it. Rating agency reports, articles from the business press and annual reports from the companies themselves – available at public libraries or on the Internet – can all provide useful insights. Your agent or broker also can be an excellent source of information about a company. References from family members, friends and trusted advisors are probably the best basis for making a decision, though.

What is Assuris and How Does It Protect the Consumer?

Assuris protects Canadian policyholders in the event that their life insurance company should fail. It provides coverage for supplementary health insurance policies. Assuris guarantees that policyholders will retain up to $60,000 or 85% of the promised benefits, whichever is higher. For more information contact the Assuris Information Centre at 1-866-878-1225 toll free, or see the Assuris website at www.assuris.ca

What is Assuris and How Does It Protect the Consumer?

Most life and health insurance companies that operate in Canada are regulated for solvency by the federal government through the Office of the Superintendent of Financial Institutions. The Autorité des marchés financiers performs the same functions for companies incorporated in Quebec. These regulators inspect companies to assess their safety and soundness. In addition, the companies must submit annual financial statements to the regulators.

Provincial government agencies regulate the licencing and conduct of agents, contractual matters and issues relating to consumer service or complaints.

This booklet is published by the Canadian Life and Health Insurance Association Inc. (CLHIA). The CLHIA is a national trade association that represents the collective interests of its member life and health insurers, which together account for 99 per cent of Canada's life and health insurance business.