honeybee

Benecaid Health Benefit Solutions Inc.
Employee Benefits Booklet

Your Honeybee Medical Plan

Plan Effective Date

09012017

Administered by:

benecaid®

Contact the Honeybee Team (Mon-Sun 8:30am - 5pm ET)

Local: 416-626-6642
Toll Free: 1-866-626-6642
help@myhoneybee.com

Benecaid Health Benefit Solutions Inc.
185 The West Mall, Suite 800
Toronto, ON M9C 5L5

Table of Contents

Contact the Honeybee Team (Mon-Sun 8:30am - 5pm ET)

Local: 416-626-6642
Toll Free: 1-866-626-6642
help@myhoneybee.com

Benecaid Health Benefit Solutions Inc.
185 The West Mall, Suite 800
Toronto, ON M9C 5L5

Welcome

The purpose of this booklet is to provide you more detail on the list of eligible expenses that are covered through your Honeybee Medical plan. Your Honeybee Statement of Benefits coverage should be read together with the information contained in this booklet. Your Statement of Benefits coverage can be downloaded from the MyHoneybee.com online portal. It contains specific coverage details. For more information, including exclusions, limitations and other conditions please refer to the appropriate sections of this booklet.

Member Online Services

MyHoneybee.com is a secure online portal that allows you to manage your Honeybee accounts anytime, anywhere. You can also download the Honeybee app from the Apple App Store and Google Play store.

The Honeybee app allows you to:

- Submit claims
- View your benefits card
- Check your Honeybee account balances

MyHoneybee.com allows you to:

- View detailed information about your Honeybee benefits plan
- Check your Honeybee account balances
- View or download current coverage booklets
- View claims history for yourself and dependents
- View claims payment history for yourself and/or the service provider

Honeybee Care Team

Should you have any questions regarding your Honeybee coverage you can email us at help@myhoneybee.com or call or text us at 1-877-797-7448. Our Honeybee Care Team is available Monday through Friday 8:30am to 5:00pm Eastern Time.

Medical Plan Details

Prescription Drugs

This benefit covers expenses for eligible drugs as defined by your Honeybee medical plan and may be subject to any deductible, co-pay, coinsurance or maximum listed in the Statement of Benefit Coverage which includes a Summary of Benefits.

Honeybee may, on an ongoing basis, add, delete or amend the list of eligible drugs on any list hereafter mentioned. Certain drugs may require prior authorization to be eligible for payment as identified by your Honeybee coverage.

The plan will cover any prescribed drug or medicine at the cost of the lowest priced equivalent generic drug.

If there is no generic equivalent product for the prescribed drug or medicine, the amount covered is the cost of the prescribed product. Drugs covered under this plan must have a Drug Identification Number (DIN) in order to be eligible.

Eligible Expenses

- Drugs that require a prescription by law and is prescribed by a doctor or dentist
- Life sustaining drugs
- Injectable drugs and vitamins
- Compounded preparations, provided that the principal active ingredients is an eligible expense and has a DIN
- Diabetic supplies
- Preventive vaccines and medicines

The following are not covered, even when prescribed:

- Any drug that does not have a drug identification number as defined by the Food and Drugs Act, Canada
- Treatment for weight loss, including drugs, protein and food or dietary supplements
- Infant Formula (milk and milk substitutes), minerals, proteins, vitamins and collagen treatment

- Contraceptives other than oral.
- Non-medical shampoos, skin cleansers, skin protectors, emollients and soaps
- Drugs dispensed by a physician, surgeon, dentist or clinic or by a non-accredited hospital pharmacy
- Hair growth stimulants
- Drugs for the treatment of infertility.
- Smoking cessation products to help you quit smoking
- Drugs for the treatment of Erectile Dysfunction
- Drugs that are used for cosmetic purposes
- Over-the-Counter Medicine
- Drugs and treatment, and any services and supplies relating to the administration of the drug and treatment, administered in a hospital, on an in-patient or out-patient basis, or in a government-funded clinic or treatment facility

Advance Supply on Prescriptions

The plan will reimburse payments for any single purchase which are limited to quantities that can reasonably be used in a 34 day period, or a 100 day period for certain maintenance drugs as ordered by a doctor.

An administration fee is charged for some injections. If the injection is covered under your plan, the administration fee will also be covered under the extended health portion of your plan to a maximum of $50. If the drug is not covered under your plan, then the administration fee will not be covered.

Ambulance Services

This plan will cover the cost of emergency transportation to and from hospital by a licensed ambulance. In addition when the circumstances dictate, coverage is provided for licensed air ambulance or by commercial air fare to the nearest hospital qualified to render the necessary emergency.

Accidental Dental

Charges for dental treatment, when sound, natural teeth have been damaged by a direct accidental blow to the mouth, or a fractured or dislocated jaw that requires setting.

This dental treatment must be rendered or reported and approved for payment within 180 days of the accident and dental work must be completed within 12 months of the accident. Eligible expense will be the dentists' usual, reasonable and customary fee up the dental fee guide for general practitioners in effect where services are rendered.

Private Duty Nursing

The plan will cover the cost of services that have been determined to be medically necessary and must be provided by a Registered Nurse, Registered Nursing Assistant or Registered Nurse Practitioner. These services must be approved in advance by submitting a Private Duty Nursing letter, see below. Approvals may also be subject to periodic reassessment.

The services must be provided in the insured person's home, and the practitioner must be someone who does not normally live with, and who is not related to you.

The plan will not cover the cost of a Registered Nurse, Registered Nursing Assistant or Registered Nurse Practitioner if the services being provided are not specific to the skilled duties they are registered to perform. Coverage will not be provided if the services are provided in a nursing home, rest home, home for the aged, hospital, or any facility that provides similar care.

Private Duty Nursing Letter

When a private duty nursing claim is received, a letter is sent out to the plan member requesting information such as:

- Patient diagnosis
- History of current condition
- Complicating factors
- List of medications and method for administration
- Level of nursing provided
- List of specific duties that will be performed

To ensure that the appropriate information is included when submitting the claims please contact the Honeybee Care team to obtain a copy of the letter that is required.

Hospital Accommodation

The plan will pay for inpatient hospital confinement in your province of residence, for the difference between the cost of hospital ward accommodation and a semi-private room and board up to the maximum as outlined on the Summary of Benefits with no limit on the number of days of confinement.

The plan does not cover:

- Alcohol/Drug rehabilitation
- Chronic care
- Home for the aged
- Mental Health
- Rest home
- Nursing home
- Private hospital (not funded by the Provincial Government)
- Palliative care

Homecare (after Hospitalization)

The cost of homecare services will be payable during the convalescent period after discharge from hospital confinement that has lasted for at least three consecutive days providing the services are rendered in your home. These services must be approved in advance by submitting a completed Homecare Letter. Approvals may also be subject to periodic reassessment.

Homecare Letter

When a homecare claim is received, a letter is sent out to the plan member requesting information such as:

- Patient diagnosis
- History of current condition
- Complicating factors
- List of medications and method for administration
- Level of nursing provided

Diagnostic Services

Diagnostic laboratory and x-ray procedures which are defined as diagnostic testing of blood, urine or other bodily fluids and tissues and radiographic examinations performed in the covered person's province of residence are covered when coverage is not available under the provincial government plan.

Hearing Aids

The plan will cover the cost of purchase and repairs of hearing aids up to the maximum shown on your Summary of Benefits page.

Note: A Physician or Audiologist's referral is required for the purchase of a hearing aid.

Provincial Assistive Device Program (ADP) maximums will be taken into consideration where applicable.

The plan will not cover:

- Hearing aid batteries
- The routine maintenance of the hearing aid
- Hearing tests
- Ear moulds

Medical Supplies and Equipment

The medical equipment and supplies listed below are covered when prescribed by a physician. Such equipment must be required for therapeutic use. Coverage is for supplies and equipment available on a rental basis, however, the cost of purchase for the equipment of supply may be considered on a case- by-case basis.

Pre-Approval may be required for specific medical equipment.
Provincial Assistive Device Program (ADP) maximums will be taken into consideration where applicable.

Breathing Equipment:

- Continuous Positive Airway Pressure Machine(CPAP, APAP)
- Maximum benefit: One (1) per lifetime per person
- Combined maximum $10,000 lifetime per person for CPAP, APAP, IPPB and Oxygen equipment
- Supplies included, unlimited maximum, per person
- Intermittent Positive Pressure Breathing Machine (IPPB)
- Maximum benefit: One (1) per lifetime per person

- Combined maximum $10,000 lifetime per person for CPAP, APAP, IPPB and Oxygen equipment
- Supplies included, unlimited maximum, per person
- Aerochamber
- Apnea Monitors
- Mist Tents and Nebulizers
- Oxygen(Including cylinder and concentrators) and the equipment needed for its administration
- Maximum Benefit: Combined maximum $10,000 lifetime per person for CPAP, APAP, IPPB and Oxygen equipment
- Tracheostoma Tubes

Prosthetic Equipment:

- External Breast Prosthesis. Max: $5000 per breast per benefit period per person
- Artificial Limbs including repair & replacement (excluding Myoelectric limbs. Max. $5,000 per limb per benefit period per person
- Artificial Eyes including repair & replacement
- Max: $5,000 per eye per benefit period per person
- Stump Socks
- Shoulder Harnesses

Mobility Aids:

- Standard wheelchair or where medically necessary electric wheelchairs including repairs. Max: $3000 every sixty (60) months per person. Repair to wheelchair is included under wheelchair maximum
- Canes, Crutches, Walkers

Other Medical Equipment:

- Blood Glucose Monitoring Machines. Max: (one (1) every 48 months per person)
- Kidney Check Device. Max: (one (1) every 48 months per person)
- Jet & Pen injectors
- Insulin Pump Max: $5,000 per lifetime per person
- Standard Hospital Beds (manual/electric) Max: $3,000/year

- Support Hose & Compression Stockings
- (Two (2) pairs per calendar year to a maximum of $250 per pair)
- Surgical Brassieres (following a mastectomy) Max: Two(2) per benefit period per person
- Transcutaneous Nerve Stimulators (TENS machine) Max: $700 per lifetime per person
- Wigs (for cancer patients undergoing chemotherapy) Max: $350 per lifetime per person
- Bed Rails
- Colostomy & Ileostomy Supplies
- Custom-Made burn garments
- Custom-Made Pressure supports for Lymphedema
- Head Halters
- Traction Apparatus
- Trapeze Bars
- Urethral Catheters
- Viscosupplementation Injections if dispensed by a physician- includes Orthovisc, Synvisc, Neovisc, Durolane, Euflexxa or any other Viscosupplementation products. Maximum $500 per benefit year.

