Delivery Agreement

Policyholder: COMPANY 3

Group Policy Number: 91965

Effective Date: November 1, 2017

The signature below confirms the Policyholder has received the policy and accepts and agrees to its terms and conditions. In the absence of a signature, the Policyholder's payment to Carrier 3 of the first month's premium following receipt of this policy will be considered acceptance by the Policyholder.

The Policyholder further agrees that all terms and conditions in the Policyholder's application for coverage will be interpreted in accordance with the terms, conditions and definitions contained in this policy.

Please sign this Delivery Agreement and return to Carrier 3.

SIGNED at _____ this ____ day of _____ 20__

_____ _____

Witness Signature

Signature of Authorized Officer for the Policyholder

_____

Title

Issued by: MR

Group Coverage Policy

Policyholder: Company 3

Group Policy Number: 12345

Effective Date: November 1, 2017

First Renewal Date for Health Benefits: March 1, 2019

First Renewal Date for Life Benefits: March 1, 2021

Subsequent Renewal Date: First day of March

This policy is issued by Carrier 3 which underwrites all dental, extended health, drug and travel benefits and Carrier 3 Life Insurance Company of Canada which underwrites all life, accidental death and dismemberment, disability and critical illness benefits. All obligations (other than the Policyholder's obligations) relating to dental, extended health, drug or travel benefits are solely those of Carrier 3, and all obligations (other than the Policyholder's obligations) relating to the life, accidental death and dismemberment, disability or critical illness benefits are solely those of Carrier 3 Life Insurance Company of Canada.

In this policy, for convenience of reference, Carrier 3 and Carrier 3 Life Insurance Company of Canada are referred to collectively as "Carrier 3".

Carrier 3 agrees to provide the benefits specified in this policy to Members and their Dependents, subject to the terms contained on this and the following pages and to the payment of premiums by the Policyholder.

Signed by Carrier 3 on March 5, 2018.

Group Policy Amendment 5

Policyholder: COMPANY 3

Group Policy Number: 91965

Effective Date: January 1, 2020

The policy, issued by Carrier 3, is amended as follows:
Under Extended Health Care, coverage for Mental Health Practitioners is revised.

The following page(s) is/are revised:
Summary of Benefits, pages S-13 and S-14

This amendment forms part of the policy between Carrier 3 and the Policyholder, and should be filed with the existing group policy. Except as specified in this amendment, all other terms and conditions of the policy remain in effect.

The signature below confirms the Policyholder has received the amendment and accepts and agrees to its terms and conditions. In the absence of a signature, this amendment will be considered effective if the Policyholder does not object to any of the revised terms and conditions within 31 days following receipt of the amendment and if the Policyholder pays premiums within 60 days of receiving the amendment.

Please sign this Group Policy Amendment and return to Carrier 3.

Signed by Carrier 3 on December 10, 2019.

Group Policy Amendment 4

Policyholder: COMPANY 3

Group Policy Number: 91965

Effective Date: September 1, 2019

The policy, issued by Carrier 3, is amended as follows:

Division 1576793 Alberta Inc. is cancelled.

The following page(s) is/are revised:
Master Group Listing

This amendment forms part of the policy between Carrier 3 and the Policyholder, and should be filed with the existing group policy. Except as specified in this amendment, all other terms and conditions of the policy remain in effect.

The signature below confirms the Policyholder has received the amendment and accepts and agrees to its terms and conditions. In the absence of a signature, this amendment will be considered effective if the Policyholder does not object to any of the revised terms and conditions within 31 days following receipt of the amendment and if the Policyholder pays premiums within 60 days of receiving the amendment.

Please sign this Group Policy Amendment and return to Carrier 3.

Group Policy Amendment 3

Policyholder: COMPANY 3

Group Policy Number: 91965

Effective Date: March 1, 2019

The policy, issued by Carrier 3, is amended as follows:

Under Travel Benefit, the Coverage Duration is revised to the first 60 days of Trip outside province of residence.

The following page(s) is/are revised:

Summary of Benefits, page S-18

This amendment forms part of the policy between Carrier 3 and the Policyholder, and should be filed with the existing group policy. Except as specified in this amendment, all other terms and conditions of the policy remain in effect.

The signature below confirms the Policyholder has received the amendment and accepts and agrees to its terms and conditions. In the absence of a signature, this amendment will be considered effective if the Policyholder does not object to any of the revised terms and conditions within 31 days following receipt of the amendment and if the Policyholder pays premiums within 60 days of receiving the amendment.

Please sign this Group Policy Amendment and return to Carrier 3.

Signed by Carrier 3 on March 9th, 2019.

Group Policy Amendment – 2

Policyholder: COMPANY 3

Group Policy Number: 91965

Effective Date: September 1, 2018

The policy, issued by Carrier 3, is amended as follows:

Applicable to Class BB (Full-time Participants) and Class CC (Part-time Participants): Under Drug Benefit, Smoking Cessation Aids are added with a Benefit Maximum of $300 per lifetime, subject to the Overall Benefit Maximum.

The following page(s) is/are revised: *Summary of Benefits, page S-12*

This amendment forms part of the policy between Carrier 3 and the Policyholder, and should be filed with the existing group policy. Except as specified in this amendment, all other terms and conditions of the policy remain in effect.

The signature below confirms the Policyholder has received the amendment and accepts and agrees to its terms and conditions. In the absence of a signature, the Policyholder's payment of premiums to Carrier 3 within 60 days following receipt of this amendment will be considered acceptance by the Policyholder.

Group Policy Amendment – 1

Policyholder: COMPANY 3

Group Policy Number: 91965

Effective Date: November 1, 2017

The policy, issued by Carrier 3, is amended as follows:

Fee Guide Schedule under Dental Benefit is revised to include Specialist fee guide.

The following page(s) is/are revised:

Summary of Benefits, pages S-16 and S-17

This amendment forms part of the policy between Carrier 3 and the Policyholder, and should be filed with the existing group policy. Except as specified in this amendment, all other terms and conditions of the policy remain in effect.

The signature below confirms the Policyholder has received the amendment and accepts and agrees to its terms and conditions. In the absence of a signature, the Policyholder's payment of premiums to Carrier 3 within 60 days following receipt of this amendment will be considered acceptance by the Policyholder.

Master Group Listing

Class Description

A1. Senior Executives

AA. All Other Executives

BB. Full-time Participants

CC. Part-time Participants

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Summary of Benefits

The Summary of Benefits summarizes, in a simplified form, the provisions of this policy but does not include all applicable exclusions and limitations. The Summary of Benefits must be read together with the policy provisions and, in the event of conflict, the policy provisions will prevail.

Summary of Benefits

Coverage Provisions

Class Description	A1. Senior Executives AA. All Other Executives BB. Full-time Participants
Eligibility Requirements	An Employee must work a minimum of 30 hours/week for the Employer and meet the other eligibility requirements set out in this policy.
Waiting Period	
Classes A1 and AA:	None
Class BB:	3 months of continuous service for all benefits with the exception of Dental Benefit and Long Term Disability Benefit 6 months of continuous service for Dental Benefit 12 months of continuous service for Long Term Disability Benefit
Participation Basis	Participation under this policy is Mandatory for all eligible Employees, excluding any optional benefits.
Beneficiary Designations Under the Previous Group Insurance Policy	The beneficiary designations for the life benefit under the previous group insurance policy are not continued under this policy.

Class Description	CC. Part-time Participants
Eligibility Requirements	An Employee must work a minimum of 20 hours/week for the Employer and meet the other eligibility requirements set out in this policy.
Waiting Period	3 months of continuous service for all benefits with the exception of Dental Benefit 6 months of continuous service for Dental Benefit
Participation Basis	Participation under this policy is Non-Mandatory for all eligible Employees.

Summary of Benefits

Coverage Provisions

Class Description	A1. Senior Executives AA. All Other Executives BB. Full-time Participants CC. Part-time Participants
Coverage During Periods of Absence from Work	
Illness/Accident	Coverage continued: All benefits Maximum period: The entire period of absence or until employment termination, subject to the *Waiver of Premium* provisions Payment of premiums: Yes, until waiver of premium starts for certain benefits
Maternity/Parental Leave	Coverage continued: Member decision to retain or discontinue all benefits* Maximum period: As required by applicable legislation Payment of premiums: If benefits are retained, premiums are payable
Temporary Layoff	Coverage continued: All benefits except disability benefits, if applicable Maximum period: 6 months Payment of premiums: Yes
Authorized Leave of Absence (Including Disciplinary Suspension)	Coverage continued: All benefits except disability benefits, if applicable Maximum period: 6 months Payment of premiums: Yes Authorized Leave of Absence extended beyond the maximum period must be approved by Carrier 3.
Strike/Lockout**	Coverage continued: None Maximum period: Not applicable Payment of premiums: Not applicable

Summary of Benefits

*Exception: Quebec Participants must at least retain drug coverage unless they benefit from drug coverage under another group plan.

**Exception: Drug coverage for Quebec Participants is retained for 30 days after any strike or lockout begins, subject to the payment of premiums.

Member Life Benefit

Class Description	A1. Senior Executives AA. All Other Executives
Benefit Formula	3 times the annual Salary
Rounding Method	To the next higher $1,000 if under age 65, and to the next higher $500 if age 65 and over
Benefit Maximum	$500,000
Non-Evidence Limit	$500,000
Terminal Illness Benefit	Included
Benefit Reduction	The amount of coverage reduces by 50% at age 65
Termination	Age 70 or retirement
Waiver of Premium	Yes

Class Description	BB. Full-time Participants
Benefit Formula	2 times the annual Salary
Rounding Method	To the next higher $1,000 if under age 65, and to the next higher $500 if age 65 and over
Benefit Maximum	$500,000

Non-Evidence Limit	$500,000
Terminal Illness Benefit	Included
Benefit Reduction	The amount of coverage reduces by 50% at age 65
Termination	Age 70 or retirement
Waiver of Premium	Yes

Summary of Benefits

Dependent Life Benefit	
Class Description	A1. Senior Executives AA. All Other Executives BB. Full-time Participants
Benefit Formula	
Spouse	$20,000
Child*	$10,000/Child
Termination	When the Member reaches age 70 or retires
Waiver of Premium	Yes

*From live birth.

Summary of Benefits

Optional Life Benefit

Class Description	A1. Senior Executives AA. All Other Executives BB. Full-time Participants
Benefit Formula	Units of $10,000
Benefit Maximum	
Member	Maximum of $200,000 $700,000 combined with member life benefit amount
Spouse	Maximum of $200,000
Non-Evidence Limit	Proof of Health is required for all amounts of coverage
Termination	
Member	Age 65 or retirement
Spouse	When the Member or Spouse reaches age 65 or when the Member retires
Waiver of Premium	Yes

Summary of Benefits

Member Accidental Death and Dismemberment Benefit

Class Description	A1. Senior Executives AA. All Other Executives
Benefit Formula	3 times the annual Salary
Rounding Method	To the next higher $1,000 if under age 65, and to the next higher $500 if age 65 and over
Benefit Maximum	Same as the member life benefit
Non-Evidence Limit	Same as the member life benefit
Benefit Reduction	The amount of coverage reduces by 50% at age 65
Termination	Age 70 or retirement
Waiver of Premium	Yes

Class Description	BB. Full-time Participants
Benefit Formula	2 times the annual Salary
Rounding Method	To the next higher $1,000 if under age 65, and to the next higher $500 if age 65 and over
Benefit Maximum	Same as the member life benefit
Non-Evidence Limit	Same as the member life benefit
Benefit Reduction	The amount of coverage reduces by 50% at age 65
Termination	Age 70 or retirement
Waiver of Premium	Yes

Optional Enhanced Critical Illness Benefit

Class Description	A1. Senior Executives AA. All Other Executives BB. Full-time Participants
Benefit Maximum	
Full Benefit Payment	
Member	Units of $10,000 to a maximum of $250,000
Spouse	Units of $10,000 to a maximum of $250,000
Partial Benefit Payment	10% of the full benefit payment
Non-Evidence Limit	Proof of health is required for all amounts of coverage.

Summary of Benefits

Maximum Conditions Payable	Up to 2 unrelated covered conditions eligible for full benefit payment/lifetime 1 per covered condition eligible for partial benefit payment/lifetime
Survival Period	30 consecutive days unless otherwise specified in the defined covered conditions
Termination	The earlier of when the Participant receives 2 full payments or when the Member or Spouse reaches age 65 or the Member retires.
Waiver of Premium	No

Summary of Benefits

Long Term Disability Benefit	
Class Description	A1. Senior Executives AA. All Other Executives
Benefit Formula	66.70% of the first $2,500 of monthly Pre-Disability Salary, plus 52.50% of the next $2,500, plus 40% of the remainder, not exceeding the All Source Maximum
Benefit Maximum	$6,000/month
Non-Evidence Limit	$6,000
Elimination Period	17 weeks (119 days) or the end of the short term disability benefit payments (if applicable), whichever is later
Benefit Period	To age 65
Taxable	No
Integration of Benefits	Yes
All Source Maximum	85% of Pre-Disability Net Salary
Duration of Own Occupation	24 months
Cost-of-Living Adjustment	CPI adjustment to a maximum of 3%
Effective Date of Adjustment	This adjustment will become effective on January 1 of each year for any Member who has been receiving long term disability benefit payments.
Pre-Existing Conditions	Yes
Termination	Age 65 less the Elimination Period or at retirement
Waiver of Premium	Yes

Long Term Disability Benefit	
Class Description	BB. Full-time Participants
Benefit Formula	66.70% of the first $2,500 of monthly Pre-Disability Salary, plus 52.50% of the next $2,500, plus 40% of the remainder, not exceeding the All Source Maximum
Benefit Maximum	$6,000/month
Non-Evidence Limit	$6,000
Elimination Period	17 weeks (119 days) or the end of the short term disability benefit payments (if applicable), whichever is later
Benefit Period	To age 65
Taxable	No
Integration of Benefits	Yes

Summary of Benefits

All Source Maximum	85% of Pre-Disability Net Salary
Duration of Own Occupation	24 months
Cost-of-Living Adjustment	None
Pre-Existing Conditions	Yes
Termination	Age 65 less the Elimination Period or at retirement
Waiver of Premium	Yes

Summary of Benefits

Drug Benefit

Class Description	A1. Senior Executives AA. All Other Executives
Deductible	None
Reimbursement Level	100%*
Method of Payment	Pay Direct
Supplemental Coverage Offered to Participants in RAMQ Public Plan	Yes
Drug Formulary	Frozen Formulary
Benefit Maximum	$500,000 per Participant per lifetime
Fertility Treatments	$2,400/lifetime**
Allergy Sera	Included**
Smoking Cessation Aids	$500/lifetime**
Vaccines	Included**
Vitamins	Included**, injectable only
Substitution Provision	Mandatory Generic Substitution
Days Supply	100 days maximum supply (30 days supply may apply to some drugs)
Termination	When the Member retires
Survivor Coverage	24 months

*The out-of-pocket maximum for Quebec Participants meets the requirements of the Régie de l'assurance maladie du Québec (RAMQ).

**Included in the overall benefit maximum.

Includes certain over-the-counter items that are considered life sustaining in nature and that are approved by Carrier 3.

Drug Benefit

Class Description	BB. Full-time Participants CC. Part-time Participants
Deductible	None
Reimbursement Level/Drug Formulary	Drugs on the Provincial Formulary - 100% less Dispensing Fee* All other Eligible Drugs - 70% less Dispensing Fee* 100% for Diabetic Supplies 70% for Vaccines Not applicable to Quebec residents

Summary of Benefits

Dispensing Fee

Method of Payment	Pay Direct
Supplemental Coverage Offered to Participants in RAMQ Public Plan	Yes
Drug Formulary	Provincial Formulary Equivalent/Managed Formulary
Benefit Maximum	$500,000 per Participant per lifetime
Smoking Cessation Aids	***$300/lifetime*** **
Vaccines	Included**
Vitamins	Included**, injectable only
Substitution Provision	Mandatory Generic Substitution
Days Supply	100 days maximum supply (30 days supply may apply to some drugs)
Termination	When the Member retires
Survivor Coverage	24 months

*The out-of-pocket maximum for Quebec Participants meets the requirements of the Régie de l'assurance maladie du Québec (RAMQ).

**Included in the overall benefit maximum.

Includes certain over-the-counter items that are considered life sustaining in nature and that are approved by Carrier 3.

Summary of Benefits

Effective Date: September 1, 2018

Summary

Extended Health Care

of Benefits

Class Description	A1. Senior Executives AA. All Other Executives	
Deductible		
Hospitalization	None	
Vision Care	None	
All other Extended Health Care	None	
	Reimbursement Level	**Benefit Maximum**
Hospitalization		
Chronic Care/Nursing Home	100%	$25/day
Medical Services and Supplies		
Ambulance Transportation	100%	$3,000/calendar year
Nursing Care	100%	$10,000/12 consecutive months
Chronic Disease Management	100%	$500/calendar year
Health Practitioners:		**Maximum per calendar year**
Mental Health Practitioners *(Psychologist/Social Worker* ***/Clinical Counsellor/Psychotherapist (combined))***	100%	$1,000*
Chiropractor (including x-rays)	100%	$1,000*
Naturopath	100%	$1,000*
Acupuncturist	100%	$1,000*
Osteopath (including x-rays)	100%	$1,000*
Chiropodist/Podiatrist (combined) (including x-rays)	100%	$1,000*
Speech Therapist	100%	$1,000*
Physiotherapist/Athletic Therapist (combined)	100%	$1,000*
Massage Therapist	100%	$1,000*

*Reimbursement per visit is limited to Usual, Customary and Reasonable charges.

