CSBT
Community Services Benefits Trust

Your Benefits Handbook

Plan Effective Date

October 1, 2018

Effective Date of this Document

May 1, 2023

Employee Class

Class 01 - Full-Time Employees

For Participants of

Community Living Kingston and District

Introduction

Policyholder	Community Living Kingston and District
Policy	A document detailing the terms and conditions of a Policy of insurance between each Insurer and the Policyholder.
Employer	A person or organization that employs Participants who receive the Group Benefits outlined in this Handbook.
Group Benefits Plan	A blend of insurance products and services designed to supplement coverage government programs in order to better ensure the physical, mental and financial health of Participants and their families.
Benefits Administrator ("We", "Us", or "Our")	GroupHEALTH Global Benefit Systems Inc. ("GroupHEALTH") and all of Our partner service providers.
Participant ("You" or "Your")	An employee who is insured under the Policy
Spouse	Someone who satisfies the definition of Your Spouse
Dependent Child	Someone who satisfies the definition of Your Dependent Child
Insured Person	You, Your Spouse or Your Dependent Child
For the purposes of this handbook:	The singular shall include the plural where required
	Other defined terms are capitalized (e.g. Dependent)

This Handbook contains information about Your Group Benefits Plan. Please keep it in a safe place. It is intended to summarize the principal features of Your plan. All rights to benefits are governed by the group Policy, of which this Handbook forms a part.

Possession of this Handbook alone does not mean that You, or Your spouse and Dependent Child(ren) are insured under the Policyholder's Group Benefits Plan. Coverage must be in effect and You must satisfy all the enrolment requirements included in the Policy. Please refer to the Table of Contents to help You locate the appropriate section in this Handbook. If You require additional information, please contact Your Plan Administrator.

Participant Eligibility

Eligible Participants	A Participant must be a Full-Time Resident of Canada, employed on a permanent, full-time basis by an Employer that provides their group benefits under the Policy, and be regularly scheduled to work a minimum of 40 hours per week, at that Employer's place of business in Canada
Eligibility Period	4 months of continuous employment
Effective Date of Insurance	Immediately upon completion of the Eligibility Period or the date a benefit is added to this Group Benefits Plan, if later

Your Insurers, Service Providers and Policy Numbers

Benefit	Insurance Company (hereinafter called the Insurer) *Service Provider*	Policy Number
Group Life Insurance	Empire Life *Disability Management Institute (DMI)*	500305
Dependent Life Insurance	Empire Life *Disability Management Institute (DMI)*	500305
Accidental Death and Dismemberment (AD&D)	Industrial Alliance	500305
Long-Term Disability*	Empire Life *Disability Management Institute (DMI)*	500305
Extended Health Care	Empire Life *GroupHEALTH*	500305
Travel Insurance and Assistance Travel Cancellation Insurance	*Industrial Alliance* *Trident Global Assistance*	500305
Medical Second Opinion	*WorldCare*	500305
Virtual Healthcare (VHC)	*TELUS Health Virtual Care*	500305
Dental Care	Empire Life *GroupHEALTH*	500305
Protector Series™ Optional Life Insurance	The Co-operators	6521
Protector Series™ Optional Accident & Serious Illness (ASI)	Industrial Alliance *Disability Management Institute (DMI)*	500305
Protector Series™ Optional Critical Illness	Industrial Alliance *Disability Management Institute (DMI)*	500305

**This benefit is Insured by Empire Life and, acting on behalf of You and the Policyholder, the DMI provides additional support and services.*

Who To Contact

Your Group Benefits Plan is developed and administered by GroupHEALTH Benefit Solutions. The provision of insured benefits and support services is a fundamental element of this exclusive plan for Canadian organizations and their employees. Insurance companies and other service providers are both involved in the delivery of Your Group Benefits Plan. They are listed in the prior pages along with the policy numbers pertaining to their benefits: the insurance Company official addresses are provided in the next section. Responsibility for the administration of your plan, answering questions regarding coverage and the payment of claims has been delegated to GroupHEALTH Benefit solutions, to whom all questions should be directed..

For all administrative and claims concerns or inquiries, please call the following telephone numbers for assistance.

Extended Health Care and Dental Care Questions/Claims
GroupHEALTH
Toll-Free: **1.833.344.6944**

Trident Global Assistance
Toll-Free: **1.855.234.3545**
Outside Canada / USA (collect): **1.416.234.3545**

Virtual Healthcare (VHC)
help@vc.telushealth.com

WorldCare
Toll-Free: **1.877.676.6439**

Disability Management Institute (DMI)
Toll-Free: **1.866.963.9995**

Inquiries for all Other Claims
Please contact Your Plan Administrator

Your Insurers are:

The insurers listed below are ultimately responsible for the payment of your benefits however all administration and payment of claims have been delegated to Us (GroupHEALTH Benefit Solutions). If you have any questions relating to benefits, personal information used to enroll and manage your eligibility for insurance coverage and claims please contact GroupHEALTH Benefit Solutions or the other service providers at the numbers provided immediately above.

The Empire Life Insurance Company
259 King Street East,
Kingston, ON
K7L 3A8
1 (877) 548-1881

Industrial Alliance Insurance and Financial Services Inc.
Special Markets Solutions
400 – 988 W Broadway
P.O. Box 5900
Vancouver, BC
V6B 5H6
1 (800) 266-5667

The Cooperators Life Insurance Company
1920 College Avenue
Regina, SK S4P 1C4
(306) 347-6200

Privacy Policy

We have Privacy Policies which governs Our collection, use, and disclosure of personal information (including personal health information) about Participants and their Dependents. The Privacy Policies requires Us to keep such personal information confidential but does permit use and disclosure of personal information in limited circumstances consistent with the proper administration of group benefit and insurance coverage plans.

A copy of Our current Privacy Policy can be obtained from us on request and is also available on Our websites. By participating in the Group Benefits Plan, and submitting Claims under those plans, You are consenting to the collection, use, and disclosure of Your personal information pursuant to the terms of Our Privacy Policy and the privacy policy of the relevant insurer related to the benefit for which personal information is collected, used and disclosed.

You can access the most recent Privacy Policies below:

- TELUS Health Virtual Care: https://www.telus.com/en/health/about-telus-health/privacy
- Disability Management Institute: www.disabilityinstitute.com/privacy-policy
- Empire Life Insurance Company: www.empire.ca/privacy-policy.
- GroupHEALTH: www.grouphealth.ca
- iA Financial Group: www.ia.ca/privacy-policy
- The Cooperators: www.cooperators.ca/en/PublicPages/Privacy.aspx
- Trident Global Assistance: www.tridentassistance.com
- WorldCare: www.worldcare.com/privacy-policy

Table of Contents

Schedule of Benefits

In this section You will find a brief summary of the benefits included in Your benefit plan.

This information includes, where applicable:

***benefit amounts** – or formulas for how they are calculated;*

***allowable expenses** – what expenses are covered under the plan;*

***plan deductibles** – how much You must pay before the plan pays;*

***reimbursement percentages** – what percentage of a specific expense will be paid by the plan; and*

***benefit maximums** – how much of a specific expense will be paid by the plan or how much can be claimed in a calendar year or in Your lifetime.*

*For detailed information regarding a particular benefit, please refer to the **Description of Benefits** section of this Handbook.*

Capitalized words or phrases appearing throughout this Handbook have specific definitions as defined in this Handbook (e.g. Dependent)

Continuation of insurance in the event of work interruption

Family Leave	12 month(s)
Authorized unpaid leave of absence	6 month(s)
Temporary lay off	6 month(s)

Group Life Insurance

Benefit Amount	2.0 times Annual Salary, rounded to the next higher $1,000 if not already a multiple thereof
Maximum Benefit with Evidence of Insurability	$225,000
Maximum Benefit without Evidence of Insurability	$225,000
Benefit Reduction	The Benefit Amount reduces by 50% at age 65 up to a maximum of $20,000
Waiver of Premium	The elimination period for Waiver of Premium matches the Elimination Period for Long-Term Disability (LTD) if You are eligible to receive LTD benefits. Otherwise, the Elimination Period for Waiver of Premium is 6 months of continuous Total Disability
Definition of Total Disability	As defined under the Long-Term Disability (LTD) benefit, or if You are not covered for LTD, then as defined in the Group Life Insurance benefit description
Conversion Privilege	Included to age 65
Living Benefit	If You suffer a terminal illness You may be eligible to receive 50% of your Benefit Amount ▪ The maximum benefit payable under this section is $50,000
Termination Age	Your insurance terminates on the day You turn 70 or retire, whichever is earlier

Dependent Life Insurance

Benefit Amount for Spouse	$5,000
Benefit Amount for Each Child	$2,500
Dependent Child Eligibility	A Dependent Child is eligible from birth to: ■ age 22, or ■ age 26 if in full-time attendance as a student at a recognized educational institute
Conversion Privilege	Included
Stillbirth Benefit	In the event of a stillbirth the Insurer will pay the Dependent Child Benefit Amount
Waiver of Premium	Premiums are waived during the period that premiums are waived for Group Life Insurance
Termination Age	Your insurance terminates on the day You turn 70 or retire, whichever is earlier

Accidental Death and Dismemberment (AD&D)

Benefit Amount

Employee's Principal Sum Equal to the Group Life Insurance amount for all employees

Benefit Reduction

Same as Group Life Insurance

Enhanced Schedule of Losses

If, within 12 months of the date of the accident, Injury results in any of the following losses, the insurer will pay as follows:

Loss or Loss of Use of:	% of Benefit Amount
Life	100%
Both Hands	100%
Both Feet	100%
Entire Sight of Both Eyes	100%
One Hand and One Foot	100%
One Hand and the Entire Sight of One Eye	100%
One Foot and the Entire Sight of One Eye	100%
Speech and Hearing in Both Ears	100%
One Arm	100%
One Leg	100%
One Hand	66⅔%
One Foot	66⅔%
Entire Sight of One Eye	66⅔%
Speech or Hearing in Both Ears	66⅔%
Thumb and Index Finger of Either Hand	33⅓%
Four Fingers of Either Hand	33⅓%
Hearing in One Ear	33⅓%
All Toes of One Foot	25%

Paralysis Benefits

Included at 200% of Benefit Amount for

- quadriplegia (complete paralysis of both upper and lower limbs)
- paraplegia (complete paralysis of both lower limbs)
- hemiplegia (complete paralysis of upper and lower limbs of one side of body)

Day Care Benefit

Included

- maximum 5% of Benefit Amount or $5,000
- payable per year for 4 years for each child

Disability Fitness Benefit

Included

- maximum $5,000

Education Benefit

Included

- maximum 5% of Benefit Amount or $5,000
- payable per year for 4 years for each child

Eyeglass & Hearing Aid Benefit

Included

- maximum $1,000

Family Transportation Benefit

Included

- maximum $15,000

Funeral Expense Benefit

Included

- maximum $5,000

Home Alteration Benefit	Included ■ also includes Vehicle Modification Benefit ■ combined maximum $25,000
Parental Care Benefit	Included ■ maximum 5% of Benefit Amount or $5,000
Psychological Therapy Benefit	Included ■ maximum $1,000
Rehabilitation Benefit	Included ■ maximum $15,000
Repatriation Benefit	Included ■ maximum $15,000
Seat Belt Benefit	Included ■ benefit payable in the event of a loss is increased by 10% if you were wearing a seat belt
Spousal Retraining Benefit	Included ■ maximum $15,000
Exposure and Disappearance	Included
Waiver of Premium	Premiums are waived during the period that premiums are waived for Group Life Insurance
Conversion Privilege	Participants have the right to convert to individual coverage without health evidence when their employment terminates ■ any individual policy issued under the conversion privilege does not include the Critical Disease Benefit
Termination Age	Your insurance terminates on the day You turn 70 or retire, whichever is earlier

Long-Term Disability (LTD)

Benefit Amount	70% of the 1st $5,000 of Monthly Salary, plus 50% of the next $3,334
Maximum Benefit with Evidence of Insurability	$5,000 per month
Maximum Benefit without Evidence of Insurability	$5,000 per month
Maximum From All Sources	The overall maximum from all sources must not exceed 85% of the pre-disability gross Monthly Salary
Elimination Period	189 day(s) for Accident 189 day(s) for Hospitalization 189 day(s) for Sickness
Maximum Benefit Period	To age 65
Definition of Total Disability	2 year own occupation from the end of the Elimination Period and any occupation thereafter
Taxability of Benefits	Benefits are taxable
Work Re-entry Program	Included
Survivor Benefit	Included ▪ Lump sum payment equal to 3 monthly benefit payments
Waiver of Premium	Included
Pre-Existing Conditions	Included
Disability Management 	Disability Management Institute (DMI) provides early intervention support after the 5th day of absence from work. Services include Participant and Policyholder support, assistance with claim forms, and return to work planning
Termination Age	Your insurance terminates on the day You turn 65 or retire, whichever is earlier

Extended Health Care

Reasonable and Customary

Claims for all expenses under the Extended Health Care benefit are paid on a Reasonable and Customary basis, unless a specific financial limit and/or claiming frequency is indicated for a specific expense.

Calendar Year Deductible

No Deductible

% Reimbursement of Allowable Expenses

Prescription Drugs	100%
Hospital	100%
Health Care Practitioners	100%
Vision Care	100%
Other Medical Expenses	100%
Out-of-Province Medical Referral	100%
Travel Insurance and Assistance (Out of Province Emergency)	100%
Travel Cancellation Insurance	100%

Note: If the Insured Person is a resident of Quebec, the percentage of reimbursement for prescription drug coverage in any calendar year will change to 100% once they have attained the out-of-pocket maximum set under Quebec's Basic Prescription Drug Insurance Plan (BPDIP) for that calendar year.

Prescription Drugs – Included

Prescription Drug Plan

Pay Direct Drug Card

- covers the lowest cost generic equivalent product
- Brand Name drugs are only covered if the Physician specifies no generic substitution

Includes the following:

- insulin supplies for diabetics
- lancets
- oral contraceptives, contraceptive patches, Nuvaring and intrauterine device (IUD)
- preventive vaccines
- anti-smoking drugs * - lifetime maximum $300

** If the Insured Person is a resident of Quebec, the maximum for anti-smoking drugs is equal to the annual limit for smoking cessation products under Quebec's BPDIP*

Prescription Drug Deductible

The Insured Person pays $2 per prescription

Hospital – Included

		Maximum
Hospital Room	Semi-private	
Hospital Indemnity	Included	Commencing on the 5th consecutive day in hospital: ▪ Cash payment of $40 per day ▪ Combined maximum of 180 days per calendar year
Convalescent Care	Included	▪ $20 per day ▪ Combined maximum of 90 days per calendar year per disability

Health Care Practitioners – Included

Maximums shown are per person per calendar year. Where certain practitioners are combined below, the fees of these practitioners are combined for purposes of satisfying the maximum indicated.

Practitioner	Maximum
Acupuncturist	$400
Chiropractor (includes x-rays)	$400
Massage Therapist/Orthotherapist	$400
Naturopath	$400
Osteopath (includes x-rays)	$400
Physiotherapist/Physical Rehabilitation Therapist	$400
Podiatrist/Chiropodist (includes x-rays)	$400
Psychologist/Social Worker/Registered Clinical Counselor Psychotherapist	$400
Speech Therapist	$400

Vision Care – Included

		Maximum
Vision Care	Eyeglasses, contact lenses and laser vision correction	▪ Adults – maximum $250 every 24 consecutive months ▪ Dependent Children – maximum $250 every 12 consecutive months
Visual Training		▪ Lifetime maximum $200

Other Medical Expenses – Included

This is a list of the most common expenses covered under the plan. For more details, please review the Description of Benefits section of this Handbook.

** Requires a referral or prescription from a Physician*
*** Subject to pre-approval*

		Maximum
Ambulance (air, rail or water require pre-approval)		Reasonable and Customary cost
Artificial Eye	Once every 60 consecutive months	Reasonable and Customary cost
Artificial Limbs	Once every 60 consecutive months	▪ $10,000 per prosthesis per limb
Blood Glucose Monitor	Supplies for Continuous Glucose Monitors are covered but limited to: ▪ a maximum of 26 sensors per calendar year ▪ a maximum of 2 transmitters per calendar year	Reasonable and Customary cost

Breathing Equipment	Rental, or purchase, whichever is more economical, of:	
	▪ Mist tents and nebulizers.	▪ Replacement period of once every 60 consecutive months
	▪ Oxygen and the equipment needed for its administration (including cylinders and concentrators)	▪ Replacement period of once every 60 consecutive months
	▪ Bi-level Positive Airway Pressure Machine (Bi-PAP)	▪ Replacement period of once every 60 consecutive months
	▪ Continuous positive airway pressure machine (CPAP & APAP).	▪ Replacement period of once every 60 consecutive months
	▪ Apnea monitors for respiratory dysrhythmias.	▪ Replacement period of once every 60 consecutive months
	▪ Aerochambers for Dependent Children	▪ Reasonable and Customary cost
	▪ CPAP and APAP Supplies (Mask, Tubing, Battery Pack, Filters, Wipes for Mask and Nose Pillows).	▪ Replacement period of once per month
	▪ Intermittent positive pressure breathing machine (IPPB) - Supplies are included	▪ One (1) per lifetime per Insured Person
	▪ Tracheostoma tubes	Reasonable and Customary cost
*Colostomy and Ileostomy Supplies**	In excess of the amount reimbursed by the government	Reasonable and Customary cost
*Custom-made burn garments**		▪ Replacement period of once every 60 consecutive months
*Custom-made pressure supports for lymphedema**		▪ Replacement period of once every 60 consecutive months and maximum $1,500 lifetime
*Dental Accident***	Care must be received within 12 months of the date of the Accident	Reasonable and Customary cost
External Breast Prostheses	1 per breast per calendar year	Reasonable and Customary cost
*Extremity Pumps for Lymphedema**		▪ Maximum $1,500 lifetime
Eye Examinations	One examination: ▪ Adults – in any period of 24 consecutive months ▪ Dependent Children – in any period of 12 consecutive months	

*Gender Affirmation Surgery***		▪ $10,000 per calendar year ▪ $20,000 per lifetime
*Head halters**		Replacement period of once every 60 consecutive months
*Hearing Aids**	Once every 36 months	▪ $500
*Hospital Bed**	Once every 60 consecutive months	▪ $3,000
Insulin infusion and reservoir sets		Reasonable and Customary cost
Insulin infusion pumps		Replacement period of once every 60 consecutive months
Laboratory analysis and x-rays	Administered in a private laboratory or clinic for purposes of prevention or Diagnosis	Reasonable and Customary cost
*Magnetic Resonance Imaging (MRI)**		▪ $1,000 per calendar year ▪ (provided that it is not prohibited by provincial legislation)
*Mechanical or Hydraulic Patient Lifters**		▪ Replacement period of once every 60 months and maximum $2,000 lifetime
*Mobility Aids***	Scooter, standard wheelchair or an electric wheelchair, crutches, canes (including cane tips) and walkers ▪ Rental or purchase, whichever is most economical	▪ Replacement period of once every 60 consecutive months
*Nursing***		▪ $5,000 per calendar year
*Orthotics**	Digitally or physically casted, custom-made foot orthotics	▪ $300 per calendar year
*Off-the-shelf Orthopaedic Shoes and Orthopaedic Modifications**	Stock-item orthopaedic shoes, including modifications and adjustments	▪ $300 per calendar year
*Orthopaedic Shoes**	Custom-made orthopaedic shoes	▪ $300 per calendar year
Orthopaedic apparatus		▪ Replacement period of once every 60 consecutive months, except for casts and trusses
*Outdoor Wheelchair Ramp**		▪ $2,000 per lifetime
Sclerosing Agents		▪ $15 per visit
Special Vision Benefit after Cataract Surgery		▪ Lifetime maximum $300
*Speech Aids**		▪ $1,000 per lifetime

*Stump Socks and shoulder harnesses**		▪ 5 pairs per calendar year ▪ Harness replacement period of harness of once every 60 consecutive months
*Support Hose**		▪ 4 pairs per calendar year
Surgical Brassiere		▪ 4 per calendar year
*Traction apparatus**		▪ Replacement period of once every 60 consecutive months
*Transcutaneous Electrical Nerve Stimulator (TENS)**	Cumulative every 60 consecutive months	▪ $1,000
*Trapeze bars**		▪ Replacement period of once every 60 consecutive months
*Urethral catheters**		▪ Reasonable and Customary cost
*Viscosupplementation Injections**		▪ Lifetime maximum $2,000
*Wigs (Including Hair Pieces)**		▪ Lifetime maximum $500

Survivor Benefit — Included

Out-of-Province Medical Referral – Included

Non-Emergency Treatment — $10,000 per calendar year

Travel Insurance and Assistance (Out of Province Emergency) – Included

Travel Insurance and Assistance — $5,000,000 per Insured Person per trip
- maximum duration of coverage: up to 180 days per trip (60 days for retirees)

Please contact the Travel Assistance Company in order to be eligible for reimbursement under this benefit.

Travel Cancellation Insurance – Included

Travel Cancellation Insurance — $5,000 per Insured Person per trip

WorldCare - Included

worldcare

Provides access to a world class Medical Second Opinion service which provides an independent report on Your diagnosis and works with Your treating Physician to ensure that You or Your Dependents have the correct diagnosis and are on the optimal treatment path for a wide range of covered conditions. Please refer to the Description of Benefits section for more details.

The GroupHEALTH Virtual Healthcare Solution (VHC)
powered by TELUS Health Virtual Care

The GroupHEALTH Virtual Healthcare Solution (VHC), powered by TELUS Health Virtual Care, is a confidential, online service that provides on-demand access by mobile phone or computer to knowledgeable, friendly primary care providers wherever You are and whenever You need it. The VHC service provides anytime/anywhere access to medical assistance without the need to use valuable sick days or personal time for doctor visits. The VHC service is accessible 24/7, 365 days a year by secure text and video and provides:

- Access medical professionals through either a mobile app (iPhone and Android) or computer.
- Advice on your medical concerns
- Write new prescriptions and renew existing prescriptions
- Make referrals to specialist and other health care professionals
- Where necessary, help facilitate appropriate in-person care.
- Provide medical documentation and notes

Consult Fees
Access to the GroupHEALTH VHC Solution is provided to You and Your Dependents as part of Your benefit plan. Depending on which province You reside in, there is Consult Fee for each virtual consult session.

Referrals to other healthcare professionals may incur additional charges.

General Benefit Provisions

Dependent Children Eligibility

Dependent Children are eligible from birth to:
- age 22, or
- age 26 if in full-time attendance as a student at a recognized educational institute

Survivor Benefit

If You die while an Insured Person, insurance will continue for Your Dependents who were covered under this benefit at the time of Your death
- without premium payment
- until the earliest of the following dates
    - 24 months from the date of Your death;
    - the date when insurance for Your Dependents would have terminated if Your death had not occurred;
    - the date when Your Dependents become eligible for similar coverage under another insurance contract;
    - the date the Policy terminates

Termination Age

Your insurance terminates on the day You turn 70 or retire, whichever is earlier

Dental Care Coverage

Calendar Year Deductible	No Deductible
Rates Based on Dental Procedure Fee Guide:	Current fee guide for general practitioners in the province where the expenses were incurred. When a fee guide is not published for a given year, the term fee guide may also mean an adjusted fee guide established by the Insurer.
% Payment of Allowable Expenses	Basic Dental Care .....100% • Examinations and Diagnostic Services • Preventive dental care Examinations and Diagnostic Services • recall or periodic oral examination: twice per calendar year • complete oral examination: once every 24 months • emergency oral examination: 2 examinations per 12 months • complete periodontal examination: twice per calendar year • Radiographs (X-rays): subject to certain limits • Laboratory tests and examinations: subject to certain limits Preventive Services • polishing of coronal portion of teeth: 2 units per calendar year • scaling and root planing: 12 units of time per calendar year • topical application of fluoride: twice per calendar year Routine Dental Care (subject to certain limits) .....100% • Minor Restorative Services • Endodontics • Periodontics • Rebase, Reline, Adjustment and Repair of Removable Dentures • Repair of Fixed Bridges and Crowns • Oral Surgery • Additional Services Dental Restorative Services (subject to certain limits) .....50% ▪ Major Restorative Services and Fixed Prosthodontics ▪ Removable Dentures ▪ Fixed Bridges Orthodontic Care (subject to certain limits) .....Not Included Please see the Dental Care coverage section of this Handbook for more details of limits
Maximum Amount Covered	Basic Dental Care/Routine Dental Care ▪ No maximum Major Restorative Services ▪ $1,500 per Insured Person per calendar year

General Benefit Provisions

Dependent Children Eligibility	Dependent Children are eligible from birth to: ▪ age 22, or ▪ age 26 if in full-time attendance as a student at a recognized educational institute
Survivor Benefit	If You die while an Insured Person, insurance will continue for Your Dependents who were covered under this benefit at the time of Your death ▪ without premium payment ▪ until the earliest of the following dates ▪ 24 months from the date of Your death; ▪ the date when insurance for Your Dependents would have terminated if Your death had not occurred; ▪ the date when Your Dependents become eligible for similar coverage under another insurance contract; ▪ the date the Policy terminates
Termination Age	Your insurance terminates on the day You turn 70 or retire, whichever is earlier

Protector Series™ Optional Life Insurance

Benefit Amount	Participant and/or Spouse ■ units of $5,000 ■ minimum Benefit Amount $10,000 Dependent Child Benefit ■ flat $5,000
Maximum Benefit with Evidence of Insurability	■ $500,000 for each of Participant and Spouse
Maximum Benefit without Evidence of Insurability	■ $50,000 for each of Participant and Spouse
Benefit Limitations	No death benefit is payable for death by suicide during the first 24 months of being insured ■ no death benefit is payable during the first 12 months of being insured unless the death is caused by an Accident ■ if death occurs in the first 12 months and is not caused by an Accident, the premiums will be refunded ■ after being insured for 12 months or more a death benefit will be paid for death from any cause In the event where insurance is issued upon approval of Evidence of Insurability submitted: ■ a death benefit will be paid for death from any cause subject to limitations
Conversion Privilege	Included to age 65
Waiver of Premium	Premiums (including premiums for any Benefit Amount for Your Spouse or Dependent Children) are waived during the period that premiums are waived for Group Life Insurance
Payment of Premium	Premiums are paid 100% by the Participant by way of payroll deduction
Termination Age	Insured Person’s 70th birthday or when Your Dependent Child is no longer eligible as a Dependent

Protector Series™ Optional Accident & Serious Illness (ASI)

Plan I	Participant Only Plan ■ You may select any Benefit Amount in units of $50,000 to a maximum of $400,000
Plan II	Family Plan ■ You may select any Benefit Amount in units of $50,000 to a maximum of $400,000 Your family will be insured for the following: ■ Your Spouse will be insured for either 50% of the benefit if You have Dependent Children or 60% of the benefit if You do not have Dependent Children ■ each Dependent Child will be insured for either 10% of the Benefit Amount if You have a Spouse or 25% of the benefit if there is no spouse, subject to a maximum of $50,000 per child
Benefits included	Loss and Loss of Use, Paralysis, Critical Disease and Serious Illness as shown in the ASI benefit
Pre-Existing Conditions Applicable to the Serious Illness Benefit	An exclusion applies to a Serious Illness which commences within 24 months of becoming insured, and which results from a pre-existing condition for which the Participant sought or received medical advice, consultation, investigation, Diagnosis, or for which treatment was required or recommended by a Physician during the 24 months immediately prior to becoming insured
Eligibility Age	A Participant who is under age 65
Evidence of Insurability Requirements	Evidence of Insurability is not required
Payment of Premium	Premiums are paid 100% by the Participant by way of payroll deduction
Waiver of Premium	Premiums are waived during the period that premiums are waived for Group Life Insurance
Conversion Privilege	Participants have the right to convert to individual coverage without health evidence when their employment terminates ■ any individual policy issued under the conversion privilege does not include the Critical Disease and Serious Illness Benefit
Termination Age	Insurance terminates at age 70 or earlier retirement

Protector Series™ Optional Critical Illness

Benefit Amount

You and/or Spouse
- units of $5,000
- minimum benefit $10,000
- maximum benefit $100,000

Dependent Children
- $10,000

In order to get coverage without providing medical information to us you must apply within 31 days of becoming eligible under the policy. Otherwise, it is considered to be a late application and no Face Amount will be available without providing medical information to us.

Guaranteed Issue Limit

Up to $50,000 is available on a guaranteed issue basis *(* i.e. medical evidence is not required)

Adult Covered Conditions at 100% of Face Amount

- Aortic Surgery
- Aplastic Anemia
- Bacterial Meningitis
- Benign Brain Tumour
- Blindness
- Cancer (Life-Threatening)
- Coma
- Coronary Artery Bypass Surgery
- Deafness
- Dementia, including Alzheimer's Disease
- Heart Attack
- Heart Valve Replacement or Repair
- Kidney Failure
- Loss of Independent Existence
- Loss of Limbs
- Loss of Speech
- Major Organ Failure on Waiting List
- Major Organ Transplant
- Motor Neuron Disease
- Multiple Sclerosis
- Occupational HIV Infection
- Paralysis
- Parkinson's Disease
- Severe Burns
- Stroke

Early Diagnosis Benefit Covered Conditions at 10% of Benefit Amount

- Coronary Angioplasty
- Ductal Carcinoma in Situ of Breast
- Stage A (T1a or T1b) Prostate Cancer
- Stage 1A Malignant Melanoma
- Early Stage Thyroid Cancer
- Early Stage Lymphocytic Leukemia
- Gastrointestinal Stromal Tumour

Dependent Child Covered Conditions (if applicable) at 100% of Benefit Amount

- Autism
- Bacterial Meningitis
- Benign Brain Tumour
- Blindness
- Cancer (Life-Threatening)
- Cerebral Palsy
- Coma
- Congenital Heart Disease Requiring Surgery
- Cystic Fibrosis
- Deafness
- Down's Syndrome
- Heart Attack
- Kidney Failure
- Loss of Limbs
- Loss of Speech
- Major Organ Transplant
- Major Organ Transplant on Waiting List
- Multiple Sclerosis
- Muscular Dystrophy
- Paralysis
- Severe Burns
- Stroke
- Type 1 Diabetes Mellitus

Multiple Event Coverage	Available for You and/or Spouse
Multiple Cancer Benefit	Available for You and/or Spouse
Portability	Available for You and/or Spouse
Payment of Premium	Premiums are paid 100% by You through payroll deduction
Termination Age	Your insurance terminates on the day You turn 70 or retire, whichever is earlier

General Information

In this section You will find information regarding defined terms used in Your benefit plan, Policy provisions, insuring provisions and claiming information.

This section may include references to benefits that are not included in Your Group Benefits Plan.

Please refer to the ***Schedule of Benefits*** *section of this Handbook to determine which benefits are included in Your Group Benefits Plan.*

General Information

Definitions

Defined terms are capitalized throughout this Handbook. Refer to Description of Benefits for further definitions. These definitions apply throughout the Handbook unless specific alternative definitions are set out in the Description of Benefits for that coverage (or otherwise specified).

Accident
A single sudden, unintended, unexpected, external event, resulting in bodily Injury, directly and independently of any other cause that results in a Claim being made under the Policy

Actively at Work
If it is a scheduled workday, You will be considered Actively at Work if You report for work at Your usual place of employment in Canada or at some other location where Your Employer's business requires You to be and when You so report You are able to perform all the usual and customary duties of Your occupation on a regular, full-time basis.

If You were not at work due to it being a non-scheduled work day, holiday or vacation day, You will be considered to be Actively at Work if on such date You are neither (i) Hospital confined nor (ii) disabled to a degree that You could not have reported to Your usual place of employment in Canada or some other location where Your Employer's business requires You to be and performed all of the usual and customary duties of Your occupation on a regular full-time basis.

If You are on Family Leave under a Provincial or Federal program, You are considered Actively at Work.