Submitting Claims

There are several convenient options to quickly and efficiently submit your claims:

- Benefits Card
- Online through the downloadable Honeybee Mobile App

Benefits Card – Electronic Data Interchange (EDI)

For prescription drug claims, present your benefits card to your provider during your visit and your claims will be automatically adjudicated. The adjudication system can automatically verify eligibility and coverage, and calculate co-payment, co-insurance or annual deductibles at the point of sale. Please note that you are able to re-submit any unpaid prescription drug claims to be reimbursed using available Honeybee Health Account funds through your Honeybee Mobile App.

Contact the Honeybee Team (Mon-Sun 8:30am - 5pm ET)
Local: 416-626-6642
Toll Free: 1-866-626-6642
help@myhoneybee.com
Benecaid Health Benefit Solutions Inc.
185 The West Mall, Suite 800
Toronto, ON M9C 5L5

Mobile App Submission

You can quickly and easily submit any claim which you have paid out of pocket (prescription drug, health, and dental) through the downloadable Honeybee Mobile App (available through the Apple App Store or the Google Play Store). Simply take a digital image of your paid-in-full receipts and submit it through the app.

Claim Guidelines

In order to be reimbursed for an eligible medical expense please ensure the following information is submitted:

Prescription Medication

Official prescription receipt with Pharmacist signature or stamp. Please retain original receipt for 5 years.

Dental Treatments

Dental receipt, including the Dentist's signature or stamp as well as a letter describing the nature and details of the dental accident. Please retain original receipt for 5 years.

Optical Services

Invoice and receipt of payment. Please retain original receipt for 5 years.

Paramedicals (ie. Chiropractic, Chiropodist, RMT, etc.)

Receipt from the licensed Medical Practitioner, including all the following information:

- Practitioner, Clinic Name, Address and Phone Number
- Name of the licensed Medical Practitioner who performed the service
- License number and credentials of the Medical Practitioner
- Patient Name, Date of Service
- Amount of money paid

Contact the Honeybee Team (Mon-Sun 8:30am - 5pm ET)

Local: 416-626-6642
Toll Free: 1-866-626-6642
help@myhoneybee.com

Benecaid Health Benefit Solutions Inc.
185 The West Mall, Suite 800
Toronto, ON M9C 5L5

- Description of service or treatment
- Signature or stamp of the licensed Medical Practitioner who performed the service
- Please retain original receipt for 5 years.

Claim Submission Period

Active Employees

Claims must be received within 180 days from the date of service.

Terminated Employees

Claims must be received within 90 days from the date of service. The service date must be prior to the date of termination.

Terminated Groups

If your group's Honeybee plan has been terminated, claims must be received by within 90 days following the group termination effective date. The service date must be prior to the date of termination.

Coordination of Benefits

If your spouse has their own plan, the benefits payable under this plan will be coordinated so that the total amount you receive from both plans will not exceed 100% of the actual expense incurred.

When submitting your claims, you should send them to the primary carrier first (i.e. you send your claims to Honeybee and your spouse's claims go to their benefits plan).

If any portion of the claim is not reimbursed by the primary carrier, then the claim should be forwarded to the other benefits plan with the original explanation of benefits (EOB) and copies of the receipts.

Children's claims will be reimbursed under the parent whose date of birth (month and day) falls first in the year. If the parents have the same date of birth then the claims will be reimbursed based on alphabetical order of the parent's first name.

Contact the Honeybee Team (Mon-Sun 8:30am - 5pm ET)

Local: 416-626-6642
Toll Free: 1-866-626-6642
help@myhoneybee.com

Benecaid Health Benefit Solutions Inc.
185 The West Mall, Suite 800
Toronto, ON M9C 5L5

The above order applies in all situations except when parents are separated or divorced and there is no joint custody of the child, in which case the following order applies:

- The plan of the parent with custody of the child
- The plan of the spouse of the parent with custody of the child
- The plan of the parent not having custody of the child
- The plan of the spouse of the parent not having custody of the child

Exclusions

The plan will not cover benefits when the claim is for an illness resulting from:

- The hostile action of any armed forces, insurrection or participation in a riot or civil commotion;
- Any work for which the person was compensated that was not done for the employer who is providing this plan;
- Committing or attempting to commit or provoking of any violation of the criminal law:
- Any attempted suicide or an intentionally self-inflicted injury or illness while sane or insane
- Amounts paid or payable under any Workplace Safety Insurance Board or similar plan

Legal Action

No legal action may be taken until 60 days after proof of claim is given to Benecaid or more than one year after the deadline for providing proof of claim. If you have received benefit payments but the payments end, no legal action may be taken more than one year after the last payment was made.

Account Information

Eligibility

Definition of an Eligible Employee

To be eligible for group benefits, you must be a resident of Canada and meet the following conditions:

- You are actively working for your employer working at least 24 hours per week
- You have completed the 3 months waiting period
- You are insured under a provincial government health insurance plan in the province in which they reside

Definition of an Eligible Dependent Spouse

- A spouse is your legal spouse or a person whom you publicly acknowledge as your spouse and with whom you have been living in a permanent manner for the period of time recognized by the law in the jurisdiction in which you reside, as the length of time necessary for the recognition of a common-law relationship
- You may only insure one spouse at a time. You must insure the same named person (spouse) for all spousal benefits provided under the benefits plan
- Insured under a provincial government health insurance plan in the province within which they reside

Definition of an Eligible Dependent Child

You or your spouse's unmarried, natural, step, adopted or foster child who is dependent on you for financial support and who is:

- Under 21 years of age; or
- Under 25 years of age if attending an Institute of Higher Learning on a full-time basis
- Unmarried
- A dependent child who is mentally or physically disabled and totally dependent on you for support will continue to be eligible provided they:
- Are covered as a dependent under the plan before attaining the age 21 (age 25 if attending an Institute of Higher Learning on a full-time basis);
- Are eligible for a disability deduction on your personal tax return;
- Are incapable of self-sustaining employment; and
- Proof of the mental or physical disability is submitted no longer than 6 months following the child attaining age 21 (age 25 if attending an Institute of Higher Learning on a full-time basis)
- Documentation from a medical practitioner confirming a disabled child's mental or physical disability must be provided

- A foster child for whom you or your spouse have been appointed legal guardian is eligible
- A child for whom you or your spouse have been appointed legal guardian is not an eligible dependent unless satisfactory proof of guardianship has been provided
- A dependent child under the age of 25 attending an Institute of Higher Learning on a full-time basis must provide on an annual basis or as required, the completed Over-Age Dependent Eligibility Declaration Form. Further proof of full time student status may be requested. Proof can be in one of two forms: A letter from the registrar stating full-time status for the current term/year or an invoice showing full time status with the current term/year paid in full
- A child completing a co-op as part of their program while attending an Institute of Higher Learning on a full-time basis is considered a full-time student
- A child is not considered a full-time student if the child is being paid while attending a training or re-training program
- A newborn is an eligible dependent for their date of birth
- A dependent child under the age of 21 working more than 30 hours per week is not eligible
- Insured under a provincial government health insurance plan in the province in which they reside

Late Applicants

You must activate your Honeybee benefits coverage within 31 days of your eligibility date, or else you will be considered a late applicant. This same rule also applies to your dependents. For example if you have a newborn baby you must add them as dependent within 31 days from the baby's date of birth otherwise the child will be considered as a late applicant. Dependents can be added online through your MyHoneybee.com portal or by contacting your Plan Administrator.

A late applicant must submit a medical application for underwriting approval of themselves and their dependents, and certain benefits may be denied as a result of the underwriting process.

When completing the medical application please ensure that all occurrences of illnesses and/or medications are included. Failure to complete the medical application with the required information may result in declination of coverage.

Account Changes

Reporting General Changes

You must report the following changes to your employer to avoid any disruptions or issues with your benefits:

- Changes in dependent coverage, including the birth of a child
- Change of spouse
- Change of name
- Change in coverage needs such as a change from single to family
- Change of address
- Change of beneficiary
- Change in coordination of spousal benefits

Failure to report member or dependent coverage changes within 31 days of the event will result in the member or dependent being treated as a late applicant which will require completion of a medical application. Please note that when completing the medical application, all illnesses and/or medications must be disclosed. Failure to do so may result in declination of coverage.

Opting Out

Medical Plan

You and your dependents may opt-out of your Honeybee Medical plan if you are covered as dependents through your spouse's group insurance plan. You must submit proof of spousal coverage including the name of your spouse's insurer and their policy number.

If you or your dependents opt-out of your Honeybee Medical plan due to spousal coverage and your spouse's coverage with their employer terminates, you have 31 days to apply for coverage from the date of loss of spousal coverage. You and your dependents may be considered late applicants if your enrollments are not received within the allotted 31 days.

End of Coverage

Employees

Your coverage terminates on the earliest of the following dates:

- The date your employment terminates
- The date the group contract terminates
- The date you no longer meet the eligibility guidelines

Dependents

A dependent's coverage terminates on the earlier of the following dates:

- The date your coverage terminates
- The date your dependent is no longer an eligible dependent

Terminated Employees

Claims must be received within 90 days from the date of service. The service date must be prior to the date of termination.

Terminated Groups

If your group plan has been terminated, claims must be received within 90 days following the group termination effective date. The service date must be prior to the date of termination.

Definitions

Benefit Period

Please refer to your Statement of Benefits coverage for your group's benefit period.

Co-Insurance

The way the cost of a service is shared between you and your plan. It exists in addition any deductibles. So for example, an 80% co-insurance means that after

the deductible has been satisfied, your plan will cover up to 80% of the bill and they would pay the rest.

Co-payment

The fixed amounts that you must pay towards the cost of a service each time they use their plan. Most often, co-payments exist in situations where a claim is settled at point of sale. For instance, you might see a drug benefit with a $2.00 co-pay amount. Regardless of the cost of the prescription being filled, you are required to pay $2.00. You pay a portion of the cost of their prescriptions by paying either the same amount each time (e.g. $5) or a percentage of the total cost (e.g. 20%). If you're paying a percentage, then you are encouraged to shop around for the best available dispensing fees and ingredient costs.

Deductible

Deductible amounts (if any) for the drug benefit will apply, until the annual out-of-pocket maximum is reached. Some plans require that employees pay a fixed amount each year before their coverage starts (e.g. first $100 of prescription costs). The higher the deductible, the more out-of-pocket expenses you will be responsible for before the insurance portion of their plan will pay. Therefore the higher the deductible chosen the lower the cost of your insurance plan.

Dentist

Legally qualified person who is licensed to practice dentistry by the appropriate authority of the jurisdiction where the services are provided.

Dispensing Fee Cap

The maximum amount applied to the part of the price of each prescription sold by a drugstore that corresponds to the standard amount covering the cost of the pharmacist's services. The maximum amount varies by province.

Drug

Must be prescribed in writing by a physician, dentist or other health care professional whose scope of practice within their province permits them to write

a prescription; dispensed by a licensed pharmacist and have been approved for use by Health Canada and have a drug identification number (DIN).

Hospital

Any hospital that is designated as such by law and is intended for the care and treatment of sick and injured individuals and which has organized facilities for diagnosis and major surgeries as well as 24 hour nursing service. It does not include a nursing home, rest home, home for the aged or the chronically ill, home for the mentally ill, convalescent hospital, or an institution for the care and treatment of alcohol and drug addiction.