Summary

Extended Health Care

Amendment - 5
Effective Date: January 1, 2020

of Benefits

Class Description	BB. Full-time Participants CC. Part-time Participants	
Deductible		
Hospitalization	None	
Vision Care	None	
All other Extended Health Care	None	
	Reimbursement Level	**Benefit Maximum**
Hospitalization		
Chronic Care/Nursing Home	100%	$25/day
Medical Services and Supplies		
Ambulance Transportation	100%	$3,000/calendar year
Nursing Care	100%	$10,000/12 consecutive months
Chronic Disease Management	100%	$500/calendar year
Health Practitioners:		**Maximum per calendar year**
Mental Health Practitioners *(Psychologist/Social Worker* ***/Clinical Counsellor/Psychotherapist (combined))***	100%	$300*
Chiropractor (including x-rays)	100%	$300*
Naturopath	100%	$300*
Acupuncturist	100%	$300*
Osteopath (including x-rays)	100%	$300*
Chiropodist/Podiatrist (combined) (including x-rays)	100%	$300*
Speech Therapist	100%	$300*
Physiotherapist/Athletic Therapist (combined)	100%	$300*
Massage Therapist	100%	$300*

*Reimbursement per visit is limited to Usual, Customary and Reasonable charges.

Summary of Benefits

Extended Health Care

Amendment - 5
Effective Date: January 1, 2020

Class Description	A1. Senior Executives AA. All Other Executives BB. Full-time Participants CC. Part-time Participants	
Medical Services and Supplies	**Reimbursement Level**	**Benefit Maximum**
Durable Medical Equipment*	100%	1/month for rental, 1/5 calendar years for approved purchase
Compression Pump		1/month for rental, $1,500/lifetime for approved purchase
Apnea Monitor, Mist Tent, EBI bone healing system		1/month for rental, purchase included
Enteral Pump		Included
Mobility Aids and Orthopedic Appliances	100%	See benefit details
Prostheses	100%	See benefit details
Diabetic Equipment	100%	One/4 calendar years
Hearing Aids	100%	$300/5 calendar years
Custom Orthopedic Shoes/ Custom Made Foot Orthotics (combined)	100%	$300/12 consecutive months
Diagnostic Tests**	100%	$1,000/calendar year for Laboratory Analyses; $2,000/calendar year for Ultrasounds, Electrocardiograms, CT Scans, X-Rays and MRI
Other Medical Services and Supplies	100%	See benefit details
Accidental Dental	100%	Predetermination of claim required
Vision Care		
Eye Examination	100%	$50/24 consecutive months
Lenses/Frames/Contact Lenses/Laser Eye Surgery (combined)	100%	$300/24 consecutive months
Intraocular lenses used in cataract surgery	100%	One pair/lifetime
Lenses/Frames/Contact Lenses following non-refractive eye surgery	100%	One pair/lifetime
Termination	When the Member retires	
Survivor Coverage	24 months	

Summary

Extended Health Care

*Pre-authorization required.

**Diagnostic imaging services coverage for residents of Quebec only.

Summary of Benefits

Dental Benefit

Class Description	A1. Senior Executives AA. All Other Executives	
Deductible	None	
Fee Guide Schedule	Current year/Province of Provider ***(Specialist and GP fee guide)***	
	Reimbursement Level	**Benefit Maximum**
Preventive Care	100%	$2,500/calendar year combined with Basic Care and Major Restoration
Oral Exam and Diagnosis		
Recall oral exams		1/9 consecutive months
Preventive Treatment		
Polishing of teeth		1/9 consecutive months
Fluoride treatment		1/9 consecutive months
Scaling		16 Units/12 consecutive months (combined with Root Planing)
Basic Care	100%	$2,500/calendar year combined with Preventive Care and Major Restoration
Endodontic Services		Included
Periodontic Services		Included
Root Planing		16 Units/12 consecutive months (combined with Scaling)
Major Restoration	50%	$2,500/calendar year combined with Preventive Care and Basic Care
Restorative and Prosthodontic Services		See benefit details
Restorations on implants		1/tooth every 10 calendar years
Orthodontic Services	50%	$2,500/lifetime
Lowest Cost Alternative Benefit	Inlays and crowns Bridgework	
Termination	When the Member retires	
Survivor Coverage	24 months	

Amendment - 1
Effective Date: November 1, 2017

Dental Benefit

Class Description	BB. Full-time Participants CC. Part-time Participants
Deductible	None

Summary of Benefits

Fee Guide Schedule	Current year/Province of Provider ***(Specialist and GP fee guide)***	
	Reimbursement Level	**Benefit Maximum**
Preventive Care	80%	$1,500/calendar year combined with Basic Care and Major Restoration
Oral Exam and Diagnosis		
Recall oral exams		1/9 consecutive months
Preventive Treatment		
Polishing of teeth		1/9 consecutive months
Fluoride treatment		1/9 consecutive months
Scaling		16 Units/12 consecutive months (combined with Root Planing)
Basic Care	80%	$1,500/calendar year combined with Preventive Care and Major Restoration
Endodontic Services		Included
Periodontic Services		Included
Root Planing		16 Units/12 consecutive months (combined with Scaling)
Major Restoration	50%	$1,500/calendar year combined with Preventive Care and Basic Care
Restorative and Prosthodontic Services		See benefit details
Restorations on implants		1/tooth every 10 calendar years
Orthodontic Services	50%	$2,500/lifetime
Lowest Cost Alternative Benefit	Inlays and crowns Bridgework	
Termination	When the Member retires	
Survivor Coverage	24 months	

Summary of Benefits

Effective Date: November 1, 2017

Travel Benefit	
Class Description	A1. Senior Executives AA. All Other Executives BB. Full-time Participants CC. Part-time Participants
Deductible	None
Reimbursement Level	100%
Coverage Duration	***First 60 days of Trip outside province of residence***
Stability Requirement	Participant must be Stable in the 90 days before the departure date
	Benefit Maximum
Emergency Hospital and Medical Travel Coverage	$2,000,000/Participant/Incident*
Worldwide Travel Assistance	Yes
Referral Outside of Canada**	$500,000/Participant/lifetime
Termination	When the Member reaches age 70 or retires
Survivor Coverage	24 months

*Incident: An individual occurrence of Emergency illness or injury.

**Pre-authorization required.

Summary of Benefits

Amendment – 3
Effective Date: March 1, 2019

Health Spending Account (HSA) Benefit

Class Description	A1. Senior Executives
Method of Payment	Reimbursement Upon Request (credits will be used to pay an HSA claim as directed by the Member on the claim form)
Credit Allocation Frequency	Annually
Benefit Details	
Policy Year	November 1st to October 31st
Carry Forward Type	Credit Carry Forward
Credits	$3,000/Policy Year
(CRA) Dependent Coverage	Yes
Grace Period for Active Members	60 days
Grace Period for Terminated Members	60 days
Termination	When the Member retires

Definitions

Accident: A sudden, fortuitous and unforeseeable event that:

- is violent in nature;
- arises solely from external means;
- causes bodily injury to the Participant directly and independently of all other causes; and is unintended by the Participant.

The resulting injury to the Participant must be certified by a Physician.

Actively at Work: Employees are Actively at Work on a specified day if they report for work at their usual place of employment and are able to perform the Regular Duties of their occupation, according to their regular work schedules.

Employees who are not required to report for work on a specified day due to holidays, shift variances, vacations or weekends are still considered to be Actively at Work if they could have reported for work and performed the Regular Duties of their occupation on that day.

Activities of Daily Living: The following 5 activities:

- Eating: the ability to manipulate prepared food or liquid into the mouth;
- Dressing: the ability to put on and remove necessary articles of clothing that are normally worn, including leg braces;
- Bathing: the ability to cleanse the entire body using soap and water, including turning on faucets and shower mechanisms, getting into and out of the bath or shower and drying oneself;
- Ambulation: the ability to move independently from place to place with or without the use of mobility aids; and
- Toileting (including continence, which is the ability to control bowel and bladder function): the ability to use a toilet, bedside commode or urinal.

Approved Provider: A provider of health care services or supplies who has been approved by Carrier 3 to provide specific Eligible Expenses.

Child: A person who:

- is a resident of Canada;
- is the natural or adopted child of the Member or Spouse, or the child over whom the Member or Spouse has been appointed as guardian with parental authority;
- is financially reliant on the Member or Spouse for care, maintenance and support;
- is not married or in a common law relationship; and meets one of the following criteria:

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a) is under age 21;
b) is under age 25 (26 for Quebec Participants) and is attending an accredited educational institution, college or university on a full-time basis; or
c) became mentally or physically disabled while a child as defined in (a) or (b) and has been continuously disabled since that time.

A child is considered to be mentally or physically disabled for the purposes of this definition if they are incapable of engaging in any substantially gainful activity and are financially reliant on the Member for care, maintenance and support due to this disability. Carrier 3 may require the provision of written proof of a child's disability as often as is reasonably necessary.

CLHIA: Canadian Life and Health Insurance Association Inc.

Deductible: The amount of Eligible Expenses that the Participant must pay before Carrier 3 will reimburse any Eligible Expenses.

The Deductible amount applies once per calendar year or per prescription drug, as specified in the Summary of Benefits. However, Eligible Expenses incurred during the last 3 months of a calendar year that totally or partially met the Deductible for that year may be used to reduce the Deductible for the following calendar year.

Dependent: The Spouse or Child of a Member.

Eligible Expenses: Charges incurred by the Participant for health care services and supplies that are:

- Medically Necessary;
- Usual, Customary and Reasonable;
- recommended or prescribed by a Physician or Health Practitioner who:
  - does not normally reside in the Participant's home;
  - is not the Participant's Family Member; and
  - is not the Participant’s employer or co-worker;
- rendered or dispensed by an Approved Provider who:
  - does not normally reside in the Participant’s home; and
  - is not the Participant's Family Member; and
- rendered or dispensed after the effective date and while this policy is in effect, unless otherwise specified.

Health care services and supplies that Participants prescribe, render or dispense to themselves are not Eligible Expenses.

An Eligible Expense is considered to be incurred on the date the service or supply was received by the Participant. Reimbursement for Eligible Expenses incurred outside of Canada will be limited to

the amount that would have been reimbursed if the expense had been incurred in the Participant's province of residence, unless the benefit is restricted to in Canada only.

Where more than one form or an alternative form of Treatment exists, Carrier 3 has the right to base its payment for Eligible Expenses on the lowest cost alternative if Carrier 3, in consultation with its health care consultants, deems the alternative Treatment to be appropriate and consistent with good health management.

Eligible Expenses are subject to post-payment audit in accordance with the *Right to Audit* provision found in the *Claim* provisions of this policy.

Employee: A person who:

- is a resident of Canada;
- is a permanent worker; and
- works for the Employer the minimum number of hours per week specified in the Summary of Benefits.

Employees on a temporary, contractual or seasonal basis, as well as Employees who work outside of Canada on a regular basis, are not eligible for coverage unless otherwise specified in the Summary of Benefits.

Employer: The Policyholder, unless otherwise specified on the application for coverage or in the Summary of Benefits (if applicable).

Experimental or Investigative: Any treatment, procedure, facility, equipment, drug, drug usage or vitamin therapy that, in the opinion of Carrier 3 after consultation with its health care consultants:

- is not Medically Necessary; or
- lacks sufficient published data to establish its medical effectiveness or safety for the purpose for which it is being provided or prescribed.

Family Member: A Participant's:

- spouse or common law partner;
- parent and parent's spouse or common law partner;
- children and spouse's or common law partner's children;
- brothers and sisters;
- grandchildren; or grandparents.

Government Health Care Coverage: Any plan, program or arrangement under the administrative or regulatory control of any government in Canada that is universally available to all residents of a particular province or territory and provides coverage, in whole or in part, for comprehensive health care benefits, services or supplies.

Health Benefits: Health Benefits include, as applicable:

- drug benefits;

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- extended health care;
- dental benefits; and travel benefits.

Health Practitioner: A health care practitioner who is a registered member of their regulatory body (if applicable) and practices within the limits of their authority as established by law. If no occupational guild applies to a particular practitioner, the practitioner must:

- be a registered member of their association;
- provide care and Treatment within the limits of their professional scope of practice; and be an Approved Provider.

Illness: A deterioration of health or a bodily disorder that has been diagnosed by a Physician and requires regular and continuous care.

Mandatory: Participation under this policy is a condition of employment and 100% of eligible Employees must apply for coverage.

Medically Necessary: A health care service or supply provided or prescribed by a Physician or Health Practitioner to treat an injury or Illness that, in the opinion of Carrier 3 after consultation with its health care consultants:

- has not been provided or prescribed primarily for convenience or cosmetic reasons;
- is the most appropriate, safe and cost-effective Treatment for the diagnosed injury or Illness; and
- is generally medically recognized as acceptable Treatment for the diagnosed injury or Illness

Member: An Employee who is eligible and approved for coverage under this policy.

Non-Evidence Limit: The amount of coverage for which a Participant is eligible without having to submit satisfactory Proof of Health. The Non-Evidence Limits are specified in the Summary of Benefits. The Non-Evidence Limit for a Participant who applies for coverage under this policy more than 31 days after becoming eligible for benefits is zero.

Non-Mandatory: Participation under this policy is not a condition of employment. Eligible Employees must either:

- apply for coverage for all benefits under this policy; or refuse coverage for all benefits under this policy.

Participant: The Member or one of the Member's Dependents who has been approved for coverage under this policy.

Physician: A doctor of medicine who is licensed in the jurisdiction in which the services are provided to prescribe and administer medical Treatment and drugs within the scope of their licence.

Policyholder: The Employer or group that is specified on the Group Coverage Policy page of this policy.

Definitions

Previous Policy: Any group insurance policy, contract or other arrangement that terminated within 31 days of the effective date of this policy and that provided coverage to Employees who are eligible for coverage under this policy. This term will be interpreted separately for each benefit contained in this policy.

Proof of Health: Statements or medical evidence about a Participant's health, as needed and requested by Carrier 3 at any time. Proof of Health must be submitted on forms approved by Carrier 3 for that purpose.

Quebec Participant: A Member or Dependent is considered to be a Quebec Participant if:

- the Policyholder has a business office in Quebec;
- the Member resides and works in Quebec; and
- the Participant is subject to the Act Respecting Prescription Drug Insurance.

Regular Duties: Work related activities that are essential to performing a particular job or occupation.

Reimbursement Level: The percentage of the Eligible Expense Carrier 3 will pay for Health Benefits as specified in the Summary of Benefits.

Salary: A Member's regular annual earnings paid by the Employer excluding overtime and bonuses. It does not include dividends or any irregular gains, such as bonuses and gratuities.

For commission-based Members, Salary is the Member's average earnings over the last 2 years of employment as indicated on their Canada Revenue Agency (CRA) taxation form. If the Member has been employed for less than 2 years, Salary will be prorated.

In determining benefits, Salary will be the lesser of:

- the Salary amount defined above; or
- the Salary last reported to Carrier 3 and used in the calculation of the premium payable.

Spouse: The person who:

- is a resident of Canada; and
- meets one of the following criteria:
  - is married to the Member;
  - is in a civil union with the Member as defined by the Civil Code of Quebec; or
  - has been living with the Member in a conjugal relationship for at least 1 year; however, where required by provincial legislation, this 1 year period is waived if a child is born of such relationship.

The Spouse must be designated by the Member on their application for coverage. Only one person may be covered as a Spouse at any one time.

Definitions

Treatment: The management and care of a Participant to improve or cure an Illness, disorder or injury. This management and care must be:

- considered appropriate and approved by Carrier 3; and
- prescribed, provided or performed by a Health Practitioner or Physician practicing in the field of medicine applicable to the Participant's disease, disorder or injury.

Usual, Customary and Reasonable: Charges incurred by the Participant that are:

- consistent with the amount typically charged by Health Practitioners or Approved Providers for similar services or supplies in the province in which the services or supplies are being purchased; and
- in the opinion of Carrier 3 in consultation with its health care consultants, consistent with the frequency and quantity that would usually be prescribed or needed for the Participant's condition.

Waiting Period: The continuous period of time during which an Employee must be Actively at Work before being eligible for coverage. However, if the Employee is on an Authorized Leave of Absence, this period of approved leave will be used to satisfy the Waiting Period. The Waiting Period is specified in the Summary of Benefits. It applies to all Employees unless a written request for a waiver of all or part of this Waiting Period with respect to a particular Employee is made by the Policyholder and approved by Carrier 3.

Coverage Provisions

Eligibility Requirements

Employees

To be eligible to apply for coverage under this policy, an Employee must:

- meet the definition of Employee;
- meet the definition of Actively at Work;
- be entitled to Government Health Care Coverage or similar coverage deemed satisfactory by Carrier 3; and
- complete the Waiting Period unless:
  - the Policyholder's written request for waiver of the Waiting Period in respect of the Employee has been approved by Carrier 3; or
  - the Employee has been rehired within 12 months of their employment termination, subject to the Reinstatement of Coverage provision.

Dependents

To be eligible for coverage under this policy, a Dependent must:

- meet the definition of Dependent; and
- be entitled to Government Health Care Coverage or similar coverage deemed satisfactory by Carrier 3.

Proof of Health

Proof of Health is needed to be approved for coverage:

a) if the coverage requested by an Employee for themselves or their Dependent exceeds the Non-Evidence Limit specified in the Summary of Benefits;

b) for all applications for the optional life benefit; or

c) for Non-Mandatory policies, if the application for any benefit is received by Carrier 3 more than 31 days after the date on which the Employee or the Dependent became eligible for coverage, subject to the following exceptions:

   i. late applicants for dental benefits do not need to submit a Proof of Health (instead their benefit maximum is limited in accordance with the *Coverage for Late*

Applicants provision found in the *Dental Benefit* provisions); and ii. Quebec Participants who are late in applying for drug benefit coverage do not need to submit Proof of Health.

Expenses incurred by the Employee to supply Proof of Health are the responsibility of:

 Carrier 3 in situations (a) or (b); and the Employee in situation (c).

Unless otherwise provided by provincial legislation, all statements provided by a Participant on a Proof of Health form with respect to any application for coverage or increase in coverage, other than fraudulent statements and omissions, will be incontestable by Carrier 3 after the coverage or increase in coverage has been in force for 2 consecutive years during the lifetime of the Participant.