Allowable Expenses
Expenses for eligible, covered medical services or supplies that qualify for reimbursement under a Group Benefits Plan.

Annual Salary
Your annual gross base earnings received from Your Employer including any additional income earned on a regular basis (overtime, bonuses, shift differentials) which is included in accordance with the standards of the Employment Insurance Act. and which Your Employer or Policyholder has reported to Us.

Where Your earnings are composed wholly or partially of commissions, Your Annual Salary will be:

a) the total of Your annual gross base earnings plus the commissions received averaged over the preceding two calendar years, as set forth on Your T4 Taxation form if You have been employed by Your Employer for at least 2 calendar years, or

b) the total of Your annual gross base earnings plus the commissions received averaged over the period You have been employed by Your Employer if You have been employed by Your Employer for less than 2 calendar years.

Under no circumstances shall benefits be based on a salary exceeding the one declared to Us and effectively used for the calculation of the premiums payable

Application
The form requesting insurance coverage under the Policy by You submitted to Us for approval, including the initial enrolment form You complete for an Insured Person when they first become eligible under the Policy.

Benefits Administrator
GroupHEALTH Global Benefit Systems Inc. ("GroupHEALTH") and all of Our partner Service Providers.

Calendar Year
The period from any January 1st to the next December 31st, both inclusive.

Claim
A formal request for payment of a benefit provided under Your Group Benefits Plan and administered by Us, along with supporting documents.

Claimant
An individual who makes a Claim for a Benefit Amount under the Group Benefits Plan.

Compassionate Care Leave
Unpaid leave that allows You to be absent from work in order to provide care and support to a Family Member or another relative or individuals considered to be like family, whether or not related by marriage, common-law partnership, or any legal parent-child relationship, who has a serious medical condition with a significant risk of death, as defined by a Provincial or Federal government program.

Consumer Price Index
The not-seasonally adjusted all-items Consumer Price Index for the whole of Canada as published monthly by Statistics Canada. Where an annual change is referred to it is the ratio of the January values for the current to the preceding year.

Date of Diagnosis
The date on which an Insured Person is first Diagnosed with a given Covered Condition, Critical Disease or Serious Illness by a Specialist. For the Covered Conditions “Major Organ Failure on Waiting List” and “Kidney Failure”, the Date of Diagnosis will be considered to be the date on which the Insured Person was added to a recognized organ waiting list.

The Date of Diagnosis must occur while the Insured Person’s coverage under the Policy is in force.

Day
A calendar day, except if otherwise defined in this Handbook.

Deductible
The Deductible is the amount You must pay before any expenses covered under a given benefit are reimbursed.

Dentist
A qualified and specialized professional, licensed by competent government authorities to practice dentistry. This person provides oral and dental care, including oral and dental surgery, as authorized under the individual’s license to practice. This definition includes dental surgeons.

Dependent
Your Spouse or Your Dependent Child. If Dependents are Insured under the Policy, "Spouse" and "Child" shall have the following meanings for purposes of the Dependent Life Insurance, Extended Health Care, Dental Care insurance and optional Protector Series ™ coverage, if included in the Schedule of Benefits:

a) Spouse

   i) The person You are married to, in a civil union with, or the person You designate and declare publicly to be Your Spouse and with whom You have been living on a permanent basis for at least one year.

   ii) A de facto separation of more than 3 months will result in this person no longer qualifying as Your Spouse for the purposes of the Policy.

   iii) If according to this definition, You have had more than one spouse, Spouse shall mean the person most recently qualified. Only one Spouse is eligible at any one time.

   iv) Your Spouse must be a Full-Time Resident of Canada

b) Dependent Child

   Your or Your Spouses’ unmarried child (including any stepchild, legally adopted child or legal ward, but not a foster child) who wholly depends on You for support and maintenance, is a Full-Time Resident of Canada, and who meets at least one of the following conditions:

   i) is under the age limit stated in the Schedule of Benefits, for each applicable benefit unless specific alternative definitions are set out in the Description of Benefits; or

   ii) if attending a recognized educational institution on a full-time basis, is under the age limit stated in the Schedule of Benefits unless specific alternative definitions are set out in the Description of Benefits, for each applicable benefit; or

   iii) has a physical or intellectual disability and is incapable of earning their own living due to such handicap provided such handicap commenced while they were a child as defined in (i) or (ii).

Diagnosis or Diagnosed
The medical Diagnosis (including diagnostic measures) by a Physician of an Insured Person with a Covered Condition, Critical Disease or Serious Illness.

Disability Insurance
Used to refer to Short-Term, Mid-Term, Long-term and Adaptable Long-term Disability Insurance (whichever are included in the Policy) collectively

Eligibility Period
The period, as specified in the *Participant Eligibility* section of the Introduction, during which You must be Actively at Work before being eligible for coverage under the Policy.

Eligibility Date
The Date You and Your Dependents, if applicable, satisfy all of the Eligibility requirements as specified under Eligibility of the General Information section.

Eligible Expenses
Allowable Expenses after the Participant has paid any Deductible, and the % Reimbursement and any Maximum or Cap have been applied, as specified in the Schedule of Benefits

Effective Date of Insurance
The date that coverage becomes effective for an Insured Person or, for an increase or decrease in coverage.

Evidence of Insurability
The part of Your Application containing the statement or medical evidence that serves as proof of Your or Your Dependents' medical, lifestyle and family medical history. All Evidence of Insurability must be submitted on forms provided by Us. If the Evidence of Insurability is approved ("**Approval of Evidence of Insurability**"), the commencement date of the coverage subject to the Evidence of Insurability will be back-dated to the date We receive the last document which allows Us to accept the risk on the applicant.

Family Caregiver Leave
Unpaid leave that allows You to be absent from work in order to provide care and support to a Family Member or another relative or individuals considered to be like family, whether or not related by marriage, common-law partnership, or any legal parent-child relationship, who is critically ill or injured, as defined by a Provincial or Federal government program.

Family Leave
Includes Compassionate Care Leave, Family Caregiver Leave, Maternity Leave and Paternity Leave

Family Member
An individual who is related to another individual in one of the following ways: spouse, son, daughter, father, mother, stepfather, stepmother, father-in-law, mother-in-law, brother, sister, half-brother, half-sister, brother-in-law, sister-in-law, son-in-law, daughter-in-law, grandparent, grandchild, uncle, aunt, nephew or niece.

Full-Time Resident of Canada
An Insured Person with a permanent residence in Canada who resides in Canada for at least 182 days a year.

Group Benefits Plan
A blend of insurance products and services designed to supplement coverage provided by government programs in order to better ensure the physical, mental and financial health of Participants and their families.

Hospital
A facility legally constituted as a hospital, which,
a) is licensed as a hospital where such licensing laws exist and, in Canada, is approved by the Province in which it is situated to provide insured hospital services in accordance with the government health insurance plan of such Province, and
b) is operated primarily to provide medical, diagnostic and surgical facilities for the care and treatment of sick and injured persons on an in-patient basis, and

c) has a staff of one or more Physicians available at all times and provides twenty-four-hour nursing service by graduate registered nurses, and
d) is not principally a tuberculosis hospital or sanatorium, an institution for the mentally ill, a rest home, a nursing home, a home for the aged or for palliative care, an institution solely for the provision of custodial care or, other than incidentally, is not principally a medical facility which provides for the treatment of alcohol or drug addiction.

Hospitalization
Overnight confinement in a Hospital on an in-patient basis and will also include Outpatient Surgery requiring time off.

Injury or Injuries
Physical harm or damage to an Insured Person's body caused by an Accident resulting directly and independently of all other causes and, in particular, is not caused or contributed to, directly or indirectly, by physical or mental illness or disease, or treatment for the illness or disease.

Insured Person or Insured
a) The Participant who is insured under the Policy, and
b) Their Spouse and Dependent Child(ren) for purposes of the Dependent Life Insurance, Critical Illness (if applicable), Extended Health Care, Dental Care insurance and for voluntary Protector Series ™ benefits, for benefits included in the Schedule of Benefits.

Late Applicant
An individual who is eligible for coverage under the Policy who applies for coverage more than 31 days after becoming eligible to apply.

Life Event
One of the following events:
a) Your marriage (including common-law) or divorce, or
b) the birth or adoption of Your Child.

For the purposes of this definition, We will consider that Your marriage has occurred on the date:
a) of Your legal marriage;
b) You have been living with another person in a role like that of a marriage partner continuously for the immediately preceding 12-month period;
c) You enter into a civil union as defined by the Civil Code of Quebec; or
d) You register a domestic partnership in Nova Scotia.

Medical Practitioner
A licensed Physician, dentist or health professional who delivers health care services who is operating within the scope of their license in the jurisdiction where they provide such services, and must not be an Insured Person, a Family Member or business associate of an Insured Person, or reside with any such person.

Maternity Leave
Maternity leave is available to a Participant who is away from work because they are pregnant or have recently given birth, as defined by a Provincial or Federal government program.

Medically Necessary
Broadly accepted and recognized by the Canadian medical profession as effective, appropriate and essential in the treatment of a Sickness or Injury.

Monthly Salary
Your Annual Salary divided by 12.

Notice
A written communication by an Insured Person or Claimant to Us, or vice versa.

Outpatient Surgery
Surgery which involves the cutting and altering of tissue and requires anaesthesia and which is performed on an out-patient basis in a Hospital and as a result of which, prevents You from returning to work. Payment will be from the first day of surgery.

Parental Leave
Parental leave is available to a Participant who is the parent of a newborn or newly adopted child, as defined by a Provincial or Federal government program.

Participant
Also referred to as "You", is a Full-Time Resident of Canada, who is employed on a permanent full-time or part-time basis by an Employer that provides a Group Benefits Plan through the Policy, and who works the minimum number of hours per week indicated in the *Participant Eligibility* section of the Introduction. The Participant must work on a regular basis for said Employer, except for periods of vacation.

Paternity Leave
Paternity leave is available to a Participant who is away from work because they are the father of a newborn or newly adopted child.

Physician
A person who is legally licensed and authorized to practice medicine and who is operating within the scope of that license in the jurisdiction where they provide such services. A Physician must not be an Insured Person, a Family Member of or business associate of an Insured Person, or reside with any such person.

Plan Administrator
An individual, appointed by the Policyholder, responsible for the administration of Your Employer's Group Benefits Plan.

Province
The use of the term "Province" refers to the Provinces of Canada, as well as the Yukon, Northwest Territories and Nunavut.

Sickness
Any deterioration in health, either through disease or malady but not as the result of Accident, requiring regular, continuous and/or curative care actively provided by a Physician.

Smoker
An individual who, in the 12 months before declaring their smoking status on an application or change in smoking status form provided by Us,

a) has used tobacco in any form (with the exception of one large cigar per month), nicotine products, nicotine substitutes, oral and nasal sprays, or smoking cessation products; or
b) has consumed marijuana or hashish more than three times per week.

Specialist
A Physician who is not the Insured Person or a Family Member, who is licensed by the appropriate provincial licensing authority to practice medicine with specialization relevant to the benefit being Claimed. In the absence or unavailability of a Specialist, and as approved by Us, a condition may be Diagnosed by a qualified Physician practicing in Canada or the United States of America.

Surgery
The treatment of disorders of the body by incision or manipulation with surgical instruments.

Temporary Lay-Off
A period during which the Participant is laid off work and for which there is a fixed recall date.

Travel Assistance Service
Trident Global Assistance – please contact them through the numbers given in the How to Claim section below

"We", "Us", or "Our"
GroupHEALTH, the Benefit Administrator of the Policy, and all of Our partner Service Providers, acting on behalf of the Insurer.

"You" or "Your"
The Participant.

Misstatement of Facts and Clerical Error

What if an Insured Person misstates any information?
If You or any Insured Person misstates any relevant information relating to the Application, the true facts will be used to determine whether or not insurance is in force under the Policy. Where Evidence of Insurability is required, You and each other Insured Person must disclose to Us at the time of Application every fact of which each other Insured Person is aware that may be material to the coverage.

What if a clerical error is made?
A clerical error is a mistake in writing or copying data that is made by Us. A clerical error will not invalidate insurance that is otherwise in force or continues insurance otherwise terminated under the terms and conditions of the Policy.

What if an Insured Person's age has been misstated?
We have the right to require satisfactory proof of the Insured Person's age before making payment of any Claim. If the age of an Insured Person has been misstated, the Benefit Amount will be adjusted upwards or downwards based on the Insured Person's true age. If You were not eligible for insurance based on Your true age, then Your coverage, and that of Your Spouse and Dependents, if any, will be voided.

If Your Spouse has misstated their age and is not eligible for insurance based on their true age, then Your Spouse's coverage will be voided.

Medical Services and/or Supplies Covered by a Government Sponsored Plan or Program

There will be no coverage under the Policy for any expenses related, directly or indirectly, to any medical services and/or supplies which would have been covered by a government sponsored plan or program if the Insured Person had not elected to receive the services and/or supplies on a private basis from a Medical Practitioner, medical facility, clinic or hospital, whether private or public, unless the services and/or supplies are explicitly stated as being covered under the Policy.

Incontestability

Whenever Evidence of Insurability is required to approve insurance or an increase in insurance for an Insured Person or to approve one of the benefits, the statements made with respect to the evidence will be, except in the case of an error in age or fraud, accepted as true and incontestable after the Insured Person's insurance or benefit has been in force for 2 years. If the insurance is cancelled and then reinstated, the 2-year period will begin again as of the date the insurance is reinstated.

Lawful Currency

All payments hereunder will be made in the lawful currency of Canada and according to the exchange rates effective at the time the event giving entitlement to a benefit took place.

Coverage Elsewhere

If You are eligible for Extended Health Care and/or Dental Care Insurance and Your Spouse is covered for comparable insurance, You may decline coverage under the Policy for such insurance.

The refusal of insurance may be in respect of Your and Your Dependents coverage, or Your Dependents coverage only.

If the insurance under Your spouse's policy ceases because of termination of such policy or because eligibility for the insurance ceases, then Application may be made under the Policy to insure those persons whose insurance has terminated.

The Application must be made within 31 days after cessation of the insurance under Your Spouse's policy and the insurance under the Policy shall be effective on the day following the date of termination of the insurance under Your Spouse's policy. Applications made later than this will require Evidence of Insurability to be considered.

Multiple Coverage and Coordination of Benefits (COB)

Effect on Benefits
If an Insured Person is covered under the Policy as a Participant and as a Dependent or as a Dependent of more than one Participant, or is covered simultaneously under any other plan which provides similar benefits, the amount of benefits payable under the policy for Eligible Expenses shall be coordinated and/or reduced so that the total benefits payable shall not exceed 100% of the actual Allowable Expenses.

How the Group Benefits Plans Coordinate Benefits
The group benefit plan that determines the benefits first (hereinafter referred to as "primary plan") will calculate its benefits as though duplicate coverage does not exist.

The plan that determines the benefits second (hereinafter referred to as "secondary plan") will limit its benefits to the lesser of:

a) the amount that would have been payable had it determined the benefits first; and
b) 100% of all Allowable Expenses reduced by all other benefits payable for the same expenses by the primary plan.

Order of Benefit Determination with Another Plan
a) If the other plan does not contain a provision for coordination of benefits with the Policy, such plan will be deemed to be the primary plan.
b) If the other plan contains a coordination of benefits provision, determination of primary plan and the secondary plan will be made on the following basis:
    i) With respect to an Insured Person who is covered as a Participant and as a Dependent under more than one plan, the plan which covers the Insured Person, other than as a Dependent, shall be deemed to be the primary plan.
    ii) With respect to an Insured Person who is covered as a Participant under more than one plan, the determination of which plan is the primary plan will be made in the following plan order:
        - the plan under which the Insured Person is covered as a full-time employee;
        - the plan under which the Insured Person is covered as a part-time employee;
        - the plan under which the Insured Person is covered as a retiree.
    iii) With respect to an Insured Person who is covered as a Dependent under more than one plan and the two people of whom they are a Dependent are neither separated nor divorced, the determination of which plan is the primary plan will be made on the following basis:
        - The plan which covers the Insured Person as the Dependent of the person whose birthday comes first in the calendar year shall be considered the primary plan;
        - The plan, which covers the Insured Person as the Dependent of the person whose first name begins with the earlier letter in the alphabet, shall be considered the primary plan, in the situation where the two individuals of whom they are a Dependent have the same birth date.
    iv) With respect to an Insured Person who is covered as a Dependent under more than one plan and the two people of whom they are a Dependent are either separated or divorced, the determination of which plan is the primary plan will be made in the following plan order:
        - The plan of the person who has custody of the Insured Person;
        - The plan of the Spouse of the person who has custody of the Insured Person;
        - The plan of the person who does not have custody of the Insured Person;
        - The plan of the Spouse of the person who does not have custody of the Insured Person.
c) When clauses a), and b) do not serve to establish an order of benefit determination, the benefits will be prorated in proportion to the amounts that would have been paid had there been coverage by just that plan.

Order of Benefit Determination Within the Same Group Benefits Plan
The rules outlined under the Order of Benefit Determination with Another Plan will be applied to ensure that the total benefits payable under the plan shall not exceed 100% of the actual Allowable Expenses.

Order of Benefit Determination in the Case of a Dental Accident
If a benefit is payable due to Allowable Expenses incurred as a result of a dental Accident, a supplementary health benefit which provides for dental accident coverage shall determine the benefits payable before a dental benefit is calculated.

Right to Receive and Release Information
For the purposes of determining the applicability of and implementing the terms of this section of the Handbook or any provision of similar purpose of any other Group Benefits Plan, We may, with proper authorization, release to or obtain from any other insurance company or other organization or person any information, with respect to any person, which We deem to be necessary for such purposes. Any person Claiming benefits under the Policy shall furnish to Us such information as may be necessary to implement this section.

Facility of Payment
Whenever payments which should have been made under the Policy in accordance with this section have been made under any other plans, We shall have the right, exercisable alone and in Our sole discretion, to pay over to any organizations making such other payments any amounts We determine to be warranted in order to satisfy the intent of this section, and amounts so paid shall be deemed to be benefits paid and, to the extent of such payments, We shall be fully discharged from liability under the Policy.

Right of recovery
Whenever payments have been made by Us with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this section, We shall have the right to recover such payments, on behalf of the Insurer, to the extent of such excess, from among one or more of the following, as We shall determine: any person to or for or with respect to whom such payments were made, any other insurance companies, any other organizations.

Eligibility

Participant
You will become eligible to be an Insured Person under the Policy as a Participant on the date ("Eligibility Date") You satisfy all of the following conditions:

a) You satisfy the definition of Participant in this Handbook.

b) You are a Full-Time Resident of Canada.

c) You are covered under the provincial health plan of Your Province of residence (only applies for Disability, Extended Health Care and Critical Illness benefits).

d) You have satisfied the eligibility requirements specified in the Introduction.

Dependents
A person will become eligible to be insured as a Dependent on the date ("Eligibility Date") the Dependent satisfies all of the following conditions:

a) They satisfy the definition of Dependent in this Handbook.

b) They are a Full-Time Resident of Canada.

c) They are covered under the provincial health plan of their Province of residence (only applies for Disability, Extended Health Care and Critical Illness benefits).

d) You become eligible to be an Insured Person under the Policy.

Application for Group Insurance

If You are eligible to become an Insured Person under the Policy You must complete and submit an Application for Yourself and for each of Your Dependents on each of Your respective Eligibility Dates, on forms supplied by or satisfactory to Us.

Effective Date of Insurance

Whether membership under the Policy is compulsory or voluntary, Your insurance and Your Dependent's insurance, if any, will take effect on the Insured Person's Eligibility Date, if the Application for group benefits has been received by Us, on or prior to such date, or within 31 days after such date.

If the Application for group benefits is not received within 31 days of the Eligibility Date, or within 31 days following the date the Insured Person can no longer be covered under another Group Benefits Plan for Extended Health Care or Dental Care, the insurance will not take effect until the Approval of Evidence of Insurability. The Evidence of Insurability will be provided at no expense to Us.

However, if

a) You were not Actively at Work on the date Your insurance would otherwise become effective, the insurance will not take effect until the earliest date thereafter that You are Actively at Work again; or

b) the Dependent is hospitalized on the date their insurance would otherwise become effective, the insurance will not take effect until the earliest date thereafter that they are no longer hospitalized. (This clause shall not apply to the Group Life Insurance benefit or in the case of a newborn child.)

c) If You or Your Dependent is not covered under a Canadian provincial health insurance plan on the respective date Disability, Extended Health Care and/or Critical Illness insurance would otherwise become effective, the Disability, Extended Health Care and/or Critical Illness insurance will not take effect until the respective date You or Your Dependent become covered under the provincial health insurance plan of Your respective Province of residence.

If You are a resident of Quebec and Your Application for Extended Health Care under this Plan is not received within 31 days of becoming eligible, or within 31 days following the date You can no longer be covered under another group benefits plan, coverage will not require Evidence of Insurability and will become effective:

a) retroactively to the date You became eligible for insurance under the Policy or ceased to be eligible for coverage under the other group benefits plan, provided You pay the premiums owing since that date; or

b) on the date We receive Notice, should You choose not to pay the premiums retroactively as stated in item (a) above.

Any amount of insurance which is in excess of the Maximum Benefit without Evidence of Insurability specified in the Schedule of Benefits will not take effect until the approval of the Evidence of Insurability submitted by the Insured Person. If the Insured Person's Evidence of Insurability is not approved, any future increases in the Maximum Benefit(s) without Evidence of Insurability will not automatically result in an increase in the Insured Person's insurance. The increase in the Maximum Benefit(s) without Evidence of Insurability will only result in an increase in the Insured Person's insurance if they submit Evidence of Insurability and it is approved by Us.

If You have been approved for an amount of insurance in excess of the "Maximum Benefit without Evidence of Insurability" specified in the Schedule of Benefits, and have salary increases up to 10% in a 12-month period, the Maximum Benefit(s) will be allowed to increase without additional Evidence of Insurability. We have the right to require that the You submit Evidence of Insurability prior to granting any increase in Maximum Benefit(s) as a result of increase in Your Salary which exceeds 10% in a 12-month period.

Effective Date of Modifications to Insurance

Increase in insurance coverage following a change in employment or family status
A change which would result in the increase in Your or Your Dependents' insurance will become effective on the latest of the following dates: a) the date of the event, if We receive Notice prior to such date: b) the date We receive the written Notice, if such receipt follows the date of the event; c) the date We receive and approve any required Evidence of Insurability for such a change.

However, for Participants, if You are not Actively at Work on the date the increase in insurance is to become effective, the increase will not become effective until the earliest date thereafter on which You are again Actively at Work.

For Dependents, if the Dependent is hospitalized on the date the increase in insurance is to become effective, the increase will not become effective until the earliest date thereafter on which they are no longer hospitalized. (This paragraph will not apply to postpone the effective date of an increase in the insurance of a newborn child)

Evidence of Your and/or Your Dependents' Insurability will be required if notification of a change is not received within 31 days of the effective date of the change. The Evidence of Insurability will be provided at no expense to Us.

Insurance that cannot be modified
During any period where You are retired, or Totally Disabled under the terms of the coverage, amounts of insurance cannot be increased and the provisions used to establish these amounts cannot be modified. Such modifications shall only become effective once You are Actively at Work again and provided You are not Totally Disabled at that time.

Reduction in insurance coverage following a change in employment or family status
Any decrease in Extended Health Care or Dental insurance coverage requested following a change in employment or family status becomes effective on the date of the change, provided We receive an Application to such effect within 31 days following the change. If We receive the application more than 31 days after the date of the event justifying a decrease in insurance, the decrease becomes effective on the date We receive the Application. Any decrease in coverage driven by a change in salary or employee class will be effective on the date such change occurred.

Termination of Insurance

Participant
Your insurance automatically terminates on the earliest of the following dates:

a) The date the Policy is terminated;

b) The date You retire, unless otherwise specified in the Schedule of Benefits;

c) The date You reach the age limit specified in the Schedule of Benefits if an age limit is indicated;

d) The date You are no longer a Full-Time Resident of Canada;

e) The date You are no longer covered by Your provincial health plan (only applies for Disability, Extended Health Care and Critical Illness benefits);

f) The date You enter the armed forces of any country on a full-time basis;

g) The date of Your death;

h) The later of the following dates:

   i) the date indicated on a written Notice received from the Policyholder;

   ii) the date this Notice was received by Us ;

i) The date You are incarcerated after committing a criminal offence for which You were found guilty;

j) The date You cease to qualify as a Participant as defined in this Handbook;

k) The date your Life Waiver of Premium terminates at age 65 or, if you do not have a life waiver of premium but have reached age 65 and you have not returned to work.

Dependents
Your Dependent's insurance terminates on the earliest of the following dates:

a) The date You cease to be covered under the Policy;

b) The date the Dependent ceases to be a Dependent as defined in this Handbook;

c) The date the Dependent reaches the age limit specified in the Schedule of Benefits if an age limit is indicated;

d) The date the Dependent is no longer a Full-Time Resident of Canada;

e) The date the Dependent is no longer covered by the provincial health plan (only applies for Prescription Drug Benefits, Extended Health Care and/or Critical Illness benefits);

f) The date the Dependent enters the armed forces of any country on a full-time basis;

g) The later of the following dates:

   i) the date indicated on a written Notice received from the Policyholder;

   ii) the date this Notice was received by Us.

The above terms and conditions also apply in the case of the partial cancellation of insurance owing to the cancellation of one or more benefits.

Continuation of Insurance in the Event of Work Interruption

1. If a Participant ceases to be Actively at Work due to Family or other leave of absence that is mandated by legislation, all insurance coverage may continue for the period of leave to which the Participant is entitled by legislation governing the Participant or the period shown in the Schedule of Benefits, if longer.
2. If a Participant ceases to be Actively at Work due to an authorized unpaid leave of absence, all insurance coverage other than Disability may continue until the Policyholder terminates it, but in no event beyond the period shown in the Schedule of Benefits from the date the authorized unpaid leave of absence began.
3. If a Participant ceases to be Actively at Work due to Temporary Lay-Off, all insurance coverage other than Disability may continue until the Policyholder terminates it, but in no event beyond the period shown in the Schedule of Benefits from the date the Temporary Lay-Off began.

If a Participant ceases to be Actively at Work but not approved for Waiver of Premium or if Waiver of Premium is not available, the Employer may choose to continue the Group Life Insurance benefit for all such Participants on a premium paying basis but no later than to age 65 or the date the Participant is no longer considered an Employee, if earlier.

If the Participant is aged 65 or older on the Date of Disability the Group Life Insurance benefit can be continued on a premium paying basis until the date Short-Term Disability benefits cease or in the absence of any payments under Short-Term Disability for up to 6 months from the Date of Disability.

Notice and Proof of Claims

All of the following benefits may not be included in Your Group Benefits Plan. Please refer to the Schedule of Benefits section of this Handbook to determine which benefits are included in Your Group Benefits Plan.

Please refer to Description of Benefits for each coverage for additional requirements for each benefit. Please contact Your Plan Administrator to obtain the forms for completion appropriate to the benefits You are Claiming under.

For a Claim to be eligible under the Policy, the Insured Person must die, become Totally Disabled or the service must be provided (as relevant to the benefit being Claimed) while premiums are still being paid or waived for the Insured Person, for that benefit under the Policy.

Extended Health Care and Dental Care
We must receive Notice of Claim and original receipts for an Extended Health Care benefit or Dental Care Insurance benefit within 12 months of the date of the event which gives entitlement to the benefit.

However, if the Policy should terminate, Notice of Claim and original receipts must be received by Us:

a) on or prior to the date of the termination with respect to Dental Care and Extended Health Care expenses, except for those expenses covered under the Travel Insurance and Assistance (Out of Province Emergency) benefit; and

b) within 90 days of the date of termination with respect to expenses covered under the Travel Insurance and Assistance (Out of Province Emergency) benefit.

Life Insurance
We should receive Notice of Claim for a Life Insurance benefit, along with the appropriate documentation required to make a Claim, as soon as possible after the date of the event which gives entitlement to the benefit, but in any event, We must receive this information within one year of the event.

Accidental Death and Dismemberment
We should receive Notice of Claim within 30 days of the Accident or Critical Disease giving rise to the Claim and the appropriate documentation within 90 days, but, if not reasonably possible We must receive this information within one year of the event.

Long-Term Disability
We should receive Notice of Claim for a Long-Term Disability benefit, along with appropriate documentation required to make a Claim, within 45 days of absence from work, but in any event, We must receive this information within 90 days of the end of Your Elimination Period.

If Notice of Claim is not received by Us within the periods set out above or additional proof or information requested by Us is not provided, We, on behalf of the Insurer, will have the right to deny the Claim.

All Notices of Claims must be submitted to Us on the forms We provide for that purpose and must include all information We deem necessary for the assessment of the Claim. If all the information We require is not received, We will have the right to deny the Claim.

We reserve the right to request additional proof or information regarding a Claim whenever We deem necessary.

At the time of Claim for a benefit which is based on Your salary, the amount of salary that will be used to determine the benefit will be the lesser of:

a) the salary that the Policyholder had last reported to Us and which has been used in the calculation of the premium payable;

b) Your actual salary at the time of the event for which a Claim is being made, as determined in accordance with the definition of salary included in the Policy.

Beneficiary

For coverages that may have a benefit payable to beneficiary, You may designate a beneficiary or change a named beneficiary, subject to the provisions of the law, by a signed written declaration.

Neither We, nor the Insurer, will be responsible for the sufficiency or validity of the beneficiary designation or change of beneficiary.

The rights of a beneficiary who dies before You revert back to You.

If You do not designate a beneficiary, any death benefit that becomes payable under the Policy due to Your death will be paid to Your estate.

If You were an Insured Person under the Policyholder's Group Benefits Plan at the time of transfer of coverage from another insurance carrier, beneficiary designations that applied under the Policyholder's previous policy with another insurance carrier do not apply under the Policy. As a result, if You do not make a new beneficiary designation to be applied under the Policy, Your beneficiary will be Your estate.

Right to Examination of a Claimant

We, at Our own expense, shall have the right and opportunity, whenever We deem necessary, to require a medical examination by a Physician designated by Us, of any Insured Person for whom a Claim is submitted, or to request an autopsy in case of death, where it is not forbidden by law. In addition, We reserve the right to obtain the report of any Medical Practitioner who has examined the Insured Person for whom a Claim was submitted.

We, at Our own expense and discretion, shall have the right and opportunity to conduct an examination under oath of any Insured Person who has submitted a Claim or for whom a Claim has been submitted under the Policy, whether or not a legal action has been commenced by the Insured Person under the Policy with respect to the Claim.

Access to Personal Information

You may request a copy of Your Application and any record or written statement not otherwise part of the Application provided to Us as Evidence of Insurability. On reasonable Notice, You may also request a copy of the Policy. First copies will be provided at no cost to You but a fee may be charged for subsequent copies.

You may request a copy of Your Claim file.

Limitation of Actions

Every action or proceeding against an Insurer or the Benefits Administrator for the recovery of insurance money payable under the Policy is absolutely barred unless commenced within the time set out in the Insurance Act (for British Columbia, Alberta and Manitoba), the Limitations Act, 2002 (for Ontario), or other applicable legislation (for all other Provinces and territories). For those actions or proceedings governed by the laws of Quebec, the prescriptive period is set out in the Quebec Civil Code

Conformity to Legislation

If this document does not conform to the provincial Insurance Act that governs it, it will automatically be deemed to be amended to comply with the applicable provincial Insurance Act.

Recovery of Overpayment

We reserve the right to recover any overpayment of benefits from the Insured Person or the organization who received the overpayment. If such overpayment cannot be recovered directly, We have the right to reduce future benefits payable to You until overpayment has been fully recovered.

Third-Party Liability and Subrogation

(Applicable to all benefits except the Group Life, Dependent Life and Group Critical Illness insurance benefits.)

You must notify Us of any notice served to and/or any legal action taken against a third party and of any judgment or settlement related to an event giving rise to entitlement to a claim under the Policy.