Immediate Family Member

Any person who is the Spouse, son, daughter, father, mother, brother, sister, son-in-law, daughter-in-law, father -in-law, mother-in-law, brother-in-law or sister - in- law of the employee.

Insured Person

Means you or any one of your Dependents who is covered under your plan.

Licensed, Certified, Registered

The status of a person who legally engages in practice by virtue of a license or certificate issued by the appropriate authority in the jurisdiction where the services are being provided.

Lifetime Maximum

The maximum amount that the benefit will pay during your lifetime.

Medical and Non Medical Travel Emergencies

Sudden, unexpected injuries which occur or unforeseen illnesses which begin while travelling out-of-province or out-of-Canada for business or pleasure and for accidents or illnesses that were not previously diagnosed or treated in Canada.

Medically Necessary

Treatment broadly accepted and recognized by the Canadian medical profession as effective, appropriate and essential in the treatment of a sickness or injury in accordance with Canadian medical standards.

Out-Of-Pocket Maximum

This is the maximum amount of money you will have to pay on your own before your insurance benefits begin to take over and pay. It includes things like deductibles, and co-insurance, but not things like co-payments or your monthly premium.

Physician

Legally qualified medical practitioner lawfully entitled to practice medicine in the jurisdiction where the medical services are provided.

Provincial Plan

Any plan that provides hospital, medical, or dental benefits established by the government in the province where the covered person lives.

Reasonable and Customary Charges

Means, with respect to charges for medical or dental services, supplies or treatment incurred by a insured, not in excess of the general level of charges made by other provides of similar standing in the locality or geographical area where the charge is incurred, when furnishing comparable medical or dental services, supplies or treatment, with due consideration given to the nature and severity of the condition involved.

Waiting Period

The period of continuous employment with your employer which you must complete before you are eligible for Group benefits.

Ward

A hospital room with 3 or more beds which provides standard accommodation for patients.

Privacy Policy

Honeybee is provided by Benecaid Health Benefit Solutions Inc. Benecaid respects your privacy. We have established a privacy policy that balances an individual's right to the privacy of personal information with the need of Benecaid to collect, use or disclose personal information for legitimate business purposes.

Why do we collect personal information?

Benecaid requires certain personal information about you in order to provide you with the products that you requested. This information is collected only when you specifically and knowingly provide it to us. This information includes you and your dependent's names, email address, mailing address, phone number, dates of birth and any medical information about you and your dependents in order to administer your Plan, adjudicate claims and to provide insurance coverage. We will do our best to base our decision on accurate and up to date personal information. We rely on our members to disclose all personal information to us and inform us of any changes.

How is the personal information used?

Personal information that is provided to Benecaid is used to develop and customize products or services to better meet your needs. Your personal information is safely recorded by Benecaid and may be disclosed to third parties such as any person or organization, including medical practitioners and institutions in order to process claims and administer insurance benefits. We may also share personal information with agents/brokers retained by your employer. When an agent/broker is participating in obtaining insurance coverage we may discuss with the agent/broker alternate coverage to better serve you.

When claims are submitted, we may request further information from you or, with your consent, information from your health care providers. Any personal information collected shall be kept confidential at all times except as already explained to you.

You may request a copy of the personal information we have on hand at any time.

When does Benecaid share my personal information?

Personal information shall NOT be used or disclosed for purposes other than those for which it was collected, except with the consent of the individual. Consent can be received either by signing your enrollment form of may be provided verbally, such as when you contact us to request certain information on your behalf. Consent may also be implied, such as where the action taken is clearly in your best interests or as required by law.

What security measures are in place?

Benecaid has security measures in place to protect against loss, misuse and interception by third parties. Benecaid assumes no liability for interception, alteration or misuse of information transmitted to us over the internet, or misdirected by mail. Internet users should be aware that when you are visiting our website, one could be directed to other sites that are beyond our control. Benecaid is not responsible, and bears no liability, for these policies and actions.

Who do I contact?

If you have questions about this privacy policy or the practices of our website, you may contact:

Chief Privacy Officer
Benecaid Health Benefit Solutions Inc.
Tel: 416-626-8786

Contact Us

The Honeybee Care Team is available Monday through Friday from 8:30AM to 5:00PM ET, and can be reached by phone, text or email.

Monday to Friday, 8:30AM to 5:00PM ET
Phone/Text (Local): 416-626-6642
Phone/Text (Toll Free): 1-877-626-6642
Email: help@myhoneybee.com

Contact the Honeybee Team (Mon-Sun 8:30am - 5pm ET)

Local: 416-626-6642
Toll Free: 1-866-626-6642
help@myhoneybee.com

Benecaid Health Benefit Solutions Inc.
185 The West Mall, Suite 800
Toronto, ON M9C 5L5

honeybee

Benecaid Health Benefit Solutions Inc. Employee Benefits Booklet

Your Honeybee Health Account

Plan Effective Date

09012017

Administered by:

benecaid®

Contact the Honeybee Team (Mon-Sun 8:30am - 5pm ET)

Local: 416-626-6642
Toll Free: 1-866-626-6642
help@myhoneybee.com

Benecaid Health Benefit Solutions Inc.
185 The West Mall, Suite 800
Toronto, ON M9C 5L5

Table of Contents

Contact the Honeybee Team (Mon-Sun 8:30am - 5pm ET)

Local: 416-626-6642
Toll Free: 1-866-626-6642
help@myhoneybee.com

Benecaid Health Benefit Solutions Inc.
185 The West Mall, Suite 800
Toronto, ON M9C 5L5

Welcome

The purpose of this booklet is to provide you more detail on the list of eligible expenses that are covered through your Honeybee Health Account. Your Honeybee Statement of Benefits coverage should be read together with the information contained in this booklet. Your Statement of Benefits coverage can be downloaded from the MyHoneybee.com online portal. It contains specific coverage details. For more information, including exclusions, limitations and other conditions please refer to the appropriate sections of this booklet.

Member Online Services

MyHoneybee.com is a secure online portal that allows you to manage your Honeybee accounts anytime, anywhere. You can also download the Honeybee app from the Apple App Store and Google Play store.

The Honeybee app allows you to:

- Submit claims
- View your benefits card
- Check your Honeybee account balances

MyHoneybee.com allows you to:

- View detailed information about your Honeybee benefits plan
- Check your Honeybee account balances
- View or download current coverage booklets
- View claims history for yourself and dependents
- View claims payment history for yourself and/or the service provider

Honeybee Care Team

Should you have any questions regarding your Honeybee coverage you can email us at help@myhoneybee.com or call or text us at 1-877-797-7448. Our Honeybee Care Team is available Monday through Friday 8:30am to 5:00pm Eastern Time.

Honeybee Health Account Details

The Honeybee Health Account funds can be used, tax-free to pay for Medical and Dental expenses that are not covered by your plan, and can also be used to cover a wide variety of other healthcare expenses like vision, paramedical services and more.

Unused Health Account Funds

Unused Honeybee Health Account funds will carry forward to be used for future months, for a maximum of 24 months.

Claims Exceeding Balance

We can only reimburse up to the amount that you have in your Honeybee Health Account. Our Claims Department will reimburse you for the amounts available in your account and indicate on your Reimbursement Summary of insufficient funds for a full reimbursement. When additional funds are deposited in to your Honeybee Health account, you will be automatically reimbursed for the remaining eligible amount, up to your account balance until the eligible amount has been paid to you in full.

Eligible Expenses

Honeybee Health Account funds can be used on a large list of eligible health expenses, including products dispensed by or treatment performed by a licensed medical practitioner. This includes expenses such as acupuncture, prescription drugs, eyeglasses, psychologist, dental services and more. You can also use your funds to cover any unpaid amounts from claims submitted to your Honeybee Medical or Dental plan, if applicable.

The following is a partial list of eligible medical expenses:

ABA Therapy*	**Chiropody Treatments**
Drugs (prescription)*	**Lifestyle Drugs***
Out of country treatments*	**Medical Equipment***
Splints	**Contact Lenses***
Acupuncture	**Naturopathic Treatments**
Eyeglasses	**Long Term Care Facilities***

Physiotherapy	**Optometrist Contraceptive Devices***
Addiction Therapy*	**Orthopedic Shoes Crowns & Bridgework**
Eye Exams	**Orthotics**
Psychotherapy	**Crutches**
Birth Control Pills*	**Orthodontics**
Hearing Aid	**Dental Implants**
Podiatric Treatments	**Dentures**
Brace	**Dental Treatments**
Cast	**Home renovation for disability***
Laser Eye Surgery	**Shadowing services for children with disability***
IBI Therapy*	
Dermatologist*	

** Must be prescribed by a Licensed Medical Practitioner*

Note: All paramedical services must be performed by a Licensed Medical Practitioner in their province of practice.

The full list of eligible medical practitioners can be found on the CRA website - http://www.cra-arc.gc.ca/medical

Licensed Medical Practitioners

Licensed medical practitioners differ based on each province or territory. However, they are defined as anyone who meets the following criteria:

- Legally allowed to render the service to the individual in the province where the service took place
- Legally certified to perform such a service in the province where the individual resides
- If applicable, is legally licensed to issue a prescription to the individual in the province where the individual resides as well as the province where the prescription is filled

Terminated Accounts

If you leave your group Honeybee plan, you are able to continue using your remaining Honeybee Health Account balance for up to 90 days or until you have no more remaining funds.

Submitting Claims

You can conveniently and quickly submit your Health Account claims online through the downloadable Honeybee Mobile App

Mobile App Submission

You can quickly and easily submit any claim which you have paid out of pocket (drug, health, and dental) through the downloadable Honeybee Mobile App (available through the Apple App Store or the Google Play Store). Simply take a digital image of your paid-in-full receipts and submit it through the app.

Claim Guidelines

In order to be reimbursed for an eligible medical expense please ensure the following information is submitted:

Prescription Medication

Official prescription receipt with Pharmacist signature or stamp. Please retain original receipt for 5 years.

Dental Treatments

Dental receipt, including the Dentist's signature or stamp as well as a letter describing the nature and details of the dental accident. Please retain original receipt for 5 years.

Optical Services

Invoice and receipt of payment. Please retain original receipt for 5 years.

Paramedicals (ie. Chiropractic, Chiropodist, RMT, etc.)

Receipt from the licensed Medical Practitioner, including all the following information:

- Practitioner, Clinic Name, Address and Phone Number
- Name of the licensed Medical Practitioner who performed the service
- License number and credentials of the Medical Practitioner
- Patient Name, Date of Service
- Amount of money paid
- Description of service or treatment
- Signature or stamp of the licensed Medical Practitioner who performed the service
- Please retain original receipt for 5 years.

Claim Submission Period

Active Employees

Claims must be received within 365 days from the date of service.