Enrolment

Application Form

To obtain coverage, an Employee must complete and submit their application form, in a format agreed on by Carrier 3, and submit Proof of Health, if required.

The completed application form must be received by Carrier 3 within 31 days of the date the Employee or Dependent became eligible for coverage if benefits are mandatory.

Scope of Coverage

Individual selection of benefits is not permitted under this policy. Employees who enrol for coverage must also enrol all eligible Dependents, subject to the exceptions noted below:

- Employees may choose whether or not to obtain coverage for optional benefits; and
- Employees may choose not to obtain Health Benefits coverage for themselves or a Dependent if the Employee or Dependent has similar coverage under another group policy. In such circumstances, the Employee or Dependent will again be eligible for Health Benefits subject to Proof of Health if required, when:

  - there is a change in the Employee's family status; or
  - the Employee's or Dependent's other coverage terminates for reasons outside of their control and the Employee applies for coverage within 31 days of the termination.

When Coverage Begins

Employees

The coverage of an Employee takes effect on the latest of the following dates:

- the effective date of the policy;
- the date the Employee meets all of the eligibility requirements; or
- the date Carrier 3 approves the Employee's Proof of Health, if required.

Coverage Provisions

If an Employee is not Actively at Work on the date they would have become eligible for coverage, their coverage begins on the date they resume being Actively at Work, subject to all applicable legislation and to CLHIA guidelines regarding policy replacement.

Drug coverage for Quebec Participants takes effect on the date Carrier 3 receives their application for coverage.

Dependents

The coverage of a Dependent takes effect on the latest of the following dates:

- the date the Member becomes eligible for coverage;
- the date the Dependent meets all of the eligibility requirements;
- the date Carrier 3 approves the Dependent's Proof of Health, if required; or
- the date following the Dependent's discharge from hospital if the Dependent was hospitalized on the date they would have become eligible for coverage, except for:
  - a Dependent covered under a Previous Policy, in which case their coverage begins on the effective date of the policy; or
  - a Child born while this coverage is in force, in which case coverage for such Child will be effective from their live birth, or for dependent life coverage, as specified in the dependent life Summary of Benefits (if applicable).

Coverage during Periods of Absence from Work

Illness/Accident

If a Member is absent from work due to any disability recognized by Carrier 3 or any disability covered by a workers' compensation board/commission or automobile insurance bureau:

- the Member remains eligible for coverage for the maximum period specified in the Summary of Benefits; and
- premiums must continue to be paid for all benefits that are not subject to the *Waiver of Premium* provisions of this policy.

Maternity/Parental Leave

A Member who is absent from work as a result of maternity or parental leave must decide whether to retain coverage for all benefits or discontinue coverage for all benefits for the maximum period provided under the applicable federal or provincial legislation. This decision is irrevocable and must be made before the leave begins. If coverage is retained, premiums must continue to be paid for the duration of the leave.

Exception: Quebec Participants must at least retain drug coverage unless they benefit from drug coverage under another group plan.

Coverage Provisions

Temporary Layoff/Authorized Leave of Absence/Disciplinary Suspension

If a Member is absent from work due to an authorized leave of absence, a temporary layoff or a disciplinary suspension, the Member retains coverage for the benefits (if any) specified in the Summary of Benefits. The maximum period during which benefits will be retained is specified in the Summary of Benefits and premiums must continue to be paid for the benefits retained.

Strike/Lockout

Unless prior written agreement is obtained from Carrier 3, coverage for all benefits is discontinued for the duration of any strike or lockout.

Exception: Drug coverage for Quebec Participants is retained for 30 days after any strike or lockout begins. Premiums must continue to be paid during this 30 day period.

Reinstatement of Coverage

Benefits that have been discontinued during one of the above-mentioned periods of absence from work are reinstated when the Member returns to work provided the Policyholder notifies Carrier 3 of their return to work within 31 days of their return. If notice is not provided within this 31 day period, the Member must provide Proof of Health to have their benefits reinstated.

A Member whose coverage ends due to termination of employment does not have to complete the Waiting Period if they are rehired by the Employer within 12 months of the end of their employment.

Change in Amount of Coverage

The Policyholder may request a change in the amount of coverage as a result of an employment status change, the addition of a benefit or a change to an existing benefit.

The request will take effect on the date the change occurs unless the request brings about an increase in coverage, in which case the following exceptions apply:

- if Proof of Health is required, the increase in coverage will take effect on the date Carrier 3 approves the Proof of Health;
- if the Member is not Actively at Work on the date the change would otherwise take effect, the change will take effect on the next date that the Member is Actively at Work for one full day; and
- if a Dependent is hospitalized on the date the change would otherwise take effect, the change will take effect on the day after the Dependent is discharged from the hospital.

When Coverage Ends

Subject to applicable legislation and CLHIA guidelines, coverage ends on the earliest of the date:

- this policy terminates;
- the Participant no longer meets one or more of the eligibility requirements;

- the Member's employment is terminated;
- the Member (or Spouse, if applicable) reaches the termination age or termination date, if any, specified in the Summary of Benefits;
- the Member retires, unless otherwise specified in the Summary of Benefits;
- the Member dies;
- the Participant commits a fraudulent act against Carrier 3; or
- the Policyholder defaults in payment of premiums.*

Coverage for Dependents will also terminate on the date the Member's coverage terminates.

No coverage will be provided to any Participant while performing duties as an active member in the armed forces of any country, unless coverage must be retained under applicable provincial legislation.

*Drug coverage for Quebec Participants will continue for 30 days after notification of non-payment of premiums has been sent to the Policyholder.

Right to Convert to Individual Coverage

When a benefit provision specifies that a Participant is eligible to apply for an individual insurance policy on termination of their group coverage, the following terms and conditions apply:

- the Participant must, within 31 days of the date of termination of their group coverage:
  - submit the application form provided by Carrier 3 for the purpose of conversion to individual coverage; and
  - pay the entire amount of the first month's premium of the individual policy, in accordance with the method of payment stipulated by Carrier 3;
- the individual policy will be issued without requiring Proof of Health;
- the premium for the individual policy is based on the Carrier 3 individual policy rates in effect on the date of application. These rates are based on the age and sex of the Participant; and
- the individual policy is subject to any maximum and minimum values or other additional terms and conditions that are specified in the *Right to Convert to Individual Coverage* provision of the applicable benefit.

Survivor Coverage

When the Summary of Benefits specifies that the Survivor Coverage applies to a particular benefit, the following terms and conditions apply.

Coverage Provisions

In the event of the Member's death, coverage for Dependents will continue without payment of premiums for certain benefits, if specified in the Summary of Benefits.

Survivor Coverage for Dependents will terminate on the earliest of the following dates:

- the policy termination date;
- the date the maximum Survivor Coverage period has been reached, as specified in the Summary of Benefits;
- the effective date of any similar coverage under another plan; or
- the date a Dependent is no longer considered to be an eligible Dependent (for reasons other than the Member's death).

Waiver of Premium Provisions

Purpose of Coverage

If a Member becomes Totally Disabled while their coverage is in force and before reaching age 65, the Member's premiums for certain benefits will be waived. The Summary of Benefits specifies the benefits to which this waiver of premium applies.

If the policy does not include the long term disability benefit, or if the disabled Member belongs to a class of Employees not covered under this benefit, proof of Total Disability must be submitted to Carrier 3 within 12 months of the onset of Total Disability and while Total Disability persists.

Definition of Total Disability

For the purpose of this provision, the definition of Total Disability or Totally Disabled is that found under the *Additional Definitions* provision in the *Long Term Disability Benefit* provisions of this policy.

If the policy does not include the long term disability benefit, or if the disabled Member belongs to a class of Employees not covered under this benefit, the definition of Total Disability or Totally Disabled is as follows:

- a state of continuous incapacity, resulting from an Illness or Accident, which prevents the Member from performing the Regular Duties of any occupation for which the Member:
  - would earn 60% or more of the Salary earned by the Member immediately before the date of disability; and
  - is reasonably qualified or may so become by training, education or experience.

The loss of a professional or occupational licence or certification does not, in itself, constitute Total Disability.

The availability of work is not considered when assessing the Member's Total Disability.

Amount of Coverage Provided

The amount of coverage subject to this *Waiver of Premiums* provisions is the amount of coverage in force on the beginning date of Total Disability.

Date the Waiver of Premium Begins

Premiums due will be waived beginning on the first day following the end of the Elimination Period of the long term disability benefit if the Member meets the definition of Total Disability found under the *Additional Definitions* provision in the *Long Term Disability Benefit* provisions of this policy.

However, if the policy does not include long term disability benefit, or the Member belongs to a class of Employees not covered under this benefit, premiums will be waived beginning on the first day following the expiry of 6 consecutive months of Total Disability, as defined in this section of the policy.

Waiver of Premium Provisions

Date the Waiver of Premium Ends

Subject to the exceptions outlined below, the waiver of premium terminates on the earliest of the date:

- the waiver of premium period expires, if any, as specified in the Summary of Benefits;
- the Member no longer meets the definition of Total Disability;
- the Member engages in any occupation for remuneration or profit, except for a rehabilitation program pre-approved by Carrier 3;
- the Member fails to submit the required proof of Total Disability;
- the Member reaches age 65;
- the Member would normally retire;
- the Member's employment terminates;
- coverage terminates for the class of Employees to which the Member belongs;
- the benefit or policy terminates; or the Member dies.

If, while a Member is Totally Disabled and benefitting from waiver of premium:

- the Member's employment terminates; or
- coverage for their class of Employees or all Employees under this policy terminates;

the waiver of premium is extended beyond the termination date outlined above in accordance with the following:

- Member life and member optional life benefit coverage will remain in force and continue to be eligible for waiver of premiums until age 65; and
- long term disability benefit coverage will remain in force and continue to be eligible for waiver of premium as long as the Member remains in receipt of long term disability benefit payments. This waiver of premium will not extend beyond the maximum benefit period of the long term disability benefit specified in the Summary of Benefits.

Recurrent Disability

If a Member who was Totally Disabled and approved for waiver of premium becomes Totally Disabled again after having returned to work, the waiver of premium will resume as of the first day

following the date of the recurrent disability. The waiver of premium will be for the same amount of coverage as was in force on the original date of Total Disability, subject to all exclusions and limitations in this policy.

The definition of recurrent disability is that found under the *Recurrent Disability* provision in the *Long Term Disability Benefit* provisions of this policy.

Waiver of Premium Provisions

If the policy does not include the long term disability benefit, or if the Totally Disabled Member belongs to a class of Employees not covered under this benefit, the definition of recurrent disability is as follows:

- a successive period of Total Disability that:
  - results from the same or related cause as a prior period of Total Disability which led to a waiver of premium; and
  - occurs within 6 months of the waiver of premium being terminated.

Waiver of Premium with Previous Carrier

The Policyholder must notify Carrier 3 when a Member is eligible for waiver of premium with a previous carrier. This notification must include the effective date of the waiver and the list of benefits to which it applies.

Member Life Benefit Provisions

Purpose of Coverage

If the Member dies while covered by this benefit, Carrier 3 will pay the Member's beneficiary the amount specified in the Summary of Benefits, subject to the conditions outlined below.

Advance Payment Due to Terminal Illness

An advance payment of the member life benefit may be paid to the Member if:

- the Member submits a request to Carrier 3 in writing;
- Carrier 3 is satisfied, on the basis of medical evidence provided by the Member's attending Physician, that the Member is suffering from a condition that is expected to result in the Member's death within 12 months of the date of the request; the Member is eligible for waiver of premium; and the Member is under age 65.

An advanced payment amount cannot be more than 50% of the member life benefit amount in effect at the time of the request or $50,000, whichever is less. It will be paid in one lump sum that will be deducted from the member life benefit amount. The remainder of the member life benefit will be paid to the Member's beneficiary on death of the Member.

Members are only eligible for an advance payment once per lifetime.

Reductions in Coverage

The Benefit Reduction schedule, if any, is specified in the Summary of Benefits.

Payment of Claims

Beneficiary

Member life benefits will be paid to the Member's beneficiary with the exception of an advance payment due to terminal illness that will be paid directly to the Member.

Rounding Amounts of Coverage

If not already a multiple of $1,000, the amount of coverage for Members under age 65 is rounded up to the next multiple of $1,000. At age 65 and over, coverage that is not already a multiple of $500 is rounded up to the next multiple of $500.

Waiver of Premium During Total Disability

This benefit is subject to the *Waiver of Premium* provisions of this policy.

When Coverage Ends

Coverage ends at the termination age specified in the Summary of Benefits. In addition, coverage may end on an earlier date, as specified in the *When Coverage Ends* provision found under the *Coverage* provisions of this policy.

Right to Convert to Individual Coverage

Eligibility for Conversion

The Member has the right to purchase an individual life policy from Carrier 3 if their member life benefit coverage terminates before the Member reaches age 65 due to retirement, termination of employment or termination of coverage for the group or class of Employees to which the Member belongs.

This conversion option also applies to any scheduled reduction or termination of coverage that becomes effective at specified ages.

Terms and Conditions of the Converted Policy

Individual policies issued under this conversion option are subject to the terms and conditions specified in the *Right to Convert to Individual Coverage* provision found under the *Coverage* provisions of this policy.

They are also subject to the following additional terms and conditions:

- during the 31 day period that the conversion option may be exercised, the amount of coverage available through this conversion option is continued without charge;
- the effective date of coverage under the individual life policy will be 31 days after the group coverage terminates;
- the individual life policy will not include any disability or other supplementary benefits;

the types of individual life policies available for conversion are:

a) a 1 year term life policy that may be exchanged, before its expiry date, for 1 of the following 2 life policy options (b) or (c);

b) a non-convertible term life policy that provides level term coverage to age 65; or

c) a term to age 100 life policy that provides lifetime coverage with no non-forfeiture options;

- the maximum amount of coverage available under the individual life policy is the lesser of:

  - the amount of member life benefit coverage in effect on the termination date or the amount of any scheduled reduction of the member life benefit coverage;
  - the amount of the reduction in coverage caused by any replacement policy that is issued to the Member within 31 days of the date of the termination;
  - $400,000 for residents of Quebec or $200,000 for residents outside of Quebec; and

the coverage provided by the individual life policy cannot be less than:

- the minimum amount Carrier 3 will normally issue for the type of policy selected; or

$10,000 for residents of Quebec.

Dependent Life Benefit Provisions

Purpose of Coverage

If a Dependent dies while covered by this benefit, Carrier 3 will pay the Member the amount specified in the Summary of Benefits, subject to the conditions outlined below.

Payment of Claims

All benefits will be paid directly to the Member.

Waiver of Premium During Total Disability

This benefit is subject to the *Waiver of Premium* provisions of this policy.

When Coverage Ends

Coverage ends when the Member reaches the termination age specified in the Summary of Benefits. In addition, coverage may end on an earlier date, as specified in the *When Coverage Ends* provision found under the *Coverage* provisions of this policy.

Right to Convert to Individual Coverage

Eligibility for Conversion

A Spouse residing in any province or a Child who is a resident of Quebec has the right to purchase an individual life policy from Carrier 3 if their dependent life coverage terminates for one of the following reasons:

- death of the Member;
- termination of the Member's life coverage for a reason that entitles the Member to convert their member life benefit to an individual policy; or
- the Spouse or Child is no longer eligible for coverage as a Dependent.

Dependent Life Benefit Provisions

Terms and Conditions of the Converted Policy

Individual policies issued under this conversion option are subject to the terms and conditions specified in the *Right to Convert to Individual Coverage* provision found under the *Coverage* provisions of this policy.

They are also subject to the following additional terms and conditions:

- during the 31 day period that the conversion option may be exercised, the amount of coverage available through this conversion option is continued without charge;
- the effective date of coverage under the individual life policy will be 31 days after the group coverage terminates;

- the individual life policy will not include any disability or other supplementary benefits;

the types of individual life policies available for conversion are:

a) a 1 year term life policy that may be exchanged, before its expiry date, for 1 of the following 2 life policy options (b) or (c);

b) a non-convertible term life policy that provides level term coverage to age 65; or

c) a term to age 100 life policy that provides lifetime coverage with no non-forfeiture options;

- the coverage provided by the individual life policy cannot be:
  - more than the amount of dependent life benefit coverage in effect on the termination date; or
  - less than the minimum amount Carrier 3 will normally issue for the type of policy selected or $5,000 for residents of Quebec.

Optional Life Benefit Provisions

Purpose of Coverage

This benefit provides additional amounts of life insurance to those available through the member life benefit and the dependent life benefit (if applicable).

If a Member or Dependent dies while covered by this benefit, Carrier 3 will pay the amount of the optional life benefit in effect at the time of death, subject to the conditions outlined below.

Eligibility for Coverage

To be eligible for this benefit, the Member and Dependent must submit Proof of Health deemed satisfactory by Carrier 3.

Amount of Coverage

The benefit is equal to the amount of optional life benefit selected by the Member for themselves or their Dependents, up to the maximum amount specified in the Summary of Benefits.

A Member may request a change in the amount of their coverage or their Dependent's coverage under this benefit at any time. However, requests to increase coverage will not be granted without submission of Proof of Health deemed satisfactory by Carrier 3.

Payment of Claims

Beneficiary

In the case of the Member's death, benefits will be paid directly to the Member's beneficiary. In the case of a Dependent's death, all benefits are payable to the Member.

Exclusions and Limitations

If the Member's or Dependent's death is a result of suicide while an amount of optional life benefit has been in effect for less than 24 consecutive months, the payment for this amount of optional life benefit will be limited to the return of premiums.

Waiver of Premiums During Total Disability

This benefit is subject to the *Waiver of Premium* provisions of this policy.

When Coverage Ends

Coverage ends at the termination age specified in the Summary of Benefits. In addition, coverage may end on an earlier date, as specified in the *When Coverage Ends* provision found under the *Coverage* provisions of this policy.