If You are entitled to receive damages or other financial compensation from any other person or organization (the "Third-Party") with respect to which benefits are payable by the Insurer under the Policy, You will be required to reimburse the Insurer in the amount of any benefits that the Insurer has paid to You, out of the financial compensation recovered from the Third-Party.

We are subrogated to all Your rights of recovery against a Third-Party liable for any damages that have given rise to an entitlement to payment of benefits under the terms of the Policy, up to the limitation of the amounts paid by the Insurer. Should We decide to exercise Our right of subrogation, You may be required to sign a letter of subrogation in Our favour

Should You choose to settle any matter prior to a judicial determination where We have a right of subrogation, and the matter is settled for a reduced amount of the full value of Your damages, it is understood that Our right of recovery is not reduced or diminished as a result of Your decision to accept a lesser amount from a Third-Party. In this case, it is understood that any lump sum settlement amount agreed to will be deemed to be full compensation for loss of income, and Our full right of subrogation will apply.

Should You receive less compensation for damages than the value of benefits that the Insurer has paid, the Insurer's reimbursement shall be limited to the amount of compensation received by You from a Third-Party, after the deduction of any legal costs and disbursements.

In the event that You settle for a lump sum payment and particulars of the amount received are not provided or available, it shall be deemed that You have received full compensation for loss of income, and Our full right of subrogation will apply.

We may bring an action in Your name against a Third-Party, should We so choose at Our sole discretion. We may, with or without Your consent , release to or obtain from any insurance company, organization or person, information which We consider necessary to implement and enforce the subrogation provision.

Description of Benefits

In this section You will find detailed information regarding benefits available in the Group Benefit Plan and the specific provisions of these benefits.

This section may contain descriptions of benefits and benefit provisions that are not included in Your Group Benefit Plan.

*Please refer to the **Schedule of Benefits** section of this Handbook to determine which benefits and benefit provisions are included in Your Group Benefit Plan.*

Group Life Insurance Benefit

Upon Your death, while You are an Insured Person under this benefit, the Insurer will pay to the beneficiary the Benefit Amount as indicated in the Schedule of Benefits, subject to the terms and conditions of this benefit and the Policy.

Definition(s)

As used in this benefit:

Total Disability and Totally Disabled
A state of total and continuous incapacity, resulting from Sickness or Injury, which prevents You from performing any work for which You are reasonably qualified by education, training or experience.

However, if You are covered by a Disability insurance benefit under the Policy, the definitions of "Total Disability" and "Totally Disabled" shall be as defined under such benefits.

Conversion Privilege

If Your life insurance is cancelled on or prior to Your 65th birthday or if on your 65th birthday you lose your life insurance because your Waiver of Premium expires, You will be able to convert all or part of Your life insurance to an individual life insurance policy without having to provide Evidence of Insurability. You may choose to convert to one of the following types of insurance on the terms then available for such insurance:

1) Permanent life
2) Term life to age 65; or
3) One year term convertible into permanent or term life to age 65 at the end of one year.

The amount of such individual policy applied for will not exceed the lesser of:

1) $200,000 (or the amount required by provincial legislation, if applicable); and
2) the difference between the Amount of Your Group Life Insurance Benefit Amount in effect on the date of termination and the amount of life insurance You are, or become eligible for, within 31 days after such termination date, as a member in another group life insurance Policy;

Such individual policy will become effective on the first day following the 31 day period after the date You became entitled to apply. If You should die during the 31-day period in which You could have exercised this conversion privilege and Your Group Life Insurance benefit has not already been converted, the amount of life insurance You were eligible to convert shall be payable under the Policy.

If You become a Participant under the Policy at some future date, the amount of Group Life Insurance benefit available to You under this provision will be reduced by the amount of such individual policy unless it has been terminated.

Waiver of Premium

a) If You become Totally Disabled You will be eligible to have Your premiums waived for this benefit if You are under age 65 and approved to receive Long-Term Disability benefits under the Policy.

   If You are not eligible for coverage for the Long-Term Disability benefit under the Policy or there is no disability insurance included in the Policy, You will be eligible to have Your premiums waived for this benefit provided:

   i) You were less than 65 years of age at the onset of Total Disability; and
   ii) You became Totally Disabled as defined under this benefit, while an Insured Person under this benefit and before any termination of employment; and
   iii) You have been Totally Disabled for at least 6 continuous months; and
   iv) proof of Total Disability, satisfactory to Us, was submitted to Us within 12 months of the onset of the Total Disability. The evidence will be submitted at no expense to Us.

b) The Benefit Amount for which the Waiver of Premiums applies will be that which was in force at the onset of the Total Disability and will be subject to any reductions and termination indicated in the Schedule of Benefits which would have been applicable to You if You had been Actively at Work.

c) Your premiums will begin to be waived on:

   i) the day following the completion of the Elimination Period under the Long-Term Disability insurance;

   ii) if You are not eligible for coverage for the Long-Term Disability insurance benefits under the Policy or there is no Long-Term Disability insurance included in the Policy, then the day following a continuous period of Total Disability of 6 months.

d) If Your premiums are waived under this section, You must provide Us with proof of Total Disability, as often as We may reasonably require. Such proof will be provided at no expense to Us.

e) The Waiver of Premiums will terminate on the earliest of the following dates:

   i) the date You cease to be eligible to receive disability insurance benefit payments under the Policy, or, if there is no disability insurance under the Policy, the date You cease to be Totally Disabled as defined under the Group Life Insurance benefit;

   ii) the date You fail to submit to an examination by a Physician designated by Us;

   iii) the date You retire or reach the normal retirement age under Your Employer's pension plan;

   iv) the date You reach the termination age for Your Group Life benefit as indicated in the Schedule of Benefits, if applicable;

   v) the date You fail to provide any proof of Total Disability required by Us;

   vi) the date You are incarcerated after committing a criminal offence for which You were found guilty;

   vii) Your 65th birthday.

f) If You die during the 31-day period after the date You ceased to be an Insured Person, a death benefit equal to the amount You were otherwise entitled to convert, will be paid to Your beneficiary, whether or not application for conversion had been made.

Living Benefit

If You are under age 62 and become terminally ill, You may apply for an advance payment of a portion of Your Benefit Amount ("Living Benefit"), subject to the conditions outlined below.

Upon receipt by Us of due proof that:

a) You are suffering from a Sickness which is expected to result in Your death within 24 months or less, supported by medical certification from Your attending Physician; and
b) You are approved for Waiver of Premium for the Group Life Insurance benefit,

the Insurer will pay a Living Benefit consisting of 50% of the Benefit Amount applicable to You up to a maximum of $50,000, provided all irrevocable beneficiaries provide consent in writing for the Living Benefit.

Upon Your death, the final death benefit payable to the beneficiary(ies) will be equal to the Benefit Amount on the date of death less the Living Benefit paid and the interest accrued on the Living Benefit. The interest on the Living Benefit payment is calculated from the date of payment to the date of death, at a rate determined by the Insurer on the date of the Living Benefit payment.

Dependent Life Insurance

Upon the death of a Dependent, while they are an Insured Person under this benefit, the Insurer will pay You the Benefit Amount, as indicated in the Schedule of Benefits, subject to the terms and conditions of this benefit and the Policy.

Waiver of Premiums

If Your life insurance premiums are waived in accordance with the Waiver of Premiums provision of the Group Life Insurance benefit, You will also be entitled to have the premiums for this benefit waived, under the same terms and conditions.

Stillbirth Benefit

In case of a stillbirth, the Insurer will pay You the Dependent Child Benefit Amount under the Dependent Life Insurance benefit, provided:

a) the fetus weighs a minimum of 500 grams, or
b) the body length is a minimum of 25 centimetres, or
c) the gestational age is at least 20 weeks.

Conversion Privilege

If the Dependent Life Insurance coverage under this benefit ceases because You are no longer eligible for insurance under the policy, You may convert Your Spouse's Benefit Amount (and Insured Dependents' Benefit Amount, as required by provincial legislation, if applicable), to an individual policy, without Evidence of Insurability. Application for the individual policy must be made while the Policy is in force and within 31 days after the earlier of:

a) the date You die, or
b) the date You cease to be an Insured Person, or
c) Your Spouse's 65th birthday.

You may choose to convert Your Spouse's (and Insured Dependents', if applicable) group life insurance to one of the following types of insurance on the terms then available for such insurance:

a) An individual life insurance policy that is comparable to the group insurance of the Insured Person as to the amount and duration;
b) A one-year term life insurance policy that can be converted into the insurance described in item a) above

The amount of such individual policy will not exceed $200,000 for all of the group life insurance benefits combined for Your Spouse, whether Your Spouse is insured as a Participant or Spouse.

Such individual policy will become effective on the first day following the 31 day period after the date You became entitled to apply. If You should die during the 31-day period in which You could have exercised this conversion privilege and Your Group Life Insurance benefit has not already been converted, the amount of life insurance You were eligible to convert shall be payable under the Policy.

Insured Dependent conversion privilege applies only where required by provincial legislation. The spousal conversion privilege applies in all Provinces and territories.

Accidental Death & Dismemberment (AD&D)

Coverage

Upon Your death due to an Accident, while You are an Insured Person under this benefit, the Insurer will pay to the beneficiary a percentage (as shown below) of the Benefit Amount as indicated in the Schedule of Benefits, subject to the terms and conditions of this benefit and the Policy. Upon a Loss due to an Accident or Your Diagnosis for the first time of a Critical Disease, while You are an Insured Person under this benefit, the Insurer will pay to You a percentage (as shown below) of the Benefit Amount as indicated in the Schedule of Benefits, subject to the terms and conditions of this benefit and the Policy.

This benefit provides coverage for Accidents which occur anywhere, at any time, on or off the job. You will be covered whether You are at home or traveling, including air travel as a passenger (but not as a pilot or Crew Member) in any Certified Aircraft flown by a duly licensed pilot.

This plan does not cover any loss resulting from suicide or self-inflicted injury or war or any act of war. It also excludes any loss suffered while on active service in the armed forces or while You are piloting or acting as a Crew Member in an aircraft.

Definitions Applicable to the AD&D Benefit

Whenever used in components of the Accidental Death and Dismemberment benefit:

Accident
means a sudden, unforeseen and unexpected event which arises from a source external to an Insured Person and that is not caused or contributed to, directly or indirectly, by physical or mental illness or disease or treatment for the illness or disease. This event must occur while this policy is in force and be the basis of claim.

Airworthiness Certificate
A “Standard” Airworthiness Certificate issued by the Federal Aviation Agency of Canada or its foreign equivalent issued by the governmental authority having jurisdiction over civil aviation in the country of its registry.

Certified Aircraft
An aircraft that holds an Airworthiness Certificate

Crew Member
A person assigned to duty in an aircraft during Flight Time, and whose occupation is related to the safety of passengers, the operation and/or the actual flying of the aircraft.

Critical Disease
Poliomyelitis, Parkinson’s Disease, Huntington’s Chorea, Multiple Sclerosis, Alzheimer’s Disease, Type 1 Diabetes (Insulin Dependent), Amyotrophic Lateral Sclerosis (ALS), Peripheral Vascular Disease and Necrotizing Fasciitis.

Date of Diagnosis
The date on which You are first diagnosed with a Critical Disease by a Specialist. The Date of Diagnosis must be later than the Effective Date of Your coverage under the Group Benefits Plan. No benefit will be paid for any Critical Disease which was diagnosed prior to Your Effective Date.

Day Care Centre
A facility which is operated according to law, including laws and regulations applicable to day care facilities and which provides care and supervision for children in a group setting on a regular basis. Day Care Centre will not include a Hospital, the child's home or care provided during normal school hours while a child is attending grades 1 through 12.

Dependent Parent
Your parents or grandparents who are dependent upon You for support, maintenance and care.

Flight Time
The total time from the moment the aircraft first moves under its own power for the purpose of take-off until the moment it comes to rest at the end of the flight.

Leased Aircraft
An aircraft whose possession is turned over to a firm or individual for a specified period of time, with the owner retaining full title to such aircraft.

Loss
with reference to hand or foot means complete severance at or above the wrist or ankle joint but below the elbow or knee joint; as used with reference to arm or leg means complete severance at or above the elbow or knee joint; as used with reference to thumb and fingers means complete severance at or above the metacarpophalangeal joint; as used with reference to toes means complete severance at or above the metatarsophalangeal joint; as used with reference to eye means the irrecoverable loss of the entire sight thereof; as used with reference to speech means the total and irrecoverable loss thereof; as used with reference to hearing means the total and irrecoverable loss thereof; and as used with reference to Quadriplegia, Paraplegia and Hemiplegia means the permanent and irrecoverable paralysis of such limbs.

Loss of Use
The inability to use a limb or body part, referred to under the definition of Loss, which is permanent, total, irrecoverable and continuous for a period of 12 months from the date of the Accident.

Psychological Therapy
The treatment or counselling by a therapist or counselor, who is licensed, registered, or certified to provide such treatment, whether You are an out-patient basis or while a patient at a medical facility licensed to provide such treatment.

Regular Care and Attendance
Medical treatment to the extent necessary under existing standards of medical practice for the condition causing Total Disability, Hospital confinement or requiring such treatment.

Residence
Your primary dwelling where You are an occupant and the premises on which it is situated.

School for Higher Learning
includes any university, college, CEGEP {College D'Enseignement General et Professionel (community colleges in Quebec)} or trade school.

Totally Disabled/Total Disability
You (1) are unable to engage in any and every occupation or employment for compensation or profit and (2) require the Regular Care and Attendance of a Specialist.

Vehicle
A passenger car, station wagon, van, SUV, truck or similar.

Benefits

Accidental Death, Dismemberment and Specific Loss Benefit
If, within 12 months of the date of the Accident, Injury results in any of the following losses, the Insurer will pay for Loss of or permanent and total Loss of Use of:

	% of Benefit Amount
Life	100%
Both Hands	100%
Both Feet	100%
Entire Sight of Both Eyes	100%
One Hand and One Foot	100%
One Hand and the Entire Sight of One Eye	100%
One Foot and the Entire Sight of One Eye	100%
Speech and Hearing in Both Ears	100%
One Arm	100%
One Leg	100%
One Hand	66 ⅔%
One Foot	66 ⅔%
Entire Sight of One Eye	66 ⅔%
Speech or Hearing in Both Ears	66 ⅔%
Thumb and Index Finger of Either Hand	33 ⅓%
Four Fingers of Either Hand	33 ⅓%
Hearing in One Ear	33 ⅓%
All Toes of One Foot	25%

Paralysis Benefits

Quadriplegia (complete paralysis of both upper and lower limbs)	200%
Paraplegia (complete paralysis of both lower limbs)	200%
Hemiplegia (complete paralysis of upper and lower limbs of one side of body)	200%

The payment made under Accidental Death, Dismemberment and Specific Loss Benefit for all losses sustained by You as the result of any one Accident will not exceed the following:

(a) With the exception of Quadriplegia, Paraplegia and Hemiplegia, the Benefit Amount;
(b) With respect to Quadriplegia, Paraplegia and Hemiplegia, two times the Benefit Amount or the Benefit Amount if loss of life occurs within 90 days after the date of the Accident.

In no event will the payment made for all losses under Accidental Death, Dismemberment and Specific Loss Benefit exceed, in the aggregate, two times the Benefit Amount as the result of the same Accident.

Continuation of Coverage During Approved Leaves

Coverage under the Policy may be continued for You during any approved leave of absence, temporary lay-off, Family leave or disability leave, provided payment of premium is continued.

Conversion Option

Upon termination of active employment with the Policyholder, You may convert to an individual accident insurance plan, with no Evidence of Insurability required, at the individual rates in force with the Insurer at the time of Your termination. You may elect an amount of insurance equal to or lower than Your Benefit Amount, to a maximum of $200,000.00, in force at the time of termination. An application for conversion must be made within 31 days of the date of termination. Individual policies issued under this option do not include the Critical Disease and Serious Illness benefits.

Critical Disease Benefit

If You, prior to age 65, are diagnosed by a Specialist with a Critical Disease while this benefit is in force and are Totally Disabled due to that Critical Disease for at least nine months following the Date of Diagnosis, the Insurer will pay 10% of the Benefit Amount up to a maximum of $50,000.00. This benefit is payable only if investigations leading to the Diagnosis of a Critical Disease is initiated more than 90 days following Your Effective Date of insurance. Payment of the Critical Disease Benefit is limited to only the first Critical Disease to occur.

Limitations and Exclusions
The Policy does not provide benefits from any of the Critical Diseases caused directly or indirectly by or resulting from any of the following:

(a) Injury or Sickness, other than one of the Critical Diseases, even though such Injury or Sickness may have been complicated by one of the Critical Diseases;

(b) a complication of Human Immunodeficiency Virus (HIV) infection or any variance thereof including AIDS and AIDS Related Complex;

(c) the use, existence or escape of nuclear weapons, material or ionizing radiation from or contamination by radioactivity from any nuclear fuel or waste from the combustion of nuclear fuel;

(d) misuse of medication or the abuse of drugs or intoxicants;

Day Care Benefit

If an Injury sustained by You results in loss of life within 12 months of the date of Accident, the Insurer will pay the Day Care Benefit stated below for each of Your Dependent Children, under 13 years of age who:

(a) are enrolled in a legally licensed Day Care Centre on the date of such loss; or

(b) enroll in a legally licensed Day Care Centre within 12 months after Your death. The Day Care Benefit is equal to the reasonable and necessary expenses actually incurred, subject to five percent of Your Benefit Amount to a maximum of $5,000.00, for each year the Dependent Child described above is enrolled in a legally licensed Day Care Centre, but not to exceed four years, which must run consecutively, with respect to any one Dependent Child.

The benefit will be paid each year immediately upon receipt of satisfactory proof that the Dependent Child is enrolled in a legally licensed Day Care Centre, but payment will not be made for expenses incurred prior to Your death, nor for room, board or other ordinary living, travelling or clothing expenses.

If, at the time of Your death, You have no Dependent Children eligible for the Day Care Benefit, the Insurer shall pay an additional amount of $2,500.00 to Your designated beneficiary.

Disability Fitness Benefit

If Injury results in an amount payable to You under the part titled “Accidental Death, Dismemberment and Specific Loss Benefit” of the Policy, the Insurer will pay the reasonable and necessary expenses actually incurred for the purposes of any specially designated fitness training or athletic equipment for disabled persons, which You would not have required except for such Injury, but not to exceed an amount of $5,000.00. The expense must be incurred within 2 years of the date of Your Accident.

The above benefit shall only be payable under one of the policies issued by the Insurer and shall not duplicate any other benefits payable.

Education Benefit

If an Injury sustained by You results in loss of life within 12 months of the date of Accident, the Insurer will pay the Education Benefit stated below for each of Your Dependent Children, who are enrolled as full-time students:

(a) in a School for Higher Learning above the secondary school level as defined, in the Province, territory or country of Residence; or

(b) at the secondary school level but who enroll as full-time students in a School for Higher Learning within 12 months after the date of death of the Insured Person.

The Education Benefit is equal to the reasonable and necessary expenses actually incurred, subject to five percent of Your Benefit Amount to a maximum of $5,000.00, for each year the Dependent Child described above continues their education on a full-time basis in a School for Higher Learning, but not to exceed four years, which must run consecutively, with respect to any one Dependent Child.

The benefit will be paid each year immediately upon receipt of satisfactory proof that the Dependent Child is enrolled as a full-time student in a School for Higher Learning, but payment will not be made for expenses incurred prior to Your death, nor for room, board or other ordinary living, travelling or clothing expenses.

If, at the time of Your death, You have no Dependent Children eligible for the Education Benefit, the Insurer shall pay an additional amount of $2,500.00 to Your designated beneficiary.

Eyeglasses, Contact Lenses and Hearing Aids Benefit

If, as the result of an Injury, You require and receive treatment by a Physician, which results in the purchase of eyeglasses, contact lenses or hearing aids within 12 months of the date of the Accident, when none of which were previously required or worn, the Insurer will pay the reasonable and necessary expenses actually incurred, subject to a maximum of $1,000.00.

Family Transportation Benefit

If, following an Injury which results in an amount payable under the part titled “Accidental Death, Dismemberment and Specific Loss Benefit” of the Policy, You are confined as an inpatient in a Hospital located not less than 150 kilometers from Your normal place of Residence and You are under the Regular Care and Attendance of a Physician, the Insurer will pay the reasonable and necessary expenses actually incurred by any Close Relative for accommodation/lodging in the vicinity of the Hospital where You are confined and transportation by the most direct route from the normal place of Residence of Your Close Relative and return to their normal place of Residence.

Payment will not be made for board or other ordinary living, travelling or clothing expenses. If transportation occurs in a Vehicle or device other than one operated under a license for the conveyance of passengers for hire, then reimbursement of transportation expenses will be limited to a maximum of $.20 per kilometer travelled.

The maximum amount payable under this part is $15,000.00 for all such expenses.

Funeral Expense Benefit

If an Injury sustained by You results in loss of life, and an amount for such loss becomes payable in accordance with the terms of this benefit, an additional amount is payable for reasonable and necessary funeral expenses actually incurred, subject to a maximum of $5,000.00.

Home Alteration and Vehicle Modification Benefit

If an Injury sustained by You does not cause loss of life, but results in an amount payable under the part titled “Accidental Death, Dismemberment and Specific Loss Benefit”, and You are subsequently required to use a wheelchair to be ambulatory, the Insurer will pay the reasonable and necessary expenses actually incurred within three years of the date of the Accident causing such Loss for:

(a) the cost of alterations to Your principal Residence; and/or

(b) the cost of modifications to one Vehicle utilized by You, when such modifications are approved by the provincial vehicle licensing authorities where required

for the purpose of making them wheelchair accessible.

Payment by the Insurer for the total of all expenses incurred by or for You is subject to a maximum of $25,000.00 as the result of any one Accident.

Parental Care Benefit

If an Injury sustained by You results in loss of life and an amount becomes payable in accordance with the terms of the Policy, the Insurer will pay a Parental Care Benefit for an eligible Dependent Parent.

A Dependent Parent is eligible for this benefit if, at the time of the Accident:

1) is a resident in a licensed nursing care facility; or
2) is enrolled in a home health care program; or
3) is living in Your Residence; or
4) is receiving support and care provided by You as evidenced by:
   i. cancelled cheques; or
   ii. income tax returns showing the parent as a dependent; or
   iii. other similar forms of proof.

The amount of Parental Care Benefit will be 5% of Your Benefit Amount, subject to an overall maximum of $ 5,000.00.

Psychological Therapy Benefit

If an Injury results in an amount payable to You under the part titled “Accidental Death, Dismemberment and Specific Loss Benefit” of the Policy, and results in You requiring Psychological Therapy, as prescribed by a Physician, the Insurer will pay the reasonable and necessary expenses actually incurred, subject to a maximum of $1,000.00, until one of the following occurs:

(a) the total Psychological Therapy Benefit amount has been paid; or
(b) two years have elapsed from the date of the Injury; or
(c) You die.

Rehabilitation Benefit

If an Injury sustained by You results in an amount payable under the part titled “Accidental Death, Dismemberment and Specific Loss Benefit”, and such Injury requires that You undergo special training in order to be qualified to engage in a special occupation in which You would not have engaged except for such Injury, the Insurer will pay the reasonable and necessary expense incurred for such training by You within two years of the date of the Accident, subject to a maximum of $15,000.00 as the result of any one Accident.

Payment will not be made for room, board or other ordinary living, travelling or clothing expenses.

Repatriation Benefit

If an Injury sustained by You results in loss of life (due to any cause) out of Canada, or if in Canada at least 150 kilometers from Your normal place of residence, and a benefit becomes payable in accordance with the terms of the Policy, the Insurer will pay the reasonable and necessary expenses actually incurred for the transportation of Your body to Your city of Residence, including the preparation of Your body for such transportation, subject to a maximum of $15,000.00.

Benefits will be reduced under this part by any amount paid or payable under any other policy providing similar expenses.

Seat Belt Benefit

If, due to a vehicular accident, Injury results in an amount payable to You under the part titled “Accidental Death, Dismemberment and Specific Loss Benefit”, Your Benefit Amount will be increased by 10% if, at the time of the Accident, You were driving or riding in a Vehicle and wearing a properly fastened seat belt.

The driver of the Vehicle must hold a current and valid driver's license of a rating authorizing them to operate such Vehicle and neither be intoxicated nor under the influence of drugs, unless such drugs are taken as prescribed by a Physician, at the time of the Accident. "Intoxicated" and "under the influence of drugs" are as defined by the local jurisdiction where the Accident occurs.

Due proof of seat belt use must be provided as part of the written Proof of Claim.

Spousal Retraining Benefit

If an Injury sustained by You results in loss of life and an amount becomes payable in accordance with the terms of this benefit, the Insurer will pay the reasonable and necessary expenses actually incurred within three years from the date of such Accident by Your Spouse who engages in a formal occupational training program in order to become specifically qualified for active employment in an occupation for which they would not otherwise have sufficient qualifications, not to exceed in the aggregate $15,000.00 for all such expenses. Payment will not be made for room, board or other ordinary living, travelling or clothing expenses.

Waiver of Premium

In the event You become totally disabled and a Waiver of Premium Claim is accepted and approved under the Group Life benefit, then premiums payable for this benefit will be waived as of the same date the Waiver of Premium Claim is effective under the Group Life benefit until one of the following occurs, whichever is earlier:

(a) the date You cease to be Totally Disabled;
(b) the termination of this benefit;
(c) the date You reach 65 years of age.

The Insurer reserves the right to request proof of Total Disability or any continuance thereof from time to time as the Insurer may reasonably require. Failure to provide proof satisfactory to the Insurer may result in termination of this Waiver of Premium benefit.

The coverage, which is continued under this benefit, will be subject to the terms and provisions of the Policy in effect as of the date of commencement of disability, including any provision providing for reductions in Benefit Amount.

Notwithstanding anything contained to the contrary in the Policy, in no event will benefits payable due to one or the total from multiple events which occur while coverage is being continued under this benefit exceed the Benefit Amount that would have been payable to the Insured Person at the date of commencement of Total Disability.

Limited Air Travel Coverage

Insurance provided under the Policy includes any Injury You may sustain in consequence of riding as a passenger, but not as a pilot or Crew Member, in, boarding or alighting from, or being struck by, or making a forced landing with or from (a) any Certified Aircraft which is operated by a person holding a current and valid pilot's license of a rating authorizing them to pilot such aircraft, or (b) any transport-type aircraft operated by the Canadian Armed Forces or by the similar air transport service of any duly constituted governmental authority of the recognized government of any nation anywhere in the world, provided the aircraft is not being used for test or experimental purposes.

Notwithstanding (a) and (b) above, the Policy excludes Injury sustained while and in consequence of riding as a passenger, pilot, operator or Crew Member, in or on, boarding or alighting from, or being struck by, or making a forced landing with or from any aircraft owned, operated or Leased by the Policyholder.

Exposure and Disappearance

If, as the result of an Accident, You are unavoidably exposed to the elements and if, as a result of such exposure and within 12 months after the date of the Accident, You suffer a loss for which an amount would otherwise have been payable under this benefit, such loss will be deemed to be the result of Injury.

Where, due to the accidental wrecking, sinking or disappearance of a conveyance in which You were riding, You disappear, and if Your body is not found within 12 months after the date of such wrecking, sinking or disappearance, it will be presumed, subject to there being no evidence to the contrary and subject to all other terms and conditions of the policy, that You suffered loss of life as a result of Injury.

Exclusions and Limitations

This benefit does not cover loss, fatal or non-fatal, caused by or resulting from:

a) declared or undeclared war or any act thereof;
b) active full-time service in the armed forces of any country;
c) suicide or any attempt thereat or intentionally self-inflicted Injury, regardless of Your state of mind;
d) committing, attempting or provoking an assault or criminal offence including without limitation driving a Vehicle with alcohol in the blood in excess of 80 milligrams of alcohol per 100 millilitres of blood.
e) medical care or treatment of any kind including surgery;
f) any drug, poison, gas or intoxicant taken, administered, absorbed or inhaled, voluntarily or otherwise (occupation-related Accidents excepted);
g) Injury sustained in consequence of riding as a passenger or otherwise in any Vehicle or device for aerial navigation, except as provided in the part titled “Limited Air Travel Coverage”.

Notice and Proof of Claim

You or Your agent, or a beneficiary entitled to make a Claim or their agent, will

(a) give written Notice of Claim to Us:

(i) by delivery thereof, or by sending it by registered mail to Us,

not later than 30 days from the date of the Accident or the Date of Diagnosis for the “Critical Disease Benefit”;

(b) within 90 days from the date of the Accident or the Date of Diagnosis for the “Critical Disease Benefit” for which the Claim is made, furnish Us such Proof of Claim as is reasonably possible in the circumstances of the happening of the Accident or Sickness, and the loss occasioned thereby; and

(c) if so required by the Insurer, furnish a satisfactory certificate as to the cause or nature of the Accident or Sickness for which the Claim may be made under this benefit.

Failure to give Notice of Claim or furnish Proof of Claim within the time prescribed does not invalidate the Claim if the Notice or proof is given or furnished as soon as reasonably possible, and in no event later than 12 months from the date of the Accident, if it is shown that it was not reasonably possible to give Notice or furnish proof within the time so prescribed.

A Claim form can be obtained from Us.

Long Term Disability

If You become Totally Disabled (as defined in this section) while You are an Insured Person under this benefit, the Insurer will pay You the Benefit Amount specified in the Schedule of Benefits and modified below, for each month, or proportionately for part of a month, during which Total Disability lasts, subject to the terms and conditions of this benefit and the Policy.

Definitions

Additional Definitions used in components of the Long-Term Disability benefit:

Elimination Period
The initial period of continuous Total Disability during which no Long-Term Disability benefit is payable. The duration of the Elimination Period is shown on the Schedule of Benefits for this benefit.

Indexed Pre-Disability Monthly Salary
Your Pre-Disability Monthly Salary increased each March 1st coincident with or next following the anniversary of the date You became entitled to a Long-Term Disability benefit by the change in the annual Consumer Price Index effective in January.

Medical Care
Any necessary medical investigation, tests, Diagnosis, treatment, services, care, attendance, consultation, medical advice, planned or pending surgery, drugs and medicines (either prescription or non-prescription), or referral to another health care professional, as a result of a Diagnosed or undiagnosed medical condition. Medical Care must be ordered by a Physician or other authorized health care professional in the treatment of the Sickness or Accident.

Motorized Vehicle
A vehicle that is drawn, propelled or driven by any means other than muscular power, including but not limited to an automobile, motorcycle, boat, snowmobile, all-terrain vehicle, personal watercraft or farm equipment.

Own Occupation Period
The length of time defined in the Schedule of Benefits – Definition of Total Disability, during which You cannot perform the essential duties of Your own occupation at Your own or any workplace, as determined by us.

Pre-Disability Gross Monthly Salary
The Monthly Salary applicable to You immediately prior to the date Your Total Disability commenced.

Pre-Disability Net Monthly Salary
The Monthly Salary applicable to You immediately prior to the date Your Total Disability commenced less the deductions for Income Tax, Canada or Quebec Pension Plan, Employment Insurance and the Quebec Parental Insurance Plan.

Rehabilitation Program
Any program or activity that, in Our opinion, would assist a You when Totally Disabled in being able to return to Your regular occupation or any gainful employment. Such Rehabilitation Program must be approved in advance and in writing by Us. A Rehabilitation Program may include any form of the following activities or programs:

1) Work hardening or return to work program on a gradual, modified, trial or part-time basis
2) Functional or occupational assessments, services for job placements or job searches.
3) Treatment or access to healthcare services or assistive devices or any other equipment.
4) Skills or knowledge development or upgrading, training, retraining or educational courses.
5) Any other programs or activities that We, at Our sole discretion, determine to be appropriate and reasonable as a Rehabilitation Program taking into account factors such as the nature and expected duration of the Your Total Disability, Your training, education or experience, and the nature, scope and cost of the program or activity.