Terminated Employees

Claims must be received within 180 days from the date of service. The service date must be prior to the date of termination.

Terminated Groups

If your group's Honeybee plan has been terminated, claims must be received by within 90 days following the group termination effective date. The service date must be prior to the date of termination.

Coordination of Benefits

If your spouse has their own plan, the benefits payable under this plan will be coordinated so that the total amount you receive from both plans will not exceed 100% of the actual expense incurred.

When submitting your claims, you should send them to the primary carrier first (i.e. you send your claims to Honeybee and your spouse's claims go to their benefits plan).

If any portion of the claim is not reimbursed by the primary carrier, then the claim should be forwarded to the other benefits plan with the original explanation of benefits (EOB) and copies of the receipts.

Children's claims will be reimbursed under the parent whose date of birth (month and day) falls first in the year. If the parents have the same date of birth then the claims will be reimbursed based on alphabetical order of the parent's first name.

The above order applies in all situations except when parents are separated or divorced and there is no joint custody of the child, in which case the following order applies:

- The plan of the parent with custody of the child
- The plan of the spouse of the parent with custody of the child
- The plan of the parent not having custody of the child
- The plan of the spouse of the parent not having custody of the child

Exclusions

The plan will not cover benefits when the claim is for an illness resulting from:

- The hostile action of any armed forces, insurrection or participation in a riot or civil commotion;
- Any work for which the person was compensated that was not done for the employer who is providing this plan;
- Committing or attempting to commit or provoking of any violation of the criminal law:
- Any attempted suicide or an intentionally self-inflicted injury or illness while sane or insane
- Amounts paid or payable under any Workplace Safety Insurance Board or similar plan

Legal Action

No legal action may be taken until 60 days after proof of claim is given to Benecaid or more than one year after the deadline for providing proof of claim. If you have received benefit payments but the payments end, no legal action may be taken more than one year after the last payment was made.

Account Information

Eligibility

Definition of an Eligible Employee

To be eligible for group benefits, you must be a resident of Canada and meet the following conditions:

- You are actively working for your employer working at least 24 hours per week.
- You have completed the 3 months waiting period.
- You are insured under a provincial government health insurance plan in the province in which they reside.

Definition of an Eligible Dependent Spouse

- A spouse is your legal spouse or a person whom you publicly acknowledge as your spouse and with whom you have been living in a permanent manner for the period of time recognized by the law in the jurisdiction in which you reside, as the length of time necessary for the recognition of a common-law relationship
- You may only insure one spouse at a time. You must insure the same named person (spouse) for all spousal benefits provided under the benefits plan
- Insured under a provincial government health insurance plan in the province within which they reside

Definition of an Eligible Dependent Child

You or your spouse's unmarried, natural, step, adopted or foster child who is dependent on you for financial support and who is:

- Under 21 years of age; or
- Under 25 years of age if attending an Institute of Higher Learning on a full-time basis
- Unmarried
- A dependent child who is mentally or physically disabled and totally dependent on you for support will continue to be eligible provided they:

- Are covered as a dependent under the plan before attaining the age 21 (age 25 if attending an Institute of Higher Learning on a full-time basis);
- Are eligible for a disability deduction on your personal tax return;
- Are incapable of self-sustaining employment; and
- Proof of the mental or physical disability is submitted no longer than 6 months following the child attaining age 21 (age 25 if attending an Institute of Higher Learning on a full-time basis)
- Documentation from a medical practitioner confirming a disabled child's mental or physical disability must be provided
- A foster child for whom you or your spouse have been appointed legal guardian is eligible
- A child for whom you or your spouse have been appointed legal guardian is not an eligible dependent unless satisfactory proof of guardianship has been provided
- A dependent child under the age of 25 attending an Institute of Higher Learning on a full-time basis must provide on an annual basis or as required, the completed Over-Age Dependent Eligibility Declaration Form. Further proof of full time student status may be requested. Proof can be in one of two forms: A letter from the registrar stating full-time status for the current term/year or an invoice showing full time status with the current term/year paid in full
- A child completing a co-op as part of their program while attending an Institute of Higher Learning on a full-time basis is considered a full-time student
- A child is not considered a full-time student if the child is being paid while attending a training or re-training program
- A newborn is an eligible dependent for their date of birth
- A dependent child under the age of 21 working more than 30 hours per week is not eligible
- Insured under a provincial government health insurance plan in the province in which they reside

Late Applicants

You must activate your Honeybee benefits coverage within 31 days of your eligibility date, or else you will be considered a late applicant. This same rule also applies to your dependents. For example if you have a baby you must add

them as dependent within 31 days of the birth of the baby otherwise the child will be considered as a late applicant. Dependents can be added online through your MyHoneybee.com portal or by contacting your Plan Administrator.

A late applicant must submit a medical application for underwriting approval of themselves and their dependents, and certain benefits may be denied as a result of the underwriting process.

When completing the medical application please ensure that all occurrences of illnesses and/or medications are included. Failure to complete the medical application with the required information may result in declination of coverage.

Account Changes

Reporting General Changes

You must report the following changes to your employer to avoid any disruptions or issues with your benefits:

- Changes in dependant coverage, including the birth of a child
- Change of spouse
- Change of name
- Change in coverage needs such as a change from single to family
- Change of address
- Change of beneficiary
- Change in coordination of spousal benefits

Failure to report member or dependent coverage changes within 31 days of the event will result in the member or dependent being treated as a late applicant which will require completion of a medical application. Please note that when completing the medical application, all illnesses and/or medications must be disclosed. Failure to do so may result in declination of coverage.

End of Coverage

Employees

Your coverage terminates on the earliest of the following dates:

- The date your employment terminates

- The date the group contract terminates
- The date you no longer meet the eligibility guidelines

Dependants

A dependant's coverage terminates on the earlier of the following dates:

- The date your coverage terminates
- The date your dependant is no longer an eligible dependent

Terminated Employees

Claims must be received within 90 days from the date of service. The service date must be prior to the date of termination.

Terminated Groups

If your group plan has been terminated, claims must be received within 90 days following the group termination effective date. The service date must be prior to the date of termination.

Definitions

Benefit Period

Please refer to your Statement of Benefits coverage for your group's benefit period.

Co-Insurance

The way the cost of a service is shared between your employee and their plan. It exists in addition any deductibles. So for example, an 80% co-insurance means that after the deductible has been satisfied, your employee's plan will cover up to 80% of the bill and they would pay the rest.

Co-payment

The fixed amounts that your employee must pay towards the cost of a service each time they use their plan. Most often, co-payments exist in situations where

Contact the Honeybee Team (Mon-Sun 8:30am - 5pm ET)
Local: 416-626-6642
Toll Free: 1-866-626-6642
help@myhoneybee.com
Benecaid Health Benefit Solutions Inc.
185 The West Mall, Suite 800
Toronto, ON M9C 5L5

a claim is settled at point of sale. For instance, they might see a drug benefit with a $2.00 co-pay amount. Regardless of the cost of the prescription being filled, the employee is required to pay $2.00. They pay a portion of the cost of their prescriptions by paying either the same amount each time (e.g. $5) or a percentage of the total cost (e.g. 20%). If they're paying a percentage, then they're encouraged to shop around for the best available dispensing fees and ingredient costs.

Deductible

Deductible amounts (if any) for the drug benefit will apply, until the annual out-of-pocket maximum is reached. Some plans require that employees pay a fixed amount each year before their coverage starts (e.g. first $100 of prescription costs). The higher the deductible, the more out-of-pocket expenses you will be responsible for before the insurance portion of their plan will pay. Therefore the higher the deductible chosen the lower the cost of your insurance plan.

Dentist

Legally qualified person who is licensed to practice dentistry by the appropriate authority of the jurisdiction where the services are provided

Dispensing Fee Cap

The maximum amount applied to the part of the price of each prescription sold by a drugstore that corresponds to the standard amount covering the cost of the pharmacist's services. The maximum amount varies by province

Drug

Must be prescribed in writing by a physician, dentist or other health care professional whose scope of practice within their province permits them to write a prescription; dispensed by a licensed pharmacist and have been approved for use by Health Canada and have a drug identification number (DIN).

Hospital

Any hospital that is designated as such by law and is intended for the care and treatment of sick and injured individuals and which has organized facilities for

Contact the Honeybee Team (Mon-Sun 8:30am - 5pm ET)
Local: 416-626-6642
Toll Free: 1-866-626-6642
help@myhoneybee.com
Benecaid Health Benefit Solutions Inc.
185 The West Mall, Suite 800
Toronto, ON M9C 5L5

diagnosis and major surgeries as well as 24 hour nursing service. It does not include a nursing home, rest home, home for the aged or the chronically ill, home for the mentally ill, convalescent hospital, or an institution for the care and treatment of alcohol and drug addiction

Immediate Family Member

Any person who is the Spouse, son, daughter, father, mother, brother, sister, son-in-law, daughter-in-law, father -in-law, mother-in-law, brother-in-law or sister - in- law of the employee

Insured Person

Means you or any one of your dependents who is covered under your plan

Licensed, Certified, Registered

The status of a person who legally engages in practice by virtue of a license or certificate issued by the appropriate authority in the jurisdiction where the services are being provided.

Lifetime Maximum

The maximum amount that the benefit will pay during your lifetime.

Medical and Non Medical Travel Emergencies

Sudden, unexpected injuries which occur or unforeseen illnesses which begin while travelling out-of-province or out-of-Canada for business or pleasure and for accidents or illnesses that were not previously diagnosed or treated in Canada.

Medically Necessary

Treatment broadly accepted and recognized by the Canadian medical profession as effective, appropriate and essential in the treatment of a sickness or injury in accordance with Canadian medical standards.

Out-Of-Pocket Maximum

This is the maximum amount of money you will have to pay on your own before your insurance benefits begin to take over and pay. It includes things like deductibles, and co-insurance, but not things like co-payments or your monthly premium.

Physician

Legally qualified medical practitioner lawfully entitled to practice medicine in the jurisdiction where the medical services are provided.

Provincial Plan

Any plan that provides hospital, medical, or dental benefits established by the government in the province where the covered person lives.

Reasonable and Customary Charges

Means, with respect to charges for medical or dental services, supplies or treatment incurred by a insured, not in excess of the general level of charges made by other provides of similar standing in the locality or geographical area where the charge is incurred, when furnishing comparable medical or dental services, supplies or treatment, with due consideration given to the nature and severity of the condition involved.

Waiting Period

The period of continuous employment with your employer which you must complete before you are eligible for Group benefits

Ward

A hospital room with 3 or more beds which provides standard accommodation for patients.

Privacy Policy

Honeybee is provided by Benecaid Health Benefit Solutions Inc. Benecaid respects your privacy. We have established a privacy policy that balances an individual's right to the privacy of personal information with the need of Benecaid to collect, use or disclose personal information for legitimate business purposes.

Why do we collect personal information?