Optional Life Benefit Provisions

Right to Convert to Individual Coverage

Eligibility for Conversion

A Member has the right to purchase an individual life policy from Carrier 3 if their optional life benefit coverage terminates before the Member reaches age 65 due to retirement, termination of employment or termination of coverage for the group or class of Employees to which the Member belongs.

A Spouse has the right to purchase an individual life policy from Carrier 3 if their optional life benefit coverage terminates for one of the following reasons:

- death of the Member;
- termination of the Member's life or Member's optional life coverage for a reason that entitles the Member to convert their member life benefit to an individual policy; or the Spouse is no longer eligible for coverage as a Dependent.

Terms and Conditions of the Converted Policy

Individual policies issued under this conversion option are subject to the terms and conditions specified in the *Right to Convert to Individual Coverage* provision found under the *Coverage* provisions of this policy.

They are also subject to the following additional terms and conditions:

- during the 31 day period that the conversion option may be exercised, the amount of coverage available through this conversion option is continued without charge;
- the effective date of coverage under the individual life policy will be 31 days after the group coverage terminates;
- the individual life policy will not include any disability or other supplementary benefits; the types of individual life policies available for conversion are:

a) a 1 year term life policy that may be exchanged, prior to its expiry date, for 1 of the following 2 life policy options (b) or (c):

b) a non-convertible term life policy that provides level term coverage to age 65; or
c) a term to age 100 life policy that provides lifetime coverage with no non-forfeiture options;

- the maximum amount of coverage provided by the Member's individual life policy is the lesser of:
  - the amount of member life benefit coverage plus optional life coverage in effect on the date of termination of the optional life benefit;
  - $400,000 for residents of Quebec or $200,000 for residents outside of Quebec;
- the amount of coverage provided by the Member's individual life policy cannot be less than: the minimum amount Carrier 3 will normally issue for the type of policy selected; or $10,000 for residents of Quebec; and
- the amount of coverage provided by the Dependent's individual life policy cannot be: more than the amount of the Dependent's optional life benefit; and for residents of Quebec, less than $5,000.

Member Accidental Death and Dismemberment Benefit Provisions

Purpose of Coverage

If, as a result of an Accident, the Member dies, falls into a Coma or suffers a Loss defined in this benefit, Carrier 3 will pay a specified percentage of the amount shown in the Summary of Benefits, subject to the conditions outlined below.

Additional Definitions

The following definitions apply to this benefit, in addition to those found under the *Definitions* provision of this policy.

Coma or comatose: State of unconsciousness with no reaction to external stimuli or response to internal needs that persists for a continuous period of at least 30 days.

Hemiplegia: Total and irrecoverable paralysis of the upper and lower limbs on one side of the body.

Loss: Any loss specified in the Table of Benefits.

Loss of arm: Complete severance at or above the elbow joint.

Loss of finger: Complete loss of two entire bones of a finger.

Loss of foot: Complete severance at or above the ankle joint but below the knee joint.

Loss of hand: Complete severance at or above the wrist joint but below the elbow joint.

Loss of hearing, sight or speech: Total and irrecoverable loss of hearing, sight or speech, certified by a Physician.

Loss of leg: Complete severance at or above the knee joint.

Loss of thumb: Complete loss of one entire bone of a thumb.

Loss of toe: Complete loss of one entire bone of the big toe or of all bones of any other toe.

Loss of use: Complete and irreversible loss of use of a limb for at least 12 months.

Quadriplegia: Total and irrecoverable paralysis of both the upper and lower limbs.

Paraplegia: Total and irrecoverable paralysis of both lower limbs.

Member Accidental Death and Dismemberment Benefit Provisions

Coverage

To be covered under this benefit, a Loss must:

 result from an Accident that occurs while the Member is covered under this benefit; and

occur within 365 days after the date of this Accident.

A Member will be considered to have suffered loss of life as a result of an Accident if the Member's death is due to accidental drowning.

What Carrier 3 Will Pay

In the event of Loss, Carrier 3 will pay the following percentages of the coverage amount specified in the Summary of Benefits:

Table of Benefits Loss of	**Amount of coverage**
Life	100%
Both hands or both feet	100%
Both arms or both legs	100%
Speech and hearing in both ears	100%
Sight in both eyes	100%
Sight in one eye and one hand	100%
Sight in one eye and one foot	100%
One hand and one foot	100%
One arm and one leg	100%
One arm or one leg	75%
One hand or one foot	66 2/3%
Sight in one eye	66 2/3%
Speech or hearing in both ears	50%
Thumb and index finger of any one hand	33 1/3%
At least four fingers of one hand	33 1/3%
Hearing in one ear	16 2/3%
All toes of one foot	12 1/2%
Paralysis	
Quadriplegia	200%
Hemiplegia	200%
Paraplegia	200%
Loss of use of	
Both arms or both legs	100%
Both hands or both feet	100%
One hand and one foot	100%
One arm and one leg	100%
One arm or one leg	75%

One hand or one foot	66 2/3%

Member Accidental Death and Dismemberment Benefit Provisions

Additional Benefits

Carrier 3 will also pay the following additional benefits, if applicable:

Coma

If the Member falls into a Coma as a result of an Accident, Carrier 3 will pay a monthly benefit equal to 1% of the amount of coverage specified in the Summary of Benefits.

For benefits to be payable, the Coma must occur within 30 days of the Accident and persist uninterrupted for at least 30 days. Benefits are then payable for the duration of the Coma or until the amount of coverage has been paid in full, whichever occurs first.

Exposure and Disappearance

If a Member is unavoidably exposed to the elements and suffers a Loss as a result of and within 365 days of this exposure, the Loss will be deemed to be the result of an Accident.

A Member will be deemed to have suffered loss of life as a result of an Accident if:

- the Member disappears due to the accidental wrecking, sinking or disappearance of a vehicle; and
- their body is not found within 365 days (unless there is contrary evidence to suggest that the Member is still alive).

Repatriation

If benefits are payable for loss of life that occurred at least 150 kilometres from the Member's place of residence, Carrier 3 will pay the expenses incurred to:

- prepare the body for burial or cremation; and
- ship the body to the place of burial or cremation or bury or cremate the body at the place of death.

The benefit maximum for all expenses under this benefit provision is $10,000. Amounts payable will be paid to any person who appears to Carrier 3 to be fairly entitled to the benefit as a result of having incurred any of the above mentioned expenses.

On receipt of written proof of anticipated expenses, Carrier 3 may make an advance payment, provided that the Policyholder confirms to Carrier 3:

- the name of the Member and the date and cause of death; and
- that the Member was eligible for this benefit on the date of death.

This coverage excludes the cost of a coffin.

Rehabilitation

If benefits are payable to a Member as a result of a Loss, Carrier 3 will pay reasonable and necessary expenses incurred by the Member for special training, provided that: these expenses are incurred within 3 years of the date of the Accident; and the training is needed:

- as a result of the Loss; or
- to enable the Member to work in an occupation for which they were not qualified before the Loss.

The amount payable under this benefit provision will not exceed $10,000.

This coverage excludes travel, clothing and ordinary living expenses.

Occupation Training for the Spouse

If benefits are payable for loss of life of a Member, Carrier 3 will pay the reasonable and necessary expenses incurred by their Spouse for a formal training program provided that:

- the Spouse is taking the program to gain active employment in any occupation for which they would not otherwise be qualified; and
- the expenses are incurred within 3 years of the Member's death.

The amount payable under this benefit provision will not exceed $10,000.

This coverage excludes travel, clothing and ordinary living expenses.

Education for Children

If benefits are payable for loss of life of a Member, Carrier 3 will pay tuition fees and other reasonable and necessary expenses incurred by each Child enrolled in a post-secondary education institution, provided that this enrolment is:

- on a full-time basis; and
- in effect at the time of the Member's death or occurs within 365 days of the Member's death.

The maximum amount payable per Child is the lesser of:

- 5% of the Member's coverage specified in the Summary of Benefits;
- the actual eligible expenses incurred; or
- $5,000 for each year a Child continues their post-secondary education on a full-time basis to a maximum of 5 years or until the Child reaches age 25, whichever occurs first.

The amount payable will be paid in annual instalments to the Child (if age 18 and over) or to the surviving parent or legal guardian of the Child (if the Child is under age 18). Each payment instalment will be issued on receipt by Carrier 3 of written proof of enrolment and of expenses incurred.

Member Accidental Death and Dismemberment Benefit Provisions

This coverage excludes travel, clothing, room, board and ordinary living expenses.

Family Travel

If a Member is confined to a hospital more than 150 kilometres from the Member's normal place of residence as a result of:

- a Loss or a Coma; or
- an Illness or injury not specified in the Table of Benefits but which requires at least 4 days of hospital confinement.

Carrier 3 will pay the reasonable and necessary travel and accommodation expenses for 1 or more Family Members to travel to the Member's place of confinement.

The maximum amount payable under this benefit provision is the lesser of:

 hotel accommodation and transportation costs actually incurred; or

$3,000.

If personal transportation is used instead of public transportation, a rate of $0.35 per kilometre applies.

Payment of Claims

Beneficiary

In the case of loss of life, Carrier 3 will pay benefits directly to the Member's beneficiary, unless otherwise specified in this benefit. For any other Loss or Coma, benefits will be paid to the Member.

Maximum Amount Payable

The total amount payable for one or more Losses or a Coma that results from the same Accident will not exceed 100% of the amount of coverage specified in the Summary of Benefits, except for Quadriplegia, Paraplegia and Hemiplegia that are paid at 200%.

Carrier 3 will only pay one amount, the largest applicable, for injuries to the same limb that result from the same Accident.

Rounding Amounts of Coverage

If not already a multiple of $1,000, the amount of coverage for Members under age 65 is rounded up to the next multiple of $1,000. At age 65 and over, coverage that is not already a multiple of $500 is rounded up to the next multiple of $500.

Proof of Claim

All Losses and a Coma must be certified by a Physician. Carrier 3 may:

- require that the Member undergo a medical examination; or
- if the Member is deceased, request an autopsy in accordance with applicable laws.

Member Accidental Death and Dismemberment Benefit Provisions

Exclusions and Limitations

Carrier 3 will not pay any benefits for a Loss or a Coma that results directly or indirectly from the following causes:

a) any medical or surgical Treatment or Illness or disease of any kind, other than septic infection caused through a wound sustained as a result of an Accident;

b) suicide, attempted suicide or voluntary injury or Illness;

c) voluntary ingestion of poison or drugs;

d) inhalation of fumes, unless an occupational health and safety board has deemed such inhalation to be an Accident;

e) any Accident or injury occurring while the Member is participating in a criminal act or attempting to commit a criminal act, regardless of whether charges are laid or a conviction is obtained;

f) insurrection, war (declared or not), the hostile action of the armed forces of any country or the Member's participation in any riot or civil commotion;

g) injuries sustained while the Member is flying or attempting to fly an airplane or other type of aircraft if the Member is part of the crew or is performing any other flight duties; or

h) any Accident or injury that occurs while the Member is operating a vehicle under the influence of any intoxicant or with a blood alcohol level in excess of the legal limit in the jurisdiction in which the Accident occurred.

Reductions in Coverage

The benefit reduction schedule, if any, is specified in the Summary of Benefits.

Waiver of Premium During Total Disability

This benefit is subject to the *Waiver of Premium* provisions of this policy.

When Coverage Ends

Coverage ends at the termination age specified in the Summary of Benefits. In addition, coverage may end on an earlier date, as specified in the *When Coverage Ends* provision found under the *Coverage* provisions of this policy.

Optional Enhanced Critical Illness Benefit Provisions

Purpose of Coverage

On satisfactory medical evidence that a Participant suffers from a Covered Condition described in this benefit, Carrier 3 will pay the benefit amount in effect for the Participant at the time of the claim, subject to the conditions outlined below.

The benefit is equal to the amount of optional enhanced critical illness benefit selected by the Member for themselves or their Dependents, up to the maximum amount specified in the Summary of Benefits.

Additional Definitions

The following definitions apply to this benefit, in addition to those found under the *Definitions* provision of this policy.

Pre-Existing Condition: Any condition for which, during the 24 months immediately before the effective date of coverage (under this policy or a Previous Policy), the Participant has:

- had a medical consultation;
- been prescribed or taken medication; or
- received Treatment, including diagnostic measures for any symptom or medical problem that leads to a diagnosis of or Treatment for a covered condition.

Survival Period: The continuous period of time between the date the definition of a covered condition is met and the date the benefit is payable, as long as the Participant is still living. The Survival Period is specified in the Summary of Benefits.

Covered Conditions Eligible for Full Benefit Payment

A full benefit amount is paid for up to 2 unrelated covered conditions. When a benefit becomes payable for a covered condition in one Category, the Participant will not be covered for any future conditions in the same Category.

Category 1: Cancer (Life Threatening)

Category 2: Aortic Surgery, Coronary Artery Bypass Surgery, Heart Attack, Heart Valve Replacement or Repair

Category 3: Blindness, Severe Burns, Deafness, Loss of Limbs, Loss of Speech, Occupational HIV Infection

Category 4: Aplastic Anemia, Bacterial Meningitis, Benign Brain Tumour, Coma, Dementia including Alzheimer's Disease, Kidney Failure, Loss of Independent Existence, Major Organ

Failure on Waiting List, Major Organ Transplant, Motor Neuron Disease, Multiple Sclerosis, Paralysis, Parkinson's Disease, Stroke

All covered conditions must be the result of Illness or disease in order to be considered eligible with the exception of Severe Burns. Severe Burns are covered even if they do not result from Illness or disease.

Optional Enhanced Critical Illness Benefit Provisions

Aortic Surgery: 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.

This coverage excludes angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non- surgical procedures.

Aplastic Anemia: 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:

 marrow stimulating agents;

immunosuppressive agents; or

bone marrow transplantation.

The diagnosis of Aplastic Anemia must be made by a specialist.

Bacterial Meningitis: Definite diagnosis of meningitis, confirmed by cerebrospinal fluid showing growth of pathogenic bacteria in culture, resulting in neurological deficit documented for at least 90 days from the date of diagnosis. The diagnosis of Bacterial Meningitis must be made by a specialist.

This coverage excludes viral meningitis.

Benign Brain Tumour: 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.

No benefit is payable under this condition if, within the first 90 days following the effective date of coverage, the Participant has any of the following:

- signs, symptoms or investigations, that lead to a diagnosis of the Benign Brain Tumour, regardless of when the diagnosis is made; or a diagnosis of Benign Brain Tumour.

Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to Carrier 3 within 6 months of the date of the diagnosis. If this information is not provided within this period, Carrier 3 has the right to deny any claim for Benign Brain Tumour or, any critical illness caused by any Benign Brain Tumour or its Treatment.

No benefit is payable under this condition for pituitary adenomas less than 10 mm.

Blindness: Definite diagnosis of the total and irreversible loss of vision in both eyes, evidenced by:

 the corrected visual acuity being 20/200 or less in both eyes; or the field of vision being less than 20 degrees in both eyes.

- The diagnosis of Blindness must be made by a specialist.

Benefit Provisions

Cancer (Life Threatening): 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.

No benefit is payable under this condition if, within the first 90 days following the effective date of coverage, the Participant has any of the following:

- signs, symptoms or investigations, that lead to a diagnosis of Cancer, regardless of when the diagnosis is made; or
- a diagnosis of Cancer.

Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to Carrier 3 within 6 months of the date of the diagnosis. If this information is not provided within this period, Carrier 3 has the right to deny any claim for cancer, or any critical illness caused by any cancer or its Treatment.

No benefit is 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 this 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 this 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.

Coma: 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.

This coverage excludes:

- a medically induced coma;
- a coma that result directly from alcohol or drug use; and a diagnosis of brain death.

Coronary Artery Bypass Surgery: Heart surgery to correct narrowing or blockage of 1 or more coronary arteries with bypass graft(s). The surgery must be determined to be Medically Necessary by a specialist.

This coverage excludes angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

Deafness: 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): Definite diagnosis, made by a specialist, of dementia which must be characterized by a progressive deterioration of memory and at least one of the following areas of cognitive function:

- aphasia (a disorder of speech);
- apraxia (difficulty performing familiar tasks);
- agnosia (difficulty recognizing objects); or
- disturbance in executive functioning (for example, inability to think abstractly and to plan, initiate, sequence, monitor, and stop complex behaviour), which is affecting daily life.

The Participant must exhibit:

- 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
- evidence of progressive worsening in cognitive and daily functioning either by serial cognitive tests or by history over at least a 6 month period.

This coverage excludes affective or schizophrenic disorders or delirium.

Heart Attack: Definite diagnosis of the death of heart muscle due to obstruction of blood flow that results in the rise and fall of biochemical cardiac markers to levels considered diagnostic of myocardial infarction, with at least one of the following:

- heart attack symptoms;
- new electrocardiogram (ECG) changes consistent with a heart attack; or
- 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.

This coverage excludes:

- elevated biochemical cardiac 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
- ECG changes suggesting a prior myocardial infarction, which do not meet the Heart Attack definition as described above.

Heart Valve Replacement or Repair: 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.

This coverage excludes angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

Kidney Failure: Definite diagnosis of chronic irreversible failure of both kidneys to function, as a result of which regular haemodialysis, peritoneal dialysis or renal transplantation is initiated. The diagnosis of Kidney Failure must be made by a specialist.

Loss of Independent Existence: Definite diagnosis of the total 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:

- Bathing: the ability to wash oneself in a bathtub, shower or by sponge bath, with or without the aid of assistive devices;
- 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;
- Toileting: the ability to get on and off the toilet and maintain personal hygiene with or without the aid of assistive devices;
- 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;
- Transferring: the ability to move in and out of a bed, chair or wheelchair, with or without the aid of assistive devices; and
- 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: 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: Definite diagnosis of the total and irreversible loss of the ability to speak as the result of physical injury or disease, for a period of at least 180 days. The diagnosis of Loss of Speech must be made by a specialist.