The approval of a Rehabilitation Program by Us does not constitute an ongoing approval of such Program into the future. We may, therefore and at Our sole discretion, terminate a Rehabilitation Program at any time and for any reason.

Substance Abuse
Includes, but is not limited to: (i) the abuse of medication (prescribed or non-prescribed), drugs or alcohol; (ii) the use of illegal drugs or products; (iii) any other drug addiction or substance abuse disorder; and (iv) any condition arising from the abuse of such medication, drugs or alcohol.

Total Disability/Totally Disabled
During the Elimination Period and the subsequent Own Occupation Period for any Class with an Own Occupation Period, is a continuous state of incapacity resulting from Accident or Sickness which wholly prevents You from engaging in the essential duties of Your own occupation at Your own or any workplace, as determined by Us.

After the expiration of the Own Occupation Period, it will mean such a continuous state of incapacity resulting from Accident or Sickness which wholly prevents You from performing substantially all of the essential duties of Your own or any other occupation for which You are reasonably qualified by training, education or experience and earn at least 66 2/3% of Your Indexed Pre-Disability Gross Monthly Salary, due to the illness or Injury, as determined by Us.

In no event will Long-Term Disability benefits be paid for any period in which You are not under the care of a licensed Physician or for any period in which You are engaged in any gainful occupation other than as part of a Rehabilitation Program or Work Re-entry Program.

The availability of work will not be considered by Us in assessing the Participant's Total Disability.

If You who must hold a permit or licence, including a driver's licence, to perform Your duties, You will not be considered Totally Disabled solely because such a permit or licence has been withdrawn or not renewed.

Beginning of Benefit Payments

Payment of the Long-Term Disability benefit begins following completion of the Elimination Period specified in the Schedule of Benefits.

Amount of Benefit Payments

The amount of the Long-Term Disability benefit payable is determined according to the formula set forth as the Benefit Amount in the Schedule of Benefits and will not exceed the Maximum Benefit specified.

Reduction of Benefit Payments

The Long-Term Disability benefit will be reduced, after the application of the Maximum Benefit, by any benefits which are payable, or which would have been payable due directly or indirectly to Your Total Disability had a satisfactory application been made, under:

a) Any payment received according to Your Employer's policy regarding continuation of salary, vacation, statutory holidays or sick leave;

b) Any payment(s) You receive in lieu of notice under a severance package from Your Employer. Where the payment is made to You in the form of a lump sum, this exclusion will apply to the period of notice for which the lump sum is attributed and the monthly payments to offset will be the lump sum divided by the period of Notice for which the lump sum is attributed.

c) Applicable legislation for compensation for workplace injuries;

d) A provincial automobile insurance law if the reduction is not prohibited by law;

e) Any amounts received by You under the Quebec or Canada Disability Pension Plan;

f) Any similar law, act or plan to those listed in c), d) and e);

g) A provincial crime victims compensation act;

h) Any damages for loss of income received from a third party which arise out of the same circumstances that caused Your Total Disability

i) Any dividends paid to You that would normally be included in the calculation of Annual Salary as defined in this document.

Moreover, the amount of the Long-Term Disability benefit payable will be adjusted so that the sum of all income and compensation from the sources listed below will not exceed 85% of Your Pre-Disability Net Monthly Salary if the Long-Term Disability benefit is non-taxable or 85% of Your Pre-Disability Gross Monthly Salary if the Long-Term Disability benefit is taxable:

(a) Your benefits under this plan before the application of the reductions above;

(b) Any disability benefits payable under any other group, franchise or association plan;

(c) Payments received by you under any retirement or pension plan including the Quebec or Canada Pension Plan;

(d) Any other source of employed or self-employed income.

Any amounts listed above that began before Your Date of Disability will not be used in any offset calculation, however, increases in any such amount (other than automatic cost-of-living increases), whether as a result of your disability or not, will be taken into consideration and the amount payable revised.

If You do not receive income or benefits from any of the above-mentioned sources, You must prove that You are not entitled to Claim such income or benefits and that all levels of appeal or late reapplication required by Us have been pursued. Otherwise, We will estimate the amount of such income or benefits and include the amount in the calculation of benefits. This provision does not apply to retirement income payable under the Canada or Quebec Pension Plan or Your Employer's pension plan.

Participant's Responsibilities

During any period of Total Disability, You must make reasonable efforts to:

a) facilitate recovery from the Accident or Sickness that caused the Total Disability,

b) participate in any reasonable Medical Care and/or Rehabilitation Program,

c) accept any reasonable offer of modified duties from their Employer,

d) return to Your own occupation, or prepare to return to work in another occupation if it becomes apparent that You will not be able to return to Your own occupation, and

e) obtain any benefits that may be available from other sources.

f) provide any evidence of Total Disability required by Us or submit to an examination by a Physician designated by Us

If You fail to comply with any of these responsibilities, Your benefits may be withheld or discontinued.

Termination of Benefit Payments

The Long -Term Disability benefit payments will not be paid after the earliest of the following dates:

a) The date the Maximum Benefit Period specified in the Schedule of Benefits has been reached;

b) The day before the date You cease to be Totally Disabled;

c) The date You reach the age of 65;

d) The day before the date You retire or reach the normal retirement age under Your Employer's pension plan, but never beyond the Termination Age indicated in the Schedule of Benefits of the Policy;

e) The date of Your death;

f) The day before the date You engage in any occupation for wage or profit except as permitted under any modified work program, Rehabilitation Program or Work Re-entry Program provided in this section;

g) Any portion of a period of disability during which You are no longer receiving regular and personal Medical Care by an appropriate Physician qualified to treat the specific ailment causing the Total Disability, where it is generally recognized that such Total Disability can be treated;

h) The date You fail to submit to an examination by the Physician designated by Us;

i) The date You fail to provide any evidence of total disability required by Us;

j) The day before the date You refuse to participate in good faith in trial work, part-time work or a modified work program or a Rehabilitation Program which We have recommended;

k) The day before the date You are incarcerated after committing a criminal offence for which You were found guilty.

l) The day before the date You are capable of earning at least 66.7% of Your Indexed Pre-Disability Gross Monthly Salary if You are involved in trial work, part-time work or a modified work program or a Rehabilitation Program as provided under the Work Re-Entry Program;

Successive Periods of Total Disability

If You, who had been Totally Disabled, return to full-time active work or gainful employment with modified responsibilities again and become disabled while this benefit is in force, such disability will be considered a continuation of the previous Total Disability, provided:

a) it is due to the same cause or causes as the previous Total Disability, and

b) during the Elimination Period, You have been back at full-time active work for 14 days or less; or

c) after the Elimination Period has been completed, You have been back at full-time active work for less than 6 months.

However, if the successive period of Total Disability is due to a cause or causes unrelated to the cause or causes of the previous period of Total Disability, it will be considered to be a new disability and a new Elimination Period will apply.

Exclusions and Limitations

a) The Long-Term Disability benefit will not be payable for a disability resulting from one of the following causes:

   i) Civil unrest, insurrection or war, whether war be declared or not, or voluntary participation in a riot or any disturbance of the public order;

   ii) Attempted suicide or intentionally self-inflicted injury, regardless of Your state of mind;

   iii) Care which is not medically required or which is given for cosmetic purposes, unless such care is for an Accidental Injury and commenced within 90 days of the Accident, or such care is for the purposes of, or resulting from, making a living organ donation, subject to written pre-approval by Us (*For greater clarity, Gender Affirmation Surgery covered by your Province or this Group Benefits Plan is not considered cosmetic)*;

iv) Committing, attempting to commit a criminal offence, under any applicable law, or provoking an assault or criminal offence, whether or not convicted of such offence;

v) Active service in the armed forces.

vi) The voluntary or intentional inhalation or administration of drugs, poison, poisonous substances, gas or fumes;

vii) Injuries sustained from Your operation of a Motorized Vehicle while Your ability to drive is impaired as a direct result of Substance Abuse or while having drug or alcohol levels that exceed the maximum levels allowable by law in the jurisdiction where the Accident occurred.

b) The Long-Term Disability benefit will not be payable:

i) During any leave taken in accordance with provincial or federal legislation or during any leave taken in agreement with Your Employer;

ii) During any extension of such leave, if You are entitled to and requested such extension.

However, if the Participant's benefit was kept in force during the leave, the Elimination Period will begin on the date the disability commenced. The Long-Term Disability benefit will be payable on the later of the date the Elimination Period is satisfied or the date You would have returned to work if not for Your disability. No Long-Term Disability benefit will be payable during the period You are absent from work due to the leave.

c) The Long -Term Disability will not be payable for any period You are not under the regular care and attendance of an appropriate Physician, qualified to treat the specific ailment causing the Total Disability or You are not undergoing a course of appropriate medical treatment or participating in a Rehabilitation Program, which in Our opinion, is medically required or where it is generally recognized that such Total Disability can be treated by a licensed Physician.

d) The Long-Term Disability benefit will not be payable if You are out of Canada for a period of 60 consecutive days or more. Your entitlement to the Long-Term Disability benefit will be restored only upon Your return to Canada, subject to all other provisions of this benefit.

e) The Long-Term Disability benefit will not be payable for a disability which occurs during a strike, lock-out or temporary lay-off if Your benefit was not kept in force during such period.

Where Your benefit was kept in force, the Elimination Period will begin on the date the disability commenced. The Long-Term Disability benefit will be payable on the later of the date the Elimination Period is satisfied or the date You would have returned to work if not for Your Total Disability. No Long-Term Disability benefit will be payable during the period You are absent from work due to the strike, lock-out or temporary lay-off.

f) The Long-Term Disability benefit will not be payable if You refuse to participate in good faith in trial work, part-time work or a modified work program or a Rehabilitation Program which has been recommended by Us.

g) No Long-Term Disability benefit is payable for disabilities that result from Substance Abuse unless You are receiving and complying with continuous treatment for such Total Disability from a rehabilitation centre, a provincially designated institution, or are actively involved in and following a Rehabilitation Program for Substance Abuse supervised by a Physician and approved by Us.

h) No Long-Term Disability benefit is payable for any period during which You are serving a sentence for a criminal offence and are confined in a prison or other place of detention including but not limited to, a hospital, mental institution, a halfway facility or private residence (under house arrest).

i) No Long-Term Disability benefit is payable for any period during which You are involved in trial work, part-time work or a modified work program or a Rehabilitation Program as provided under the Work Re-Entry provision and are earning at least 100% of Your Pre-Disability Gross Monthly Salary;

Right of Recovery

If You do not apply for benefits from another source that You may be eligible for, the amount of such benefits will be estimated by Us, assumed to be paid and offset from the benefit amount.

Pre-existing Condition Exclusion

Please refer to the Schedule of Benefits section of this document to determine if this Limitation is included in Your Long-Term Disability benefit.

If included in Your plan, "pre-existing condition" as used in this provision means an illness or Injury:

a) which was sustained or contracted, or

b) for the symptoms of which You were under treatment by a Physician, or

c) for the symptoms of which a Physician had undertaken an investigation or review of, or

d) for which You were taking medication as prescribed by a Physician,

during the 3 months prior to the date on which You became covered under this benefit.

No Long-Term Disability benefit will be payable for a disability that:

a) resulted either directly or indirectly from, or was in any manner or degree associated with or occasioned by a pre-existing condition; and

b) which begins in the first 12 months after You became covered under this benefit.

However, if the Policy is a replacement group policy, a Long-Term Disability benefit will be payable for a disability due to a pre-existing condition, provided You:

a) were covered under the previous policy on the date it was terminated; and

b) became covered under this benefit on the effective date of the Policy; and

c) was actively at work on the effective date of the Policy; and

d) satisfies the pre-existing condition exclusion period under the Policy, giving consideration towards continuous time covered under both policies, or the prior policy giving consideration towards continuous time covered under both policies.

Waiver of Premiums

If Your life insurance premiums are waived in accordance with the Waiver of Premiums provision of the Group Life Insurance benefit, You will also be entitled to the Waiver of Premiums for this benefit, under the same terms and conditions.

Work Re-entry Program

Gradual return to work
We must give prior approval to any period of a gradual return to work, both with regard to duration and number of hours worked per week.

During the gradual return to work period, Your Disability Insurance benefit payments will be reduced by an amount corresponding to the percentage of hours You normally work each week during this period in relation to the hours You normally worked each week before You became Totally Disabled

Rehabilitation
In the event You become Totally Disabled, You must agree to participate in good faith in any Rehabilitation Program approved and supervised by Us.

Your benefits will be reduced by any remuneration You receive during the Rehabilitation period that, when combined with other income from the sources specified under the Reduction Of Benefit Payments section, exceeds 100% of Your Indexed Pre-Disability Net Monthly Salary if the Long-Term Disability benefit is non-taxable, or 100% of Your Indexed Pre-Disability Gross Monthly Salary if the Long-Term Disability benefit is taxable.

Survivor Benefit

Please refer to the Schedule of Benefits section of this document to determine if this benefit provision is included in Your Long-Term Disability benefit.

If You die while a Long-Term Disability benefit Claim is payable, a Survivor Benefit will be paid if:

a) Long-Term Disability premiums are being waived; and
b) Your current disability has continued for a period of 6 months beyond the Elimination Period.

A lump-sum benefit payment equal to 3 full months' benefits will be made to Your estate, or to Your designated beneficiary, as applicable. The lump sum is calculated based on the amount of the last payment made.

Extended Health Care

Definitions

Additional Definitions used in components of the Extended Health Care benefit:

Basic Daily Activities
Feeding oneself, dressing oneself, moving around and providing for one's own basic hygiene needs.

Reasonable and Customary Expenses
The costs incurred for eligible, covered medical services or supplies that do not exceed the standard costs of other providers of similar standing in the same geographic area, for the same treatment of a similar illness or Injury.

Scope of Coverage

Expenses for medical treatment, services, products or articles specified in the following sections are considered Allowable Expenses and therefore eligible for reimbursement, in accordance with the provisions specified in the Schedule of Benefits, insofar as they are deemed Reasonable and Customary and provided such treatment, services, products or articles are:

(a) obtained while You are covered under this Extended Health Care benefit;
(b) administered in compliance with current health practice standards;
(c) used in compliance with the manufacturer's instructions, or, where no such instructions exist, in accordance with government-approved directives;
(d) prescribed by a Physician, when such requirement is specified in the Schedule of Benefits;
(e) deemed necessary for the treatment of illness or Injury.

Preapproval recommendation:
You are advised to contact Us before obtaining treatment or medical services or purchasing costly medical products or articles to check if these expenses are *covered. (as noted in this Handbook some services require pre-approval by Us)*

Reimbursement of Allowable Expenses

The amount of Allowable Expenses reimbursed – the Eligible Expenses - takes into account the Deductible, % Reimbursement and Maximums specified in the Schedule of Benefits

Expenses Related to a Workplace or Automobile Accident

Most medical and Hospital expenses incurred due to an Accident in the workplace may be reimbursed in full by the workplace safety board of the Insured Person's Province of residence.

Most medical and Hospital expenses incurred due to an automobile Accident may be reimbursed in full by the Insured Person's provincial auto insurance plan or private automobile insurance policy, if applicable.

Before filing a Claim with Us, the Insured Person should first submit expenses to these government agencies or private automobile insurer for reimbursement.

Medical Expenses Covered by Provincial and Federal Governments

Each Province offers programs covering certain medical expenses. Contact Your provincial authority for more information about the programs available before filing a Claim with Us. You may also contact Us or use the myGroupHEALTH portal for more information.

Multiple Coverage and Coordination of Benefits (COB)

Effect on Benefits
If an Insured Person is covered under the Policy as a Participant and as a Dependent or as a Dependent of more than one Participant, or is covered simultaneously under any other plan which provides similar benefits, the amount of benefits payable under Group Benefits Plan for Eligible Expenses shall be coordinated and/or reduced so that the total benefits payable shall not exceed 100% of the actual Allowable Expenses. Please refer to the General Information section of this Handbook for more information on how this coordination is done.

Deadline for filing Claims

We recommend You file Your Claims at regular intervals, once every 3 months.

We must receive Notice of Claim for an Extended Health Care benefit within 12 months of the date of the event which gives entitlement to the benefit.

However, if the Policy should terminate, Notice of Claim for Extended Health Care expenses must be received by Us:

a) on or prior to the date of the termination with respect to all expenses except for those covered under the Travel Insurance and Assistance (Out of Province Emergency) benefit; and

b) within 90 days of the date of termination with respect to expenses covered under the Travel Insurance and Assistance (Out of Province Emergency) benefit.

Exclusions

This insurance does not cover any treatment, service, product or article related directly or indirectly, in whole or in part, to:

a) A criminal act that the Insured Person commits or attempts to commit;
b) Active participation in a riot or insurrection;
c) War or civil war, whether declared or undeclared;
d) Active service in the armed forces of a country;
e) Attempted suicide or intentionally self-inflicted injury, regardless of the state of mind of the Insured Person;
f) Medical expenses resulting from voluntary or intentional inhalation or administration of drugs, poison, poisonous substances, gas or fumes.

Furthermore, no benefits will be paid for treatment, services, products or articles:

a) That are covered under any social legislation or law governing hospitalization or health insurance, industrial Accidents and occupational Sicknesses, or legislation regarding automobile Accidents in the Insured Person's Province of residence, regardless of whether or not the Insured Person is eligible for coverage under such plans or legislation;
b) That are obtained through a municipal, provincial or federal clinic;
c) That are usually covered by government organizations;
d) That are required by a third party or received collectively;
e) Obtained for aesthetic or cosmetic treatments, unless otherwise specified;
f) For expenses related to services, supplies, examination or treatments that do not comply with Reasonable and Customary standards of current practice in the health care profession in question.
g) In relation to appointments not kept, filing Claims, treatment plans, written reports, travelling expenses, correspondence expenses, legal identification, appearance in court as an expert witness or telephone consultations.

Survivor Benefit

In the event of Your death, Extended Health Care coverage in force for Your Spouse and Dependent Children will be maintained without premium payment until the earliest of the following:

a) The end of a period of 24-months immediately following Your death, as noted in the Schedule of Benefits;
b) The date when insurance for Your Spouse and Dependent Children would have terminated if Your death had not occurred;
c) The date when Your Spouse and Dependent Children become eligible for similar coverage under another insurance Policy;
d) The date the Policy terminates.

Extended Health Care – Prescription Drugs

If Prescription Drugs coverage is listed as “Included” in the Schedule of Benefits, the Insurer will pay the Eligible Expenses incurred by Insured Persons for Prescription Drugs that are prescribed and filled while they are an Insured Person covered by this benefit.

Definitions

Additional Definitions used in components of the Prescription Drugs benefit:

Emergency Drug Release Program
Health Canada's Emergency Drug Release (EDR) program is supported by sections C.08.010 and C.08.011 of the Food and Drug Regulations. The EDR program considers requests for access to drugs for veterinary use:

a) that are unavailable for sale in Canada; and,
b) that are submitted by veterinary practitioners, for the purpose of diagnosing or treating a medical emergency in a patient (or group of animals) under their care.

A veterinary practitioner means a person who is registered and entitled under the laws of a Province to practice the profession of veterinary medicine.

Prescription Drugs (“Drugs”)
Drugs that meet all of the following conditions:

a) Has a valid DIN (Drug Identification Number) issued by the federal government;
b) Are prescribed by a Medical Practitioner legally authorized to do so;
c) Are only available in a pharmacy;
d) Are only available with a prescription; and
e) Are dispensed by a pharmacist or Medical Practitioner legally authorized to do so.

“Prior Authorization” drugs
Payment for certain drugs and medicines for some or all conditions is subject to Prior Authorization, as determined by Us. Refer to Your myGroupHEALTH portal to access a current Prior Authorization form. You are responsible for any charges for completion of forms.

How to Claim

When using a direct payment system
Your Group Benefits Plan includes access to a direct payment system for eligible Prescription Drug expenses, which means that Drug Claims are sent electronically by Your pharmacist directly to Us, and the Allowable Expense is automatically reimbursed.

The Insured Person should present their oneCard™ to their pharmacist when purchasing prescribed medications, and pay only the portion that is not an Eligible Expense. The Eligible Expense will be paid directly to the pharmacist.

If You do not show Your oneCard™ to Your pharmacist or if the pharmacist suggests You submit Your Claim directly, You may submit your claim though the eClaims or PhotoClaims features on the myGroupHEALTH portal or you may complete a health insurance Claim form and send it to Us along with the original receipts or paid invoices.

When a direct payment system is not used
If the Insured Person does not show their oneCard™ to their pharmacist You may submit your claim though the eClaims or PhotoClaims features on the myGroupHEALTH portal or you may complete a health insurance Claim form and send it to Us along with the original receipts or paid invoices.

Exclusions

The following treatment, services, products or articles are not considered Allowable Expenses, regardless of whether or not they are considered medical drugs, unless they are specifically included in the list of covered Prescription Drugs in the Schedule of Benefits:

a) Products used for aesthetic, cosmetic or personal hygiene purposes;
b) Substances or drugs used or administered for preventive purposes;
c) Experimental drugs or those obtained under the federal Emergency Drug Release Program which considers requests for access to drugs for veterinary use;
d) Drugs supplied during hospitalization, supplied by a Hospital pharmacy, or administered at a Hospital;
e) In the case of a medical drug injected by a Medical Practitioner in a private clinic, only the cost of the substance injected is covered, not the medical procedure;
f) Hospital drugs and treatments, including but not limited to intravenous or intrathecal injections on an in-patient, out-patient or emergency basis, that require Hospital or medical professional monitoring (e.g. Physician, nurse or other authorized healthcare professional where applicable, based on provincial legislation), regardless of whether the drug or treatment is administered in a Hospital, in a government or privately funded clinic or treatment facility, or in a private residence.
g) The cost of services payable by an Insured Person as a contribution to a public prescription drug insurance plan, which in many Provinces is described as a premium and, in particular, any contribution to the cost of drugs and pharmaceutical services which must be paid by the Insured Person under the Basic Prescription Drug Insurance Plan of Quebec. However, unless precluded by law in any Province, deductible amounts or coinsurance payments will be covered;
h) Homeopathic or natural products;
i) Sunscreens; However, sunscreens meeting the conditions provided for under this clause that are necessary for individuals afflicted with an illness requiring treatment with such products may be covered. A complete medical report detailing all conditions justifying the prescription of such products must be provided to Us;
j) Proteins, dietary supplements or amino acids, unless such products can only be obtained with a written prescription of a Medical Practitioner who is legally licensed to prescribe them and are required to be dispensed by a pharmacist;
k) food supplements and infant formula which are not covered by government health insurance plans;
l) Growth hormones; However, growth hormones prescribed for the treatment of hypophysial dwarfism may be covered. A complete medical report confirming the Diagnosis of hypophysial dwarfism and justifying the prescription of such products must be provided to Us;
m) Anabolic steroids;.
n) Drugs used for the treatment of infertility, artificial insemination or in vitro fertilization;
o) Smoking cessation products;
p) Drugs used to treat erectile dysfunction (Viagra and other similar drugs);
q) Anti-obesity drugs, and/or vitamin injections administered for the purpose of weight loss;
r) Alcohol swabs/pads for the treatment of diabetes
s) First aid and surgical supplies.

For residents of Quebec, under no circumstances may the exclusions, limitations and restrictions that apply to the prescription drug coverage of this Plan render the plan less generous than the Basic Prescription Drug Insurance Plan (BPDIP) of the Régie de l’assurance maladie du Québec (RAMQ).

Extended Health Care – Hospital

If Hospital coverage is listed as “Included” in the Schedule of Benefits, the Insurer will pay the Eligible Expenses that are incurred by Insured Persons during a Hospital stay while they are an Insured Person covered by this benefit.

Definitions

Additional Definitions used in components of Hospital coverage:

Convalescent Hospital

A facility staffed by Medical Practitioners offering short-term care and recovery for patients after surgeries and long-term illness. These facilities are a lower level extension of hospital care.

Hospital Room

If Hospital coverage is listed as “Included” in the Schedule of Benefits, the Insurer will pay You the difference between the cost of hospital ward accommodation and a semi-private or private hospital room (whichever is indicated in the Schedule of Benefits) up to a maximum of $10,000 per Insured Person per calendar year.

Expenses will be eligible for reimbursement provided the Insured Person is admitted to a Hospital in Canada for the purpose of receiving curative or palliative treatment or care related to pregnancy.

Exclusions

The following expenses are not covered:
a) Administrative or incidental fees charged to the patient by the Hospital;
b) Fees or room charges for outpatient care, day surgery, private Hospital, nursing home, chronic care facilities, home for the aged, rest home.

Hospital Indemnity

If the Hospital Indemnity coverage is listed as a covered expense in the Schedule of Benefits, the Insured Person may be eligible to receive a daily cash benefit as outlined in the Schedule of Benefits.

Convalescent Care

If Convalescent Care coverage is listed as “included” in the Schedule of Benefits, the Insurer will cover charges in excess of the Hospital’s public ward charge for accommodation and meals while in a Convalescent Hospital as an in-patient, up to the amount specified in the Schedule of Benefits. Benefits are only payable if:

a) The accommodation was specifically elected by the Insured Person;
b) The patient is admitted to the Convalescent Hospital within 3 or more days following Hospital confinement for acute care;
c) Convalescent Hospital was prescribed by a Physician.

All confinement in a Convalescent Hospital will be considered as one period unless separated by at least ninety days. In order to qualify under this covered expense, the Convalescent Hospital must be approved by the appropriate provincial ministry governing health and social services.

Exclusions

a) Charges for custodial care, long-term care or chronic care in a Convalescent Hospital, nursing home or similar institution will not be considered Allowable Expenses.
b) Room charges for alcohol and substance abuse, mental health or home for the aged will not be considered Allowable Expenses.
c) Charges for administrative fees charged by the Hospital will not be considered an Allowable Expense.

How to Claim

Hospital Room
The Insured Person should present their oneCard™ at the Hospital and the Hospital will send their Claim to Us.

Hospital Indemnity and Convalescent Care
To file a claim You may submit your claim though the eClaims or PhotoClaims features on the myGroupHEALTH portal or you may complete a health insurance Claim form and send it to Us along with the original receipts or paid invoices.

Extended Health Care – Health Care Practitioners

If Health Care Practitioners coverage is listed as “Included” in the Schedule of Benefits, the Insurer will pay the Eligible Expenses that are incurred by Insured Persons for treatment, services or supplies obtained from the Health Care Practitioners specified in the Schedule of Benefits (“Health Care Practitioners”) while they are an Insured Person covered by this benefit.

Expenses Covered

Only one treatment by the same practitioner is covered per Insured Person per day, regardless of the number of fields of specialization the practitioner is licensed to practice in.

Expenses paid are eligible for reimbursement, provided the Health Care Practitioner is a member of a professional order governing the practice of the practitioner’s activities and/or use of the professional title. In the absence of such an order, the Health Care Practitioner must be a member of a professional association recognized by Us.

For expenses paid to be eligible for reimbursement, the Health Care Practitioner must not reside with You, be a Family Member, or be insured under the Policy, and services provided must be within the scope of their practice.

How to Claim

When using Pay Direct Health Services
We offer a direct payment system for Health Care Practitioners coverage called Pay Direct Health Services. This allows a Claim for eligible services or supplies received from one of the Health Care Practitioners listed in the Schedule of Benefits to be submitted directly to, and reimbursed directly by, Us. Any amount not covered by Your Plan will be payable by the Insured Person directly to the Health Care Practitioner. In order to benefit from the Pay Direct Health Services method of payment, the Insured Person must choose a Health Care Practitioner that has agreed to this type of billing arrangement. The list of practitioners offering this type of direct billing can be found by accessing the following website: https://plus.telushealth.co/locator/eclaims.You will need to show Your oneCard™ to the Health Care Practitioner so that they may submit the Claim electronically on Your behalf.

When Pay Direct Health Services are not used
To obtain reimbursement for services or supplies received from one of the Health Care Practitioners listed in the Schedule of Benefits, You must provide an original receipt or paid invoice.

The receipt or paid invoice must include the following information:
1. The Health Care Practitioner’s name, association or professional order, and membership number;
2. The type of treatment or services provided;
3. The date when treatment or services were obtained or products or articles were purchased;
4. The cost of the treatment, services, products or articles;
5. The name of the Insured Person for whom treatment, services, products or articles were obtained.

To file a Claim for expenses related to the treatment or supplies, You may submit your claim though the eClaims or PhotoClaims features on the myGroupHEALTH portal or you may complete a health insurance Claim form and send it to Us along with the original receipts or paid invoices. issued by the Health Care Practitioner who administered the treatment or provided the supplies .

Treatment or supplies requiring a prescription
When filing a Claim for treatments or supplies requiring a prescription, You must provide the Medical Practitioner’s prescription and the original receipt or paid invoice with Your Claim.

Exclusions and Limitations

If Chiropractor X-rays are included in the list of Health Care Practitioners in the Schedule of Benefits, they are limited to those taken by a Chiropractor to determine the necessity for corrections to the spinal column, pelvic bones or other articulations of the body.

If the treatment or services of a Naturopath are included in the list of Health Care Practitioners in the Schedule of Benefits, such treatment or services are limited to the fees for a consultation to obtain dietary advice, a health assessment or establish a diet based on natural products. Laboratory tests performed by a Naturopath are eligible for reimbursement if the test is done and analyzed in their office. If the test is not done in their office and is sent off-site to be analyzed then the test is not eligible. Natural products, massages, baths, posturology, physical exercises or other products or services are not covered.

Extended Health Care – Vision Care

If Vision Care coverage is listed as “Included” in the Schedule of Benefits, the Insurer will pay the Eligible Expenses that are incurred by Insured Persons for Expenses Covered for eye care services while they are an Insured Person covered by this benefit.

Expenses Covered

Eyeglasses
Purchase of glasses for correction of vision prescribed by an optometrist or ophthalmologist. Prescription safety glasses, prescription sunglasses or prescription safety goggles are also covered.

Contact lenses
Purchase of contact lenses for correction of vision prescribed by an optometrist or ophthalmologist.

Laser vision correction
Expenses for laser eye surgery to correct myopia, hypermetropia or astigmatism, when recommended by an ophthalmologist.

How to Claim

When using Pay Direct Health Services
We offer a direct payment system for Vision Care coverage called Pay Direct Health Services. This allows a Claim for eligible services or supplies received from an optometrist or ophthalmologist to be submitted directly to, and reimbursed directly by, Us. Any amount not covered by Your Plan will be payable by the Insured Person directly to the optometrist or ophthalmologist. In order to benefit from the Pay Direct Health Services method of payment, the Insured Person must choose an optometrist or ophthalmologist that has agreed to this type of billing arrangement. The list of Medical Practitioner offering this type of direct billing can be found by accessing the following website: https://plus.telushealth.co/locator/eclaims.You will need to show Your oneCard™ to the Medical Practitioner so that they may submit the Claim electronically on Your behalf.

When Pay Direct Health Services are not being used
To obtain reimbursement for services or supplies received from an optometrist or ophthalmologist You must provide an original receipt or paid invoice.

The receipt or paid invoice must include the following information:

a) The optometrist or ophthalmologist name, association or professional order, and membership number;
b) The date when treatment or services were obtained or products or articles were purchased;
c) The cost of the treatment, services, products or articles;
d) The name of the Insured Person for whom treatment, services, products or articles were obtained.

To file a Claim, You may submit your claim though the eClaims or PhotoClaims features on the myGroupHEALTH portal or you may complete a health insurance Claim form and send it to Us along with the original receipts or paid invoices issued by the optometrist or the ophthalmologist who provided the treatment, services, products or articles.

Exclusions

The following products are not considered Allowable Expenses under Vision Care:

a) Non-prescription sunglasses;
b) Refractions required by a client, government body or other third party;
c) Intraocular lens implants.

Extended Health Care – Other Medical Expenses

If Other Medical Expenses coverage is listed as “Included” in the Schedule of Benefits, the Insurer will pay the Eligible Expenses that are incurred by Insured Persons for the following Expenses Covered while they are an Insured Person covered by this benefit. This section should be read in conjunction with the limits outlined in the Schedule of Benefits at the beginning of this Handbook.