Benecaid requires certain personal information about you in order to provide you with the products that you requested. This information is collected only when you specifically and knowingly provide it to us. This information includes you and your dependent's names, email address, mailing address, phone number, dates of birth and any medical information about you and your dependents in order to administer your Plan, adjudicate claims and to provide insurance coverage. We will do our best to base our decision on accurate and up to date personal information. We rely on our members to disclose all personal information to us and inform us of any changes.

How is the personal information used?

Personal information that is provided to Benecaid is used to develop and customize products or services to better meet your needs. Your personal information is safely recorded by Benecaid and may be disclosed to third parties such as any person or organization, including medical practitioners and institutions in order to process claims and administer insurance benefits. We may also share personal information with agents/brokers retained by your employer. When an agent/broker is participating in obtaining insurance coverage we may discuss with the agent/broker alternate coverage to better serve you.

When claims are submitted, we may request further information from you or, with your consent, information from your health care providers. Any personal information collected shall be kept confidential at all times except as already explained to you.

You may request a copy of the personal information we have on hand at any time.

When does Benecaid share my personal information?

Personal information shall NOT be used or disclosed for purposes other than those for which it was collected, except with the consent of the individual. Consent can be received either by signing your enrollment form of may be provided verbally, such as when you contact us to request certain information on your behalf. Consent may also be implied, such as where the action taken is clearly in your best interests or as required by law.

What security measures are in place?

Benecaid has security measures in place to protect against loss, misuse and interception by third parties. Benecaid assumes no liability for interception, alteration or misuse of information transmitted to us over the internet, or misdirected by mail. Internet users should be aware that when you are visiting our website, one could be directed to other sites that are beyond our control. Benecaid is not responsible, and bears no liability, for these policies and actions.

Who do I contact?

If you have questions about this privacy policy or the practices of our website, you may contact:

Chief Privacy Officer
Benecaid Health Benefit Solutions Inc.
Tel: 416-626-8786

Contact Us

The Honeybee Care Team is available Monday through Friday from 8:30AM to 5:00PM ET, and can be reached by phone, text or email.

Monday to Friday, 8:30AM to 5:00PM ET
Phone/Text (Local): 416-626-6642
Phone/Text (Toll Free): 1-877-626-6642
Email: help@myhoneybee.com

Contact the Honeybee Team (Mon-Sun 8:30am - 5pm ET)

Local: 416-626-6642
Toll Free: 1-866-626-6642
help@myhoneybee.com

Benecaid Health Benefit Solutions Inc.
185 The West Mall, Suite 800
Toronto, ON M9C 5L5

honeybee

Benecaid Health Benefit Solutions Inc.
Employee Benefits Booklet

Your Honeybee Dental Plan

Plan Effective Date

09012017

Administered by:

benecaid®

Contact the Honeybee Team (Mon-Sun 8:30am - 5pm ET)

Local: 416-626-6642
Toll Free: 1-866-626-6642
help@myhoneybee.com

Benecaid Health Benefit Solutions Inc.
185 The West Mall, Suite 800
Toronto, ON M9C 5L5

Table of Contents

Contact the Honeybee Team (Mon-Sun 8:30am - 5pm ET)

Local: 416-626-6642
Toll Free: 1-866-626-6642
help@myhoneybee.com

Benecaid Health Benefit Solutions Inc.
185 The West Mall, Suite 800
Toronto, ON M9C 5L5

Welcome

The purpose of this booklet is to provide you more detail on the list of eligible expenses that are covered through your Honeybee Dental plan. Your Honeybee Statement of Benefits coverage should be read together with the information contained in this booklet. Your Statement of Benefits coverage can be downloaded from the MyHoneybee.com online portal. It contains specific coverage details. For more information, including exclusions, limitations and other conditions please refer to the appropriate sections of this booklet.

Member Online Services

MyHoneybee.com is a secure online portal that allows you to manage your Honeybee accounts anytime, anywhere. You can also download the Honeybee app from the Apple App Store and Google Play store.

The Honeybee app allows you to:

- Submit claims
- View your benefits card
- Check your Honeybee account balances

MyHoneybee.com allows you to:

- View detailed information about your Honeybee benefits plan
- Check your Honeybee account balances
- View or download current coverage booklets
- View claims history for yourself and dependents
- View claims payment history for yourself and/or the service provider

Honeybee Care Team

Should you have any questions regarding your Honeybee coverage you can email us at help@myhoneybee.com or call or text us at 1-877-797-7448. Our Honeybee Care Team is available Monday through Friday 8:30am to 5:00pm Eastern Time.

Dental Plan Details

Your Plan will cover the cost of eligible expenses that you incur for dental performed by a licensed dentist, denturist and dental hygienist while you are covered under the Plan.

The Plan will only cover the reasonable expenses for each procedure performed. The Plan will not cover more than the fee stated in the Dental Association Fee Guide for General Practitioners in the province where the employee lives, regardless of where the treatment is performed. The Plan will reimburse based on the current guide at the time the treatment is received.

Pre-Determinations

If the cost of dental treatment is more than $500, Benecaid recommends that you submit pre-determination before the treatment begins. A pre-determination is a completed dental claim form that outlines the treatment and the proposed cost. Once received, Benecaid will issue a written estimate outlining how much you are responsible for paying before the treatment begins.

There may be a delay in processing your claim if you receive the work before the pre-determination has been submitted. This delay usually results in the need for models or x-rays to determine the amount that will be covered.

Level One – Basic

Services include Diagnostic, Preventive and Minor Restorative:

1. Diagnostic (services to diagnose a dental condition)

a. Complete Examination (One (1) every thirty-six (36) consecutive months)
b. Recall Examination
c. Specific Examination (Two (2) every twelve (12) consecutive months)
d. Emergency Examination (Two (2) every twelve (12) consecutive months)
e. Complete radiographs or panoramic radiographs (One (1) every thirty-six (36) consecutive months)
f. Bite-wing radiographs (One (1) occurrence every recall examination pd.)
g. Bacteriological tests/analyses

Contact the Honeybee Team (Mon-Sun 8:30am - 5pm ET)
Local: 416-626-6642
Toll Free: 1-866-626-6642
help@myhoneybee.com
Benecaid Health Benefit Solutions Inc.
185 The West Mall, Suite 800
Toronto, ON M9C 5L5

h. Histopathological tests/analyses
i. Microbiological tests/analyses
j. Occlusal radiographs
k. Periapical radiographs
l. Treatment Planning
m. Consultation with Patient

2. Preventative (services to prevent future dental problems)

a. Fluoride treatments (One (1) treatment every recall examination period/Children under 14 years of age)
b. Polishing (One (1) unit every recall examination period)
c. Scaling/Root planning
d. Interproximal disking
e. Pit and fissure sealants (Children under 14 years of age)
f. Space maintainers and maintenance of space maintainers (Children under 14 years of age)
g. Finishing restorations

3. Minor Restorative (services to repair teeth)

a. Amalgam restorations (Non-bonded amalgam restorations. Bonded amalgam restorations are paid up to the cost of non-bonded amalgam restorations)
b. Prefabricated restorations (Primary teeth only)
c. Prefabricated crowns restorations
d. Tooth coloring restorations (White fillings on molar teeth)
e. Trauma/Pain control
f. Prefabricated posts
g. Retentive pins

4. Minor Oral Surgical (oral surgery services)

a. Alveoplasty-simple
b. Antral surgery
c. Extractions & residual root removal
d. Fractures
e. Frenectomy
f. Hemorrhage control

g. Surgical excision
h. Surgical exposure
i. Surgical Incision
j. Treatment of salivary glands
k. Vestibuloplasty

5. Crown/Bridge/Dental Maintenance (services for the repair of prosthetic appliances)

a. Denture rebase (One (1) per arch every thirty-six (36) consecutive months)
b. Denture reline and repair (One (1) per arch every thirty-six (36) consecutive months)
c. Recementation and repair of crowns/bridgework

6. Adjunctive Services

a. Deep sedation
b. General anaesthesia
c. Nitrous oxide (and with oral sedation)
d. Parental conscious sedation
e. Therapeutic Injections

Level Two – Comprehensive Basic Services

Services include Endodontics and Periodontics:

1. Endodontic Treatment (services to treat the pulp chamber of the tooth)

a. Routine root canal therapy (Complicated root canal therapy reduced to cost of routine root canal therapy. No coverage for primary teeth)
b. Apexification
c. Apicoectomy
d. Bleaching of endodontically treated teeth
e. Hemisection
f. Surgery, Endodontic, Exploratory
g. Intentional removal
h. Isolation of endodontic tooth
i. Open and drain
j. Root amputation
k. Pulpectomy

l. Pulpotomy
m. Retrofilling

2. Periodontal Treatment (services to treat the tissue supporting the teeth)

a. Periodontal appliances and maintenance (One (1) appliance per arch every thirty-six (36) consecutive months)
b. Management of oral disease
c. Occlusal equilibration (8 units per benefit period)
d. Periodontal surgery (osteoplasty, gingival curettage, gingivolplasty, gingivectomy, soft tissue grafts)

Level Three – Major Restorative Services

Services include major restorative and major oral surgical services. **Please refer to your Statement of Benefits coverage to see if these services are covered through your Honeybee Dental plan.**

1. Dentures

a. Complete dentures
b. Cast partial dentures
c. Overdentures and complicated dentures
d. Partial acrylic dentures

2. Crowns

a. Inlays (metal, composite, porcelain)
b. Outlays (metal, composite, porcelain)
c. Acrylic crowns
d. Cast metal crowns
e. Porcelain crowns
f. Ceramic crowns
g. Gold foil restorations
h. Retentive pins for inlays, onlays and crowns

3. Bridgework

a. Cast metal pontics
b. Porcelain/Ceramic pontics

c. Acrylic retainers
d. Cast metal retainers
e. Metal, composite and porcelain inlay retainers
f. Metal, composite and porcelain onlay retainers

4. Major Surgery

a. Alveoloplasty
b. Crown lengthening
c. Reconstruction
d. Remodeling floor of mouth
e. Surgical movement of teeth

Level Four – Orthodontics (coverage for children who begin treatment under 18 years of age)

Please refer to your Statement of Benefits coverage to see if these services are covered through your Honeybee Dental plan.

a. Diagnostic photographs
b. Cephalometric radiographs
c. Enucleation
d. Full orthodontic treatment
e. Hand & wrist radiographs
f. Oral surgery performed in conjunction with Orthodontics (These services will be evaluated on a case by case basis)
g. Orthodontic examinations
h. Orthodontic casts
i. Surgical exposure
j. Tracing & Interpretation

Limitations & Exclusions

- Replacement of removable dentures and bridgework are eligible only if:
  - A natural tooth is extracted and the existing appliance cannot be made serviceable
  - It is 5 years (or more) old and cannot be made serviceable

    - The existing appliance is temporary and is replaced with the permanent denture within 12 months of installation
- General anesthetics and intravenous sedation only when done in conjunction with eligible extractions and oral surgery
- Dental services or supplies that the insured person is eligible to claim under the Workers' Compensation benefit in their province of residence.
- Any dental charges not included in the current Dental Association Fee Guide for General Practitioners
- Cosmetic procedures
- Charges for appointments that are not kept
- Charges for completing claim forms
- Treatment to correct temporomandibular joint dysfunction
- Any orthodontic treatment which was started before the effective date of coverage
- The replacement of dental appliances that are lost, misplaced or stolen
- Any treatment related to orthognathic surgery (remodeling or reconstruction of your jaw)
- Charges related to implants including crowns on implants and surgery charges
- Transplants and the repositioning of the jaw
- Services or supplies for which no charge would have been made in the absence of this coverage
- Dental work resulting from self-inflicted injuries
- Dental work resulting from participation in the committal of a criminal offence
- Dental work resulting from war, insurrection, the hostile actions of any armed forces or participation in a riot or civil commotion

Submitting Claims

There are several convenient options to quickly and efficiently submit your claims:

- Benefits Card
- Online through the downloadable Honeybee Mobile App

Benefits Card – Electronic Data Interchange (EDI)

Dental claims, present your benefits card to your provider at your visit and your claims will be automatically adjudicated. The adjudication system can automatically verify eligibility and coverage, and calculate co-payment, co-insurance or annual deductibles at your point of sale. Please note that you are able to re-submit any unpaid dental claims to be reimbursed using available Honeybee Health Account funds.