This coverage excludes all psychiatric related causes.

Major Organ Failure on Waiting List: 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 Participant 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 purposes of the Survival Period, the date of diagnosis is the date of the Participant's enrolment in the transplant centre. The diagnosis of the major organ failure must be made by a specialist.

Major Organ Transplant: Definite diagnosis of irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, such that an organ transplant is Medically Necessary.

To qualify under Major Organ Transplant, the Participant 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: 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 limited to these conditions.

The diagnosis of Motor Neuron Disease must be made by a specialist.

Multiple Sclerosis: Definite diagnosis of at least one of the following:

- two or more separate clinical attacks, confirmed by magnetic resonance imaging (MRI) of the nervous system, showing multiple lesions of demyelination;
- well-defined neurological abnormalities lasting more than 6 months, confirmed by MRI imaging of the nervous system, showing multiple lesions of demyelination; or
- 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.

Occupational HIV Infection: Definite diagnosis of infection with Human Immunodeficiency Virus (HIV) resulting from accidental injury during the course of the Participant's normal occupation, which exposed the person to HIV contaminated body fluids.

The accidental injury leading to the infection must have occurred after the effective date of the coverage.

Payment under this condition requires satisfaction of all of the following:

a) The accidental injury must be reported to Carrier 3 within 14 days of the accidental injury;

b) A serum HIV test must be taken within 14 days of the accidental injury and the result must be negative;

c) A serum HIV test must be taken between 90 days and 180 days after the accidental injury 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 accidental injury 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.

No benefit is payable under this condition if:

- The Participant has elected not to take any available licensed vaccine offering protection against HIV;
- A licensed cure for HIV infection becomes available prior to the accidental injury; or
- HIV infection has occurred as a result of non-accidental injury including, but not limited to, sexual transmission and intravenous (IV) drug use.

Paralysis: Definite diagnosis of the total loss of muscle function of two or more limbs as a result of injury or disease 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: 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 Participant 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 are defined as 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 neurologist.

No benefit is payable for Parkinson's Disease or Specified Atypical Parkinsonian Disorders if, within the first year following the effective date of coverage, the Participant has any of the following:

- 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
- a diagnosis of Parkinson's Disease, a Specified Atypical Parkinsonian Disorder or any other type of parkinsonism.

Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to Carrier 3 within 6 months of the date of the diagnosis. If this information is not provided within this period, Carrier 3 has the right to deny any claim for Parkinson's Disease or Specified Atypical Parkinsonian Disorders or, any critical illness caused by Parkinson's Disease or Specified Atypical Parkinsonian Disorders or its Treatment.

No benefit is payable under Parkinson's Disease and Specified Atypical Parkinsonian Disorders for any other type of parkinsonism.

Severe Burns: 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): Definite diagnosis of an acute cerebrovascular event caused by intra-cranial thrombosis or haemorrhage, or embolism from an extra-cranial source, with:

- acute onset of new neurological symptoms; and
- 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.

No benefit is payable under this condition for:

- Transient Ischaemic Attacks;
- Intracerebral vascular events due to trauma; or
- Lacunar infarcts which do not meet the definition of Stroke as described above.

Covered Conditions Eligible for Partial Benefit Payment

A partial benefit payment up to the amount specified in the Summary of Benefits is payable for any of the following non-life threatening critical conditions:

- Coronary Angioplasty;
- Ductal Carcinoma in Situ of the Breast; Stage A (T1a or T1b)

  Prostate Cancer; or Stage 1A Malignant Melanoma.

Participants may be eligible for one partial benefit payment per lifetime for each covered condition eligible for partial benefit payment. A partial benefit payment does not reduce the amount of coverage available for covered conditions eligible for full benefit payment.

Optional Enhanced Critical Illness Benefit Provisions

All covered conditions must be the result of Illness or disease in order to be considered eligible for partial benefit payment. The following conditions are covered to the partial benefit payment limits specified in the Summary of Benefits:

Coronary Angioplasty: 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.

Ductal Carcinoma In Situ Of The Breast: A non-invasive cancer that must be confirmed by biopsy. The diagnosis of ductal carcinoma in situ of the breast must be made by a specialist.

No benefit is payable under this condition if, within the first 90 days following the effective date of coverage, the Participant has any of the following:

- signs, symptoms or investigations, that lead to a diagnosis of Cancer, regardless of when the diagnosis is made; or
- a diagnosis of Cancer.

Stage A (T1a or T1b) Prostate Cancer: The diagnosis of stage A (T1a or T1b) prostate cancer must be made by a specialist and confirmed by pathological examination of prostate tissue.

No benefit is payable under this condition if, within the first 90 days following the effective date of coverage, the Participant has any of the following:

- signs, symptoms or investigations, that lead to a diagnosis of Cancer, regardless of when the diagnosis is made; or
- a diagnosis of Cancer.

Stage 1A Malignant Melanoma: A melanoma confirmed by biopsy to be less than or equal to 1.0 mm in thickness, not ulcerated and without Clark level IV or level V invasion. The diagnosis of state 1A malignant melanoma must be made by a specialist.

No benefit is payable under this condition if, within the first 90 days following the effective date of coverage, the Participant has any of the following:

- signs, symptoms or investigations, that lead to a diagnosis of Cancer, regardless of when the diagnosis is made; or
- a diagnosis of Cancer.

Payment of Claims

The benefit amount is payable after the expiration of the Survival Period specified in the Summary of Benefits, provided the Participant is still living at that time.

The benefit amount is limited to the Benefit Maximum specified in the Summary of Benefits, regardless of the number of covered conditions a Participant may experience.

Optional Enhanced Critical Illness Benefit Provisions

A full benefit amount is payable for up to 2 unrelated covered conditions eligible for full benefit payment. Once a benefit has become payable for a covered condition in one category (Category 1, 2, 3 or 4), the Participant is not covered for any future covered condition specified under the same category. However, a Participant is eligible to receive a second full benefit amount for a covered condition specified under a different category.

A partial benefit amount is payable for up to 4 covered conditions eligible for partial benefit payment. The Participant is eligible for 1 partial benefit payment per non-life threatening covered condition.

Exclusions and Limitations

Carrier 3 will not pay benefits for any condition that results, directly or indirectly, from any of the following causes:

a) a Pre-Existing Condition, unless the covered condition occurs after 24 consecutive months of coverage;

b) an Accident, unless the covered condition is a Severe Burn;

c) attempted suicide or voluntary injury or Illness;

d) participation in a criminal act or an attempt to commit a criminal act, regardless of whether charges are laid or a conviction is obtained;

e) any Accident or injury occurring while operating a vehicle under the influence of any intoxicant or with a blood alcohol level in excess of the legal limit in the jurisdiction in which the Accident occurs; or

f) insurrection, war (declared or not), the hostile action of the armed forces of any country or participation in any riot or civil commotion.

Waiver of Premium During Total Disability

This benefit is subject to the *Waiver of Premium* provisions of this policy.

When Coverage Ends

Coverage ends at the termination age specified in the Summary of Benefits. In addition, coverage may end on an earlier date, as specified in the *When Coverage Ends* provision found under the *Coverage* provisions of this policy.

Long Term Disability Benefit Provisions

Purpose of Coverage

If the Member becomes Totally Disabled following an Illness or Accident, Carrier 3 will pay up to the maximum amount specified in the Summary of Benefits, subject to the conditions outlined below.

Additional Definitions

The following definitions apply to this benefit, in addition to those found under the *Definitions* provision of this policy.

Benefit Period: The maximum duration for which Carrier 3 will pay benefits. This maximum is specified in the Summary of Benefits.

Elimination Period: The continuous period of time from the date the Member becomes Totally Disabled until the date benefits are payable. This period is specified in the Summary of Benefits.

If Total Disability is not continuous, the days the Member is Totally Disabled may be accumulated to satisfy the Elimination Period, provided that:

- coverage remains in force during the entirety of the accumulated Elimination Period;
- there is no interruption in Total Disability that is longer than 30 days;
- successive disabilities are due to the same or related causes; and the Elimination Period is completed within a 1 year period.

Integration of Benefits: The process by which amounts payable under this benefit are reduced by income amounts payable to the Member from other sources. The calculations associated with this process are set out in Step 2 and Step 3 of the *Calculation of the Benefit Amount* provision of this benefit.

Net Salary: The Member's Salary less income taxes and contributions to the Canada Pension Plan, Quebec Pension Plan, the Canada Employment Insurance Commission (CEIC) and the Quebec Parental Insurance Plan, if applicable.

Pre-Disability Salary: The Member's Salary immediately before the date of Total Disability.

Total Disability or Totally Disabled: During the Elimination Period and for the Own Occupation Duration specified in the Summary of Benefits, a Member is considered Totally Disabled if, as result of illness or accident, the Member is completely and continuously unable to perform the Regular Duties of their Own Occupation which took at least 60% of their time at work to complete.

Afterward, a Member is Totally Disabled if the Member is completely and continuously unable to perform the Regular Duties of any occupation for which the Member:

- would earn 70% or more of the Member's Pre-disability Salary; and
- is reasonably qualified or may so become by training, education or experience.

Long Term Disability Benefit Provisions

If a Member was performing modified work duties for at least 6 months before applying for long term disability benefits, these modified work duties constitute the Member's own occupation for purposes of assessing Total Disability.

The loss of a professional or occupational licence or certification does not, in itself, constitute Total Disability.

The availability of work is not considered when assessing the Member's disability.

Payment of Benefits

When Benefit Payments Begin

Benefit payments begin on expiry of the Elimination Period. Carrier 3 will pay benefits at monthly intervals for each day a Member is Totally Disabled following expiry of the Elimination Period.

The benefit for each day of Total Disability will be equal to 1/30 of the monthly amount.

Calculation of the Benefit Amount

Carrier 3 calculates the monthly benefit amount in accordance with the following 3 step process:

Step 1. Carrier 3 applies the benefit formula specified in the Summary of Benefits to obtain a monthly benefit amount (to the benefit maximum specified in the Summary of Benefits);

Step 2. Carrier 3 subtracts from this monthly benefit amount any income amounts that are payable to the Member as a result of the same or a subsequent disability under any of the following:

a) the Quebec Pension Plan or the Canada Pension Plan;

b) any workers' compensation board/commission;

c) any automobile insurance bureau, if applicable;

d) the Canada Employment Insurance Commission (CEIC); or

e) any other federal or provincial law or legislation;

Step 3. If the amount of long term disability benefit calculated in Step 2 and all the applicable Additional Sources of Income listed below exceed the All Source Maximum specified in the Summary of Benefits, then the long term disability benefit will be further reduced to ensure the total benefits received from all sources does not exceed this percentage.

Additional Sources of Income means:

a) any of the following income amounts payable to the Member, as a result of their current or subsequent disability, under one of the following plans:

i. any fringe-benefits plan offered by the Employer as defined by the Income Tax Act;

ii. any plan under which the Member is covered as a member of an association; or iii.

any fringe-benefits plan set up according to any provincial or federal law, including the

disability payments from any of the plans specified in Step 2; and

b) any income amounts payable to the Member under any retirement or pension plan funded in whole or in part by the Employer. This includes the Quebec Pension Plan or Canada Pension Plan if the application for retirement benefits is made following the date of Total Disability.

With respect to the income amounts calculated in Step 2 and Step 3:

- income amounts received for children are not included;
- if it appears to Carrier 3 that there are income amounts to which the Member is eligible, Carrier 3 may include these amounts in its calculations even if the Member fails to apply for or exercise their right to these amounts;
- Carrier 3 may estimate income amounts pending their actual award;
- Carrier 3 will perform its calculations without including subsequent increases to these income amounts by way of cost-of-living adjustments; and
- if an income amount is paid by lump sum rather than monthly instalments, Carrier 3 will include in its calculations the amount obtained by dividing this lump sum by:

 the number of monthly instalments the lump sum represents, if known to Carrier 3; or

60, if Carrier 3 does not know the number of months represented.

Cost-of-Living Adjustment

If the Summary of Benefits specifies a cost-of-living adjustment, it will be applied on the effective date of the adjustment as specified in the Summary of Benefits.

The amount of the cost-of-living adjusted benefit payment is calculated as follows:

Step 1. The average Consumer Price Index (CPI) for the 12-month period ending on October 31 of the previous year is divided by the average CPI for the 12-month period ending on October 31 of the year prior to the previous year; and

Step 2. The resulting figure is multiplied by the current benefit payment amount to obtain the new benefit payment amount.

If the figure obtained in Step 1 is less than 1, it will be rounded up to 1.

If the calculations in Step 1 and 2 result in a percentage cost-of-living adjustment that exceeds the maximum percentage specified in the Summary of Benefits, the percentage cost-of-living

adjustment will be reduced to the extent needed to ensure that this maximum adjustment percentage is not exceeded.

The benefit maximum amount specified in the Summary of Benefits will have no effect on any costof-living adjustment calculated in accordance with this clause.

When Benefit Payments End

Benefit payments end on the earliest of the date:

 the Member is no longer Totally Disabled;

the Member fails to:

- provide Carrier 3 with satisfactory proof of continued Total Disability;
- submit to an independent examination requested by Carrier 3; or
- participate in any reasonable Treatment or rehabilitation program considered appropriate by Carrier 3;

- the Member reaches the termination age specified in the Summary of Benefits;
- the Benefit Period expires;
- the Member engages in any occupation, employment or volunteer work other than a rehabilitation program pre-approved by Carrier 3;
- the Member refuses to accept any reasonable offer of modified duties or alternative employment from the Employer; or the Member dies.

Recurrent Disabilities

If a Member who was Totally Disabled and receiving long term disability benefits becomes Totally Disabled again after having returned to work, Carrier 3 will consider the recurrent disability to be a continuation of the initial disability if the disability results from:

- the same or related causes within the first 6 consecutive months of the Member returning to work according to their normal work schedule; or
- different and unrelated causes and the Member did not fully recover from the first disability and did not return to work for at least a full day before the start of the recurrent disability.

When the recurrent disability is considered to be a continuation of the initial period of Total Disability:

- the Elimination Period will not be applied a second time;
- the benefit amount payable is that which was calculated for the initial period of Total Disability; and
- benefits will only be paid for the balance of the initial Benefit Period.

Total Disability During Periods of Absence

The *Coverage During Periods of Absence from Work* provision found under the *Coverage* provisions of this policy and the Summary of Benefits specify whether coverage under this benefit is retained during periods of absence from work.

If a Member becomes Totally Disabled during a period of absence from work where disability coverage has been discontinued, no disability benefit will be payable.

If a Member becomes Totally Disabled during a period of absence from work during which disability coverage has been retained and premiums have been paid:

- the Elimination Period will begin on the onset of Total Disability;
- the Benefit Period will be deemed to begin on expiry of the Elimination Period; and
- benefit payments will begin on the later of the expiry of the Elimination Period or the date the Member was scheduled to return to work.

Rehabilitation Program

If considered appropriate by Carrier 3, Carrier 3 may require a Member to participate in a rehabilitation program pre-approved by Carrier 3 consisting of:

- medical care, Treatment, diagnostic measures or prescribed medications;
- full-time work, part-time work or volunteer work whether or not wages or remuneration are received for such work; or
- a vocational assessment, training or re-training program for the purpose of rehabilitation.

When a Member participates in a rehabilitation program while receiving benefits, the following conditions apply:

- the Member's Total Disability will not be considered to have ended simply because they undertook a rehabilitation program;
- if the Member becomes Totally Disabled again while participating in a rehabilitation program, the terms and conditions of this benefit will apply as if the Member had remained Totally Disabled for the full duration of the rehabilitation program;
- the Benefit Period continues despite participation in the rehabilitation program; and
- during the rehabilitation program, monthly benefits will be reduced as necessary to ensure that the Member's total income from all sources does not exceed 100% of the Member's Pre-Disability Salary.

Exclusions and Limitations

1. Benefits are not payable for any Total Disability that results, directly or indirectly, from any of the following causes:
    a) participation in a criminal act or an attempt to commit a criminal act, regardless of whether charges are laid or a conviction is obtained;

b) any Accident or injury occurring while operating a motor vehicle under the influence of any intoxicant or with a blood alcohol level in excess of the legal limit in the jurisdiction in which the Accident occurred;

c) medical care or treatment that is not Medically Necessary or that is performed for cosmetic purposes only; or

d) insurrection, war (declared or not), the hostile action of the armed forces of any country or participation in any riot or civil commotion.

2. Benefits are not payable during any periods in which the Member:

a) receives maternity or parental benefits under any provincial or federal law or takes maternity or parental leave in accordance with any provincial or federal law or any agreement between the Member and the Employer, subject to the following exception:

 benefits will be payable during the health-related portion of the maternity leave when required by applicable law or legislation, provided coverage has been continued for the Member. The health-related portion of the maternity leave will be considered to be the normal post-natal recovery period deemed reasonable and appropriate by Carrier 3;

b) is absent from Canada for any reason, unless Carrier 3 agrees in writing, in advance, to pay benefits during the period; or

c) is imprisoned in a correctional facility or community residence or while under house arrest by order of a criminal court.

Pre-Existing Conditions

A Pre-Existing Condition is any Illness or injury for which, during the 3 months immediately before the Member's effective date of coverage (under this policy or a Previous Policy), the Member has:

- had a medical consultation;
- been prescribed or taken medication; or
- received treatment, including diagnostic measures.

If the Summary of Benefits specifies the Pre-Existing Conditions provision of this benefit applies, then benefits are not payable if Total Disability results from a Pre-Existing Condition unless Total Disability begins after the Member has been covered for long term disability benefits (under this policy or a Previous Policy) for at least 12 consecutive months.

Waiver of Premium During Total Disability

This benefit is subject to the *Waiver of Premium* provisions of this policy.

Long Term Disability Benefit Provisions

When Coverage Ends

Coverage ends at the termination age specified in the Summary of Benefits. In addition, coverage may end on an earlier date, as specified in the *When Coverage Ends* provision found under the *Coverage* provisions of this policy.