Expenses Covered

Expenses for medical equipment or supplies must be submitted to Your provincial health plan first for their consideration as first payor. Any remaining balance of Reasonable and Customary expenses may be eligible under this Group Benefits Plan up to the maximum specified in the Schedule of Benefits. Equipment or supplies normally eligible through Your provincial health plan that are deemed not eligible due to lack of medical necessity are not eligible under this Group Benefits Plan. Equipment or supplies not eligible under Your provincial health plan may be eligible under this Group Benefits Plan.

Ambulance
Reasonable and Customary Expenses for emergency transportation to the nearest Hospital by a licensed ground ambulance service. In addition, when the circumstances dictate (as pre-approved by Us), coverage may be considered for transportation by air or rail or water.

Artificial Eye
The cost of purchasing, repairing and replacing an artificial eye.

Artificial Limbs
The cost of purchasing an artificial limb, including myoelectric and electric artificial prostheses. The cost of repair and replacement of the artificial limb is also covered.

Blood Glucose Monitor
Device used to measure blood sugar levels. Allowable Expenses include continuous glucose monitors, sensors and transmitters.

Breathing equipment
Rental, or purchase, whichever is more economical, of:

a) Mist tents and nebulizers.
b) Oxygen and the equipment needed for its administration (including cylinders and concentrators);
c) Continuous positive airway pressure machine (CPAP & APAP);
d) CPAP and APAP Supplies (Mask, Tubing, Battery Pack, Filters, Wipes for Mask and Nose Pillows);
e) Bi-level Positive Airway Pressure Machine (Bi-PAP) ;
f) Intermittent positive pressure breathing machine (IPPB);
g) Apnea monitors for respiratory dysrhythmias;
h) Tracheostoma tubes;
i) Aerochambers for Dependent Children.

Colostomy and ileostomy supplies
Colostomy and ileostomy supplies prescribed by a Physician, in excess of the amount reimbursed by the government.

Custom-made burn garments
The purchase of custom-made burn garments when prescribed by a Physician.

Custom-made pressure supports for lymphedema
The purchase of custom-made pressure supports when prescribed by a Physician for treatment of lymphedema only.

Dental treatment following Accidental injury to natural teeth
Professional fees of a Dentist for treatment of damage to healthy, natural teeth sustained as the result of an Accident.

For the purposes of this section, a tooth is deemed to be healthy if it is not afflicted with any pathology, either in itself or the adjacent structures. A tooth that has been treated or restored to normal function is considered to be healthy.

These expenses are only covered if the following conditions are met:

a) The Insured Person was covered under this benefit at the time the Accident occurred;
b) Treatment is administered by a licensed Dentist or denturist;
c) Treatment or services are received within the 12 months following the date the Accident occurred, provided You are still covered under this benefit.

Limitations

Expenses will be covered up to the amount specified in the official general practitioners' fee guide published by Your provincial dental association for the year during which treatment or services are received.

When a fee guide is not published for a given year, the term fee guide may also mean an adjusted fee guide established by Us.

Exclusions

Any treatment, procedures, or prostheses related to dental implants are excluded.

Damage to teeth occurring while chewing, regardless of the nature or cause of such damage, is not covered.

Preapproval

Before incurring any expenses for this product or care, prior approval is required. Participants should forward all relevant medical information obtained from Your attending Medical Practitioner to Us for assessment.

External breast prosthesis
The cost of purchasing an external breast prosthesis is covered provided the loss is the result of a total or radical mastectomy.

Extremity pump for lymphedema
The purchase of an extremity pump when prescribed by a Physician for treatment of lymphedema only.

Eye examination
Eye examination by an optometrist or ophthalmologist.

Gender Affirmation
Covers Surgical procedures not available under Your provincial health plan to assist in the physical alignment of the Insured Person's transitioned gender. The Insured Person must be Diagnosed with Gender Dysphoria by, and be under care of, a Specialist in this field. Further the Insured Person must be at least 18 years old; meet the criteria for, and been approved by, their relevant Provincial program; and have been on hormone treatment continuously for at least 12 months. All procedures must be performed in Canada by a Medical Practitioner and coverage must be in place at time of Surgery.

Preapproval
Before incurring any expenses for Gender Affirmation Surgery, prior approval is required. Participants are required to forward all relevant medical information obtained from Your Specialist to Us for assessment.

Exclusion
Travel or accommodation expenses; Any procedures payable

Head halters
Purchase of head halters when prescribed by a Physician.

Hearing aids
Purchase, adjustment, replacement or repair of a hearing aid when prescribed by a Physician. Batteries and ear moulds are included.

Hospital bed
Rental or purchase, whichever is most economical, of a Hospital bed of the type normally used in a Hospital when prescribed by a Physician. Bed rails and electric Hospital beds are also covered.

Insulin infusion sets and reservoir sets
Purchase of insulin infusion sets and reservoir sets.

Insulin infusion pumps
Purchase of insulin infusion pumps.

Laboratory analyses and X-Rays
Analyses of tissues and body fluids (e.g. blood, urine) of the same type as those available in a Hospital, administered in a private laboratory for purposes of prevention or Diagnosis and x-rays taken outside a Hospital centre in a private clinic for the purpose of prevention or Diagnosis.
Exclusion
Computed axial tomography (CAT) are excluded from this coverage. Allowable Expenses for MRIs are not covered under Laboratory Analyses and X-rays and are subject to a separate maximum as indicated in the Schedule of Benefits.

MRI (Magnetic Resonance Imaging)
Magnetic Resonance Imaging (MRI) is a test that uses powerful magnets, radio waves, and a computer to make detailed pictures inside Your body, when prescribed by a physician.

Mechanical or hydraulic patient lifters
The purchase of a mechanical or hydraulic patient lifter, excluding stair lifts, when prescribed by a Physician.

Mobility aids
Rental or purchase, whichever is most economical, of a scooter, standard wheelchair or an electric wheelchair if medically necessary. Wheelchair and scooter repairs are considered Allowable Expenses as are supplies such as cushions, foot rests, foot plates, head rests, tires, parts and labour when under repair and when there is a need to replace. The purchase and rental for crutches, canes and cane tips, and walkers are also included, when prescribed by a Physician.

Preapproval
Before incurring any expenses for wheelchairs or walkers, prior approval is required. Participants are required to forward all relevant medical information obtained from Your attending Physician to Us for assessment.

Nursing
Continuous and exclusive care provided to the Insured Person, at home, by a registered nurse (RN), registered practical nurse (RPN), licensed practical nurse (LPN), or registered nursing assistant (RNA) who is not a Family Member of the Insured Person. To be eligible for reimbursement, expenses must be incurred for care that requires the specific skills of one of the aforementioned nurses, when prescribed in writing by a Physician and approved in advance by Us.

Preapproval
Before incurring any expenses for this product or care, Our prior approval is required. Participants must forward all relevant medical information obtained from Your attending Physician to Us for assessment.

Orthopaedic Shoes, orthopaedic modifications to regular shoes and off the shelf orthopaedic shoes
Orthopaedic shoe(s) or the permanent modification of a regular shoe on the written recommendation of a Physician (MD), Podiatrist (DPM) or Chiropodist (D CH or D Pod M), accompanied by a Diagnosis of the conditions and symptoms and a gait analysis/biomechanical exam. The orthopaedic shoes must be dispensed by an Orthotist (CO or CPO(c)), Pedorthist (CPed(c) or CPed (MC)), Podiatrist (DPM), Chiropodist (D CH or D Pod M) or Orthésiste du Pied (member of CCCOP). The dispenser must be a different provider than the prescriber. Modifications may include sole build-ups, lifts, wedges, steel plates, stirrups to accommodate braces and self-adhesive closures.

A description of the modifications made to the shoes including a breakdown of the costs and the brand name of the shoe must accompany the Claim. The name and license number of the dispenser must also be provided.

Exclusion
Off–the–shelf shoes purchased only to accommodate orthotics or as comfortable walking shoes, including but not limited to Birkenstock, Nike, Brooks and Rockport, are not covered. Sandals are also not covered.

Orthopaedic apparatus
Purchase, adjustment, rental, replacement or repair of corsets, splints, casts, trusses, collars, leg orthoses or braces (other than foot braces).

For any other orthopaedic apparatus necessary to perform basic daily activities, expenses may be considered eligible for reimbursement up to an amount deemed reasonable by Us.

Exclusion
Orthopaedic shoes, orthopaedic modifications to regular shoes and Orthotics are not covered under Orthopaedic Apparatus. Intra-oral splints are not covered.

Orthotics
Foot orthotics may be obtained on the written recommendation of a Physician (MD), Podiatrist (DPM), Chiropodist (D CH or D Pod M) or Chiropractor, accompanied by a Diagnosis of the conditions and symptoms and a gait analysis/biomechanical exam. The orthoses must be dispensed by an Orthotist (CO or CPO(c)), Pedorthist (CPed(c) or CPed (MC)), Podiatrist (DPM), Chiropodist (D CH or D Pod M), Chiropractor or Orthésiste du Pied (member of CCCOP). The dispenser must be a different provider than the prescriber.

A description of how the orthotic was constructed and the raw materials used, plus a breakdown of the costs must accompany the Claim. The name and license number of the dispenser must also be provided.

Outdoor Wheelchair Ramp
A device installed outside of Your home with an inclined plane joining two different levels, enabling individuals to access buildings safely and easily, when prescribed by a Physician.

Sclerosing agents
Purchase of sclerosing agents. The professional fees charged by the Physician are not considered to be expenses for sclerosing agents.

Special vision benefit after cataract surgery
An initial pair of frames and 1 corrective lens, contact lens, prosthetic lens or intraocular lens after cataract surgery.

Speech aids
Speech aids, including Bliss boards and laryngeal speaking aids, prescribed by a Physician, when no alternative method of communication is possible.

Stump socks and shoulder harnesses
The cost of purchasing stump socks and shoulder harnesses are covered when prescribed by a Physician.

Support hose
Purchase of graduated compression stockings, 20mmHG or more, from a pharmacy or medical facility for the treatment of a venous or lymphatic system deficiency when prescribed by a Physician.

Surgical brassiere
Purchase of a brassiere to support an external breast prosthesis worn by mastectomy patients.

Traction apparatus
Purchase of traction apparatus when prescribed by a Physician.

Transcutaneous electrical nerve stimulator
Purchase, rental, adjustment, replacement or repair of a transcutaneous electrical nerve stimulator when prescribed by a Physician.

Trapeze bars
Purchase of trapeze bars when prescribed by a Physician.

Urethral catheters
Purchase of urethral catheters when prescribed by a Physician.

Viscosupplementation injections (for the treatment of knees only)
Purchase of Orthtovisc, Synvisc, Neovisc, Durolane, Eufelxxa or any other viscosupplementation product, when dispensed by a physician. The physician and other fees are not covered

Wigs (including hair pieces)
Cost of wigs or hair pieces when required as a result of chemotherapy, alopecia areata, alopecia universalis or alopecia totalis when prescribed by a Physician.

How to Claim

To obtain reimbursement for expenses paid for the services or supplies listed above, You must submit original copies of receipts or paid invoices.

The receipts and invoices must include the following information:

a) The Medical Practitioner's name, association or professional order, and the provider's membership number, or the name and address of the supplier from whom products or articles were purchased;
b) The date when treatment or services were received or products or articles were purchased;
c) The cost of the treatment, services, products or articles;
d) The name of the Insured Person for whom the treatment, services, products or articles were obtained.

To file a Claim for expenses related to the treatment or supplies, You must complete a health Claim form and send to Us along with the receipts or paid invoices issued by the Medical Practitioner who administered the treatment or provided the supplies.

Treatment, services, products or articles requiring a prescription
When filing a Claim for treatments or supplies requiring a prescription, You must provide the Medical Practitioner's prescription and the original receipt or paid invoice with Your Claim.

For eye examinations
If eye examinations are covered under the Group Benefits Plan, there is the option of using a direct payment system called Pay Direct Health Services which allows a Claim to be submitted directly to, and reimbursed directly by, Us. Any amount not covered by Your Group Benefits Plan will be payable by the Insured Person directly to the Ophthalmologist or Optometrist. In order to benefit from the Pay Direct Health Services method of payment, You must choose a provider that has agreed to this type of billing arrangement. The list of providers offering this type of direct billing can be found by accessing the following website: https://plus.telushealth.co/locator/eclaims.You will need to show Your oneCard™ to the provider so that they may submit the Claim electronically on Your behalf.

Extended Health Care – Out-of-Province Medical Referral

If Out-of-Province Medical Referral coverage is listed as “Included” in the Schedule of Benefits, the Insurer will pay the Eligible Expenses that are incurred by Insured Persons for the following Expenses Covered while they are an Insured Person covered by this benefit.

Expenses Covered

For Insured Persons covered by the health and hospitalization insurance plan of their Province of residence, expenses incurred outside the Province of residence for the following medical treatment, services, products and articles are covered, provided that such expenses are pre-approved by the insured’s provincial health and hospitalization insurance plan and by Us, and provided the required medical treatment is not available in the insured’s Province of residence:

- hospitalization in a hospital where the insured receives curative treatment;
- professional fees of a Physician for medical, surgical or anaesthetic care;
- transportation and accommodation expenses paid by the Insured Person;
- expenses incurred for medications, x-rays and laboratory analyses.

Before incurring any expenses for this product or care, prior approval is required. Please forward all relevant medical information obtained from Your attending Physician to Us.

The Insurer will reimburse the difference between the Eligible Expenses incurred and the benefits payable under the Insured Person’s provincial health and hospitalization insurance plan or by any other public plan that has an agreement with the Insured Person’s Province of residence in Canada.

Exclusions

In addition to the exclusions applicable to all coverage under the Extended Health Care insurance, the following are not eligible for reimbursement under Out-of-Province Medical Referral:

- Any expense related to dental care;
- Any expense not specifically included under this coverage.

Extended Health Care – Travel Insurance and Assistance (Out of Province Emergency)

You are insured under this coverage only if Travel Insurance and Assistance (Out of Province Emergency) is listed as “Included” in the Schedule of Benefits.

For information before You travel, to obtain approval before incurring or paying any eligible expenses, to request assistance, or to submit a claim for an emergency, please contact Trident Global Assistance at one of the following numbers:

From Canada or the United States**: 1.855.234.3545**

From elsewhere in the world: **(416) 234.3545 (collect call)**

You must provide the Contract/Policy Number and Certificate Number specified on Your benefit card.

Definitions

Additional definitions used in this benefit:

Close relative
An individual who is related to another individual in one of the following ways: spouse, son, daughter, father, mother, brother, sister.

Family member
An individual who is related to another individual in one of the following ways: spouse, son, daughter, father, mother, stepfather, stepmother, father-in-law, mother-in-law, brother, sister, half-brother, half-sister, brother-in-law, sister-in-law, son-in-law, daughter-in-law, grandparent, grandchild, uncle, aunt, nephew or niece.

Travel Companion
Refers to the person with whom the Insured shares accommodation at the travel destination, or whose transportation expenses were paid with those of the Insured.

Trip
A trip taken outside the Insured’s usual province of residence. In this case, the term Trip also applies to the Insured’s transportation between the departure and the return.

Expenses covered

The percentage of reimbursement applicable to the following eligible expenses is specified in the Schedule of Benefits.

Coverage under this benefit is limited to the period during which individuals are outside their province of residence and are also covered under their public health and hospitalization plans. In the event that the Insured dies during the coverage period, or suffers accidental injury or a sudden and unexpected illness during such period, emergency expenses incurred by or for the Insured as described below are eligible, up to the maximum reimbursement specified in the Schedule of Benefits.

Travel Insurance and Assistance only covers eligible expenses in excess of those reimbursed under the public health and hospitalization plans of the Insured's province of residence. Insureds planning a Trip scheduled to last more than 180 days must contact Trident Global Assistance in advance for information about applicable conditions.

In the following cases, approval must be requested as soon as possible from Trident Global Assistance, either by the Insured or by any other adult able to do so: hospitalization, medical care, transportation by ambulance.

In the following cases, Insureds must obtain prior approval from Trident Global Assistance: treatment provided by a nurse, chiropractor, podiatrist, physiotherapist or dentist; repatriation; medical escort; living expenses and transportation of a Close Relative of the Insured; transportation of the Insured's body if deceased; return of a vehicle; expenses described under the “Services, products and articles” section.

For the expenses described below to be considered eligible, Insureds must be covered under the public health and hospitalization plans of their province of residence.

In all cases, services must be obtained from an individual who does not reside with the Insured and is neither a Close Relative nor a Travel Companion of the Insured.

Insureds who already have a known disease or illness before the Trip must ensure before departure that:

- Their health condition is good, and stable. The Insured's state of health is considered unstable, and its effects are not considered to be those of a sudden and unexpected illness, in the following cases:
  - Symptoms worsen;
  - A relapse is suffered;
  - The disease or illness is in its terminal phase;
  - The disease or illness is chronic and shows signs that deterioration may occur or foreseeable complications may arise during the Trip;
- They are able to carry out usual daily activities; and
- They are experiencing no symptoms that may reasonably suggest that any complications may arise or medical care may be required during the Trip outside the province of residence.

Trident Global Assistance can clarify the term "sudden and unexpected illness" and confirm whether coverage may be limited in any way by the Insured's condition.

Hospitalization
Hospitalization expenses incurred due to treatment in a hospital.

Physician fees
Professional fees of a physician for medical, surgical or anaesthetic care, other than fees for dental care.

Nursing fees
When prescribed by the attending physician, professional fees of a registered nurse for private nursing care provided exclusively in hospital. Eligible expenses for nursing fees may not exceed $5,000 per Insured per Trip.

Chiropractor, podiatrist or physiotherapist fees
Professional fees of a chiropractor, podiatrist or physiotherapist.

Dentist fees
Professional fees of a dentist for accidental injury to natural teeth. The accident must occur outside the Insured's province of residence. Treatment must be received while the individual's insurance is in force. Eligible expenses for professional fees of a dentist may not exceed $1,000 per Insured per Trip.

Prescription drugs
Expenses for the purchase of drugs available only on prescription from a Health Care Provider legally authorized to do so.

Transportation by ambulance
The cost of transportation by ambulance to the nearest hospital by a licensed ambulance service.

Repatriation of the Insured
The cost of returning the Insured to the province of residence for immediate hospitalization and the cost of transporting the Insured to the nearest location where appropriate medical services are available. Benefits are limited to the cost of the most economical transport option, taking the Insured's health condition into account.

Transportation by plane of a medical escort
The cost of economy class round-trip transportation by air for a medical escort who is neither a member of the Insured's family nor a Travel Companion, when required by the air carrier or the attending physician of the Insured.

Living expenses and transportation of a Close Relative
The cost of accommodation and meals in a commercial establishment and the cost of economy class round-trip transportation for one Close Relative between the place of residence and the hospital when the Insured is hospitalized for at least 7 days or, in case of death, between the place of residence and the place where the deceased Insured's body must be identified. Eligible expenses are subject to the following limits:

- Transportation: $2,500 per Trip for all insured Family Members;
- Accommodation and meals: $300 per day for all insured Family Members, up to a maximum of $2,400 for the whole duration of the stay.

Eligible transportation expenses are limited to the cost of making the Trip by the most economical means (bus, train or air). The attending physician must certify in writing that the visit was necessary.

In case of death of the Insured, preparation and transportation of the body, or burial or cremation on the spot
The expenses of preparing and returning the remains of the Insured by the most direct route home, or burial or cremation on the spot, excluding expenses incurred for a coffin or funeral urn. Eligible expenses are limited to a total maximum of $10,000 for preparation of the body and transportation.

Return of vehicle
The cost of returning the Insured's personal vehicle home or rental vehicle to the nearest appropriate vehicle rental agency. Eligible expenses are limited to a maximum of $2,000 per Trip.

The vehicle must be returned by a recognized commercial agency. The Insured must be incapable of doing so personally due to an illness or injury that is confirmed by the attending physician, and the Insured's Travel Companions, if applicable, must also be unable to return the vehicle.

Services, products and articles
Expenses paid for the following medical services, products or articles:

- Rental of a wheelchair, hospital bed or respirator;
- X-rays and laboratory analyses;
- Purchase of trusses, corsets, crutches, splints, casts and other orthopaedic devices.

Living expenses
The cost of accommodation and meals in a commercial establishment the Insured must incur when obliged to modify the planned Trip due to hospitalization of the Insured, a Family Member or a Travel Companion.

The duration of hospitalization must be at least 24 hours. Eligible expenses are subject to a maximum of $300 per day, or $2,400 per Trip outside the province of residence of the Insured, for all individuals covered.

Travel assistance services
Your insurance provides access to certain travel assistance services when you need them. These services may not be available in all countries and are subject to change by Industrial Alliance without notice.

The following services are available:

a) Directing the Insured to an appropriate clinic or hospital;

b) Verifying medical insurance coverage to avoid, wherever possible, the Insured having to pay for hospital care up front;

c) Ensuring the proper follow-up of the Insured's medical file;

d) Coordinating the return and transport of the Insured as soon as medically possible;

e) Providing emergency support and coordinating settlement applications;

f) Arranging the transportation of a Family Member to the bedside of the Insured, to identify the Insured's body if deceased and/or coordinate the repatriation of the deceased Insured;

g) Arranging for the return of Insured persons to their home (return expenses not included);

h) Arranging for the return of the Insured's personal vehicle if the Insured is unable to do so due to illness or accident;

i) Communicating with the Insured's family or employer;

j) Acting as an interpreter for emergency calls;

k) Recommending a lawyer in the event of legal difficulties.

Coordination and reduction of benefits

Expenses eligible for reimbursement under this Travel Insurance and Assistance benefit will be reduced by the amount of any corresponding benefits payable under another insurance contract. However, if you are entitled to benefits for the same expenses under other provisions of your Extended Health Care coverage, benefits will only be payable under the provisions of Travel Insurance.

Exclusions, limitations and restrictions

In addition to the exclusions, limitations and restrictions applicable to all benefits of the Extended Health Care benefit under this plan, the following exclusions apply to Travel Insurance.

The following expenses are not eligible for reimbursement under the Travel Insurance benefit of this plan:

a) Expenses incurred as a result of the Insured's refusal to be repatriated to the province of residence, upon Industrial Alliance's request;

b) Expenses incurred by the Insured outside the province of residence when such expenses could have been incurred in the province of residence, without danger to the Insured's life or health. For the purposes of this exclusion, the fact that the treatment available in the province of residence may be of a different quality than that available outside the province of residence does not constitute a danger to the Insured's life or health;

c) Expenses incurred in a location for which the Government of Canada issued a travel advisory not to stay in or not to travel to. This exclusion does not apply to Insureds already present at the location in question at the time the Government of Canada issues a travel advisory, provided they then take the necessary measures to comply with the advisory as soon as possible;

d) Expenses payable under any public plan;

e) Expenses related to elective or non-emergency surgery or treatment;

f) In the case of a Trip taken for the purposes of obtaining or with the intention of receiving medical treatment, expenses incurred in relation to the medical condition for which the Trip is taken, whether or not the Trip is taken upon the recommendation of a physician;

g) Expenses for chronic care incurred in a facility treating chronic illnesses;

h) Expenses incurred for Insureds in thermal spa facilities or extended care homes;

i) Expenses incurred due to injury or death as a result of practising any of the following activities or sports: gliding, hang-gliding, paragliding, mountaineering, bungee jumping, parachuting skydiving or any other similar activity, all extreme or combat sports, any motorized vehicle competition, as well as any sporting or underwater activity for which a remuneration is paid to the individual this insurance plan applies to;

j) Expenses related to an event occurring during the Trip, or shortly thereafter, that Insureds may reasonably have predicted due to their state of health at the start of the Trip. This category of events includes pregnancy, miscarriage, childbirth and related complications, where such events occur within the 2 months preceding the normal expected date of delivery or thereafter;

k) Hospital or medical expenses incurred for treatment for which no reimbursement is provided for under the public health or hospitalization plan of the Insured's province of residence.

How to Claim

In the event of an emergency that occurs during an Insured's stay outside the province of residence, all travel assistance services, and reimbursement for most expenses eligible under Travel Insurance, will be coordinated by Trident Global Assistance, provided the Insured contacts one of its representatives.

When the Insured returns home, Trident Global Assistance will send you:

- The documents you need to file your claim. Originals of all receipts and paid invoices for eligible expenses paid should be enclosed with your claim
- A form for you to sign, authorizing Trident Global Assistance to obtain reimbursement on your behalf for expenses eligible under your provincial health and hospitalization plan

For information before you travel, to obtain approval before incurring or paying any eligible expenses, or to request assistance, contact Trident Global Assistance at one of the numbers below:

From Canada or the United States: 1.855.234.3545

From elsewhere in the world: (416) 234.3545 (collect call)

You must provide the Contract Number specified on Your benefit card when calling.

Extended Health Care – Travel Cancellation Insurance

You are insured under this coverage only if Travel Cancellation Insurance is listed as “Included” in the Schedule of Benefits.

Definitions

Additional definitions used in this benefit:

Business Partner
An individual with whom the Insured is associated for business purposes as part of a corporation comprised of 4 shareholders or fewer, or a commercial or non-commercial corporation comprised of 4 partners or fewer.

Commercial Activity
An assembly, conference, convention, exhibition or seminar of a professional or commercial nature. The activity must be public, under the responsibility of an official organization and in compliance with the legislation, regulations and policies of the region where it will be held. The Commercial Activity must be the main reason for the Trip.

Family Member
An individual who is related to another individual in one of the following ways: spouse, son, daughter, father, mother, stepfather, stepmother, father-in-law, mother-in-law, brother, sister, half-brother, half-sister, brother-in-law, sister-in-law, son-in-law, daughter-in-law, grandparent, grandchild, uncle, aunt, nephew or niece.

Host at Destination
An individual at whose principal residence the Insured is planning to stay for at least part of the Trip.

Prepaid Travel Expenses
Refers to the following:

- Expenses incurred by the Insured to purchase a package trip, including tickets from a public carrier, rental of motor vehicles from an accredited firm and hotel room reservations;
- Amounts paid by the Insured for travel arrangements usually included in a package trip;
- Amounts paid by the Insured in relation to registration fees for a Commercial Activity.

Travel Companion
Refers to the person with whom the Insured shares accommodation at the travel destination, or whose transportation expenses were paid with those of the Insured.

Trip
An occasional trip made by an Insured from the usual place of residence to temporarily visit a place at least 200 kilometres away. To be recognized as a Trip under Trip Cancellation Insurance, the Trip must also require a period of absence of at least 2 consecutive nights and must be for tourism, pleasure or attendance at a Commercial Activity. In addition, in the case of a cruise, it must be operated under the responsibility of an accredited firm.

Reasons for cancellation

For cancellation expenses to be considered eligible, the Trip must be cancelled, extended or interrupted due to one of the following causes:

a) An illness or accident suffered by the Insured, a Travel Companion or a Business Partner of the Insured, or suffered by a member of the Insured's family or Travel Companion’s family. The illness or accident must prevent the individual from performing his usual activities and must be sufficiently serious to justify or force the cancellation or interruption of the Insured’s Trip;

b) Death of: the Insured; the Insured's spouse; the Insured's or spouse's child; the Insured's Travel Companion; or the Insured's Business Partner;

c) Death of a Family Member of any of the following individuals: the Insured; the Insured's spouse; the Insured's child; the Insured's Travel Companion. The funeral must be scheduled to take place during the period extending from 31 days before and 31 days after the planned Trip;

d) Death, illness or accident suffered by a person for whom the Insured is the legal guardian;

e) Notwithstanding any other provision of the policy, suicide or attempted suicide of the Insured's Travel Companion or a member of the Insured's family;

f) Death of a person for whom the Insured is the testamentary executor;

g) Death or emergency hospitalization of the Host at Destination;

h) The Insured's or Travel Companion's summons for jury duty or subpoena to act as a witness in a case scheduled to be heard during the Trip, provided the person involved has taken all necessary measures to have the hearing postponed. A summons or subpoena is not considered cause for cancellation or interruption of a Trip when the person involved institutes legal proceedings or is a defendant in the case or is a police officer and has been subpoenaed as part of his regular duties;

i) Quarantine of the Insured, provided that quarantine ends 7 days or fewer before the scheduled date of departure, or occurs during the time of the Trip;

j) Hijacking of the airplane on which the Insured is travelling;

k) Damage rendering the principal residence of the Insured or of the Host at Destination uninhabitable. The residence must remain uninhabitable 7 days or fewer before the scheduled date of departure, or the damage must occur during the time of the Trip;

l) Transfer of the Insured, for the same employer, to a location more than 100 kilometres from the current place of residence, provided the transfer is required by the employer within the 30 days preceding the scheduled date of departure;

m) Notwithstanding any other provision of the policy, terrorism, war, whether declared or undeclared, or an epidemic or pandemic in the location which the insured plans to travel to or leave, provided the Government of Canada issues an advisory not to travel to such location or one to leave such location. The advisory must be in force for the period of the planned Trip or stay and have been issued after the Insured has already finalized the travel arrangements or when the Insured was already staying in such location;

n) Delay of the transportation used by the Insured to reach the point of departure of the planned Trip or to the point of departure of a scheduled connection after departure of the planned Trip, provided that the means of transport used provides for scheduled arrival at the point of departure at least 3 hours prior to the time of departure or at least 2 hours prior to departure if the distance to be covered is less than 100 kilometres. The delay must be caused by mechanical problems (except for a private automobile), a traffic accident, or an emergency road closure, each of the latter two causes requiring confirmation by a police report;

o) Weather conditions such that:

- the departure of the public carrier used by the Insured, at the point of departure of the planned Trip, is cancelled or delayed by at least 30% (minimum 48 hours) of the planned duration of the Trip; or
- the Insured is unable to make a scheduled connection after departure with another carrier, provided the scheduled connection after departure is cancelled or delayed by at least 30% (minimum 48 hours) of the planned duration of the Trip;

p) Damage occurring to a commercial establishment or to the location where a Commercial Activity is to be held. The damage must prevent the activity in question from taking place. A written cancellation notice must be issued by the organization officially responsible for the activity ;

q) Death or hospitalization of the person with whom the Insured had arranged a business meeting or Commercial Activity. In such case, reimbursement is limited to transportation expenses and a maximum of 3 days' accommodation.

Expenses covered

To be eligible, expenses must be incurred by the Insured following the cancellation, extension or interruption of a Trip, provided such expenses are related to amounts paid in advance by the Insured and that, at the time travel arrangements were finalized, the Insured was not aware of any event that could reasonably lead to the cancellation, extension or interruption of the planned Trip. Expenses must also be incurred for one of the specified eligible reasons for cancellation. Expenses are reimbursed in accordance with the provisions hereafter and with the provisions specified in the Schedule of Benefits.

In the event of cancellation prior to departure
In the event of cancellation prior to departure, the Insured must notify the travel agent or carrier, as well as Trident Global Assistance, at the latest 48 hours following the event causing cancellation. In the event that this period ends on a statutory holiday, notice of cancellation may be submitted on the next working day.

a) The non-refundable portion of Prepaid Travel Expenses;

b) Additional expenses incurred by the Insured if the Travel Companion who was to share accommodation at destination must cancel due to one of the eligible reasons for cancellation and the Insured decides to proceed with the Trip as initially planned. Expenses are eligible up to the amount of the cancellation penalty applicable at the time the Travel Companion had to cancel;

c) The non-refundable portion of Prepaid Travel Expenses, up to 70% of such expenses, if departure is delayed due to weather conditions and the Insured decides not to proceed with the Trip.

In the event of missed departure, flight cancellation or if the Trip must be interrupted temporarily
The additional cost of a one-way economy class ticket on a scheduled flight of a public carrier, by the most direct route to the initially-planned Trip destination. Departure must be missed due to a cancelled flight or a delay in the means of transportation used by the Insured, subject to the conditions specified in the eligible reasons for cancellation. In the event of interruption of a Trip, the interruption must be due to an illness or accident suffered by the Insured or Travel Companion, subject to the conditions specified under the eligible reasons for cancellation.