Mobile App Submission

You can quickly and easily submit any claim which you have paid out of pocket (drug, health, and dental) through the downloadable Honeybee Mobile App (available through the Apple App Store or the Google Play Store). Simply take a digital image of your paid-in-full receipts and submit it through the app.

Claim Guidelines

In order to be reimbursed for an eligible dental expense please ensure the following information is submitted:

Dental Treatments

Dental receipt, including the Dentist's signature or stamp

Claim Submission Period

Active Employees

Claims must be received within 180 days from the date of service.

Terminated Employees

Claims must be received within 90 days from the date of service. The service date must be prior to the date of termination.

Terminated Groups

If your group's Honeybee plan has been terminated, claims must be received by within 90 days following the group termination effective date. The service date must be prior to the date of termination.

Contact the Honeybee Team (Mon-Sun 8:30am - 5pm ET)

Local: 416-626-6642
Toll Free: 1-866-626-6642
help@myhoneybee.com

Benecaid Health Benefit Solutions Inc.
185 The West Mall, Suite 800
Toronto, ON M9C 5L5

Coordination of Benefits

If your spouse has their own plan, the benefits payable under this plan will be coordinated so that the total amount you receive from both plans will not exceed 100% of the actual expense incurred.

When submitting your claims, you should send them to the primary carrier first (i.e. you send your claims to Honeybee and your spouse's claims go to their benefits plan).

If any portion of the claim is not reimbursed by the primary carrier, then the claim should be forwarded to the other benefits plan with the original explanation of benefits (EOB) and copies of the receipts.

Children's claims will be reimbursed under the parent whose date of birth (month and day) falls first in the year. If the parents have the same date of birth then the claims will be reimbursed based on alphabetical order of the parent's first name.

The above order applies in all situations except when parents are separated or divorced and there is no joint custody of the child, in which case the following order applies:

- The plan of the parent with custody of the child
- The plan of the spouse of the parent with custody of the child
- The plan of the parent not having custody of the child
- The plan of the spouse of the parent not having custody of the child

Exclusions

The plan will not cover benefits when the claim is for an illness resulting from:

- The hostile action of any armed forces, insurrection or participation in a riot or civil commotion;
- Any work for which the person was compensated that was not done for the employer who is providing this plan;
- Committing or attempting to commit or provoking of any violation of the criminal law:
- Any attempted suicide or an intentionally self-inflicted injury or illness while sane or insane

- Amounts paid or payable under any Workplace Safety Insurance Board or similar plan

Legal Action

No legal action may be taken until 60 days after proof of claim is given to Benecaid or more than one year after the deadline for providing proof of claim. If you have received benefit payments but the payments end, no legal action may be taken more than one year after the last payment was made.

Account Information

Eligibility

Definition of an Eligible Employee

To be eligible for group benefits, you must be a resident of Canada and meet the following conditions:

- You are actively working for your employer working at least 24 hours per week
- You have completed the 3 months waiting period
- You are insured under a provincial government health insurance plan in the province in which they reside

Definition of an Eligible Dependent Spouse

- A spouse is your legal spouse or a person whom you publicly acknowledge as your spouse and with whom you have been living in a permanent manner for the period of time recognized by the law in the jurisdiction in which you reside, as the length of time necessary for the recognition of a common-law relationship
- You may only insure one spouse at a time. You must insure the same named person (spouse) for all spousal benefits provided under the benefits plan
- Insured under a provincial government health insurance plan in the province within which they reside

Definition of an Eligible Dependent Child

You or your spouse's unmarried, natural, step, adopted or foster child who is dependent on you for financial support and who is:

Contact the Honeybee Team (Mon-Sun 8:30am - 5pm ET)
Local: 416-626-6642
Toll Free: 1-866-626-6642
help@myhoneybee.com
Benecaid Health Benefit Solutions Inc.
185 The West Mall, Suite 800
Toronto, ON M9C 5L5

- Under 21 years of age; or
- Under 25 years of age if attending an Institute of Higher Learning on a full-time basis
- Unmarried
- A dependent child who is mentally or physically disabled and totally dependent on you for support will continue to be eligible provided they:
- Are covered as a dependent under the plan before attaining the age 21 (age 25 if attending an Institute of Higher Learning on a full-time basis);
- Are eligible for a disability deduction on your personal tax return;
- Are incapable of self-sustaining employment; and
- Proof of the mental or physical disability is submitted no longer than 6 months following the child attaining age 21 (age 25 if attending an Institute of Higher Learning on a full-time basis)
- Documentation from a medical practitioner confirming a disabled child's mental or physical disability must be provided
- A foster child for whom you or your spouse have been appointed legal guardian is eligible
- A child for whom you or your spouse have been appointed legal guardian is not an eligible dependent unless satisfactory proof of guardianship has been provided
- A dependent child under the age of 25 attending an Institute of Higher Learning on a full-time basis must provide on an annual basis or as required, the completed Over-Age Dependent Eligibility Declaration Form. Further proof of full time student status may be requested. Proof can be in one of two forms: A letter from the registrar stating full-time status for the current term/year or an invoice showing full time status with the current term/year paid in full
- A child completing a co-op as part of their program while attending an Institute of Higher Learning on a full-time basis is considered a full-time student
- A child is not considered a full-time student if the child is being paid while attending a training or re-training program
- A newborn is an eligible dependent for their date of birth
- A dependent child under the age of 21 working more than 30 hours per week is not eligible

- Insured under a provincial government health insurance plan in the province in which they reside

Late Applicants

You must activate your Honeybee benefits coverage within 31 days of your eligibility date, or else you will be considered a late applicant. This same rule also applies to your dependents. For example if you have a baby you must add them as dependent within 31 days of the birth of the baby otherwise the child will be considered as a late applicant. Dependents can be added online through your MyHoneybee.com portal or by contacting your Plan Administrator.

A late applicant must submit a medical application for underwriting approval of themselves and their dependents, and certain benefits may be denied as a result of the underwriting process.

When completing the medical application please ensure that all occurrences of illnesses and/or medications are included. Failure to complete the medical application with the required information may result in declination of coverage.

Account Changes

Reporting General Changes

You must report the following changes to your employer to avoid any disruptions or issues with your benefits:

- Changes in dependent coverage, including the birth of a child
- Change of spouse
- Change of name
- Change in coverage needs such as a change from single to family
- Change of address
- Change of beneficiary
- Change in coordination of spousal benefits

Failure to report member or dependent coverage changes within 31 days of the event will result in the member or dependent being treated as a late applicant which will require completion of a medical application. Please note that when completing the medical application, all illnesses and/or medications must be disclosed. Failure to do so may result in declination of coverage.

Contact the Honeybee Team (Mon-Sun 8:30am - 5pm ET)
Local: 416-626-6642
Toll Free: 1-866-626-6642
help@myhoneybee.com
Benecaid Health Benefit Solutions Inc.
185 The West Mall, Suite 800
Toronto, ON M9C 5L5

Opting Out

Dental Plan

You and your dependents may opt-out of your Honeybee Dental plan if you are covered as dependents through your spouse's group insurance plan. You must submit proof of spousal coverage including the name of your spouse's insurer and their policy number.

If you or your dependents opt-out of your Honeybee Dental plan due to spousal coverage and your spouse's coverage with their employer terminates, you have 31 days to apply for coverage from the date of loss of spousal coverage. You and your dependents may be considered late applicants if your enrollments are not received within the allotted 31 days.

End of Coverage

Employees

Your coverage terminates on the earliest of the following dates:

- The date your employment terminates
- The date the group contract terminates
- The date you no longer meet the eligibility guidelines

Dependents

A dependent's coverage terminates on the earlier of the following dates:

- The date your coverage terminates
- The date your dependent is no longer an eligible dependent

Terminated Employees

Claims must be received within 90 days from the date of service. The service date must be prior to the date of termination.

Contact the Honeybee Team (Mon-Sun 8:30am - 5pm ET)

Local: 416-626-6642
Toll Free: 1-866-626-6642
help@myhoneybee.com

Benecaid Health Benefit Solutions Inc.
185 The West Mall, Suite 800
Toronto, ON M9C 5L5

Terminated Groups

If your group plan has been terminated, claims must be received within 90 days following the group termination effective date. The service date must be prior to the date of termination.

Definitions

Benefit Period

Please refer to your Statement of Benefits coverage for your group's benefit period.

Co-Insurance

The way the cost of a service is shared between your employee and their plan. It exists in addition any deductibles. So for example, an 80% co-insurance means that after the deductible has been satisfied, your employee's plan will cover up to 80% of the bill and they would pay the rest.

Co-payment

The fixed amounts that your employee must pay towards the cost of a service each time they use their plan. Most often, co-payments exist in situations where a claim is settled at point of sale. For instance, they might see a drug benefit with a $2.00 co-pay amount. Regardless of the cost of the prescription being filled, the employee is required to pay $2.00. They pay a portion of the cost of their prescriptions by paying either the same amount each time (e.g. $5) or a percentage of the total cost (e.g. 20%). If they're paying a percentage, then they're encouraged to shop around for the best available dispensing fees and ingredient costs.

Deductible

Deductible amounts (if any) for the drug benefit will apply, until the annual out-of-pocket maximum is reached. Some plans require that employees pay a fixed amount each year before their coverage starts (e.g. first $100 of prescription costs). The higher the deductible, the more out-of-pocket expenses you will be

Contact the Honeybee Team (Mon-Sun 8:30am - 5pm ET)
Local: 416-626-6642
Toll Free: 1-866-626-6642
help@myhoneybee.com
Benecaid Health Benefit Solutions Inc.
185 The West Mall, Suite 800
Toronto, ON M9C 5L5

responsible for before the insurance portion of their plan will pay. Therefore the higher the deductible chosen the lower the cost of your insurance plan.