Drug Benefit Provisions

Purpose of Coverage

Carrier 3 will pay the Eligible Expenses described in this benefit, subject to the conditions outlined below.

Additional Definitions

The following definitions apply to this benefit, in addition to those found under the *Definitions* provision of this policy.

Eligible Drug: A drug that is:

- approved by Health Canada;
- assigned a drug identification number (DIN) or a natural health product number (NPN) in Canada;
- considered by Carrier 3 to be a Life-Sustaining Drug or a drug that requires a prescription by law;
- prescribed by a Physician or by a Health Practitioner who is licensed to prescribe under applicable provincial legislation;
- approved by Carrier 3 as an Eligible Expense; and
- dispensed by an Approved Provider that is a licensed retail pharmacy or another provider that is approved by Carrier 3.

Carrier 3 may, on an ongoing basis, add, delete or amend its list of Eligible Drugs.

Interchangeable Drug: An Eligible Drug that can be substituted for another Eligible Drug as both drugs:

- are considered pharmaceutical equivalents by Health Canada;
- contain the same active ingredients; and have the same route of administration.

Life-Sustaining Drug: An Eligible Drug that does not require a prescription by law but which Carrier 3 is satisfied is necessary for the survival of the Participant. A prescription from a Physician or Health Practitioner is still needed for reimbursement.

Medication Advisory Panel: The group of health care and other industry professionals appointed by Carrier 3 to review new drugs and decide which drugs Carrier 3 includes on its formularies.

Special Authorization: Eligible Drugs that are identified by Carrier 3 as requiring prior or ongoing authorization by Carrier 3 to qualify for reimbursement. The criteria to be met for Special Authorization are established by Carrier 3 and may include requiring the Participant to participate in related patient support programming.

Drug Benefit Provisions

What Carrier 3 Will Pay

Carrier 3 will pay Eligible Expenses subject to the following terms and conditions:

- payment is limited to the Reimbursement Level and the benefit maximums specified in the Summary of Benefits;
- the Member must pay the Deductible, if any, specified in the Summary of Benefits; Carrier 3 may determine that certain Eligible Drugs are subject to:
  - dollar, quantity or frequency maximums;
  - Special Authorization; or
  - co-ordination with patient assistance programs;
- payment for prescriptions for Interchangeable Drugs is limited in accordance with the Substitution Provision of this benefit; and
- payment is limited in accordance with the *Exclusions and Limitations* provision of this benefit.

This benefit covers the expenses listed below, provided they also meet the definition of Eligible Expenses contained under the *Definitions* provision of this policy:

- diabetic supplies, including test strips, lancets, needles, syringes, continuous glucose monitoring (CGM) sensors and insulin pump supplies;
- preparations and compounds if their main ingredient is an Eligible Drug; and
- prescribed Eligible Drugs that appear on the following drug formularies for the Employee classes specified in the *Summary of Benefits*:
  - **Frozen Formulary:** This list is established at a specific date and, after that date, only drugs approved by the Medication Advisory Panel will be added to the list.
  - **Managed Formulary:** List of Eligible Drugs and Life-Sustaining Drugs that are subject to the decisions of the Medication Advisory Panel.
  - **Provincial Formulary Equivalent:** List of prescription and non-prescription drugs as determined by the appropriate provincial program. This list is not subject to the Medication Advisory Panel decisions.

Substitution Provision

If the Summary of Benefits specifies Substitution Provision applies and an Interchangeable Drug has been prescribed, Carrier 3 will reimburse to the lowest ingredient cost Interchangeable Drug.

Participants may request a higher cost Interchangeable Drug; however, they will be responsible for paying the difference in cost between the Interchangeable Drugs.

Regardless of whether the Participant's Physician indicates the prescribed Interchangeable Drug cannot be substituted, Carrier 3 will only reimburse to the lowest ingredient cost Interchangeable Drug.

For Participants with an adverse reaction to the Interchangeable Drug dispensed, Carrier 3 will consider reimbursement to another Interchangeable Drug on a case by case basis only through the Special Authorization process.

Payment of Claims

How Payments are Made

The Summary of Benefits specifies the Method of Payment that applies to Participants under this policy.

Pay Direct: At the time of purchase, the Approved Provider will submit the Participant's claim to Carrier 3 electronically to verify eligibility. The Participant will pay the Approved Provider only the portion of the claim that is not covered by this benefit. Carrier 3 will reimburse the balance of the claim to the Approved Provider directly.

If the Participant submits to Carrier 3 a paid-in-full prescription drug receipt, despite the fact pay direct was offered, Carrier 3 will only reimburse the amount that would have been paid to the Approved Provider if the claim had been submitted electronically.

Exclusions and Limitations

Unless otherwise specified in the Summary of Benefits, expenses associated with the following categories of drugs are not eligible for reimbursement:

a) varicose vein injections;

b) antihistamines and allergy sera;

c) smoking cessation aids;

d) vaccines;

e) vitamins;

f) weight loss treatments;

g) natural health products, homeopathic and naturopathic products, herbal medicines and traditional medicines, nutritional and dietary supplements;

h) fertility treatments;

i) erectile dysfunction treatments;

j) hair growth stimulants;

k) services, Treatment or supplies that:

i. are not Medically Necessary; ii. are for

cosmetic purposes only; iii. are elective in nature;

or iv. have Experimental or Investigative

indication;

l) procedures related to drugs injected by a Health Care Professional in a private clinic;

Drug Benefit Provisions

m) drugs that Carrier 3 determines are intended to be administered in hospital, based on the route of administration and the condition the drug is used to treat;

n) expenses that are covered under any Government Health Care Coverage or charges payable under a workers' compensation board/commission, any automobile insurance bureau or any other similar law or public plan;

o) services, Treatment or supplies the Participant receives free of charge;

p) charges that would not have been incurred if no coverage existed; or

q) drugs that are eligible under the travel benefit provided by this policy (if applicable).

Carrier 3 reserves the right to make exceptions for drugs that fall into one or more of the above mentioned categories.

When Coverage Ends

Coverage ends on the date specified in the *Summary of Benefits*. In addition, coverage may end on an earlier date, as specified in the *When Coverage Ends* provision found under the *Coverage* provisions of this policy.

Right to Convert to Individual Coverage

A Participant who is not a Quebec Participant and who is no longer eligible under this benefit may convert their group coverage to a similar individual drug plan provided by Carrier 3.

Individual policies issued under this conversion option are subject to the terms and conditions specified in the *Right to Convert to Individual Coverage* provision found under the *Coverage* provisions of this policy.

Quebec Participants who are no longer eligible for drug benefit coverage cannot convert their group drug coverage to an individual plan. If they are not eligible under another group plan, they must contact the Régie de l'assurance maladie du Québec (RAMQ) to obtain coverage from the RAMQ's public drug plan.

Drug Benefit Provisions

Minimum Requirements for Drug Coverage in Quebec

This provision applies to Quebec Participants.

Act Respecting Prescription Drug Insurance

This policy must be administered in accordance with the *Act Respecting Prescription Drug Insurance* ("the Act") for Quebec Participants, including the Act's provisions about maximum coinsurance, out-of-pocket maximums, eligible drugs, exception drugs and eligible pharmacy services.

Under no circumstances will the *Exclusions and Limitations* provision of this benefit render drug benefit coverage for Quebec Participants less generous than the basic prescription drug insurance plan established by the Act.

Out-of-pocket Maximum per Calendar Year

If, in any calendar year, a Member spends more than the maximum contribution amount established by the RAMQ on Eligible Expenses for themselves or their Dependent Children, the amounts in excess of the maximum contribution amount will be reimbursed by Carrier 3 at a rate of 100% until the end of that calendar year. The contribution amount includes the Deductible, amounts in excess of the Reimbursement Level or co-payment, if applicable.

If, in any calendar year, the Spouse spends more than the maximum contribution amount established by the RAMQ on Eligible Expenses for themselves, the amounts in excess of the maximum contribution amount will be reimbursed by Carrier 3 at a rate of 100% until the end of that calendar year. The contribution amount includes the Deductible, amounts in excess of the Reimbursement Level or co-payment, if applicable.

Participants Age 65 Years and Over

At age 65, a Quebec Participant is automatically registered as a beneficiary of the RAMQ public drug plan. Therefore, on reaching age 65, a Quebec Participant must decide whether to:

- cancel their automatic registration with the RAMQ drug plan in order to continue their coverage under this benefit; or
- accept coverage under the RAMQ public drug plan.

The decision to accept coverage under the RAMQ public drug plan is irrevocable.

Quebec Participants who decide to accept coverage under the RAMQ public drug plan are no longer eligible for coverage under this benefit.

Exception: If the Summary of Benefits specifies the policy is supplemental to the RAMQ public drug plan coverage, the following expenses are eligible:

- the Deductible and coinsurance paid by the Quebec Participant under the RAMQ public drug plan; and
- reimbursement for any Eligible Drug that is not included in the RAMQ public drug plan but is covered under this benefit, subject to the Deductible and Reimbursement Level specified in the Summary of Benefits.

Drug Benefit Provisions

If the Member decides to join the RAMQ public drug plan, the Member's Dependents must also register with the RAMQ public drug plan.

If a Quebec Participant decides to maintain coverage under this benefit, Carrier 3 reserves the right to modify the premium rates applicable to this benefit for any Quebec Participant age 65 and over.

Extended Health Care Provisions

Purpose of Coverage

Carrier 3 will pay the Eligible Expenses described in this benefit, subject to the conditions outlined below.

Additional Definitions

The following definitions apply to this benefit, in addition to those found under the *Definitions* provision of this policy.

Acute Care: Short-term Treatment that is necessary to:

- prevent deterioration of a severe injury, episode of Illness or urgent medical condition;
- promote recovery from surgery; or
- provide palliative care for an individual diagnosed with a terminal illness whose life expectancy is less than 3 months.

Chronic Care: Care for patients with long term conditions for which medical care is required.

Such care must be provided in a public establishment that provides Chronic Care to patients who are under the direct care of a physician at all times. The establishment must be licensed by the appropriate government body and must provide 24 hour nursing care services.

Chronic Care facilities do not include rest homes, nursing homes, retirement homes, drug addiction or alcohol treatment centres.

Hospital: A licensed Acute Care facility. This does not include any part of such facility that is intended for long term care. The facility must:

- have facilities for diagnostic Treatment and major surgery;
- qualify to participate in and be eligible to receive payments under the provisions of the provincial hospital act in the jurisdiction in which it is located;
- operate in accordance with the applicable laws of the jurisdiction in which it is located;
- provide 24 hour nursing care services; and
- require that every patient be under the direct care of a Physician.

Hospitals do not include convalescent care facilities, physical or psychiatric rehabilitation facilities, maternity homes, nursing homes, rest homes, retirement residences, homes for the aged, blind, deaf, chronically or mentally ill, long-term care or assisted living facilities or drug addiction and alcohol treatment centres. It also does not include any part of a Hospital consisting of nursing care or beds that have been set aside for any of the purposes outlined in this paragraph.

What Carrier 3 Will Pay

Carrier 3 will pay Eligible Expenses subject to the following terms and conditions:

- payment is limited to the Reimbursement Level and benefit maximums specified below and in the Summary of Benefits;
- the Member must pay the Deductible, if any, specified in the Summary of Benefits; and
- payment is limited in accordance with the *Exclusions and Limitations* provision of this benefit.

This benefit covers the expenses explicitly listed in the following categories, provided they also meet the definition of Eligible Expenses under the *Definitions* provision of this policy. Carrier 3 reserves the right to make exceptions for expenses not explicitly listed in the policy but fall into one of the categories mentioned below.

Hospitalization

Chronic Care/Nursing Home: Room accommodation when a Participant is admitted to a Chronic Care facility, including a nursing home, on the recommendation and written approval of a physician.

Coverage under this category is limited to room and board only.

Hospitalization coverage excludes administrative and incidental fees (for example, television, telephone and parking).

Medical Services and Supplies

Ambulance Transportation: Charges for emergency transportation of a stretcher patient by a licensed ambulance to and from the nearest Hospital equipped to provide the emergency care needed by the Participant. This includes air or rail transportation.

This coverage excludes inter-Hospital transfers.

Nursing Care: Charges for the services of a registered nurse, registered nursing assistant or licensed practical nurse where such services are provided at the Participant's home and are not primarily for custodial care or midwifery.

Nursing care services may require pre-approval from Carrier 3 to be eligible for payment in whole or in part. Benefit payment amounts for approved nursing care services are based on the provincial payment schedule established by Carrier 3.

This coverage excludes expenses for custodial care, homemaking duties, shopping, transportation, respite care and services not related to the Activities of Daily Living.

Chronic Disease Management: Charges for the services rendered by an Approved Provider, as defined by Carrier 3, specialized in chronic disease management. Services must be delivered by the Approved Provider for medical conditions deemed eligible by Carrier 3. Coverage includes:

- initial assessment, counselling and follow up sessions;
- education relating to symptom management, medication usage; and development of action plans.

Health Practitioners: Eligible Expenses for Treatment provided by any Health Practitioner specified in the Summary of Benefits. Coverage is limited to:

- Treatment within the scope of the Health Practitioner's practice; and 1 Treatment by the same Health Practitioner per day.

Unless otherwise specified in the Summary of Benefits, a Physician referral is not necessary for Treatment to be eligible for coverage.

This coverage excludes:

- products provided by a Health Practitioner (unless specified as a benefit under this policy);
- comprehensive health assessments; charges for services obtained in Hospital; and group Treatment sessions.

Durable Medical Equipment: Charges for rental of the following medical equipment:

- manual or electric wheelchair (including the purchase of batteries for electric wheelchair up to the usual, customary and reasonable charges), cushions and inserts and the purchase of an outdoor wheelchair ramp (limited to one per lifetime to a maximum of $2,000);
- industrial hospital bed, including mattress and safety side rails;
- equipment for the administration of oxygen, percussor, suction pump, bi-level positive air pressure (BiPAP), continuous positive airway pressure (CPAP) and ventilator;
- insulin pump for the Treatment of type 1 diabetes;
- traction equipment;
- patient lifter (purchase maximum of $2,000); and
- bed rails, trapeze bars, bathtub rails, commodes, shower chairs and raised toilet seats up to the usual, customary and reasonable charges.

The purchase of durable medical equipment requires pre-approval from Carrier 3; otherwise it may be ineligible for payment in whole or in part.

If there is a long-term need for equipment due to extended Illness or disability, Carrier 3 may, at its discretion, approve the purchase of these items. If such purchase is approved, the rental or approved purchase of a second piece of similar equipment is limited to once every 5 consecutive calendar years, unless otherwise stated in the *Summary of Benefits*.

Two pieces of equipment are similar if they serve the same purpose (for example, facilitate breathing, provide mobility, deliver insulin).

This coverage excludes charges for special mattresses and air conditioning or air purifying equipment.

Mobility Aids and Orthopedic Appliances: Charges for the purchase or rental of crutches, canes and walking aids, casts, splints, trusses, braces and cervical collars.

Prostheses: Charges for the following prosthetic appliances:

- standard artificial limbs to a maximum of 1 per limb per lifetime;
- myoelectric arms to a maximum of 1 per arm per lifetime. A $10,000 maximum applies to myoelectric arms;
- artificial eyes to a maximum of 1 per eye per lifetime;
- artificial nose to a maximum of 1 per lifetime;
- breast prosthesis when needed following a mastectomy to a maximum of 1 per breast per 12 consecutive months (including internal breast prosthesis up to the cost of an external prosthesis);
- wigs when hair loss is due to an underlying pathology or its Treatment to a maximum of $200 per lifetime; and
- cleft palate obturators.

Repair or adjustments of eligible prosthetic appliances are covered to a maximum of $300 per calendar year.

This coverage excludes:

- microprocessor knees;
- wigs when hair loss is not due to an underlying pathology or its treatment, hair replacement therapy and other procedures for physiological hair loss (for example, male pattern baldness); and
- replacement of prostheses unless required due to pathological or physiological change.

Diabetic Equipment: Charges for glucometer, pressurized insulin injector, continuous blood glucose monitoring transmitters, insulin dosing systems or other equipment approved by Carrier 3 that performs similar functions. The equipment must be used for the Treatment and control of diabetes. Insulin pumps are eligible under the durable medical equipment benefit.

Hearing Aids: Charges for the purchase and repair of hearing aids (including initial tubing, ear molds and batteries at time of purchase) when prescribed by an otorhinolaryngologist or otologist or recommended by an audiologist to a combined maximum for both ears.

This coverage excludes exams and batteries after initial purchase.

Custom Orthopedic Shoes and Foot Orthotics: Charges for:

- the purchase and repair of custom made orthopedic shoes or prefabricated orthopedic shoes with permanent modifications to accommodate, relieve or remedy a mechanical foot defect or abnormality provided that:

  - the shoes have been prescribed by an attending Physician, orthopedic surgeon, physiatrist, rheumatologist or chiropodist/podiatrist;

  - the Participant provides a copy of the biomechanical or gait analysis from the prescribing Health Practitioner; and

  - the shoes are dispensed by an Approved Provider of orthopedic shoes.

- custom made foot orthotics to accommodate, relieve or remedy a mechanical foot defect or abnormality providing that:

  - they have been prescribed by the attending Physician, orthopedic surgeon, physiatrist, rheumatologist or chiropodist/podiatrist; and

  - they are dispensed by an Approved Provider of custom made foot orthotics.

This coverage excludes the purchase and repair of pre-fabricated orthopedic shoes without permanent modifications and extra-depth shoes.

Diagnostic Tests: Charges for the following diagnostic tests when provided by a laboratory approved by Carrier 3:

- laboratory analyses; and
- for residents of Quebec, diagnostic imaging services (ultrasounds, electrocardiograms, computerized tomography (CT Scans), X-rays and magnetic resonance imagery (MRI)). Expenses must be incurred in Canada.