If the return is earlier or later than planned
a) The additional cost of a one-way economy class ticket, by the most direct route, for a return Trip to the point of departure, by the means of transportation initially planned. If the initially-planned means of transportation cannot be used, whether or not travel expenses have been prepaid, the expenses eligible will be equal to the fees charged by a scheduled public carrier for economy class travel, by the most economical means of transportation, via the most direct route, for the Insured to return to the initial point of departure. These expenses must be pre-approved by Trident Global Assistance;

b) The unused and non-refundable portion of the ground portion of Prepaid Travel Expenses.

Restriction
If the Insured's return is delayed by more than 7 days, the expenses incurred are eligible, provided the Insured or the Insured's Travel Companion was admitted to hospital as an in-patient for more than 48 hours within the seven-day period.

If travel expenses were not paid in advance, the expenses incurred by the Insured are covered provided that before the scheduled date of departure, the Insured was not aware of any event that could reasonably lead to the interruption of the planned Trip.

Round-trip transportation
The cost of transportation by the most economical means, following approval by Trident Global Assistance, for the Insured to return to the province of residence and then back to the Trip destination, provided the return to the province of residence is due to one of the following reasons:

a) Death or hospitalization of a member of the Insured's family, a person for whom the Insured is the legal guardian or a person for whom the Insured is the testamentary executor;

b) A disaster that has made the principal residence of the Insured uninhabitable or has caused significant damage to the Insured's business establishment.

Coordination and reduction of benefits

Expenses eligible for reimbursement under this Trip Cancellation Insurance benefit will be reduced by the amount of any corresponding benefits payable under another insurance contract. However, if you are entitled to benefits for the same expenses under other provisions of your Extended Health Care coverage, benefits will only be payable under the provisions of Trip Cancellation Insurance.

Exclusions, limitations and restrictions

In addition to the exclusions, restrictions and limitations applicable to all benefits of the Extended Health Care benefit of this plan, the following exclusions apply to Trip Cancellation Insurance.

Trip Cancellation Insurance does not cover losses due to the following causes or to which such causes have contributed:

a) War, whether declared or not, an epidemic or pandemic or an act of war or of terrorism, it being understood that this exclusion does not apply to the Insured already present in a place at the time a war or an epidemic or pandemic breaks out, or an act of war or of terrorism occurs, provided the Insured takes the necessary measures to leave such place as soon as the Government of Canada issues an advisory to do so. This exclusion does not apply to Insureds whose travel plans are finalized on or before the day the government advisory is issued;

b) Active participation of the Insured in a riot or insurrection, perpetration or attempted perpetration of a criminal act by the Insured or the Insured's Travel Companion or participation of the Insured or the Insured's Travel Companion in a criminal act;

c) Abusive or excessive consumption of medication, drugs or alcohol and the ensuing consequences;

d) Intentional self-inflicted injury by the Insured or Travel Companion, or, suicide or attempted suicide by the Insured, regardless of the state of mind of the Insured or Travel Companion;

e) Participation in any of the following activities or sports: gliding, hang-gliding, paragliding, mountaineering, bungee jumping, parachuting, skydiving or any other similar activity, all extreme or combat sports, any motorized vehicle competition, as well as any sporting or underwater activity for which a remuneration is paid to the individual this insurance plan applies to;

f) The reason for which the Trip is purchased, in the event that it is purchased for the purposes of obtaining or with the intention of receiving medical treatment, a medical consultation or hospital services, whether or not the Trip is taken upon the recommendation of a physician;

g) In the event that the Trip is purchased to visit or be at the bedside of a person who is ill or has suffered an accident, change in medical condition or death of such person;

h) A cause which, beyond any possible doubt, does not prevent the Insured from proceeding with the Trip.

If notice of cancellation of a Trip prior to departure is not provided within the time specified herein, Industrial Alliance's liability is limited to the cancellation expenses stipulated in the travel contract that are applicable at the time such notice should have been given. However, this limitation will not apply if the Insured and any adult accompanying the Insured on the planned Trip provide proof deemed satisfactory by Industrial Alliance that they were totally incapable of doing so. In such case, the Trip must be cancelled as soon as one of these persons is able to do so, and Industrial Alliance's 's liability is limited to the applicable cancellation fees stipulated in the travel contract at the time of cancellation.

How to Claim

To file a claim, contact Trident Global Assistance at one of the numbers below:

From Canada or the United States: 1.855.234.3545

From elsewhere in the world: (416) 234.3545 (collect call)

You must provide the Contract Number specified on Your benefit card when calling.

Insureds must include the following supporting documents with their claim:

a) Unused travel tickets;
b) Official receipts for additional transportation expenses;
c) Receipts for travel arrangements. Receipts must include the contracts officially issued by a travel agent or accredited firm, specifying the non-refundable amounts in the event of cancellation;
d) Written proof that you have requested a reimbursement of travel expenses from the travel agent or accredited firm, along with the reply you receive from the travel agent or accredited firm;
e) Official documents certifying the reason for cancellation. If the Trip is cancelled for medical reasons, the Insured must provide a medical certificate issued by a legally authorized physician practising where the illness or accident occurred. The medical certificate must specify the complete diagnosis confirming the need to cancel, delay or interrupt the Trip;
f) An official police report, if the means of transportation used is delayed because of a traffic accident or emergency road closure;
g) An official report pertaining to weather conditions;
h) Written proof issued by the official organizer of a Commercial Activity to the effect that an event is cancelled and the specific reasons why;
i) Any other report required by Trident Global Assistance in support of the Insured's claim.

WorldCare Medical Second Opinion

Receiving a life-changing catastrophic health diagnosis can cause mental, emotional and physical distress for You and Your Dependents. Ensuring You have an accurate diagnosis and are prescribed the most appropriate treatment and care is important to Your long-term health outcomes. A Worldcare Medical Second Opinion is there to support You and Your Physician.

WorldCare provides a very personalized, high-touch medical second opinion (MSO) service to You and Your Dependents. WorldCare recognizes that the future of healthcare lies in a patient-centric, holistic view of health including lifestyle, habits and emotional and social well-being. and provides access to the best academic medical institutions in the world to ensure You and Your Dependents have the correct diagnosis and are on the optimal treatment path. WorldCare is the only institution-based MSO service, providing access to teams of specialists for each Medical Second Opinion versus just one other physician's review.

What will WorldCare do for You and Your Dependents?

- Provide access to some of the best medical expertise available in the world today.
- Work with Your treating Physician to advocate and support You and Your family in the event You are facing a potentially life-changing catastrophic condition like cancer.
- Furnish You with a comprehensive client reporting package, including diagnosis, treatment options and impacts in consistent turnaround times.
- Receive the benefit of expert opinions, guidance on the appropriate care allowing You to focus on Your usual daily activities with minimal unnecessary treatments and travel.
- Reduce the occurrences of misdiagnoses or incorrect treatment and provide the most appropriate treatment plan with the highest chance of success.

If You receive a diagnosis for one of the following conditions and reach out to WorldCare, they will arrange a medical second opinion (MSO) from a specialized team that has cared for hundreds to thousands of patients with a related diagnosis and treatment plan. Covered Conditions include:

Neurological & Mental Health

- Neuro-degenerative disorders: Alzheimer's disease, Multiple Sclerosis, etc.
- Vascular disorders: aneurysm, AVM, cerebrovascular accident
- Cancer: brain and spinal cord tumors
- Trauma: brain and spinal cord, coma
- Infections: encephalitis, meningitis, brain and spinal cord abscess
- Mental Illness: bipolar disorder, clinical depression, anxiety disorder.

Cardiovascular conditions

- Cardiac infarction/cardiac failure
- Aortic aneurysm

Gastrointestinal tract

- Cancer: esophagus, stomach, colon, pancreas, liver
- Pancreatitis, ulcerative colitis, Crohn's disease

Respiratory tract

- Lung cancer
- Complicated chronic obstructive airways disease
- Complicated COVID-19 infection

Musculoskeletal

- Complicated degenerative disease of the spine, hip, knee, shoulder
- Severe trauma
- Infections (Lyme Disease)

Hematology

- Complications of Sickle cell disease/Thalassemia
- Leukemia, Lymphoma, Multiple myeloma

Otolaryngology/Ophthalmology

- Cancer: thyroid, upper respiratory tract
- Sudden blindness/disabling retinal disease

Breast

- Cancer
- Infection

Skin/Dermatology

- Cancer/Melanoma
- Autoimmune disease
- Major burns

WorldCare is continually expanding the list of covered conditions. For an up to date list please visit **www.worldcare.com**

How to access WorldCare Services

Once diagnosed with a serious illness, You initiate a WorldCare Medical Second Opinion by simply calling 1.877.676.6439. The rest of the MSO service is made easy for You and is managed by the WorldCare Medical Hub. The Hub consists of a team of physicians, registered nurses and administrators who work together to guide You or Your Dependents through the various steps professionally and seamlessly.

Virtual Healthcare (VHC)

The GroupHEALTH Virtual Healthcare (VHC) Solution, powered by TELUS Health Virtual Care, is a confidential, online service that provides on-demand access, by mobile phone or computer, to knowledgeable, friendly primary care providers wherever You are and whenever You need it. The VHC service provides anytime/anywhere access to virtual medical care without the need to use valuable sick days or personal time for doctor visits.

What is Virtual Healthcare?

VHC is a benefit provided by Your organization to You and Your Dependents and provides convenient access by mobile phone or computer to nurse practitioners and doctors to discuss, diagnose and treat many common health problems. The VHC service is accessible 24/7, 365 days a year by secure text and video and provides the following:

- Access medical professionals anytime/anywhere through either a mobile app (iPhone and Android) or computer.
- Diagnose medical concerns
- Provide advice on your medical concerns
- Write new prescriptions and renew existing prescriptions
- Make referrals to specialist and other health care professionals
- Where necessary, help facilitate appropriate in-person care.
- Provide medical documentation and notes

How to Access Virtual Healthcare

First You will need to enroll in the VHC Solution. Go to the GroupHEALTH's Solutions Centre https://solutions.grouphealth.ca/s/virtualhealthcare/ and follow the enrollment process. You will need your Policy # and Certificate # from Your oneCard. Once enrolled, You will be given a user ID and password and have access to the VHC Solution.

Mobile app
The mobile app is the best way to keep the VHC Solution with You on the go, wherever You go. Simply download the **TELUS Health Virtual Care app** (TELUS Health Virtual Care: Healthcare on Demand) on an Apple or Android device. Follow the instructions to log in, using Your username and password provided during the enrollment process. After that initial log in, You will be able to create a medical profile, add Dependents to the service and connect with a healthcare professional. The VHC Solution is also available by computer at TELUS Health Virtual Care.

Consult Fees

Access to the GroupHEALTH VHC Solution is provided to You and Your Dependents as part of Your benefit plan. Depending on which province You reside in, there may be a Consult Fee for each virtual consult session. Referrals to other healthcare professionals may incur additional charges.

For questions, regarding the VHC Solution, please either visit TELUS Health Virtual Care or contact TELUS Health Virtual Care at help@vc.telushealth.com**.**

Dental Care Coverage

If Dental Care coverage is listed as “Included” in the Schedule of Benefits, the Insurer will pay the Eligible Expenses that are incurred by Insured Persons for dental treatment, services and products specified in the Schedule of Benefits given while they are an Insured Person covered by this benefit.

Scope of coverage

Expenses for treatment, services, products or articles specified in the following sections are considered Allowable Expenses and therefore eligible for reimbursement in accordance with the provisions specified in the Schedule of Benefits, provided such treatment, services, products or articles have been paid for and are:

a) Obtained while the Insured Person is covered by this Dental Care benefit;

b) Provided by an accredited Dentist, dental specialist, denturist or dental hygienist, who neither resides with the Insured Person nor is a Family Member;

c) Administered in compliance with current dental practice standards;

d) Used in compliance with the manufacturer’s instructions, or, where no such instructions exist, in accordance with government-approved directives.

Reimbursement of Covered Expenses

The amounts eligible for reimbursement are specified in the general practitioners’ or specialists’, if covered, fee guide approved by Your provincial dental association for the year indicated in the Schedule of Benefits.

Eligible laboratory expenses are limited to 50% of the fees specified for the dental treatment or service in question.

The amount of Allowable Expenses reimbursed – the Eligible Expenses - takes into account the Deductible, % of Payment and Maximums specified in the Schedule of Benefits

Expenses covered

Basic dental care: see Schedule of Benefits for frequency limits

Diagnostic services

Clinical oral examination

- Recall or periodic oral examination
- Complete oral examination: see Schedule of Benefits for frequency limits
- Complete periodontal examination
- Emergency examination
- Specific oral examination

Radiographs (X-rays)

a) Intraoral films
- Periapical film
- Occlusal film
- Bitewing film: 1 every 12 consecutive months
- Complete series

b) Extraoral films
- Extraoral film
- Sinus examination
- Sialography
- Use of radiopaque dyes to demonstrate lesions
- Temporomandibular joint
- Panoramic film
- Cephalometric film

c) Other

- Interpretation of radiographs from another source: one film per calendar year
- Duplicate radiograph: 2 times per calendar year

Laboratory tests and examinations

- Histological tests: Biopsy of soft tissue, biopsy of hard tissue
- Bacteriological tests
- Diagnostic casts (excluded if associated with restorative treatment or prosthodontics)
- Case presentation / treatment plan
- Consultation with patient
- Vitality test

Preventive services:

- Polishing of coronal portion of teeth
- Scaling and root planing
- Topical application of fluoride
- Finishing restorations
- Pit and fissure sealants, including prophylactic odontotomy and acid etch preparation **(**only on occlusal surfaces of premolar and permanent molar teeth)
- Removal of subgingival filling material requiring anaesthesia, without flap
- Interproximal discing
- Enameloplasty (recontouring of a natural tooth for non-aesthetic reasons)
- Oral hygiene instruction
- Space maintainers for children under age 18

Routine dental care

Minor Restorative Services

- Sedative filling
- Smoothing of a traumatized tooth
- Amalgam and composite restorations*
- Retentive pins
- Prefabricated restoration (Prefabricated crowns) for primary teeth only

* Treatment for the same surface or class of the same tooth is reimbursed once per period of 12 months, regardless of the material used and the treating dentist.

Endodontics

- Endodontic emergency: pulpotomy, pulpectomy, open and drain
- Endodontic trauma, treatment and surgery
- Apexification

Retreatment of previously completed root canal therapy is reimbursed if more than 36 months have elapsed since previous root canal therapy.

Periodontics

- Non-surgical treatment
- Periodontal surgery
- Gingival curettage
- Splinting
- Periodontal irrigation
- Periodontal appliances: 2 appliances combined per period of 60 months. Maintenance and repairs are excluded.
- Occlusal equilibration: 8 units of time per calendar year

Rebase (jump), reline, adjustment and repair of removable dentures

- Rebase, reline: one per visit per period of 24 months
- Repairs with or without impression
- Remount and equilibration of complete or partial dentures: one visit per period of 60 months

Repair of fixed bridges and crowns

- Repair of fixed bridges
- Repair of crowns
- Recementation, Immobilization, sectioning

Oral surgery

- Removal of erupted teeth, complex or uncomplicated
- Removal of impacted teeth, roots and tooth fragments
- Alveolectomy, alveoloplasty, osteoplasty, tuberoplasty, stomatoplasty, gingivoplasty
- Removal of hyperplasic tissue or excess mucosa, surgical excision of cysts or tumours
- Extension of mucosal folds
- Surgical incision and drainage
- Reduction of fracture
- Frenectomy
- Treatment of salivary glands
- Sinus treatment or surgery
- Hemorrhage control
- Post-surgical treatment
- Repair of soft tissue or through & through laceration

Additional services

- Local anaesthesia
- General anaesthesia (anaesthetic cost only)
- Conscious sedation
- Deep sedation
- Therapeutic injections
- Home, Hospital or dental office visit outside normal office hours

Dental restorative services

Major restorative services and fixed prosthodontics (see gold foil, inlay and replacement denture limitation)

- Gold foil
- Inlays and retentive pins
- Metal cast retainer, Maryland type: once per period of 60 months for any one tooth
- Individual crown
- Coping crown (cap), precious metal or not
- Cast metal posts
- Prefabricated post
- Tooth reconstruction (core build up) in preparation for a crown
- Supplement for restoration
- Post removal

Removable dentures (see limitation on replacement dentures)

- Complete dentures*
- Partial dentures*

* Equilibrated dentures are reimbursed on the basis of the equivalent standard dentures.

Fixed bridges (see limitation on replacement dentures)

- Pontics
- Butterfly bridge (Maryland, Rochette or other)
- Metal cast retainer (inlay) for Monarch bridge
- Retention bar for attachment to coping crowns
- Abutments, inlays or onlays: metal, porcelain, ceramic or resin
- Other prosthetic services: precision attachment
- Retentive pin for crowns and/or abutments
- Supplement for preparation of crown under existing partial denture clasp

Limitations

a) We, will determine the benefits payable taking into account possible alternate procedures, services or courses or treatment based on accepted dental practice.

b) Payment will not be made for any portion of the charge over the fee guide cost of the least expensive alternate service or material consistent with adequate dental services when such alternate service or material is customarily provided.

c) All Insured Persons are considered as being eligible for the public health insurance plan of their Province of residence. If this is not the case, the Insurer shall not pay any amount greater than that payable if the Insured Persons were eligible for coverage under the public health insurance plan of the Province of residence.

d) Where the general practitioners' fee guide approved by the dental association of the Province mentioned in the Schedule of Benefits uses the word sextant or quadrant in the description of a treatment, the code or codes for services corresponding to such treatment are limited to 6 different sextants or 4 different quadrants, as the case may be, per calendar year, per Insured Person.

e) Where the general practitioners' fee guide approved by the dental association of the Province mentioned in the Schedule of Benefits stipulates a rate based on units of time for a treatment or service, the rate covering the maximum number of units of time for the treatment or service in question shall be eligible for reimbursement under the Group Benefits Plan. Any costs related to additional units are not covered under the Group Benefits Plan.

f) If Major Restorative Services is included in Your Dental Care coverage, no benefits will be paid for gold foil, inlays or replacement dentures (individual crown, veneer (if covered), cast post, prefabricated post, removable dentures, fixed bridge) if installed within 60 months of the previous one. However, expenses for partial or complete permanent removable dentures are eligible for reimbursement when such replacement is carried out within 12 months of the date the transitional dentures were installed (only when waiting for completion of the healing process).

g) Damage to teeth occurring while chewing, regardless of the nature or cause of such damage, is not covered.

Preapproval of Treatment Costs

When expenses exceed five hundred dollars ($500), particularly in the case of Dental Restorative Services, a detailed written treatment plan and radiographs must be submitted to Us prior to the start of treatment. This allows Us to determine the eligibility of treatment and the amount of benefits payable.

Certain expenses are only eligible for reimbursement if pre-approved by Us, following analysis of appropriate supporting documents, such as a copy of the patient's chart, radiograph(s), periodontal chart, diagnostic cast, etc.

How to Claim

When Your dentist uses electronic Claim submission
When You, Your Spouse or Your Dependent Children, if applicable, incur dental expenses, present Your oneCard™ to Your Dentist and pay only the portion of the expenses not covered by Your Group Insurance Plan. The Insurer will reimburse the Allowable Expense directly to Your Dentist.

When Your dentist does not use electronic Claim submission
You may submit your claim though the eClaims or PhotoClaims features on the myGroupHEALTH portal or you may complete and return the dental eClaim form provided by Your Dentist to Us.

Multiple Coverage and Coordination of Benefits (COB)

Effect on benefits
If an Insured Person is covered under the Policy as a Participant and as a Dependent or as a Dependent of more than one employee or is covered simultaneously under any other plan which provides similar benefits, the amount of benefits payable under the Group Benefits Plan for Eligible Expenses shall be coordinated and/or reduced so that the total benefits payable shall not exceed 100% of the actual Allowable Expenses. Please refer to the General Information section of this Handbook for more information on how this coordination is done.

Deadline for filing Claims

We recommend that You file Your Claims at regular intervals, once every 3 months.

We must receive Notice of Claim for a Dental Care benefit within 12 months of the date of the event which gives entitlement to the benefit.

However, if the Policy should terminate, Claims must be received by Us on or prior to the date of termination of the Policy.

Exclusions

This Dental Care Benefit does not consider an Allowable Expense to include any treatment, service, product or article related directly or indirectly, in whole or in part, to:

a) A criminal act the Insured Person commits or attempts to commit;

b) Active participation in a riot or insurrection;

c) War or civil war, whether declared or not;

d) Active service in the armed forces of a country;

e) Attempted suicide or intentionally self-inflicted injury, regardless of the state of mind of the Insured Person.

Furthermore, no benefits will be paid for treatment, services, products or articles:

a) Required by a third party or received collectively;

b) Provided for aesthetic care, including transformation, extraction or replacement of healthy teeth to modify their appearance;

c) Used for experimental purposes or at the medical research stage;

d) Regarding implants and any implant-related treatment or prosthesis;

e) Regarding an intra-oral appliance and services related to the treatment of temporomandibular joint dysfunction and vertical dimension correction;

f) Regarding the replacement of removable appliances or dentures that are lost or stolen;

g) In relation to appointments not kept, filing Claims, treatment plans, written reports, travelling expenses, correspondence expenses, legal identification, appearance in court as an expert witness or telephone consultations;

h) Regarding sports appliances, e.g. mouth guards;

i) That the Insured Person would not have had to pay for if uninsured, that the Insured Person is not obliged to pay for or that the Insured Person would not be obliged to pay for if covered under the provisions of a public insurance or social security plan, government program, applicable legislation, or any regulation or decree adopted with regard to such plans, programs or legislation;

j) Regarding a dental appliance for treatment of snoring or sleep apnea;

k) Regarding transfer copings, duplicate dentures, or palliative treatments to alleviate dental discomfort;

l) Regarding transitional pontics or abutments;

m) Related to microbiological tests or analyses;

n) Regarding diagnostic photographs;

o) For expenses related to services, supplies, examinations or treatments that do not comply with Reasonable and Customary standards of current practice in the dental / health care profession in question.

Survivor Benefit

In the event of Your death, Dental Care coverage in force for Your Spouse and Dependent Children will be maintained without premium payment until the earliest of the following:

a) The end of a period of select from list months immediately following Your death, as noted in the Schedule of Benefits;

b) The date when insurance for Your Spouse and Dependent Children would have terminated, if Your death had not occurred;

c) The date when Your Spouse and Dependent Children become eligible for similar coverage under another insurance Policy;

d) The date the Policy terminates.

Protector Series™ Optional Benefits

In this section you will find details regarding Protector Series™ Optional Benefits available to all employees (and their family members) insured under your benefit plans.

The following optional benefits are available to both you and your spouse:

Protector Series™ Optional Life Insurance
Protector Series™ Optional Critical Illness

It is not necessary for you to apply for coverage in order for your spouse to be eligible to apply.

Protector Series™ Optional Accident and Serious Illness
benefits are available in two plans:

Employee Only Plan (covers you only)
Family Plan (covers you, your spouse and your dependent children)

Premiums for all Protector Series™ optional benefits are outlined in separate brochures available from your Plan Administrator and are paid by you by way of payroll deduction.

Protector Series™ Optional Life Insurance

You may wish to apply for an additional amount of group life insurance for both You and Your Dependents by completing the Application form available from Us. If Your Applications are approved, upon Your or Your Dependents death while they are an Insured Person under this benefit, the Insurer will, subject to the Limitations below, pay to the beneficiary the Benefit Amount chosen by You and approved in writing by Us.

The Benefit Amount shown in the Schedule of Benefits is available to You and Your Dependents.

Written Application for any Benefit Amount must be made on the forms available from Us and coverage shall not be effective until the first day of the month next following the date that We notify approval in writing.

For any amounts that are subject to approval by providing satisfactory Evidence of Insurability the Insurer will be responsible for the cost of medical fees incurred in obtaining any medical information that may be required in order to proceed with the Application.

If You have ever been approved for an amount of Optional Life Insurance over the Maximum Benefit Amount without Evidence of Insurability You are not eligible to apply for any additional amount of insurance without providing Evidence of Insurability. In addition, if You have ever been declined for Optional Life Insurance You are not eligible for any amounts of insurance without providing Evidence of Insurability.

Optional Life Insurance Conversion Privilege

If Your Optional Life Insurance (and Your Spouse's Optional Life Insurance, if applicable) terminates on or prior to Your 65th birthday You will be able to convert all or part of Your Optional Life Insurance to an individual life insurance policy without having to provide Evidence of Insurability. You may choose to convert to one of the following types of insurance:

1) Permanent life
2) Term life to age 65; or
3) One year non-renewable term plan

at the Insurer's rates in effect at the date of conversion based on the class of risk applicable to You and/or Your Spouse and the new policy (determined by the Insurer's rules at the time of conversion) and Your or Your Spouse's then attained age (nearest birthday).

The individual life insurance policy will not include any Total Disability Benefits or Accidental Death Benefits or any other special benefit.

Such individual policy will become effective on the first day following the 31 day period after the date You became entitled to apply.

Amount of Insurance
Where Your or Your Spouse's insurance terminates and Your employer's coverage under the master policy remains in force, the Amount of Insurance which You or Your Spouse may convert will be limited to the lesser of:

- $200,000, or
- the full amount of Optional Life Insurance at the time of termination less the full amount of Optional Life Insurance for which You (or Your spouse) is eligible under a new group policy within 31 days after termination of the Optional Life Insurance under this Group Benefits Plan.

Premium
The premium for the individual life insurance policy will be based on the Insured Person's age (nearest birthday), sex, class of risk and on the type and amount of policy being issued at the time of conversion.

Termination of the master policy
If Your or Your Spouse's Optional Life Insurance terminates due to termination of the master policy or termination of Your employer's coverage under the Policy, the following will apply:

- the amount of Optional Life Iinsurance that may be converted will not exceed three times the year's Maximum Pensionable Earnings as established under the Canada Pension Plan, and
- the conversion right will be limited to Insured Persons who have been insured under the Group Benefits Plan for at least five continuous years, and
- the conversion privilege will apply only if the Optional Life Insurance is not being replaced within 31 days by another Policy of group insurance or if the Optional Life Insurance is being replaced by an amount that is less than the amount for which You (or Your Spouse) is eligible under the first point above.

Application for conversion
The individual life insurance policy will be issued if a written Application (including the required first premium) is completed and received by the Insurer at its Head office within 31 days from the date of termination of Your or Your Spouse's Optional Life Insurance. The Individual Life Policy will become effective on the day following the expiration of the 31-day period.

Death during the Conversion Period
Where You (or Your Spouse, if Your Spouse has Optional Life Insurance) have not converted insurance You are eligible to do so and where You (or Your spouse, if insured) dies within the 31 days allowed for conversion, the Optional Life Insurance Benefit Amount eligible for conversion, will be payable by the Insurer.

Subsequent Eligibility under the Master Policy
If You or Your Spouse obtains an individual life insurance policy through this provision and later becomes eligible for Optional Life Insurance under the Policy, the amount for which the person is eligible will be reduced by the amount of insurance remaining in force under the individual life insurance policy.

No Obligation to Advise
We and the Insurer are under no obligation to advise any person of their right to convert.

Limitations

No Optional Life Insurance benefit shall be payable where the cause of death is suicide occurring within 2 years from the date Your or Your Spouse's Optional Life Insurance coverage became effective, and premiums will not be refunded.

In the event You or Your Spouse have been approved for an amount without providing Evidence of Insurability, benefits will not be payable and only premiums will be refunded under this Provision if You or Your Spouse die within 12 months from the date Your Optional Life Insurance coverage became effective unless the death is caused by an "Accident." Under this provision, "Accident" does **not** mean death which is caused by or results directly or indirectly from one or more of the following:

- self-inflicted Injury, regardless of Your state of mind, or
- committing, attempting or provoking an assault or criminal offense, or
- a situation where the covered loss results from Injuries sustained in, or directly or indirectly from, a Vehicle accident where the Participant was driving the Vehicle involved in the accident and had either:
  (a) alcohol in the insured person's blood in excess of 80 milligrams of alcohol per hundred millilitres of blood; or
  (b) the insured person's capacity impaired as a result of drug or alcohol usage, or
- disease, or bodily or mental infirmity, or medical or surgical treatment of any kind, except surgical reattachment, or
- death where there is no visible contusion on the exterior of the body (except death by drowning), or
- any drug, poison, gas or fumes, voluntarily or otherwise taken administered, absorbed or inhaled, other than as a result of an Accident arising from a hazard incident to the Participant's occupation, or

- insurrection or war (whether war be declared or not) or participation in any riot, or active service in the armed forces of any country, or
- travel or flight in any aircraft, or descent from such aircraft, if the Participant is a pilot or a member of the crew of the aircraft, or if such flight is made for the purpose of instruction, training or testing.

Waiver of Premium

In the event You become Totally Disabled and a Waiver of Premium Claim is accepted and approved under the Group Life benefit, then premiums payable for this benefit (including premiums for any Benefit Amount for Your Spouse and Dependent Children) will be waived as of the same date the Waiver of Premium Claim is effective under the Group Life benefit and will continue to be waived until the Waiver of Premium Claim under the Group Life benefit terminates.
The coverage, which is continued under this benefit, will be subject to the terms and provisions of the Policy in effect as of the date of commencement of disability. No increase in benefits will be permitted while premiums are being waived.

When and How to Submit a Protector Series™ Optional Life Claim

The Claim form available from Us must be submitted to the Insurer within **12 months** from the date of death.

Failure to furnish proof within this time will not invalidate nor reduce any Claim if it is shown not to have been reasonably possible to furnish the proof and that the proof was furnished as soon as was reasonably possible, but in no event will this be more than **12 months** after the date of death.

Protector Series™ Optional Accident & Serious Illness (ASI)

You may wish to apply for an additional amount of Accident & Serious Illness insurance.

Who Is Eligible?

All Participants under the Termination Age stated in the Schedule of Benefits, their Spouse and unmarried Dependent Children.

Note: All Participants must be under the age of 65 to first enroll in this benefit.

Coverage

Upon Your (or Your Dependent's, if applicable) death due to an Accident, while an Insured Person under this benefit, the Insurer will pay to the beneficiary a percentage (as shown below) of the Benefit Amount as indicated in the Schedule of Benefits, subject to the terms and conditions of this benefit and the Policy. Upon a Loss due to an Accident or Your Diagnosis for the first time of a Critical Disease or Serious Illness, while an Insured Person under this benefit, the Insurer will pay to You a percentage (as shown below) of the Benefit Amount as indicated in the Schedule of Benefits, subject to the terms and conditions of this benefit and the Policy. Upon any amount payable under this benefit in respect of an Accident occurring to an Insured Person other than Yourself, the Insurer will pay You the amount payable.

This benefit provides coverage for Accidents which occur anywhere, at any time, on or off the job. An Insured Person will be covered whether they are at home or traveling, including air travel as a passenger (but not as a pilot or Crew Member) in any Certified Aircraft flown by a duly licensed pilot.

This plan does not cover any loss resulting from suicide or self-inflicted injury or war or any act of war. It also excludes any loss suffered while on active service in the armed forces or while You are piloting or acting as a Crew Member in an aircraft.

Definitions Applicable to the ASI Benefit

Whenever used in Protector Series Optional Accident and Serious Illness benefit:

Airworthiness Certificate
A "Standard" Airworthiness Certificate issued by the Federal Aviation Agency of Canada or its foreign equivalent issued by the governmental authority having jurisdiction over civil aviation in the country of its registry.

Cancer (Life-Threatening)
a definite Diagnosis of a tumour, which must be characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. Types of cancer include carcinoma, melanoma, leukemia, lymphoma, and sarcoma. The Diagnosis of Cancer (Life Threatening) must be made by a Specialist.