Dentist

Legally qualified person who is licensed to practice dentistry by the appropriate authority of the jurisdiction where the services are provided.

Fee Guide

The Dental Association Fee Guide for General Practitioners of the Province in which the client is a resident.

Insured Person

Means you or any one of your dependents who is covered under your plan.

Licensed, Certified, Registered

The status of a person who legally engages in practice by virtue of a license or certificate issued by the appropriate authority in the jurisdiction where the services are being provided.

Lifetime Maximum

The maximum amount that the benefit will pay during your lifetime.

Medically Necessary

Treatment broadly accepted and recognized by the Canadian medical profession as effective, appropriate and essential in the treatment of a sickness or injury in accordance with Canadian medical standards.

Out-Of-Pocket Maximum

This is the maximum amount of money you will have to pay on your own before your insurance benefits begin to take over and pay. It includes things like deductibles, and co-insurance, but not things like co-payments or your monthly premium.

Contact the Honeybee Team (Mon-Sun 8:30am - 5pm ET)

Local: 416-626-6642
Toll Free: 1-866-626-6642
help@myhoneybee.com

Benecaid Health Benefit Solutions Inc.
185 The West Mall, Suite 800
Toronto, ON M9C 5L5

Provincial Plan

Any plan that provides hospital, medical, or dental benefits established by the government in the province where the covered person lives.

Reasonable and Customary Charges

Means, with respect to charges for medical or dental services, supplies or treatment incurred by a insured, not in excess of the general level of charges made by other provides of similar standing in the locality or geographical area where the charge is incurred, when furnishing comparable medical or dental services, supplies or treatment, with due consideration given to the nature and severity of the condition involved.

Waiting Period

The period of continuous employment with your employer which you must complete before you are eligible for Group benefits.

Contact the Honeybee Team (Mon-Sun 8:30am - 5pm ET)

Local: 416-626-6642
Toll Free: 1-866-626-6642
help@myhoneybee.com

Benecaid Health Benefit Solutions Inc.
185 The West Mall, Suite 800
Toronto, ON M9C 5L5

Privacy Policy

Honeybee is provided by Benecaid Health Benefit Solutions Inc. Benecaid respects your privacy. We have established a privacy policy that balances an individual's right to the privacy of personal information with the need of Benecaid to collect, use or disclose personal information for legitimate business purposes.

Why do we collect personal information?

Benecaid requires certain personal information about you in order to provide you with the products that you requested. This information is collected only when you specifically and knowingly provide it to us. This information includes you and your dependent's names, email address, mailing address, phone number, dates of birth and any medical information about you and your dependents in order to administer your Plan, adjudicate claims and to provide insurance coverage. We will do our best to base our decision on accurate and up to date personal information. We rely on our members to disclose all personal information to us and inform us of any changes.

How is the personal information used?

Personal information that is provided to Benecaid is used to develop and customize products or services to better meet your needs. Your personal information is safely recorded by Benecaid and may be disclosed to third parties such as any person or organization, including medical practitioners and institutions in order to process claims and administer insurance benefits. We may also share personal information with agents/brokers retained by your employer. When an agent/broker is participating in obtaining insurance coverage we may discuss with the agent/broker alternate coverage to better serve you.

When claims are submitted, we may request further information from you or, with your consent, information from your health care providers. Any personal information collected shall be kept confidential at all times except as already explained to you.

You may request a copy of the personal information we have on hand at any time.

When does Benecaid share my personal information?

Personal information shall NOT be used or disclosed for purposes other than those for which it was collected, except with the consent of the individual. Consent can be received either by signing your enrollment form of may be provided verbally, such as when you contact us to request certain information on your behalf. Consent may also be implied, such as where the action taken is clearly in your best interests or as required by law.

What security measures are in place?

Benecaid has security measures in place to protect against loss, misuse and interception by third parties. Benecaid assumes no liability for interception, alteration or misuse of information transmitted to us over the internet, or misdirected by mail. Internet users should be aware that when you are visiting our website, one could be directed to other sites that are beyond our control. Benecaid is not responsible, and bears no liability, for these policies and actions.

Who do I contact?

If you have questions about this privacy policy or the practices of our website, you may contact:

Chief Privacy Officer
Benecaid Health Benefit Solutions Inc.
Tel: 416-626-8786

Contact Us

The Honeybee Care Team is available Monday through Friday from 8:30AM to 5:00PM ET, and can be reached by phone, text or email.

Monday to Friday, 8:30AM to 5:00PM ET
Phone/Text (Local): 416-626-6642
Phone/Text (Toll Free): 1-877-626-6642
Email: help@myhoneybee.com

Contact the Honeybee Team (Mon-Sun 8:30am - 5pm ET)

Local: 416-626-6642
Toll Free: 1-866-626-6642
help@myhoneybee.com

Benecaid Health Benefit Solutions Inc.
185 The West Mall, Suite 800
Toronto, ON M9C 5L5

honeybee

Benecaid Health Benefit Solutions Inc.
Employee Benefits Booklet

Your Honeybee Allowance Account

Plan Effective Date

09012017

Administered by:

benecaid®

Contact the Honeybee Team (Mon-Sun 8:30am - 5pm ET)

Local: 416-626-6642
Toll Free: 1-866-626-6642
help@myhoneybee.com

Benecaid Health Benefit Solutions Inc.
185 The West Mall, Suite 800
Toronto, ON M9C 5L5

Table of Contents

Contact the Honeybee Team (Mon-Sun 8:30am - 5pm ET)

Local: 416-626-6642
Toll Free: 1-866-626-6642
help@myhoneybee.com

Benecaid Health Benefit Solutions Inc.
185 The West Mall, Suite 800
Toronto, ON M9C 5L5

Welcome

The purpose of this booklet is to provide you more detail on the list of eligible expenses that are covered through your Honeybee Allowance Account. Your Honeybee Statement of Benefits coverage should be read together with the information contained in this booklet. Your Statement of Benefits coverage can be downloaded from the MyHoneybee.com online portal. It contains specific coverage details. For more information, including exclusions, limitations and other conditions please refer to the appropriate sections of this booklet.

Member Online Services

MyHoneybee.com is a secure online portal that allows you to manage your Honeybee accounts anytime, anywhere. You can also download the Honeybee app from the Apple App Store and Google Play store.

The Honeybee app allows you to:

- Submit claims
- View your benefits card
- Check your Honeybee account balances

MyHoneybee.com allows you to:

- View detailed information about your Honeybee benefits plan
- Check your Honeybee account balances
- View or download current coverage booklets
- View claims history for yourself and dependents
- View claim payment history for yourself and/or the service provider

Honeybee Care Team

Should you have any questions regarding your Honeybee coverage you can email us at help@myhoneybee.com or call or text us at 1-877-797-7448. Our Honeybee Care Team is available Monday through Friday 8:30am to 5:00pm Eastern Time.

Honeybee Allowance Account Details

The Honeybee Allowance Account is customized and funded by your employer. These benefits are a mix of unique health and lifestyle products that reflect your company culture. Depending on the Allowances customized for you, these taxable benefits can be used to cover things like a yoga class or dinner with your boss. Think of this as a monthly allowance your employer has given you so you can cover work related activities, and all the other extras that help get you through your life.

Monthly Maximum

Each Allowance Category has a monthly maximum to spend on eligible expenses within that category, regardless of your available balance. If you submit a claim that is more than your monthly maximum, don't worry, we will hold onto that claim and pay out the remaining amount when more funds have been deposited in to your account, until the balance of the eligible claim has been paid for in full.

Unused Allowance Account Funds

Unused Honeybee Allowance Account funds will carry forward to be used for future months, for a maximum of 3 months.

Claims Exceeding Balance

You will only be reimbursed for eligible expenses up to the unreserved funds in your Honeybee Allowance Account. Our Claims Department will reimburse you for the amounts available in your account and indicate on your explanation of benefits of insufficient funds for a full reimbursement. When additional funds are deposited in to your Honeybee Allowance account, you will be automatically reimbursed for the remaining eligible amount, up to your unreserved funds balance until the eligible amount has been paid to you in full.

Submitting Claims

You can conveniently and quickly submit your Health Account claims online through the downloadable Honeybee Mobile App

Mobile App Submission

You can quickly and easily submit your claims through the downloadable Honeybee Mobile App (available through the Apple App Store or the Google Play Store). Simply take a digital image of your paid-in-full receipts and submit it through the app.

Claim Guidelines

In order to be reimbursed for eligible claim please ensure the following information is submitted:

Receipt including all the following information:

- Provider name
- Date of service/purchase
- Amount of money paid
- Must indicate that the expense has been paid for in full
- Description of service or product
- Claims must be for a member expense only, expenses for dependents are not eligible
- Please retain original receipts for 24 months

Claim Submission Period

Active Employees

Claims must be received within 90 days from the date of service.

Terminated Employees

Claims must be received within 30 days from the date of service. The service date must be prior to the date of termination.

Terminated Groups

If your group's Honeybee plan has been terminated, claims must be received by within 30 days following the group termination effective date. The service date must be prior to the date of termination.

Legal Action

No legal action may be taken until 60 days after proof of claim is given to Benecaid or more than one year after the deadline for providing proof of claim. If you have received benefit payments but the payments end, no legal action may be taken more than one year after the last payment was made.

Account Information

Eligibility

Definition of an Eligible Employee

To be eligible for group benefits, you must be a resident of Canada and meet the following conditions:

- You are actively working for your employer working at least 24 hours per week.
- You have completed the 3 months waiting period.

Account Changes

Reporting General Changes

You must report the following changes to your employer to avoid any disruptions or issues with your benefits:

- Change of name
- Change of address

End of Coverage

Employees

Your coverage terminates on the earliest of the following dates:

- The date your employment terminates
- The date the group contract terminates
- The date you no longer meet the eligibility guidelines

Terminated Employees

Claims must be received within 30 days from the date of service. The service date must be prior to the date of termination.

Terminated Groups

If your group plan has been terminated, claims must be received within 30 days following the group termination effective date. The service date must be prior to the date of termination.

Definitions

Unreserved Funds

Funds that is available for the member to spend on eligible expenses.

Reserved Funds

Funds that are not available for the member to spend as they have been allocated to pay for future product premiums.

Pro-rated Funds (Termination)

An allocation of funds based on the termination date of coverage, members will have a portion of their annual fund allocation available based on when their coverage was terminated.

Immediate Family Member

Any person who is the Spouse, son, daughter, father, mother, brother, sister, son-in-law, daughter-in-law, father -in-law, mother-in-law, brother-in-law or sister - in- law of the employee

Insured Person

Means you or any one of your dependents who is covered under your plan

Licensed, Certified, Registered

The status of a person who legally engages in practice by virtue of a license or certificate issued by the appropriate authority in the jurisdiction where the services are being provided.