This coverage excludes charges for diagnostic services if they are incurred for the purpose of health screening or if the Participant's Government Health Care Coverage prohibits payment of these expenses.

Other Medical Services and Supplies: Charges for the following medical services and supplies:

- allergy testing materials to a maximum of $50 per calendar year;
- purchase of an artificial larynx to a maximum of 1 per lifetime;
- repair of an artificial larynx to a maximum of $300 per calendar year;
- burn pressure garments to a maximum of $500 per calendar year;
- graduated compression garments (including stockings) to a maximum of 4 pairs per calendar year;
- intrauterine contraceptive device (IUD) to a maximum of $75 per 2 calendar years;
- ostomy supplies, catheters and catheterization supplies;
- oxygen;

- spacing device to a maximum of 1 per calendar year;
- speech aid equipment for persons who do not have oral communication ability to a maximum of $500 per lifetime;
- sleeves for lymphedema to a maximum of 2 per calendar year;
- surgical brassieres to a maximum of 2 per 12 consecutive months;
- transcutaneous electrical nerve stimulator (TENS) device to a maximum of $700 per lifetime; and
- visual training and remedial eye exercises performed by an ophthalmologist or optometrist to a maximum of $150 per lifetime.

Accidental Dental: Charges for dental Treatment when required to repair or replace a sound natural tooth. A tooth is considered sound if, before the accident:

- it was free from injury, disease or defect;
- it did not need further restorations to remain intact or hold secure; and it had no breakdown or loss of root structure or loss of bone.

To be eligible for coverage, Treatment must be:

- required as a result of a direct accidental blow to the mouth or a fractured or dislocated jaw that requires setting;
- incurred while covered for accidental dental benefits with the Employer;
- initiated within 60 days of the Accident or dislocation or a detailed Treatment plan satisfactory to Carrier 3 must be submitted for approval within that period; and
- performed within 12 months of the date of the Accident or dislocation, unless the Participant has been approved by Carrier 3 for deferred Treatment due to the Participant's age.

Coverage amounts are determined in accordance with the fee guide for dental general practitioners applicable to the dentist's province of practice in the year during which expenses are incurred.

This coverage excludes accidental damage to teeth that occurs while eating, denture repair/replacement and orthodontic diagnostic services and treatment.

Vision Care

Eye Examination: Charges for an eye examination performed by an ophthalmologist or optometrist.

Lenses, Frames, Contact Lenses and Laser Eye Surgery: These benefits only apply if indicated in the Summary of Benefits. Charges for the following products and services are eligible when prescribed by an ophthalmologist or optometrist:

- corrective eyeglasses (frames and lenses) and contact lenses;
- laser eye surgery; and

- intraocular lenses used in cataract surgery.

This coverage excludes expenses incurred for non-corrective sunglasses and safety glasses.

Payment of Claims

How Payments are Made

The Participant will pay the full cost of any expense to the Approved Provider at the time of purchase. Carrier 3 will then reimburse any Eligible Expenses on receipt of proof of payment from the Participant.

Certain Approved Providers may offer a pay direct arrangement. In such circumstances, the Approved Provider will submit the Participant's claim to Carrier 3 electronically to verify eligibility at the time of purchase and the Participant will only pay the Approved Provider the portion of the claim that is not covered by this benefit. Carrier 3 will reimburse the balance of the claim to the Approved Provider directly.

Exclusions and Limitations

No payment will be made (or payment will be reduced) for:

a) services, treatment, articles or supplies that do not fall within the categories of Eligible Expenses listed in this benefit;

b) health care covered under any Government Health Care Coverage or charges payable under any occupational health and safety board, automobile insurance bureau or other similar law or public plan;

c) health care that was covered under any Government Health Care Coverage or charges payable under a workers' compensation board/commission, automobile insurance bureau or other similar law or public plan, when this benefit was issued but has since been modified, suspended or discontinued;

d) services, Treatment or supplies that the Participant receives free of charge;

e) charges that would not have been incurred if no coverage existed;

f) services, Treatment or supplies that are:

   i. not Medically Necessary; ii. for cosmetic purposes only; iii. elective in nature; or

   iv. Experimental or Investigative.

g) all services relating to family planning (except for intrauterine contraceptive devices (IUDs)), including artificial insemination, laboratory fees or other charges incurred in relation to infertility treatment, regardless of whether or not infertility is considered to be an Illness;

h) charges that are eligible under the travel benefit provided by this policy (if applicable);

i) services or supplies normally intended for recreation or sports;

j) extra supplies that are spares or alternates;

k) charges for missed appointments or the completion of forms;

l) medical examinations or routine general check-ups;

m) mileage or delivery charges to or from a Hospital or Health Practitioner; or

n) services or expenses incurred as a result of:

   i. insurrection, war (declared or not), the hostile action of the armed forces of any country or participation in any riot or civil commotion; or

   ii. participation in a criminal act or attempt to commit a criminal act, regardless of whether charges are laid or a conviction is obtained.

When Coverage Ends

Coverage ends on the date specified in the Summary of Benefits. In addition, coverage may end on an earlier date, as specified in the *When Coverage Ends* provision found under the *Coverage* provisions of this policy.

Right to Convert to Individual Coverage

A Participant who is no longer eligible for coverage under this benefit may convert their group coverage to a similar individual extended health care plan provided by Carrier 3.

Individual policies issued under this conversion option are subject to the terms and conditions specified in the *Right to Convert to Individual Coverage* provision found under the *Coverage* provisions of this policy.

Dental Benefit Provisions

Purpose of Coverage

Carrier 3 will pay the Eligible Expenses described in this benefit, subject to the conditions outlined below.

Additional Definition

The following definition applies to this benefit, in addition to those found under the *Definitions* provision of this policy.

Unit: A 15 minute interval of time or any portion of a 15 minute interval of time.

Exception: When coverage is limited by Units but fees are not described in terms of Units by either:

- the fee guide in effect where Treatment is rendered; or
- the fee guide specified by this plan; each incident of service is considered 1

Unit, regardless of its duration.

What Carrier 3 Will Pay

Carrier 3 will pay Eligible Expenses subject to the following terms and conditions:

- payment of all Eligible Expenses is limited to the Reimbursement Level and benefit maximums specified below and in the Summary of Benefits;
- the Member must pay the Deductible, if any, specified in the Summary of Benefits;
- the amount of the Eligible Expense to which the Reimbursement Level applies is the lesser of:
  - the expense actually incurred by the Member; or
  - the fee amounts specified in the dental fee guide approved by Carrier 3 (the applicable guide and annual edition are specified in the Summary of Benefits);
- the Eligible Expenses for laboratory fees are limited to 60% of the amount indicated in the provider fee guide for the dental service provided;
- if one or more forms of alternative Treatment exist, payment is limited to the cost of the least expensive Treatment that will meet the Participant's basic dental needs. This limitation applies to the benefits specified as Lowest Cost Alternative Benefit in the Summary of Benefits;
- Eligible Expense must have been performed by:
  - a licensed dentist;

- a licensed denturist when the services are within the scope of their profession; or
- a licensed dental hygienist under the supervision of a licensed dentist or independently where permitted by provincial legislation; and

- payment is limited in accordance with the *Exclusions and Limitations* provision of this benefit.

This benefit covers the expenses explicitly listed in the following categories, provided they also meet the definition of Eligible Expenses under the *Definitions* provision of this policy. Carrier 3 reserves the right to make exceptions for expenses not explicitly listed in the policy but fall into one of the categories mentioned below.

Preventive Care

Oral Examinations and Diagnosis: Charges for:

- complete or general oral examination to a maximum of 1 per 36 consecutive months;
- recall oral examination;
- emergency oral examination; and
- limited or specific oral examination to a maximum of 1 per provider per 9 consecutive months.

X-rays: Charges for:

- complete series to a maximum of 1 per 36 consecutive months;
- panoramic to a maximum of 1 per 36 consecutive months; intra-oral:
  - periapical to a maximum of 15 films per 36 consecutive months combined with occlusal and bitewings; and
  - occlusal and bitewings to a maximum of 15 films per 36 consecutive months combined with periapical;
- sialography; and
- radiopaque dyes.

Laboratory Tests and Examinations: Charges for:

- bacterial culture;
- biopsy of soft oral tissue;
- biopsy of hard oral tissue; and cytological examination.

Preventive Treatment: Charges for:

- polishing of teeth;
- fluoride treatment;

- pit and fissure sealants to a maximum of 1 per 60 consecutive months; and scaling.

Space maintainers

Basic Care

Restorations: Charges for:

- amalgam, acrylic, silicate or composite restorations on anterior and posterior teeth;
- retentive pins;
- pre-fabricated steel or plastic restorations; and pulp capping.

Endodontic Services: Charges for:

- pulpotomy;
- pulpectomy;
- root canal therapy, limited to 2 treatments per tooth per lifetime (retreatments must be separated by 18 consecutive months);
- endodontic surgery;
- bleaching (endodontically treated teeth); and apexification.

Isolation of teeth, enlargement of pulp chambers and root canal therapy on primary teeth are excluded.

Periodontic Services: Charges for:

- periodontal surgery;
- provisional splinting;
- management of acute infections;
- periodontal curettage;
- root planing;
- occlusal adjustments to a maximum of 4 Units per 12 consecutive months;
- periodontal appliances to a maximum of 1 per 2 calendar years;
- adjustments to appliances to a maximum of 3 Units per calendar year; and other adjunctive periodontal services.

Subgingival periodontal irrigation, post-surgical treatment and periodontal re-evaluations are excluded.

Removable Denture Adjustments: Charges for:

- rebasing or relining to a maximum of 1 upper and 1 lower each per 36 consecutive months;
- prophylaxis and polishing; and

- soft liners: resilient liners to a maximum of 1 per 36 consecutive months; and other liners up to the usual, customary and reasonable charges.

Oral Surgery: Charges for:

- removal of teeth and roots;
- surgical exposure and movement of teeth (excluding surgical movement of teeth);
- surgical incision, excision and drainage of tumours or cysts;
- frenectomy (surgical alteration of the frenum);
- removal, reduction or remodelling of bone or gum tissue (excluding alveoloplasty and gingivoplasty performed in conjunction with extractions); and post-surgical care.

Implantology is excluded.

Palatal obturators, excluding cleft palate obturators.

General adjunctive services: Charges for:

- anesthesia;
- temporary dressing for the emergency relief of pain; and finishing restorations.

Major Restoration

Extensive Restorations: Charges for:

- inlays;
- onlays; and
- crowns: for teeth damaged due to caries or traumatic injury (does not include prefabricated steel restorations).

Inlays, onlays and crowns are eligible to a combined maximum of 1 per tooth per 5 calendar years. Recontouring existing crowns and staining porcelain on crowns and onlays are excluded.

Other Restorative Services: Charges for:

- cast post;
- prefabricated metal post;
- recementation of inlays, onlays or crowns; and removal of inlays, onlays or crowns.

Prosthodontic Services: Charges for:

- complete and partial dentures to a maximum of 1 per 5 calendar years;
- bridgework to a maximum of 1 per tooth per 5 calendar years;
- restorations on implants (i.e. crowns, bridgework and dentures) to a maximum of 1 per tooth per 10 calendar years, if specified in the Summary of Benefits;

- construction and insertion of an initial permanent denture or bridgework;
- replacement of an existing denture or bridge with a permanent denture or bridge so long as the existing appliance is at least 5 years old; and
- tooth coloured retainers and pontics on molars limited to the cost of metal retainers and pontics.

Removable Denture Adjustments: Charges for:

- repairs;
- adjustments to a maximum of 1 per 12 consecutive months;
- remakes to a maximum of 1 per 36 consecutive months;
- tissue conditioning; and
- stents related to denture surgery.

Orthodontic Services

Charges for:

- orthodontic examinations;
- unmounted orthodontic diagnostic casts;
- removable appliances for tooth guidance;
- fixed or cemented appliances (braces);
- appliances to control harmful oral habits;
- retention appliances; and
- comprehensive treatment.

Payment of Claims

How Payments are Made

At the time of purchase, the Approved Provider will either submit the Participant's claim to Carrier 3 or provide a completed claim form and proof of payment to the Participant to submit to Carrier 3. The Participant will then be required to either:

- pay the portion of the claim that is not covered by this benefit and Carrier 3 will reimburse the balance to the Approved Provider directly; or
- pay the total amount requested by the Approved Provider and the Participant will receive the portion of the expenses refundable by Carrier 3.

Predetermination for Claims over $200

If the total cost of any Treatment is expected to exceed $200, the Member must submit to Carrier 3, before the Treatment begins, a detailed Treatment plan outlining the type of Treatment to be provided and the amounts to be charged.

Carrier 3 will then notify the Member of the amount eligible for reimbursement. The Treatment must be performed by the dentist who prepared the Treatment plan; otherwise a new Treatment plan must be submitted to Carrier 3 for re-assessment.

Date of Treatment

Eligible Expenses are considered to have been incurred on the date the service or supply was provided. For procedures requiring more than 1 appointment, the Eligible Expense is considered to have been incurred on the date that the entire procedure was completed or the appliance was placed.

Reimbursement for Orthodontic Services

Orthodontic services will be reimbursed in accordance with the following schedule:

- at the time the Participant makes their payment for orthodontic services, Carrier 3 will reimburse the lesser of:
  - the initial payment made by the Participant; or
  - one half of the total Eligible Expense amount in relation to the Treatment; and
- the balance of the total Eligible Expense amount will be divided by the months of active Treatment remaining and reimbursed in equal monthly instalments for the duration of Treatment.

Exclusions and Limitations

Unless otherwise specified in the Summary of Benefits, no payment will be made (or payment will be reduced) for:

a) services, treatment, articles or supplies that do not fall within the categories of Eligible Expenses listed in this benefit;

b) services, Treatment or supplies covered by any Government Health Care Coverage or charges payable under a workers' compensation board/commission, automobile insurance bureau or other similar law or public plan;

c) dental care that was covered under any Government Health Care Coverage or charges payable under a workers' compensation board/commission, automobile insurance bureau or other similar law or public plan, when this benefit was issued but has since been modified, suspended or discontinued;

d) services, Treatment or supplies the Participant receives free of charge;

e) charges that would not have been made if no coverage had existed;

f) anti-snoring or sleep apnea devices;

g) services rendered by a dental hygienist but not administered under the supervision of a dentist, except in provinces where such supervision is not legally required;

h) services, Treatment or supplies that are:

i. not Medically Necessary (except for Preventive Care services); ii.

for cosmetic purposes only; or

iii. Experimental or Investigative;

i) services or expenses incurred as a result of:
   i. insurrection, war (declared or not), the hostile action of the armed forces of any country or participation in any riot or civil commotion; or
   ii. participation in a criminal act or attempt to commit a criminal act, regardless of whether charges are laid or a conviction is obtained;

j) expenses incurred after the termination date of the Participant's coverage, even if a detailed Treatment plan was submitted and accepted by Carrier 3 before this date;

k) services that are eligible under the extended health care (if applicable);

l) splinting for periodontal reasons, where cast crowns, inlays or onlays are used for this purpose;

m) Treatment or appliance, related directly or indirectly to full mouth reconstruction, to correct vertical dimension or TMJ (temporomandibular joint)/myofascial pain dysfunction; n) veneers;

o) implants and related services;

p) extra supplies that are spares or alternates; or

q) charges for missed appointments or for the completion of forms.

Coverage for Late Applicants

In the case of Non-Mandatory policies, for Participants who apply for coverage more than 31 days after their date of eligibility, the maximum amount reimbursed under this benefit is limited to $100 for the first 12 consecutive months of coverage for Preventive Care and Basic Care. Major Restoration will not be eligible for the first 12 consecutive months of coverage, and Orthodontic Services for the first 24 consecutive months of coverage.

When Coverage Ends

Coverage ends on the date specified in the Summary of Benefits. In addition, coverage may end on an earlier date, as specified in the *When Coverage Ends* provision found under the *Coverage* provisions of this policy.

Travel Benefit Provisions

Purpose of Coverage

Carrier 3 will pay the Eligible Expenses described in this benefit, subject to the conditions outlined below.

Additional Definitions

The following definitions apply to this benefit, in addition to those found under the *Definitions* provision of this policy.

Emergency: an illness or injury that requires immediate medical Treatment due or related to:

- an injury resulting from an Accident;
- a new medical condition which begins during a Trip;
- a medical condition that existed prior to a Trip provided that it is Stable.

Stable means the Participant, in the 90 days before the departure date, has not:

- been treated or evaluated for new symptoms or related conditions;
- had symptoms that increased in frequency or severity, or examination findings indicating the condition has worsened;
- been prescribed a new Treatment or change in Treatment for the condition (generally does not include reductions in medication due to improvement in the condition, or regular changes in medication as part of an established Treatment plan);
- been admitted to or treated in a hospital for the condition; or
- been awaiting new treatments or tests regarding the medical condition (does not include routine tests).

The above criteria will be considered collectively in relation to the overall medical condition.

Hospital: A facility that:

- is licensed as an accredited hospital outside of the Participant's province of residence;
- offers care and Treatment to either inpatients or outpatients;
- has a registered nurse on duty 24 hours a day;
- has a laboratory; and
- has an operating room where surgical operations are performed by a legally qualified surgeon.

Coverage excludes any facility used primarily as a clinic, continued or extended care facility, convalescent home, rest home, health spa or drug addiction or alcohol treatment centre unless specifically authorized by Carrier 3.

Immediate Family Member: A Participant's parents, spouse, child, brother or sister.

Incident: An individual occurrence of Emergency illness or injury.

Travel Companion: Persons who are sharing prepaid travel arrangements with the Participant. No more than 3 persons can qualify as a Travel Companion for any given Trip.

Trip: Travel outside of the Participant's province of residence.