Medical Information about the Diagnosis and any signs, symptoms or investigations leading to the Diagnosis must be reported to Us within 6 months of the Date of Diagnosis. If this information is not provided within this period, the Insurer has the right to deny any Claim for Cancer (Life Threatening) or any Serious Illness caused by any cancer or its treatment.

No benefit will be payable for the following:

- lesions described as benign, pre-malignant, uncertain, borderline, non-invasive, carcinoma in-situ (Tis), or tumours classified as Ta;
- malignant melanoma skin cancer that is less than or equal to 1.0 mm in thickness, unless it is ulcerated or is accompanied by lymph node or distant metastasis;
- any non-melanoma skin cancer, without lymph node or distant metastasis;
- prostate cancer classified as T1a or T1b, without lymph node or distant metastasis;
- papillary thyroid cancer or follicular thyroid cancer, or both, that is less than or equal to 2.0 cm in greatest diameter and classified as T1, without lymph node or distant metastasis;
- chronic lymphocytic leukemia classified less than Rai stage 1; or

- malignant gastrointestinal stromal tumours (GIST) and malignant carcinoid tumours, classified less than AJCC Stage 2.
- For purposes of the Policy, the terms Tis, Ta, T1a, T1b, T1 and AJCC Stage 2 are to be applied as defined in the American Joint Committee on Cancer (AJCC) Cancer Staging Manual, 7th Edition, 2010.
- For purposes of the Policy, the term Rai staging is to be applied as set out in KR Rai, A Sawitsky, EP Cronkite, AD Chanana, RN Levy and BS Pasternack: Clinical staging of chronic lymphocytic leukemia. Blood 46:219, 1975.

Certified Aircraft
An aircraft that holds an Airworthiness Certificate

Crew Member
A person assigned to duty in an aircraft during Flight Time, and whose occupation is related to the safety of passengers, the operation and/or the actual flying of the aircraft.

Critical Disease
Poliomyelitis, Parkinson's Disease, Huntington's Chorea, Multiple Sclerosis, Alzheimer's Disease, Type 1 Diabetes (Insulin Dependent), Amyotrophic Lateral Sclerosis (ALS), Peripheral Vascular Disease and Necrotizing Fasciitis.

Date of Diagnosis
The date on which The Insured Person is first diagnosed with a Critical Disease or Serious Illness by a Specialist. The Date of Diagnosis must be later than the Effective Date of The Insured Person's coverage under the Group Benefits Plan. No benefit will be paid for any Critical Disease or Serious Illness which was diagnosed prior to The Insured Person's Effective Date.

Day Care Centre
A facility which is operated according to law, including laws and regulations applicable to day care facilities and which provides care and supervision for children in a group setting on a regular basis. Day Care Centre will not include a Hospital, the child's home or care provided during normal school hours while a child is attending grades 1 through 12.

Dependent Parent
The Insured Person's parents or grandparents who are dependent upon the Insured Person for support, maintenance and care.

Flight Time
The total time from the moment the aircraft first moves under its own power for the purpose of take-off until the moment it comes to rest at the end of the flight.

Heart Attack
A definite Diagnosis of the death of heart muscle due to obstruction of blood flow that results in a rise and fall of cardiac biochemical markers to levels considered diagnostic of myocardial infarction, with at least one of the following:

a) heart attack symptoms;
b) new electrocardiogram (ECG) changes consistent with a heart attack; or
c) development of new Q waves during or immediately following an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty.

The Diagnosis of Heart Attack must be made by a Specialist.

Exclusion: No benefit will be payable under this Covered Condition for:

a) elevated cardiac biochemical markers as a result of an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty, in the absence of new Q waves;
b) ECG changes suggesting a prior myocardial infarction, which do not meet the Heart Attack definition as described above; or

Kidney Failure
End stage renal disease due to chronic irreversible failure of both of The Insured Person's kidneys' ability to function, requiring The Insured Person to undergo regular hemodialysis, peritoneal dialysis, or renal transplantation. A Physician who is certified in nephrology must confirm Diagnosis in writing.

Leased Aircraft
An aircraft whose possession is turned over to a firm or individual for a specified period of time, with the owner retaining full title to such aircraft.

Loss
with reference to hand or foot means complete severance at or above the wrist or ankle joint but below the elbow or knee joint; as used with reference to arm or leg means complete severance at or above the elbow or knee joint; as used with reference to thumb and fingers means complete severance at or above the metacarpophalangeal joint; as used with reference to toes means complete severance at or above the metatarsophalangeal joint; as used with reference to eye means the irrecoverable loss of the entire sight thereof; as used with reference to speech means the total and irrecoverable loss thereof; as used with reference to hearing means the total and irrecoverable loss thereof; and as used with reference to Quadriplegia, Paraplegia and Hemiplegia means the permanent and irrecoverable paralysis of such limbs.

Loss of Use
The inability to use a limb or body part, referred to under the definition of Loss, which is permanent, total, irrecoverable and continuous for a period of 12 months from the date of the Accident.

Psychological Therapy
The treatment or counselling by a therapist or counselor, who is licensed, registered, or certified to provide such treatment, whether The Insured Person is an out-patient basis or while a patient at a medical facility licensed to provide such treatment.

Regular Care and Attendance
Medical treatment to the extent necessary under existing standards of medical practice for the condition causing Total Disability, Hospital confinement or requiring such treatment.

Residence
The Insured Person's primary dwelling where the Insured Person are an occupant and the premises on which it is situated.

School for Higher Learning
includes any university, college, CEGEP {College D'Enseignement General et Professionel (community colleges in Quebec)} or trade school.

Serious Illness
Cancer (Life Threatening), Heart Attack, Kidney Failure or Stroke

Stroke
A definite Diagnosis of an acute cerebrovascular event caused by intracranial thrombosis or haemorrhage, or embolism from an extra-cranial source, with:

a) acute onset of new neurological symptoms, and
b) new objective neurological deficits on clinical examination
c) persisting for more than 30 days following the Date of Diagnosis. These new symptoms and deficits must be corroborated by diagnostic imaging testing.

The Diagnosis of Stroke must be made by a Specialist.

Exclusion: No benefit will be payable under this Covered Condition for:

a) transient Ischaemic Attacks;
b) intracerebral vascular events due to trauma; or
c) lacunar infarcts which do not meet the definition of Stroke as described above.

Totally Disabled/Total Disability
You (1) are unable to engage in any and every occupation or employment for compensation or profit and (2) require the Regular Care and Attendance of a Specialist.

Vehicle
A passenger car, station wagon, van, SUV, truck or similar.

Benefits

Accidental Death, Dismemberment and Specific Loss Benefit
If, within 12 months of the date of the Accident, Injury results in any of the following losses, the Insurer will pay for Loss of or permanent and total Loss of Use of:

	% of Insured Person's Benefit Amount
Life	100%
Both Hands	100%
Both Feet	100%
Entire Sight of Both Eyes	100%
One Hand and One Foot	100%
One Hand and the Entire Sight of One Eye	100%
One Foot and the Entire Sight of One Eye	100%
Speech and Hearing in Both Ears	100%
One Arm	100%
One Leg	100%
One Hand	66 ⅔%
One Foot	66 ⅔%
Entire Sight of One Eye	66 ⅔%
Speech or Hearing in Both Ears	66 ⅔%
Thumb and Index Finger of Either Hand	33 ⅓%
Four Fingers of Either Hand	33 ⅓%
Hearing in One Ear	33 ⅓%
All Toes of One Foot	25%

Paralysis Benefits

Quadriplegia (complete paralysis of both upper and lower limbs)	200%
Paraplegia (complete paralysis of both lower limbs)	200%
Hemiplegia (complete paralysis of upper and lower limbs of one side of body)	200%

The payment made under Accidental Death, Dismemberment and Specific Loss Benefit for all losses sustained by The Insured Person as the result of any one Accident will not exceed the following:

(a) With the exception of Quadriplegia, Paraplegia and Hemiplegia, their Benefit Amount;

(b) With respect to Quadriplegia, Paraplegia and Hemiplegia, two times their Benefit Amount or their Benefit Amount if loss of life occurs within 90 days after the date of the Accident.

In no event will the payment made for all losses for an Insured Person under Accidental Death, Dismemberment and Specific Loss Benefit exceed, in the aggregate, two times their Benefit Amount as the result of the same Accident.

Continuation of Coverage During Approved Leaves

Coverage under the Policy may be continued for You during any approved leave of absence, temporary lay-off, Family leave or disability leave, provided payment of premium is continued.

Conversion Option

Upon termination of active employment with the Policyholder, You may convert to an individual accident insurance plan, with no Evidence of Insurability required, at the individual rates in force with the Insurer at the time of Your termination. You may elect an amount of insurance equal to or lower than Your Benefit Amount, to a maximum of $400,000.00, in force at the time of termination. An application for conversion must be made within 31 days of the date of termination. Individual policies issued under this option do not include the Critical Disease and Serious Illness benefits.

Critical Disease Benefit

If The Insured Person, prior to age 65, is diagnosed by a Specialist with a Critical Disease while this benefit is in force and are Totally Disabled due to that Critical Disease for at least nine months following the Date of Diagnosis, the Insurer will pay 10% of their Benefit Amount up to a maximum of $40,000.00. This benefit is payable only if investigations leading to the Diagnosis of a Critical Disease is initiated more than 90 days following The Insured Person's Effective Date of insurance. Payment of the Critical Disease Benefit is limited to only the first Critical Disease to occur.

Serious Illness Benefit

If The Insured Person, prior to age 65, is diagnosed by a Specialist with a Serious Illness, and The Insured Person survive for a period of 30 days following the Date of Diagnosis, the Insurer will pay 10% of their Benefit Amount up to a maximum of $10,000.00.

The Insurer shall only be obligated to pay the Serious Illness Benefit once notwithstanding that The Insured Person may be diagnosed with more than one Serious Illness.

Pre-Existing Condition Provision
If a Sickness suffered by or Injury sustained by The Insured Person for which The Insured Person sought or received medical advice, consultation, investigation, Diagnosis, or for which treatment was required or recommended by a Physician during the 24 months immediately prior to The Insured Person's Effective Date or the date of any increase in The Insured Person's Benefit Amount, and which directly or indirectly causes the condition to occur within the first 24 months from The Insured Person's Effective Date or the date of any increase in the Insured Person's Benefit Amount. (Except for increases caused by annual salary changes.)

Limitations and Exclusions
The Policy does not provide benefits from any of the Critical Diseases or Serious Illnesses caused directly or indirectly by or resulting from any of the following:

(a) Injury or Sickness, other than one of the Critical Diseases or Serious Illnesses, even though such Injury or Sickness may have been complicated by one of the Critical Diseases or Serious Illnesses;

(b) a complication of Human Immunodeficiency Virus (HIV) infection or any variance thereof including AIDS and AIDS Related Complex;

(c) the use, existence or escape of nuclear weapons, material or ionizing radiation from or contamination by radioactivity from any nuclear fuel or waste from the combustion of nuclear fuel;

(d) misuse of medication or the abuse of drugs or intoxicants;

(e) any Pre-existing Medical Condition, except where coverage has been in effect for a period of 24 consecutive months following The Insured Person's Effective Date.

90 Day Cancer Exclusion
The Cancer Exclusion period is 90 days from the later of the effective date, or the date of the last reinstatement of the policy.

Within this exclusion period, there shall be no coverage for Cancer if a Diagnosis of any type of Cancer, whether included or excluded under this Policy, is made or if any symptoms or medical problems manifest themselves which, or the persistence or recurrence of which, subsequently result in an investigation leading to the Diagnosis of Cancer. In the event of any such Diagnosis the coverage will remain in force but Cancer will no longer be considered a Serious Illness, except for a subsequent Diagnosis of an unrelated Cancer.

Day Care Benefit

If an Injury sustained by The Insured Person results in loss of life within 12 months of the date of Accident, the Insurer will pay the Day Care Benefit stated below for each of The Insured Person's Dependent Children, under 13 years of age who:

(a) are enrolled in a legally licensed Day Care Centre on the date of such loss; or

(b) enroll in a legally licensed Day Care Centre within 12 months after The Insured Person's death. The Day Care Benefit is equal to the reasonable and necessary expenses actually incurred, subject to five percent of The Insured Person's Benefit Amount to a maximum of $5,000.00, for each year the Dependent Child described above is enrolled in a legally licensed Day Care Centre, but not to exceed four years, which must run consecutively, with respect to any one Dependent Child.

The benefit will be paid each year immediately upon receipt of satisfactory proof that the Dependent Child is enrolled in a legally licensed Day Care Centre, but payment will not be made for expenses incurred prior to The Insured Person's death, nor for room, board or other ordinary living, travelling or clothing expenses.

If, at the time of The Insured Person's death, The Insured Person have no Dependent Children eligible for the Day Care Benefit, the Insurer shall pay an additional amount of $2,500.00 to You.

Disability Fitness Benefit

If Injury results in an amount payable to The Insured Person under the part titled "Accidental Death, Dismemberment and Specific Loss Benefit" of the Policy, the Insurer will pay the reasonable and necessary expenses actually incurred for the purposes of any specially designated fitness training or athletic equipment for disabled persons, which The Insured Person would not have required except for such Injury, but not to exceed an amount of $5,000.00. The expense must be incurred within 2 years of the date of The Insured Person's Accident.

The above benefit shall only be payable under one of the policies issued by the Insurer and shall not duplicate any other benefits payable.

Education Benefit

If an Injury sustained by The Insured Person results in loss of life within 12 months of the date of Accident, the Insurer will pay the Education Benefit stated below for each of The Insured Person's Dependent Children, who are enrolled as full-time students:

(a) in a School for Higher Learning above the secondary school level as defined, in the Province, territory or country of Residence; or

(b) at the secondary school level but who enroll as full-time students in a School for Higher Learning within 12 months after the date of death of the Insured Person.

The Education Benefit is equal to the reasonable and necessary expenses actually incurred, subject to five percent of the Insured Person's Benefit Amount to a maximum of $5,000.00, for each year the Dependent Child described above continues their education on a full-time basis in a School for Higher Learning, but not to exceed four years, which must run consecutively, with respect to any one Dependent Child.

The benefit will be paid each year immediately upon receipt of satisfactory proof that the Dependent Child is enrolled as a full-time student in a School for Higher Learning, but payment will not be made for expenses incurred prior to The Insured Person's death, nor for room, board or other ordinary living, travelling or clothing expenses.
The above benefit shall only be payable under one of the policies issued by the Company and shall not duplicate any other benefits payable.

If, at the time of the Insured Person's death, they have no Dependent Children eligible for the Education Benefit, the Insurer shall pay an additional amount of $2,500.00 to You.

Eyeglasses, Contact Lenses and Hearing Aids Benefit

If, as the result of an Injury, The Insured Person require and receive treatment by a Physician, which results in the purchase of eyeglasses, contact lenses or hearing aids within 12 months of the date of the Accident, when none of which were previously required or worn, the Insurer will pay the reasonable and necessary expenses actually incurred, subject to a maximum of $1,000.00.

Family Transportation Benefit

If, following an Injury which results in an amount payable under the part titled "Accidental Death, Dismemberment and Specific Loss Benefit" of the Policy, The Insured Person is confined as an inpatient in a Hospital located not less than 150 kilometers from The Insured Person's normal place of Residence and The Insured Person is under the Regular Care and Attendance of a Physician, the Insurer will pay the reasonable and necessary expenses actually incurred by any Close Relative for accommodation/lodging in the vicinity of the Hospital where The Insured Person is confined and transportation by the most direct route from the normal place of Residence of The Insured Person's Close Relative and return to their normal place of Residence.

Payment will not be made for board or other ordinary living, travelling or clothing expenses. If transportation occurs in a Vehicle or device other than one operated under a license for the conveyance of passengers for hire, then reimbursement of transportation expenses will be limited to a maximum of $.20 per kilometer travelled.

The maximum amount payable under this part is $15,000.00 for all such expenses.

Funeral Expense Benefit

If an Injury sustained by The Insured Person results in loss of life, and an amount for such loss becomes payable in accordance with the terms of this benefit, an additional amount is payable for reasonable and necessary funeral expenses actually incurred, subject to a maximum of $5,000.00.

Home Alteration and Vehicle Modification Benefit

If an Injury sustained by The Insured Person does not cause loss of life, but results in an amount payable under the part titled "Accidental Death, Dismemberment and Specific Loss Benefit", and The Insured Person is subsequently required to use a wheelchair to be ambulatory, the Insurer will pay the reasonable and necessary expenses actually incurred within three years of the date of the Accident causing such Loss for:

(a) the cost of alterations to The Insured Person's principal Residence; and/or

(b) the cost of modifications to one Vehicle utilized by The Insured Person, when such modifications are approved by the provincial vehicle licensing authorities where required

for the purpose of making them wheelchair accessible.

Payment by the Insurer for the total of all expenses incurred by or for The Insured Person is subject to a maximum of $25,000.00 as the result of any one Accident.

Parental Care Benefit

If an Injury sustained by The Insured Person results in loss of life and an amount becomes payable in accordance with the terms of the Policy, the Insurer will pay a Parental Care Benefit for an eligible Dependent Parent.

A Dependent Parent is eligible for this benefit if, at the time of the Accident:

(a) is a resident in a licensed nursing care facility; or

(b) is enrolled in a home health care program; or

(c) is living in Your Residence; or

(d) is receiving support and care provided by You as evidenced by:
   (i) cancelled cheques; or
   (ii) income tax returns showing the parent as a dependent; or
   (iii) other similar forms of proof.

The amount of Parental Care Benefit will be 5% of the Insured Person's Benefit Amount, subject to an overall maximum of $ 5,000.00.

Psychological Therapy Benefit

If an Injury results in an amount payable to The Insured Person under the part titled "Accidental Death, Dismemberment and Specific Loss Benefit" of the Policy, and results in The Insured Person requiring Psychological Therapy, as prescribed by a Physician, the Insurer will pay the reasonable and necessary expenses actually incurred, subject to a maximum of $1,000.00, until one of the following occurs:

(a) the total Psychological Therapy Benefit amount has been paid; or

(b) two years have elapsed from the date of the Injury; or

(c) The Insured Person die.

Rehabilitation Benefit

If an Injury sustained by The Insured Person results in an amount payable under the part titled "Accidental Death, Dismemberment and Specific Loss Benefit", and such Injury requires that The Insured Person undergoes special training in order to be qualified to engage in a special occupation in which The Insured Person would not have engaged except for such Injury, the Insurer will pay the reasonable and necessary expense incurred for such training by The Insured Person within two years of the date of the Accident, subject to a maximum of $15,000.00 as the result of any one Accident.

Payment will not be made for room, board or other ordinary living, travelling or clothing expenses.

Repatriation Benefit

If an Injury sustained by The Insured Person results in loss of life (due to any cause) out of Canada, or if in Canada at least 150 kilometers from The Insured Person's normal place of Residence, and a benefit becomes payable in accordance with the terms of the Policy, the Insurer will pay the reasonable and necessary expenses actually incurred for the transportation of The Insured Person's body to The Insured Person's city of Residence, including the preparation of The Insured Person's body for such transportation, subject to a maximum of $15,000.00.

Benefits will be reduced under this part by any amount paid or payable under any other policy providing similar expenses.

Seat Belt Benefit

If, due to a vehicular accident, Injury results in an amount payable to The Insured Person under the part titled "Accidental Death, Dismemberment and Specific Loss Benefit", The Insured Person's Benefit Amount will be increased by 10% if, at the time of the accident, The Insured Person was driving or riding in a Vehicle and wearing a properly fastened seat belt.

The driver of the Vehicle must hold a current and valid driver's license of a rating authorizing them to operate such Vehicle and neither be intoxicated nor under the influence of drugs, unless such drugs are taken as prescribed by a Physician, at the time of the Accident. "Intoxicated" and "under the influence of drugs" are as defined by the local jurisdiction where the Accident occurs.

Due proof of seat belt use must be provided as part of the written Proof of Claim.

Spousal Retraining Benefit

If an Injury sustained by The Insured Person results in loss of life and an amount becomes payable in accordance with the terms of this benefit, the Insurer will pay the reasonable and necessary expenses actually incurred within three years from the date of such Accident by their spouse who engages in a formal occupational training program in order to become specifically qualified for active employment in an occupation for which they would not otherwise have sufficient qualifications, not to exceed in the aggregate $15,000.00 for all such expenses. Payment will not be made for room, board or other ordinary living, travelling or clothing expenses.

Waiver of Premium

In the event You become totally disabled and a Waiver of Premium Claim is accepted and approved under the Group Life benefit, then premiums payable for this benefit will be waived as of the same date the Waiver of Premium Claim is effective under the Group Life benefit until one of the following occurs, whichever is earlier:

(a) the date You cease to be Totally Disabled;

(b) the termination of this benefit;

(c) the date You reach 65 years of age.

We reserve the right to request proof of Total Disability or any continuance thereof from time to time as We may reasonably require. Failure to provide proof satisfactory to Us may result in termination of this Waiver of Premium benefit.

The coverage, which is continued under this benefit, will be subject to the terms and provisions of the Policy in effect as of the date of commencement of disability, including any provision providing for reductions in Benefit Amount.

Notwithstanding anything contained to the contrary in the Policy, in no event will benefits payable due to one or the total from multiple events which occur to a single Insured Person while coverage is being continued under this benefit exceed the Benefit Amount that would have been payable to the Insured Person at the date of commencement of disability.

Limited Air Travel Coverage

Insurance provided under the Policy includes any Injury The Insured Person may sustain in consequence of riding as a passenger, but not as a pilot or Crew Member, in, boarding or alighting from, or being struck by, or making a forced landing with or from (a) any Certified Aircraft which is operated by a person holding a current and valid pilot's license of a rating authorizing them to pilot such aircraft, or (b) any transport-type aircraft operated by the Canadian Armed Forces or by the similar air transport service of any duly constituted governmental authority of the recognized government of any nation anywhere in the world, provided the aircraft is not being used for test or experimental purposes.

Notwithstanding (a) and (b) above, the Policy excludes Injury sustained while and in consequence of riding as a passenger, pilot, operator or Crew Member, in or on, boarding or alighting from, or being struck by, or making a forced landing with or from any aircraft owned, operated or Leased by the Policyholder.

Exposure and Disappearance

If, as the result of an Accident, The Insured Person is unavoidably exposed to the elements and if, as a result of such exposure and within 12 months after the date of the Accident, The Insured Person suffers a loss for which an amount would otherwise have been payable under this benefit, such loss will be deemed to be the result of Injury.

Where, due to the accidental wrecking, sinking or disappearance of a conveyance in which The Insured Person was riding, The Insured Person disappear, and if The Insured Person's body is not found within 12 months after the date of such wrecking, sinking or disappearance, it will be presumed, subject to there being no evidence to the contrary and subject to all other terms and conditions of the policy, that The Insured Person suffered loss of life as a result of Injury.

What Amounts Are Available?

You may elect to insure Yourself only or Yourself and Your Dependents for one of these plans:

A. PARTICIPANT ONLY PLAN
You may select any amount of benefit desired from a minimum of $50,000.00 to a maximum of $400,000.00 in units of $50,000.00.

B. FAMILY PLAN
You may select amounts of insurance from a minimum of $50,000.00 to a maximum of $400,000.00 in units of $50,000.00 AND Your Dependents will automatically be insured for the following:

Spouse - Your Spouse will have a Benefit Amount equal to 50% of the Benefit Amount You elect for Yourself if You have Dependent Children, or 60% if You do not.

Children - Each Dependent Child will have a Benefit Amount equal to 10% of Your Benefit Amount if You have a Spouse, or 25% if You do not, subject to a maximum of $50,000.00.

Exclusions and Limitations

This benefit does not cover loss, fatal or non-fatal, caused by or resulting from:

(a) declared or undeclared war or any act thereof;

(b) active full-time service in the armed forces of any country;

(c) suicide or any attempt thereat or intentionally self-inflicted Injury, regardless of The Insured Person's state of mind;

(d) committing, attempting or provoking an assault or criminal offence including without limitation driving a Vehicle with alcohol in the blood in excess of 80 milligrams of alcohol per 100 millilitres of blood.

(e) medical care or treatment of any kind including surgery;

(f) any drug, poison, gas or intoxicant taken, administered, absorbed or inhaled, voluntarily or otherwise (occupation-related Accidents excepted);

(g) Injury sustained in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as provided in the part titled "Limited Air Travel Coverage".

How May I Enroll?

You may enroll in Protector Series Optional Accident and Sickness plan by completing the group enrolment form/card available from Us.

1) Select the type of Plan desired: PARTICIPANT ONLY PLAN or FAMILY PLAN.

2) Select the Benefit Amount desired from the description of What Amounts are Available (immediately above) which best suits Your needs.

Notice and Proof of Claim

The You or Your agent, or a beneficiary entitled to make a Claim or their agent, will

(a) give written Notice of Claim to Us:

(ii) by delivery thereof, or by sending it by registered mail to Us,

not later than 30 days from the date of the Accident or the Date of Diagnosis for the “Critical Disease Benefit” and “Serious Illness Benefit”;

(b) within 90 days from the date of the Accident or the Date of Diagnosis for the “Critical Disease Benefit” and “Serious Illness Benefit” for which the Claim is made, furnish Us such Proof of Claim as is reasonably possible in the circumstances of the happening of the Accident or Sickness, and the loss occasioned thereby; and

(c) if so required by Us, furnish a satisfactory certificate as to the cause or nature of the Accident or Sickness for which the Claim may be made under this benefit.

Failure to give Notice of Claim or furnish Proof of Claim within the time prescribed does not invalidate the Claim if the Notice or proof is given or furnished as soon as reasonably possible, and in no event later than 12 months from the date of the Accident, if it is shown that it was not reasonably possible to give Notice or furnish proof within the time so prescribed.

A Claim form can be obtained from Us.

This Handbook is for illustrative purposes only and carries no Policy, Contractual or other rights. All rights with respect to the benefits of a Participant will be governed by the Group Master Policy, a copy of which is filed with Us.

Protector Series™ Optional Critical Illness

You may wish to apply for an additional amount of group optional critical insurance for You and Your Dependents by completing the Application form available from Us. If Your Application is approved, coverage will take effect the first day of the next month following the date We notify You of approval in writing.

Benefit Features

If Diagnosed with a Covered Condition while an Insured Person under this benefit, the Insurer will pay to You a Claim Amount determined by the Benefit Amount of insurance the Insured Person is approved and paying premiums for, subject to the terms and conditions of this benefit and the Policy.

Please read this Handbook as coverage is subject to exclusions, including, without limitation, an exclusion relating to Pre-Existing Conditions and Covered Condition Exclusions.

The Policy contains a provision removing or restricting Your right to designate persons to whom or for whose benefit insurance money is to be payable.

Definitions

Additional Definitions used in components of Optional Critical Illness:

Claim Amount
The dollar amount of coverage that is payable in the event of a Diagnosis of a Covered Condition in accordance with the terms of the Policy, calculated as all or a portion of the Insured Person's Benefit Amount.

Covered Conditions
The medical conditions or events for which a Claim Amount may be paid under the Policy.

Benefit Amount
The dollar amount of insurance coverage applicable to an Insured Person that is used to determine the Claim Amount payable for any Claim.

Irreversible
Not able to be undone or alterable.

Life Support
The Insured Person is under the regular care of a Physician for nutritional, respiratory and/or cardiovascular support when Irreversible cessation of all functions of the brain has occurred.

Multiple Event Categories
The categories of Covered Conditions that are included in the Multiple Event Coverage Benefit.

Pre-Existing Condition
A condition, whether Diagnosed or not, for which the Insured Person sought medical investigation, medical care or services, Diagnosis, treatment, including diagnostic measures, medication or medical advice, or for which there were symptoms, signs or evidence that should have caused an individual to seek medical care or services, Diagnosis, treatment, including diagnostic measures, medication or medical advice.

Pre-Existing Condition Exclusion Period
The 24-month period immediately following the Pre-Existing Condition Starting Date.

Pre-Existing Condition Period
The 24-month period immediately prior to the Pre-Existing Condition Starting Date.

Pre-Existing Condition Starting Date
With respect to any Insured Person:

a) the Effective Date of Insurance of such Insured Person; or
b) in respect of any new Covered Condition, the date of the amendment to the Insured Person's coverage under the Policy to add such new Covered Condition.

Survival Period
The period starting on the Date of Diagnosis and ending 14 days later, except as specifically provided elsewhere under the Policy. The Survival Period does not include the number of days on Life Support. The Insured Person must not have experienced Irreversible cessation of all functions of the brain and must be alive at the end of the Survival Period.

For those conditions which have a qualifying period, for example, 90 days for Bacterial Meningitis and Paralysis, the Survival Period runs concurrently with that condition's qualifying period.

Payment of Claim Amount

When is the Claim Amount payable?
If an Insured Person is first Diagnosed with a Covered Condition while insured under the Policy, the Insurer will pay the Claim Amount for that Covered Condition, subject to the terms and conditions of the Policy.
The Claim Amount will become payable provided that the following conditions are met:
a) We receive evidence, satisfactory to Us, including but not limited to medical evidence, documenting the Insured Person's Diagnosis;
b) the Diagnosis is made by a Physician unless the Policy requires that the Diagnosis be made by a Specialist. If the Diagnosis is made outside of Canada, We reserve the right to require the Diagnosis be confirmed by a Physician or Specialist licensed and practising in Canada; and
c) no Policy Exclusions or Limitations apply.

Early Diagnosis Benefit

What is the Early Diagnosis Benefit?
If a You or Your Spouse is Diagnosed with an Early Diagnosis Benefit Covered Condition while insured under the Policy, the Insurer will pay You the applicable Claim Amount for that Covered Condition, subject to the terms and conditions of the Policy.

The Claim Amount for Early Diagnosis Benefit Covered Conditions is 10% of the Benefit Amount and is only payable once per Covered Condition per Insured Person.

This benefit is not available for Dependent Children.

Multiple Event Categories

If You or Your Spouse receive a Claim Amount under the Policy, the Insured Person's coverage may remain in force subject to the terms and conditions of the Policy, specifically, the following paragraph.
The Claim Amount may be Claimed for up to four Covered Conditions, with one Claim being eligible in each of the Multiple Event Categories listed below. In order to be eligible for this coverage, the subsequent Diagnosis must be made 90 days or more after the date the prior Covered Condition was Diagnosed.

The Multiple Event Categories are:

Category 1	Cancer (Life-Threatening)
Category 2	Aortic Surgery, Coronary Artery Bypass Surgery, Heart Attack, Heart Valve Replacement or Repair, and Stroke (Cerebrovascular Accident)
Category 3	Blindness, Deafness, Loss of Limbs, Loss of Speech, Occupational HIV Infection, and Severe Burns

Category 4 Aplastic Anemia, Bacterial Meningitis, Benign Brain Tumour, Coma, Dementia including Alzheimer's Disease, Kidney Failure, Loss of Independent Existence, Motor Neuron Disease, Multiple Sclerosis, Major Organ Transplant, Major Organ Failure on Waiting List, Paralysis, and Parkinson's Disease and Specified Atypical Parkinsonian Disorders.

Payment of Early Diagnosis Benefit Covered Conditions will not affect the ability to make a Claim under the Multiple Event Categories.

Limitations

Once a benefit has become payable, the Insured Person will not be covered under the Policy for another Claim that is:

a) in the opinion of the Insurer's chief medical officer, caused by, or contributed to, has spread from or has occurred as a result of the same Covered Condition;
b) in the opinion of the Insurer's chief medical officer, directly or indirectly associated with, or is likely to have been caused by, a Covered Condition that the Insured Person has already Claimed under the Policy; or
c) for another Covered Condition within the same Multiple Event Category as a Claim that has already been paid under the Policy.

This benefit is not available for Dependent Children.