Provincial Plan

Any plan that provides hospital, medical, or dental benefits established by the government in the province where the covered person lives.

Reasonable and Customary Charges

Means, with respect to charges for medical or dental services, supplies or treatment incurred by a insured, not in excess of the general level of charges made by other provides of similar standing in the locality or geographical area where the charge is incurred, when furnishing comparable medical or dental services, supplies or treatment, with due consideration given to the nature and severity of the condition involved.

Waiting Period

The period of continuous employment with your employer which you must complete before you are eligible for Group benefits

Privacy Policy

Honeybee is provided by Benecaid Health Benefit Solutions Inc. Benecaid respects your privacy. We have established a privacy policy that balances an individual's right to the privacy of personal information with the need of Benecaid to collect, use or disclose personal information for legitimate business purposes.

Why do we collect personal information?

Benecaid requires certain personal information about you in order to provide you with the products that you requested. This information is collected only when you specifically and knowingly provide it to us. This information includes you and your dependent's names, email address, mailing address, phone number, dates of birth and any medical information about you and your dependents in order to administer your Plan, adjudicate claims and to provide insurance coverage. We will do our best to base our decision on accurate and up to date personal information. We rely on our members to disclose all personal information to us and inform us of any changes.

How is the personal information used?

Personal information that is provided to Benecaid is used to develop and customize products or services to better meet your needs. Your personal information is safely recorded by Benecaid and may be disclosed to third parties such as any person or organization, including medical practitioners and institutions in order to process claims and administer insurance benefits. We may also share personal information with agents/brokers retained by your employer. When an agent/broker is participating in obtaining insurance coverage we may discuss with the agent/broker alternate coverage to better serve you.

When claims are submitted, we may request further information from you or, with your consent, information from your health care providers. Any personal information collected shall be kept confidential at all times except as already explained to you.

You may request a copy of the personal information we have on hand at any time.

When does Benecaid share my personal information?

Personal information shall NOT be used or disclosed for purposes other than those for which it was collected, except with the consent of the individual. Consent can be received either by signing your enrollment form of may be provided verbally, such as when you contact us to request certain information on

your behalf. Consent may also be implied, such as where the action taken is clearly in your best interests or as required by law.

What security measures are in place?

Benecaid has security measures in place to protect against loss, misuse and interception by third parties. Benecaid assumes no liability for interception, alteration or misuse of information transmitted to us over the internet, or misdirected by mail. Internet users should be aware that when you are visiting our website, one could be directed to other sites that are beyond our control. Benecaid is not responsible, and bears no liability, for these policies and actions.

Who do I contact?

If you have questions about this privacy policy or the practices of our website, you may contact:

Chief Privacy Officer
Benecaid Health Benefit Solutions Inc.
Tel: 416-626-8786

Contact Us

The Honeybee Care Team is available Monday through Friday from 8:30AM to 5:00PM ET, and can be reached by phone, text or email.

Monday to Friday, 8:30AM to 5:00PM ET
Phone/Text (Local): 416-626-6642
Phone/Text (Toll Free): 1-877-626-6642
Email: help@myhoneybee.com

Contact the Honeybee Team (Mon-Sun 8:30am - 5pm ET)

Local: 416-626-6642
Toll Free: 1-866-626-6642
help@myhoneybee.com

Benecaid Health Benefit Solutions Inc.
185 The West Mall, Suite 800
Toronto, ON M9C 5L5

AKIRA

On-demand access to board-certified Canadian doctors and nurse practitioners by secure text and video.

No appointments necessary.

PRESCRIPTIONS

Our medical professionals can prescribe and renew existing prescriptions.

SPECIALIST REFERRALS

Receive referrals to medical specialists or allied health professionals.

LAB TESTS

Get lab requisitions via email or send them directly to a lab or imaging clinic.

SICK NOTES

Get sick notes without waiting for hours at a walk-in clinic.

SPECIALIST VIDEO CONSULTS

Schedule video consults with mental health professionals, paediatricians and dietitians.

FAMILY PLAN

Unlimited access for you, your partner and your children.

> *One of my team members stopped me in the halls to thank me for saving him time, stress and concern by being able to get to a specialist in a day versus weeks. Employee satisfaction is key and Akira is part of making that happen!*
>
> – **Randy Frisch**, COO, Uberflip

Keep employees healthy and happy, reducing absenteeism.

7.8
days lost in Canada per employee for sick days

>$2k
annual cost per employee missing work

70%
of clinic visits can be dealt with over telemedicine

Commonly Treated Conditions

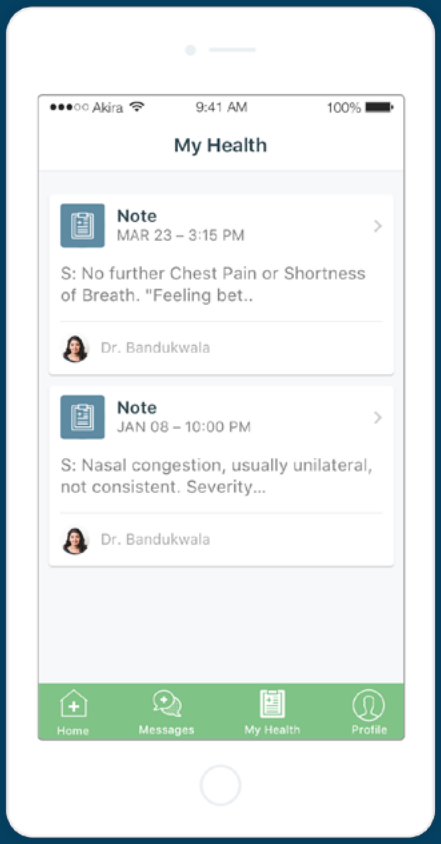
- Cold & Flu
- UTIs
- Sexual Health
- Family Planning
- Skin Issues
- Travel Medicine
- Medication Renewals
- Sinus & Allergy Issues
- Eye Issues
- Birth Control

4

Average user consults per year

4.7/5

Average consult feedback score



SECURE

Health records & conversation history are encrypted and stored in a secure data centre in Toronto.

TouchID enabled

****

PIN Code Auth

CONFIDENTIAL

Medical records can only be accessed by the patient and their care team - we will only contact your GP with your consent.

Our hours

Mon – Fri 9am – 11pm
Weekends 10am – 4pm
Closed on statutory holidays

For more information

support@akira.md
www.akira.md

Benecaid Health Benefit Solutions – Benefit Plan (as of September 2020)

Couple / Family Health Account Funding

Honeybee Health Account	**$987.00/Quarterly**

Single Health Account Funding

Honeybee Health Account	**$504.00/Quarterly**

Allowance Account Funding

Honeybee Allowance Account	**$50.00/Monthly**

Medical Plan

At time of enrollment (or annual re-enrollment) each employee can select the Drug Deductible option of their choice; $0, $250, or $500

Medical Plan

Benefit Period : Sep-01-2020 to Aug-31-2021

Annual Prescription Drug Deductible:

Coverage	*Coverage Amount*	*Coinsurance*
Termination Age	70	N/A
Accidental Dental	$5,000 / Person / Year $10,000 / Family / Year	100
Ambulance	$100 / Person / Visit $500 / Person / Year	100
Diagnostic Services	$300 / Person / Year	100
Hearing Aids	$500 / Person / 3 Years $2,000 / Family / 3 Years	100
Prescription drug coverage	$15,000 / Person / Year $60,000 / Family / Year	80
Private Duty Nursing	$10,000 / Person / Year $40,000 / Family / Year	100
Semi-Private Hospital	$300 / Person / Day $30,000 / Person / Year	100
Home Care	$1,875 / Person / Year $7,500 / Family / Year	100
Other EHC	Maximums vary by benefit. See booklet for details	100

Dental Plan

At time of enrollment (or annual re-enrollment) each employee can select the Dental Co-Insurance option of their choice; 60%, 80% or 100%

Dental Plan

Benefit Period : Sep-01-2020 to Aug-31-2021

Coverage	Coverage Amount	Coinsurance
Termination Age	70	N/A
Reimbursement Basis	Current Fee Guide Based on your Province of Residence	N/A
Full Mouth Exams	Every 3 years	
Level One and Level Two - Diagnostic, Preventive & Minor Restorative, Endodontics and Periodontics	$1,000 / Person / Year $2,000 / Family / Year (Combined with Level Two)	
Plaque Removal (Scaling)	8 scaling units/person	
Routine Cleanings (Recall Exams)	Every 9 months	
Coverage for white fillings	Yes	N/A

Additional Benefits (Wellness)

Additional Protection

Benefits	Coverage Details
Expert Medical Advice By Best Doctors	InterConsultation℠ FindBestDoc℠ FindBestCare℠ Best Doctors 360°® Ask The Expert℠ Medical Records eSummary℠
On-demand 24/7 virtual medical consults with Akira	Annual Membership Unlimited text and video consults
Employee and Family Assistance Plans By Shepell	24-7, toll-free telephone access to EFAP for crisis counselling, risk assessment and matching to appropriate service(s) Professional EFAP Counselling Services – Telephonic; e-Counselling; First Chat; Video Counselling; Text-based Wellness Website Online Support Programs - Financial planning, Stress Management, Separation and Divorce, Smoking Cessation, Relationship Management

Allowance Account Benefits

Honeybee Allowance Account

Your Honeybee Allowance **$50.00/Monthly**

Please refer to your Honeybee benefits booklets for a complete list of eligible expenses.

Allowance Name	Eligible Expenses
Fitness	Fitness Classes Gym Equipment Gym Membership Personal Training Pilates Sports Leagues, Lessons, Programs Yoga
Education	Conferences & Seminars Continuing Education Tuition Reimbursement Student Loans Training & Course Fees
Convenience	Grocery Delivery Home Office Electronics Home Office Furniture Home Office Supplies Home Repair Services Household Supplies Lunch Delivery at Work Lunch Take Out at Work Remote work station Retail Delivery Shipping and Delivery Expenses
Kids & Pets	Baby Sitting Child Activities & Programs Child Care Services Child Tutoring Services Pet Day Care & Walking Pet Food Pet Grooming Pet Insurance Veterinarian
Transportation	Gas Parking Public Transit Taxi Uber / Lyft

Pooled Coverage

Pooled Benefits

Coverage	Coverage Amout
Accidental Death and Dismemberment	
Benefit Amount	Flat $25,000
Coverage Reduction	50% at Age 65
Termination Age	Earlier of Retirement, Termination or Age 70
Employee Life Insurance	
Benefit Amount	Flat $25,000
Coverage Reduction	50% at Age 65
Termination Age	Earlier of Retirement, Termination or Age 70
Long Term Disability Insurance	
Benefit Amount	% of Salary
Maximum Amount of Insurance	5,850
Non Evidence Maximum	6,000
Termination Age	Earlier of Retirement, Termination or Age 65