Multiple Cancer Benefit

If You or Your Spouse receive a Claim Amount under the Policy as a result of a Cancer (Life-Threatening) Diagnosis, Your/the Insured Person's eligibility to Claim in the future for Cancer (Life-Threatening) will be restored subject to the definition of Multiple Cancer Benefit below, provided that no exclusions or limitations apply.

The Multiple Cancer Benefit is defined as the subsequent Diagnosis of the Insured Person with Cancer (Life-Threatening), provided that:

a) the Insured Person has not received any treatment relating directly or indirectly to the previous cancer within the 60-month period prior to the subsequent Diagnosis;
b) the Insured Person does not have any new signs, symptoms or deliberate or incidental findings, during the 60-month period prior to the subsequent Diagnosis, for which they sought medical investigation, consultation to investigate and or diagnose, Diagnosis, treatment, care, medication or medical advice, or for which there were symptoms that should have caused an individual to seek the same relating to a Diagnosis of Cancer (Life-Threatening) or Cancer (Non-Life-Threatening); and
c) both the first and subsequent Diagnoses are made while the Insured Person is covered under the Policy and prior to the Termination Date.

This benefit is not available for Dependent Children.

Pre-Existing Condition Limitation

No Claim Amount will be payable for a Pre-Existing Condition, whether Diagnosed or not, that existed during the Pre-Existing Condition Period and is Diagnosed during the Pre-Existing Condition Exclusion Period.

Premium

Payment of Premiums

Your premiums are due on the first of each month ~~for~~ that coverage is in force, and are calculated based on the premium rates in effect at the time they are due. The premium due is the sum of the monthly premiums for You and Your Dependents, if any, insured under the Policy.

Premium rate tables are used to calculate premiums due. Rates are grouped into 5-year age bands and premiums are calculated based on Your and Your Spouse's respective:

a) Age
b) Gender
c) Smoking status
d) Benefit Amount of insurance

Dependent children are covered at a single rate per family.

Premiums for any increase in Benefit Amount or new Insured Persons whose coverage becomes effective during a Policy month will be charged effective from the next premium due date. The premium for insurance terminated during a Policy month will cease at the end of the Policy month in which such insurance terminates.

You must pay all premiums due under the Policy, including adjustments, if any, on or before their due date.

You will pay Your premiums through pre-authorized payroll deduction or We will bill You directly, and collect premiums using pre-authorized banking or credit card information You provide.

Except for fraud, premium adjustments or refunds will be made for only:
a) the current Policy Year, and
b) the prior Policy Year.

Premium Rates
The Insurer has the right to set new premium rates when any of the following occur:
a) the terms of the Policy are changed;
b) coincident with the passage of Provincial or Federal law or regulation which results in a change to:
   i. the liability for the provision of benefits under the Policy; or
   ii. the taxability of premiums or benefits; or
c) on any premium due date, but, subject to item b above, not more than once in any 12-month period.

No premium rate may be increased unless the Insurer notifies the Policyholder at least 60 days in advance of the increase. Premium rate increases may take effect on an earlier date when both the Insurer and the Policyholder agree.

Grace Period
The Grace Period is 31 days following a premium due date and will apply to each Insured Person. Coverage will continue in force during the Grace Period unless You give the Insurer written Notice to terminate coverage for You and Your Dependents.

If Your premium is received during the Grace Period it is not considered late. If it is not received before the Grace Period ends, Your coverage under the Policy will automatically terminate. The date of termination will be the premium due date for which premiums were not paid.

Termination of Your Insurance

You will cease to be insured on the earliest of the following dates:
a) the date the Policy terminates;
b) the date You no longer belong to a class of Eligible Participants specified in the Policy;
c) the date Your employment with the Policyholder terminates;
d) any Coverage Anniversary upon which You are no longer a Full-Time Resident of Canada;
e) The date You enter the armed forces of any country on a full-time basis;
f) the date You reach the age of 70 years;
g) the date You die; and
h) the date the maximum amount payable to You under the Policy is paid out.

Termination of a Spouse's Insurance

Your Spouse will cease to be insured on the earliest of the following dates:
a) the date the Policy terminates;
b) the date You cease to be an Insured Person;
c) the last day of the month You request termination of Your Spouse's insurance in writing;
d) the date Your Spouse ceases to be legally married to You, or in a civil union with You as defined by the Civil Code of Quebec, or in a registered domestic partnership in Nova Scotia, or has ceased living with You in a role like that of a marriage partner;

e) the Coverage Anniversary if Your Spouse is no longer a Full-Time Resident of Canada;
f) The date Your Spouse enters the armed forces of any country on a full-time basis;
g) the date Your Spouse reaches the age of 70 years;
h) the date the maximum amount payable to Your Spouse under the Policy has been paid out; and
i) the date Your Spouse dies.

Termination of a Dependent Child's Insurance

Your Child will cease to be insured on the earliest of the following dates:
a) the date the Policy terminates;
b) the date You cease to be an Insured Person;
c) the date the Dependent Child becomes employed on a full-time basis;
d) the date the Dependent Child turns 21, or 26 if in attendance at a recognized educational institution as a full-time student;
e) the date the Dependent Child gets married or enters into a civil union as defined by the Civil Code of Quebec or a registered domestic partnership in Nova Scotia, or has been living with another person in a role like that of a marriage partner continuously for the immediately preceding 12-month period;
f) the date the Dependent Child becomes eligible for Critical Illness insurance as an employee under any group benefits plan;
g) the Coverage Anniversary if the Dependent Child is no longer a Full-Time Resident of Canada;
h) The date the Dependent Child enter the armed forces of any country on a full-time basis;
i) the last day of the month You request termination of the Dependent Child coverage in writing;
j) the date a Claim Amount is paid for this Child under the Policy; and
k) the date the Dependent Child dies.

Portability

If Your coverage under the Policy terminates, You may be eligible to transfer Your coverage to a group Critical Illness policy set up by Industrial Alliance for this purpose and administered by Us. Portability will also be triggered upon Your death for Your insured Spouse and Dependent Children. You will be eligible if You meet the eligibility requirements of the new policy and continue to pay premiums to prevent a gap in coverage.

If You are eligible to transfer Your coverage, We will contact You to initiate the transfer and provide You with the necessary forms. You must complete and return the necessary forms to Us within 60 days of the termination of Your coverage under the Policy.

The Portability Privilege is not available if Your coverage under the Policy terminates:
a) when You enters the armed forces of any country on a full-time basis;
b) when You reach the age of 70 years; or
c) when You have received the maximum amount payable under this benefit.

Conversion Privilege

There is no conversion for Optional Critical Illness insurance.

Waiver of Premium

There is no Waiver of Premium for Optional Critical Illness insurance.

Claims

Notice of Claim
Written Notice of Claim must be given to Us within 30 days of the Date of Diagnosis. If such Notice of Claim is not provided within that time, the Claim will not be invalidated if Notice of Claim is given as soon as reasonably possible.

Proof of Claim
You must submit a Claim for benefits under the Policy using the approved Claim forms provided by Us. We will not pay any Claim until We receive satisfactory proof in writing that such benefits are payable under the terms of the Policy. Written Proof of Claim must be provided to Us within 90 days of the Date of Diagnosis. Failure to provide such Proof of Claim within this time will not invalidate the Claim if the Proof of Claim is given as soon as reasonably possible, provided the information is sent to Us within one year of Date of Diagnosis. The Claimant will be responsible for expenses incurred for providing Claim information.

We may determine a physical examination of the Insured Person by one or more Physicians is necessary to assist in adjudicating the Claim. We will be responsible for any costs associated with such physical examinations. If the Insured Person refuses to be examined, We may not be able to make a favourable decision in respect of the Claim.

Beneficiary
Benefits are paid to You. If You are no longer living at the time payment is made, these benefits are payable to Your estate. The Insurer does not accept Beneficiary designations for any benefits under the Policy, other than in Quebec.

Assignment of Benefits
No Insured Person is permitted to assign their rights under the Policy.

Method of Payment
The Claim Amount is payable as a lump sum.

Legal Proceedings
No legal action may be brought against the Insurer within 60 days after Proof of Claim has been submitted, or after the time limit for bringing such an action set out in applicable legislation has expired.

Every action or proceeding against an insurer for the recovery of insurance money payable under the Policy is absolutely barred unless commenced within the time set out in the Insurance Act (Alberta, Manitoba and British Columbia), the Limitations Act, 2002 (Ontario), or other applicable provincial legislation.

Covered Conditions

An Insured Person is only covered for those Covered Conditions set out as applicable to them on the Schedule of Benefits.

Aortic Surgery
The undergoing of Surgery for disease of the aorta requiring excision and surgical replacement of any part of the diseased aorta with a graft. Aorta means the thoracic and abdominal aorta but not its branches. The Surgery must be determined to be Medically Necessary by a Specialist.

Exclusion: No benefit will be payable under this Covered Condition for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

Aplastic Anemia
A definite Diagnosis of a chronic persistent bone marrow failure, confirmed by biopsy, which results in anemia, neutropenia and thrombocytopenia requiring blood product transfusion, and treatment with at least one of the following:
a) marrow stimulating agents;
b) immunosuppressive agents;
c) bone marrow transplantation.

The Diagnosis of Aplastic Anemia must be made by a Specialist.

Autism
An organic defect in brain development characterized by failure to develop communicative language or other forms of social communication, with the Diagnosis confirmed by a Specialist before the third birthday of the Dependent Child.

Bacterial Meningitis
A definite Diagnosis of meningitis, confirmed by cerebrospinal fluid showing growth of pathogenic bacteria in culture, resulting in neurological deficit(s) documented for at least 90 days from the Date of Diagnosis.
The Diagnosis of Bacterial Meningitis must be made by a Specialist.

Exclusion: No benefit will be payable under this condition for viral meningitis.

Benign Brain Tumour
A definite Diagnosis of a non-malignant tumour located in the cranial vault and limited to the brain, meninges, cranial nerves or pituitary gland. The tumour must require surgical or radiation treatment or cause Irreversible objective neurological deficit(s). The Diagnosis of Benign Brain Tumour must be made by a Specialist.

Medical information about the Diagnosis and any signs, symptoms or investigations leading to the Diagnosis must be reported to Us within 6 months of the Date of the Diagnosis. If this information is not provided within this period, We have the right to deny any Claim for Benign Brain Tumour or any Covered Condition caused by any Benign Brain Tumour or its treatment.

Exclusion: No benefit will be payable under this Covered Condition if, within the first 90 days following the later of:
a) the Effective Date of Insurance, or
b) the date of the last reinstatement of the Insured Person's coverage, the Insured Person has any of the following:
    i. signs, symptoms, evidence or investigations that lead to a Diagnosis of Benign Brain Tumour (covered or excluded under the Policy), regardless of when the Diagnosis is made; or
    ii. a Diagnosis of Benign Brain Tumour (covered or excluded under the Policy).

No benefit will be payable under this Covered Condition for pituitary adenomas less than 10 mm.

Blindness
A definite Diagnosis of the total and Irreversible loss of vision in both eyes, evidenced by:
a) the corrected visual acuity being 20/200 or less in both eyes; or
b) the field of vision being less than 20 degrees in both eyes.

The Diagnosis of Blindness must be made by a Specialist.

Cancer (Life-Threatening)
A definite Diagnosis of a tumour, which must be characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. Types of cancer include carcinoma, melanoma, leukemia, lymphoma, and sarcoma. The Diagnosis of Cancer must be made by a Specialist.

Exclusion: No benefit will be payable under this Covered Condition if, within the first 90 days following the later of (i) the Effective Date of Insurance or (ii) the date of the last reinstatement of the Insured Person's coverage, the Insured Person has any of the following:

a) signs, symptoms or investigations that lead to a Diagnosis of Cancer (covered or excluded under the Policy), regardless of when the Diagnosis is made; or
b) a Diagnosis of Cancer (covered or excluded under the Policy).

Medical information about the Diagnosis and any signs, symptoms or investigations leading to the Diagnosis must be reported to Us within 6 months of the Date of the Diagnosis.

If this information is not provided within this period, the Insurer has the right to deny any Claim for Cancer or any Critical Illness caused by any Cancer or its treatment.

Exclusion: No benefit will be payable for the following:

a) lesions described as benign, pre-malignant, uncertain, borderline, noninvasive, carcinoma in-situ (Tis), or tumours classified as Ta;
b) malignant melanoma skin cancer that is less than or equal to 1.0 mm in thickness, unless it is ulcerated or is accompanied by lymph node or distant metastasis;
c) any non-melanoma skin cancer, without lymph node or distant metastasis;
d) prostate cancer classified as T1a or T1b, without lymph node or distant metastasis;
e) papillary thyroid cancer or follicular thyroid cancer, or both, that is less than or equal to 2.0 cm in greatest diameter and classified as T1, without lymph node or distant metastasis;
f) chronic lymphocytic leukemia classified less than Rai stage 1; or
g) malignant gastrointestinal stromal tumours (GIST) and malignant carcinoid tumours, classified less than AJCC Stage 2.

For purposes of the Policy, the terms Tis, Ta, T1a, T1b, T1 and AJCC Stage 2 are to be applied as defined in the American Joint Committee on Cancer (AJCC) cancer staging manual, 7th Edition, 2010.

For purposes of the Policy, the term Rai staging is to be applied as set out in KR Rai, A Sawitsky, EP Cronkite, AD Chanana, RN Levy and BS Pasternack: Clinical staging of chronic lymphocytic leukemia. Blood 46:219, 1975.

Cancer (Non-Life-Threatening)

Includes:

a) **Ductal Carcinoma in Situ of Breast**, which is defined as the Diagnosis of non-life-threatening ductal carcinoma in situ of the breast, confirmed by biopsy.
b) **Early Stage Lymphocytic Leukemia**, which is defined as the Diagnosis of chronic lymphocytic leukemia classified less than Rai stage 1.
c) **Early Stage Thyroid Cancer**, which is defined as the Diagnosis of papillary thyroid cancer or follicular thyroid cancer, or both, that is less than or equal to 2.0 cm in greatest diameter and classified as T1, without lymph node or distant metastasis.
d) **GIST (Gastrointestinal Stromal Tumour)**, which is defined as the Diagnosis of malignant gastrointestinal stromal tumours (GIST) and malignant carcinoid tumours, classified less than AJCC Stage 2.
e) **Stage A (T1a or T1b) Prostate Cancer**, which is defined as the Diagnosis of prostate cancer classified as T1a or T1b, without lymph node or distant metastasis.
f) **Stage 1A Malignant Melanoma**, which is defined as the Diagnosis of malignant melanoma skin cancer that is less than or equal to 1.0 mm in thickness, unless it is ulcerated or is accompanied by lymph node or distant metastasis.

Exclusion: No benefit will be payable under this Covered Condition if, within the first 90 days following the later of:

a) the Effective Date of Insurance, or
b) the date of the last reinstatement of coverage, the Insured Person has any of the following:
    i. signs, symptoms or investigations that lead to a Diagnosis of cancer (covered or excluded under the Policy), regardless of when the Diagnosis is made; or
    ii. a Diagnosis of cancer (covered or excluded under the Policy).

Cerebral Palsy
A definitive Diagnosis of Cerebral Palsy, a non-progressive neurological defect characterized by spasticity and incoordination of movements.

Coma
A definite Diagnosis of a state of unconsciousness with no reaction to external stimuli or response to internal needs for a continuous period of at least 96 hours, and for which period the Glasgow coma score must be 4 or less. The Diagnosis of Coma must be made by a Specialist.

Exclusion: No benefit will be payable under this Covered Condition for:
a) a medically induced coma;
b) a coma which results directly from alcohol or drug use; or
c) a Diagnosis of brain death.

Congenital Heart Disease
Any one or more Diagnosis(es) from the following lists of heart conditions that are Covered Conditions:

List A
a) Atresia of any heart valve
b) Coarctation of The Aorta
c) Double Inlet Ventricle
d) Double Outlet Left Ventricle
e) Ebstein's Anomaly
f) Eisenmenger Syndrome
g) Hypoplastic Left Heart Syndrome
h) Hypoplastic Right Ventricle
i) Single Ventricle
j) Tetralogy of Fallot
k) Total Anomalous Pulmonary Venous Connection
l) Transposition of The Great Vessels
m) Truncus Arteriosus

The Covered Conditions described in List A will be covered commencing from the date of birth. The Diagnosis of any of the Covered Conditions in List A must be made by a Specialist who is a qualified pediatric cardiologist and supported by appropriate cardiac imaging.

List B
a) Aortic Stenosis
b) Atrial Septal Defect
c) Discrete Subvalvular Aortic Stenosis
d) Pulmonary Stenosis
e) Ventricular Septal Defect

The Covered Conditions described in List B will be covered only when open heart Surgery is performed for correction of the Covered Condition following the date of birth. The Diagnosis of any of the Covered Conditions in this List B must be made by a Specialist who is a qualified pediatric cardiologist and supported by appropriate cardiac imaging. The Surgery must be recommended by a Specialist who is a qualified pediatric cardiologist and performed by a Specialist who is a cardiac surgeon in Canada.

List B Exclusion: Trans-catheter procedures such as balloon valvuloplasty or percutaneous Atrial Septal Defect closure are excluded.

General Congenital Heart Disease Exclusion: All other congenital cardiac conditions not specifically described in List A or List B are not Covered Conditions and are excluded.

Coronary Angioplasty
The undergoing of an interventional procedure to unblock or widen a coronary artery that supplies blood to the heart to allow an uninterrupted flow of blood. The procedure must be determined to be Medically Necessary by a Specialist.

Coronary Artery Bypass Surgery
The undergoing of heart Surgery to correct narrowing or blockage of one or more coronary arteries with bypass graft(s). The Surgery must be determined to be Medically Necessary by a Specialist.

Exclusion: No benefit will be payable under this Covered Condition for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

Cystic Fibrosis
A definitive Diagnosis of Cystic Fibrosis with evidence of chronic lung disease and pancreatic insufficiency.

Deafness
A definite Diagnosis of the total and Irreversible loss of hearing in both ears, with an auditory threshold of 90 decibels or greater within the speech threshold of 500 to 3,000 hertz. The Diagnosis of Deafness must be made by a Specialist.

Dementia, including Alzheimer's Disease
A definite Diagnosis of dementia, which must be characterized by a progressive deterioration of memory and at least one of the following areas of cognitive function:
a) aphasia (a disorder of speech);
b) apraxia (difficulty performing familiar tasks);
c) agnosia (difficulty recognizing objects); or
d) disturbance in executive functioning (e.g. inability to think abstractly and to plan, initiate, sequence, monitor, and stop complex behaviour), which is affecting daily life.

The Insured Person must exhibit:
a) dementia of at least moderate severity, which must be evidenced by a Mini Mental State Exam of 20/30 or less, or equivalent score on another generally medically accepted test or tests of cognitive function; and
b) evidence of progressive worsening in cognitive and daily functioning either by serial cognitive tests or by history over at least a 6-month period.

The Diagnosis of Dementia must be made by a Specialist.

For the purposes of the Policy, reference to the Mini Mental State Exam is to Folstein MF, Folstein SE, McHugh PR, Journal of Psychiatric Research 1975;12(3):189.

Exclusion: No benefit will be payable under this Covered Condition for affective or schizophrenic disorders, or delirium.

Down Syndrome
A definitive Diagnosis of Down Syndrome, confirmed by a Specialist with expertise in the specialty normally designated to assess and manage Down Syndrome.

Heart Attack
A definite Diagnosis of the death of heart muscle due to obstruction of blood flow that results in a rise and fall of cardiac biochemical markers to levels considered diagnostic of myocardial infarction, with at least one of the following:
a) heart attack symptoms;
b) new electrocardiogram (ECG) changes consistent with a heart attack; or
c) development of new Q waves during or immediately following an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty.

The Diagnosis of Heart Attack must be made by a Specialist.

Exclusion: No benefit will be payable under this Covered Condition for:
a) elevated cardiac biochemical markers as a result of an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty, in the absence of new Q waves; or
b) ECG changes suggesting a prior myocardial infarction, which do not meet the Heart Attack definition as described above;

Heart Valve Replacement or Repair
The undergoing of Surgery to replace any heart valve with either a natural or mechanical valve or to repair heart valve defects or abnormalities. The Surgery must be determined to be Medically Necessary by a Specialist.

Exclusion: No benefit will be payable under this Covered Condition for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

Kidney Failure
A definite Diagnosis of chronic Irreversible failure of both kidneys to function, as a result of which regular hemodialysis, peritoneal dialysis or renal transplantation is initiated. The Date of Diagnosis is the date of the Insured Person's initiation into the transplant program. The Diagnosis of Kidney Failure must be made by a Specialist.

Loss of Independent Existence
A definite Diagnosis of the total and permanent inability to perform, by oneself, at least 2 of the following 6 Activities of Daily Living for a continuous period of at least 90 days with no reasonable chance of recovery. The Diagnosis of Loss of Independent Existence must be made by a Specialist.
Activities of Daily Living are:
a) **bathing** — the ability to wash oneself in a bathtub, shower or by sponge bath, with or without the aid of assistive devices;
b) **dressing** — the ability to put on and remove necessary clothing, braces, artificial limbs or other surgical appliances with or without the aid of assistive devices;
c) **toileting** — the ability to get on and off the toilet and maintain personal hygiene with or without the aid of assistive devices;
d) **bladder and bowel continence** — the ability to manage bowel and bladder function with or without protective undergarments or surgical appliances so that a reasonable level of hygiene is maintained;
e) **transferring** — the ability to move in and out of a bed, chair or wheelchair, with or without the aid of assistive devices; and
f) **feeding** — the ability to consume food or drink that already has been prepared and made available, with or without the use of assistive devices.

Loss of Limbs
A definite Diagnosis of the complete severance of two or more limbs at or above the wrist or ankle joint as the result of an Accident or medically required amputation. The Diagnosis of Loss of Limbs must be made by a Specialist.

Loss of Speech
A definite Diagnosis of the total and Irreversible loss of the ability to speak as the result of physical Injury or Sickness for a period of at least 180 days. The Diagnosis of Loss of Speech must be made by a Specialist.

Exclusion: No benefit will be payable under this Covered Condition for all psychiatric-related causes.

Major Organ Failure on Waiting List
A definite Diagnosis of the Irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be Medically Necessary. To qualify under Major Organ Failure on Waiting List, the Insured Person must become enrolled as the recipient in a recognized transplant centre in Canada or the United States of America that performs the required form of transplant Surgery. For the purpose of the Survival Period, the Date of Diagnosis is the date of the Insured Person's enrolment in the transplant centre.

The Diagnosis of the major organ failure must be made by a Specialist.

Major Organ Transplant
A definite Diagnosis of the Irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow and transplantation must be Medically Necessary. To qualify under Major Organ Transplant, the Insured Person must undergo a transplantation procedure as the recipient of a heart, lung, liver, kidney or bone marrow, and limited to these entities. The Diagnosis of the major organ failure must be made by a Specialist.

Motor Neuron Disease
A definite Diagnosis of one of the following: amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease), primary lateral sclerosis, progressive spinal muscular atrophy, progressive bulbar palsy, or pseudo-bulbar palsy, and is limited to these conditions. The Diagnosis of Motor Neuron Disease must be made by a Specialist.

Multiple Sclerosis
A definite Diagnosis of at least one of the following:
a) two or more separate clinical attacks, confirmed by magnetic resonance imaging (MRI), of the nervous system showing multiple lesions of demyelination;
b) well-defined neurological abnormalities lasting more than 6 months, confirmed by MRI imaging of the nervous system showing multiple lesions of demyelination; or
c) a single attack confirmed by repeated MRI imaging of the nervous system, which shows multiple lesions of demyelination which have developed at intervals at least one month apart.

The Diagnosis of Multiple Sclerosis must be made by a Specialist.

Muscular Dystrophy
A definitive Diagnosis of Muscular Dystrophy, characterized by well-defined neurological abnormalities, confirmed by electromyography and muscle biopsy.

Occupational HIV Infection
A definite Diagnosis of infection with Human Immunodeficiency Virus (HIV) resulting from an Accident causing Injury during the course of the Insured Person's normal occupation which exposed the Insured Person to HIV-contaminated body fluids.

The Injury from Accident leading to the infection must have occurred after the later of the Effective Date of Insurance or the Effective Date of the last reinstatement of the Insured Person's coverage.

Payment under this Covered Condition requires satisfaction of all of the following:
a) the Injury from Accident must be reported to Us within 14 days of the Accident causing the Injury;
b) a serum HIV test must be taken within 14 days of the Injury from Accident and the result must be negative;
c) a serum HIV test must be taken between 90 days and 180 days after the Accidental Injury from Accident and the result must be positive;
d) all HIV tests must be performed by a duly licensed laboratory in Canada or the United States of America; and
e) the Injury from Accident must have been reported, investigated and documented in accordance with current Canadian or United States of America workplace guidelines.

The Diagnosis of Occupational HIV Infection must be made by a Specialist.

Exclusion: No benefit will be payable under this Covered Condition if:
a) the Insured Person has elected not to take any available licensed vaccine offering protection against HIV;
b) a licensed cure for HIV infection has become available prior to the Injury from Accident; or
c) HIV infection has occurred as a result of any Injury not from Accident including, but not limited to, sexual transmission and intravenous (IV) drug use.

Paralysis
A definite Diagnosis of the total loss of muscle function of two or more limbs as a result of Injury or Sickness to the nerve supply of those limbs, for a period of at least 90 days following the precipitating event. The Diagnosis of Paralysis must be made by a Specialist.

Parkinson's Disease and Specified Atypical Parkinsonian Disorders

Parkinson's Disease
A definite Diagnosis of primary Parkinson's Disease, a permanent neurologic condition which must be characterized by bradykinesia (slowness of movement) and at least one of: muscular rigidity or rest tremor. The Insured Person must exhibit objective signs of progressive deterioration in function for at least one year, for which the treating neurologist has recommended dopaminergic medication or other generally medically accepted equivalent treatment for Parkinson's Disease.

Specified Atypical Parkinsonian Disorders
A definite Diagnosis of progressive supranuclear palsy, corticobasal degeneration, or multiple system atrophy. The Diagnosis of Parkinson's Disease or a Specified Atypical Parkinsonian Disorder must be made by a Specialist who is a neurologist.

Medical information about the Diagnosis and any signs, symptoms or investigations leading to the Diagnosis must be reported to Us within 6 months of the Date of the Diagnosis. If this information is not provided within this period, the Insurer has the right to deny any Claim for Parkinson's Disease, Specified Atypical Parkinsonian Disorders or any Covered Condition caused by Parkinson's Disease or Specified Atypical Parkinsonian Disorders or its treatment.

Exclusion: No benefit will be payable under this Covered Condition if, within the first year following the later of: (i) the Effective Date of Insurance or (ii) the date of the last reinstatement of the Insured Person's coverage, the Insured Person has any of the following:
a) signs, symptoms or investigations that lead to a Diagnosis of Parkinson's Disease, a Specified Atypical Parkinsonian Disorder or any other type of Parkinsonism, regardless of when the Diagnosis is made; or
b) a Diagnosis of Parkinson's Disease, a Specified Atypical Parkinsonian Disorder or any other type of Parkinsonism.

No benefit will be payable under this Covered Condition for any other type of Parkinsonism.

Severe Burns
A definite Diagnosis of third-degree burns over at least 20% of the body surface. The Diagnosis of Severe Burns must be made by a Specialist.

Stroke (Cerebrovascular Accident)
A definite Diagnosis of an acute cerebrovascular event caused by intracranial thrombosis or haemorrhage, or embolism from an extra-cranial source, with:
1. acute onset of new neurological symptoms, and
2. new objective neurological deficits on clinical examination,
   persisting for more than 30 days following the Date of Diagnosis. These new symptoms and deficits must be corroborated by diagnostic imaging testing.

The Diagnosis of Stroke must be made by a Specialist.

Exclusion: No benefit will be payable under this Covered Condition for:
a) transient Ischaemic Attacks;
b) intracerebral vascular events due to trauma; or
c) lacunar infarcts which do not meet the definition of Stroke as described above.

Type 1 Diabetes Mellitus (Juvenile Diabetes)
The Diagnosis of type 1 diabetes mellitus, characterized by absolute insulin deficiency and continuous dependence on exogenous insulin for survival. The Diagnosis must be made by a Specialist who is a qualified pediatrician or endocrinologist licensed and practising in Canada, and there must be evidence of dependence on insulin for a minimum of 3 months.

Child Critical Illness Exclusions

a) When a Child is born within ten months of Your Effective Date of Insurance and is Diagnosed with any Covered Condition within 31 days after their date of birth, no benefit will be payable for such Covered Condition.
b) Any cancer tumour in the presence of the human immunodeficiency virus (HIV).

General Exclusions for All Covered Conditions

a) No benefit will be payable if the Pre-Existing Condition Limitation applies.
b) No benefit will be payable for a Covered Condition Diagnosed while the Insured Person is not covered under the Policy.
c) No benefit will be payable if the Survival Period limitations are not satisfied.
d) No benefit will be payable if the Insured Person's condition was either directly or indirectly caused by, contributed to, resulted from or was in any way associated with one or more of the following:
    i. attempted suicide or self-inflicted Injury or Sickness;
    ii. committing or attempting to commit a criminal offence;
    iii. the use of alcohol or any medications or drugs, other than taken as prescribed by a Physician;
    iv. insurrection, riot, civil commotion, hostilities of any kind, war (whether declared or not), or active service in the armed forces of any country;
    v. any Accident, Injury or Sickness caused by hazardous activities or sports such as, but not limited to: professional sports, racing, B.A.S.E. jumping, bungee jumping, parachuting, ultra-light flying, hang gliding, scuba diving, rock or mountain climbing, back country or heli-skiing, motocross or extreme sports;
    vi. Injuries sustained while operating a motor vehicle, either while under the influence of any intoxicant or if the Insured Person's blood contained more than 80 milligrams of alcohol per 100 millilitres of blood at the time of the Injury;
    vii. medical care which is not Medically Necessary or which is cosmetic in nature (the donation of an organ or tissue will be considered as Medically Necessary care); or
    viii. any specific exclusions relating to any given Covered Condition as set out within the definition for that Covered Condition in this article.
e) No benefit will be payable if the Insured Person fails to seek treatment in order to avoid the Pre-Existing Condition Period limitations or other conditions and restrictions of the Policy.
f) No benefit will be payable if, within 90 days following the later of the Effective Date of Insurance or date of the last reinstatement of coverage:
    i. a Diagnosis of Cancer (Life-Threatening) or Cancer (Non-Life-Threatening) is made or the Insured Person has any signs, symptoms or investigations that lead to a Diagnosis of Cancer (life-threatening) or Cancer (non-life-threatening) (covered or excluded under this benefit), regardless of when the Diagnosis is made; or
    ii. a Diagnosis of Benign Brain Tumour is made or the Insured Person has any signs, symptoms or investigations that lead to a Diagnosis of Benign Brain Tumour (covered or excluded under this benefit), regardless of when the Diagnosis is made.
g) No benefit will be payable if, within 365 days following the later of the Effective Date of Insurance or date of the last reinstatement of coverage, a Diagnosis of Parkinson's Disease or Specified Atypical Parkinsonian Disorders is made or the Insured Person has any signs, symptoms or investigations that lead to a Diagnosis of Parkinson's Disease or Specified Atypical Parkinsonian Disorders, regardless of when the Diagnosis is made.

Contacts

In this section You will find contact information for Your company's benefits advisor. Please contact Your advisor for any information regarding Your benefit plan, and for any personal insurance requirements for You and Your family.

Any questions regarding administrative matters should be directed to the plan administrator at Your company.

Benefits Administrator

As Your Benefits Administrator, We are responsible for all day-to-day matters pertaining to the administration of Your Group Benefits Plan, such as premium billing, establishing and maintaining all necessary records, and acting as Your advocate with the Insurers. The Plan Administrator at Your organization who was appointed by Your Employer works with Us to ensure that all information is reported quickly and accurately and that the Plan is meeting all of Your expectations. Please contact Your Plan Administrator if You have any questions or concerns about Your coverage.

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