What Carrier 3 Will Pay

Carrier 3 will pay for the expenses explicitly listed in the categories below, subject to the following terms and conditions:

- payment is limited to the Reimbursement Level, benefit maximums and coverage duration specified below and in the Summary of Benefits;
- prior approval of Carrier 3 must be obtained before the Eligible Expense is incurred; the charges must be usual, customary and reasonable, meaning that:
  - the amount charged is consistent with the amount generally charged by health practitioners for similar products or services in the geographical area in which the service or supply is being purchased; and
  - the frequency and quantity in which services or supplies are purchased by the Participant are, in the opinion of Carrier 3 in consultation with its health care consultants, consistent with the frequency and quantity that would usually be prescribed or needed for the Participant's condition;
- payment is limited in accordance with the *Exclusions and Limitations* provision of this benefit;
- payment of this benefit is limited to amounts that are in excess of coverage provided by any other plan (where a court determines that this policy and any other plans provide primary coverage, this benefit will be co-ordinated with the other plan, as specified in the *Other Coverage* provision found in the *Claims* provisions of this policy); and
- payment is subject to post-payment audit in accordance with the *Right to Audit* provision found under the *Claim* provisions of this policy.

Emergency Hospital and Medical Travel Coverage

Carrier 3 will pay the Eligible Expenses listed in this section if:

- they are incurred as a result of an Emergency;

- the Participant is covered by Government Health Care Coverage when the Emergency occurs; and
- Carrier 3 is satisfied the expense is necessary to stabilize the Participant's medical condition.

Hospitalization: Charges for Hospital room accommodation (not a suite of rooms) and for Medically Necessary inpatient and outpatient services.

Physician Fees: Fees charged for Physician or surgeon services.

Medical Appliances: The cost of casts, crutches, canes, slings, splints, trusses, braces or the temporary rental of a wheelchair or scooter, when prescribed by the attending Physician.

Nursing Care: Fees for private duty nursing performed by a professional nurse or nursing assistant when prescribed by the attending Physician. The nurse providing the service must not be a Family Member of the Participant or an employee of the Hospital.

This coverage excludes nursing fees for custodial care.

Diagnostic Services: Charges for laboratory tests, X-rays and diagnostic imaging, when prescribed by the attending Physician.

Drugs: The cost of drugs prescribed by a Physician, but only in a quantity sufficient to treat the condition for the duration of Trip. The Participant must provide satisfactory proof of purchase of this medication that includes:

- the name of the Participant;
- the date of purchase;
- the name of the medication;
- the Drug Identification Number, if available;
- the quantity and strength of the drug; and the total cost.

Paramedical Services: The cost of services rendered by chiropractors, osteopaths, chiropodists/podiatrists and physiotherapists. This coverage excludes charges for X-rays.

Accidental Dental and Other Dental Emergencies: Fees of a dental practitioner for Treatment:

a) of damage to natural teeth that occurs as a result of a direct accidental blow to the mouth;

b) that is necessary to repair a fracture or reposition a dislocation of the jaw resulting from an Accident; or

c) that is needed to relieve pain caused by an Emergency other than those listed in (a) or (b).

With respect to Treatment under categories (a) or (b):

- Treatment must begin while the Participant is covered by this benefit and end within 6 months of the Accident, unless deferred Treatment is approved by Carrier 3 due to the age of the Participant; and
- the maximum reimbursement per Participant per Incident is $2,000.

With respect to Treatment under category (c), the maximum reimbursement per Participant per Incident is $200.

Ambulance Service: The cost of ground or air ambulance for transportation of a stretcher patient to the nearest qualified medical facility. This includes the cost of an inter-Hospital transfer if the attending Physician and Carrier 3 determine that existing facilities are inadequate for Treatment or stabilization.

Repatriation to the Province of Residence: The cost of repatriating the Participant to their province of residence to receive immediate medical attention, along with the cost of simultaneously returning a Travel Companion or any Immediate Family Member covered by the policy. If Medically Necessary, this cost may include an accompanying medical attendant.

If returning on a commercial aircraft, coverage includes:

- economy fare to the Participant’s home city in Canada; and
- in the case of a medical attendant, round-trip economy fare.

Unless the repatriation or transfer of the Participant is not possible for medical reasons acceptable by Carrier 3, Carrier 3 may require repatriation of any Participant or transfer to other medical facilities. If the Participant refuses repatriation or transfer, all rights to benefits in relation to the Incident are terminated.

Transportation to Visit the Participant: The cost of round-trip economy fare (by airline, bus or train) for an Immediate Family Member to the Hospital where the Participant has been confined for 7 or more days if the attending Physician provides written acknowledgement that this attendance is required. Carrier 3 may waive the 7 day waiting period if Carrier 3 is satisfied that this waiver is required.

The cost of round-trip economy fare (by airline, bus or train) for an Immediate Family Member to identify the body of the Participant, if deceased.

Vehicle Return: The fees charged by a commercial agency to return the Participant's vehicle, whether private or rental, to the Participant's residence or to the nearest appropriate vehicle-rental agency, when the Participant is unable to drive as a result of an Emergency illness or injury. A medical certificate from the attending Physician confirming the Participant’s medical incapacity to operate the vehicle is required. This benefit is subject to a maximum of $1,000 per Trip.

Return of the Deceased: The cost of preparing and transporting the remains of the deceased Participant to their province of residence to a maximum of $5,000.

Meals and Accommodation: The cost of commercial accommodation and meals when the

Participant's travel is delayed due to Emergency illness or injury of the Participant or Travel Companion. The medical reason for the delay must be verified by the attending Physician. The maximum reimbursement is $150 per Participant per day for a maximum of 20 days (up to a total maximum of $3,000 per Incident).

All costs must be supported by receipts from commercial organizations.

Worldwide Travel Assistance

Carrier 3, through its travel assistance provider, will provide an emergency toll-free line available 24 hours a day, 7 days a week, for Participants who need medical assistance or general assistance while travelling.

Medical Assistance

If the Participant requires hospitalization or a consultation with a Physician as a result of an Emergency, the travel assistance provider appointed by Carrier 3 will provide the following support services:

- direct the Participant to an appropriate clinic or Hospital;
- confirm with the service provider that the Participant is covered;
- ensure a follow-up of the medical file and communicate with the Participant's family Physician;
- co-ordinate the return home of a Child if the Participant is hospitalized;
- repatriation of the Participant to the province of residence if the Participant meets the eligibility requirements of this expense;
- arrange for the transportation of an Immediate Family Member to the Participant's bedside if the Participant meets the eligibility requirements of this expense; and
- co-ordinate the return of the Participant's vehicle if the Participant meets the eligibility requirements of this expense.

General Assistance

In Emergency situations, the travel assistance provider appointed by Carrier 3 will also provide the Participant with the following services:

- transmittal of urgent messages;
- co-ordination of claims;
- services of an interpreter for Emergency calls;
- referral to legal counsel in the event of a serious Accident;
- settlement of formalities in the event of death; assistance with the loss or theft of identity papers; and information regarding embassies and consulates.

In addition, pre-travel advice regarding visas and vaccines is available.

Carrier 3 and its travel assistance provider are not responsible for the quality of medical and Hospital care provided to the Participant or for the availability of such care.

Referral Outside of Canada

When an attending Physician refers a Participant outside of Canada for medical services not available in Canada, Carrier 3 will cover the portion of expenses listed below which exceed those covered by the Participant's Government Health Care Coverage.

Hospital Services: Charges for:

- hospital room accommodation;
- intensive care room accommodation;
- nursing services;
- operating and recovery room services;
- diagnostic and laboratory services, including X-rays;
- oxygen and blood;
- prescription drugs including intravenous solutions; and physiotherapy.

Physicians and Surgeons: Charges for services rendered by a Physician or surgeon.

Ambulance Transportation and Attendant: Charges for licensed ambulance services needed to transport a stretcher patient to and from the nearest hospital able to provide acute care, including any charges for travel expenses of an accompanying registered nurse or qualified medical attendant, other than a relative.

To be eligible for coverage under this category, all expenses must be pre-approved by Carrier 3 and the Participant's Government Health Care Coverage must agree to cover a portion of the expenses.

Payment of Claims

How Payments are Made

Carrier 3 may approve payment directly to the service provider. In certain circumstances, the Participant will pay the full cost of any Eligible Expense at the time of purchase. Carrier 3 will then reimburse any Eligible Expenses on receipt of proof of payment from the Participant.

Exclusions and Limitations

Exclusions Applicable to all Travel Benefit Claims

No payment will be made (or payment may be reduced) if:

a) the Participant fails to communicate with Carrier 3 in the event of medical consultation or hospitalization following an injury or Illness;

b) expenses are incurred beyond the coverage duration period specified in the Summary of Benefits;

c) the purpose of the Trip is primarily or incidentally to seek medical advice or treatment, even if this Trip is on the recommendation of a Physician, with the exception of Referral Outside of Canada;

d) expenses have already been paid or are eligible for refund from a third party;

e) expenses are incurred while travelling in a country (or a specific region of a country) for which there is a Government of Canada travel warning to avoid all travel or avoid nonessential travel, when such travel warning was issued before the departure date and the loss or expense is related to the reason for which the travel warning was issued; or

f) expenses are incurred as a result of:

   i. participation in a criminal act or attempt to commit a criminal act, regardless of whether charges are laid or a conviction is obtained;

   ii. an Illness or injury that occurred while operating a vehicle under the influence of any intoxicant or with a blood alcohol level that was proven to be in excess of the legal limit in the jurisdiction in which the Accident occurred;

   iii. an injury or Illness resulting from non-compliance with medical Treatment or therapy that has been prescribed;

   iv. suicide, attempted suicide or voluntary injury or Illness; or

   v. insurrection, war (declared or not), the hostile action of the armed forces of any country or participation in any riot or civil commotion.

Specific Exclusions and Limitations

Emergency Hospital and Medical Travel Coverage

No payment will be made for:

a) expenses for any care, treatment, surgery, products or services that:

   i. are not incurred as a result of an Emergency; ii. are not Medically Necessary; iii. are performed for cosmetic purposes only; iv. are not required for the immediate relief of acute pain and suffering; or v. could be delayed until the Participant's return to Canada;

b) expenses incurred due to pregnancy or pregnancy complications that occur within 8 weeks of the expected date of delivery; or

c) expenses incurred due to an Emergency that occurs while participating in:

   i. a sport for remuneration; ii. a motor vehicle or speed contest of any kind; or iii. any Extreme Sport, defined as an activity with a high level of inherent danger

and which often involves speed, height, a high level of physical exertion, highly specialized gear or spectacular stunts.

Referral Outside of Canada

No payment will be made for:

a) services available in Canada;
b) health care services or treatments unavailable in Canada due to waiting lists;
c) health care services or treatments that Physicians in Canada have refused to perform;
d) services, Treatment or supplies that are Experimental or Investigative;
e) services provided while the Participant is not under the Treatment of a Physician; and
f) any expenses relating to any Pre-Existing Condition, as defined below.

Pre-Existing Condition: An Illness:

- that begins within 12 months of the date the Participant obtained coverage under this benefit; and
- for which, in the 12 month before the date the Participant obtained coverage under this benefit, the Participant has:
  - had a medical consultation;
  - been prescribed or taken medication; or
  - received treatment, including diagnostic services.

When Coverage Ends

Coverage ends on the date specified in the Summary of Benefits. In addition, coverage may end on an earlier date, as specified in the *When Coverage Ends* provision found under the *Coverage* provisions of this policy.

Health Spending Account (HSA) Benefit Provisions

Purpose of Coverage

HSA is administered by Carrier 3 on behalf of the Policyholder, who assumes the sole legal and financial liability for this benefit, subject to the conditions outlined below.

Additional Definition

The following definition applies to this benefit, in addition to those found under the *Definitions* provision of this policy.

(CRA) Dependent: Defined by the Canada Revenue Agency. This could include family members who are financially reliant on the Member such as parents, grandparents or grandchildren.

What Carrier 3 Will Pay

Carrier 3 will pay eligible medical expenses based upon Canada Revenue Agency guidelines. Eligible medical expenses include deductible amounts, co-payment amounts, and amounts exceeding plan maximums, as well as expenses which are not covered by any applicable group policy, individual policy, Government Health Care Coverage, or any other private program.

HSA Credits

The Policyholder pre-determines the amount of credits allocated to the HSA at the beginning of each policy year specified in the Summary of Benefits. Credits represent the monetary value allocated to the HSA by the Policyholder and the amount that may be reimbursed by Carrier 3 on the Policyholder's behalf.

The credits will be allocated to the HSA at the credit allocation frequency specified in the Summary of Benefits.

Under no circumstances will unused HSA credits be paid out as cash.

HSA credit allocation may only change in the case of a Life Event or a change in the employment status.

Life Event: a Member is adding a Dependent for the first time or no longer has any eligible Dependents, as a result of one of the following:

- Marriage or common law union;
- Birth or adoption of a child; Divorce or legal

  separation;

- Dependent no longer meets eligibility criteria; or

  Death of a Dependent.

If a Member's coverage is terminated, the Policyholder may adjust the credits allocated to the HSA for that policy year. The Policyholder must promptly notify Carrier 3 of the adjusted amount of credits.

Health Spending Account (HSA) Benefit Provisions

If the terminated Member has outstanding claims which were incurred prior to their termination date, these claims may be submitted within the grace period for terminated Members specified in the Summary of Benefits. These claims will be applied against any remaining credits.

Payment of Claims

How Payments are Made

The Summary of Benefits specifies the Method of Payment that applies to Participants under this policy.

Carry Forward Type

Credit Carry Forward

This plan allows unused credits to be transferred into the next policy year.

Credits may be used to reimburse eligible medical expenses incurred in the same policy year in which the credits were allocated. Unused credits will be carried forward into the next policy year. Unused credits cannot be carried forward into further policy years. At the end of a policy year, unused credits that have been carried forward from a previous policy year are forfeited.

Claims will be applied to credits that have been carried forward from a previous policy year before being applied against credits allocated during the current policy year.

Claims must be submitted in the policy year they were incurred or within the grace period specified in the Summary of Benefits.

Exclusions and Limitations

No payment will be made (or payment may be reduced) for:

a) expenses incurred by Members and (CRA) Dependents prior to the effective date of this benefit or following termination, in accordance with this policy;

b) over the counter medications that can be acquired without the intervention of a Health Professional, such as vitamins, minerals, and herbal remedies; or

c) services, treatment or supplies that:

i. are not Medically Necessary; ii. are

for cosmetic purposes only; or iii. are

elective in nature.

When Coverage Ends

Coverage ends on the date specified in the Summary of Benefits. In addition, coverage may end on an earlier date, as specified in the *When Coverage Ends* provision found under the *Coverage* provisions of this policy.

Premium Provisions

Calculation of Premiums

Amount Payable

The monthly premium payable to Carrier 3 by the Policyholder is equal to the total of all Members' premiums calculated in accordance with the premium rates in force at that time.

The premium rates in force on the effective date of this policy have been communicated and accepted by the Policyholder in a separate document to the policy.

Adjustments to Premium Rates

This policy is renewed on an annual basis, unless otherwise noted in the policy. Carrier 3 may modify premium rates at the time of policy renewal provided that written notice of this modification is provided to the Policyholder at least 31 days in advance of the renewal date. The modification is then effective on the renewal date.

Carrier 3 may also modify the premiums rates at any time if:

- the coverage or categories of eligible Employees change;
- there is a 25% change in Members since the effective date or the most recent renewal date of the policy;
- there is a change in the nature of the risk covered;
- there is a change to any government-sponsored plan or any other program that would affect the amounts of benefits payable by Carrier 3. In such circumstances, benefits will

continue to be paid as if such plans or programs had not been modified until a new premium rate agreed on by Carrier 3 and the Policyholder takes effect; or

- the costs of Carrier 3 under the policy change due to a change in government legislation, including but not limited to changes in tax legislation.

Payment of Premiums

Method of Payment

The Policyholder must pay all premiums in a single sum and in accordance with the provisions of this policy.

Carrier 3 is not responsible for verifying that the Policyholder collects Members' contributions, if any, or for ensuring that contributions collected from Members by the Policyholder are used to pay the premiums due to Carrier 3.

Carrier 3 may defer payment of benefits as long as any premium remains unpaid.

Premium Provisions

Premium Due Date

The first monthly premium is due on or before the effective date of the policy. Subsequent premiums are payable on the first day of each month.

Grace Period

The policy will remain in force until the last day of the month for which the premium has been paid, subject to the following grace period:

- if the first premium is not paid on or before the effective date of the policy, no coverage is provided under this policy; and
- if a premium other than the first premium is not paid on or before the date it is due, the policy will remain in force for a grace period of 31 days from this due date (unless it is terminated during this period for a reason other than non-payment of premiums). If the premium is not paid by the final day of the grace period, the policy will terminate and all unpaid premiums, including those applicable to the grace period, must be paid.

Claim Provisions

Proof of Claim

Information and Documentation Required

Proof of claim must be provided in writing and in a form acceptable by Carrier 3.

Before reimbursing a claim, Carrier 3 has the right to:

- obtain any information that is needed to administer the claim;
- require that the Participant provide additional proof or information in support of their claim; and
- require that the Participant undergo a medical examination by a Physician or Health Professional chosen by Carrier 3 as often as deemed necessary.

Carrier 3 has the right to suspend or deny payment of a claim until any additional proof or information requested by Carrier 3 has been submitted by the Participant.

The Participant is responsible for any costs associated with providing proof of claim.

Time Limitations to Submit Proof of Claim

Life and Accidental Death and Dismemberment Coverage: Carrier 3 must receive proof of claim as soon as is reasonably possible and no later than 15 months following the date of the loss.

Critical Illness Coverage: Carrier 3 must receive proof of claim within 15 months of the expiry of the Survival Period.

Disability Benefits Coverage: Carrier 3 must receive proof of claim within 90 days of the expiry of the Elimination Period. Proof of claim consists of 3 forms (Declaration of the Employee, Declaration of the Employer, Declaration of the Physician). If this 90 day time limit is not met for reasons Carrier 3 considers unacceptable, the Elimination Period will begin on the date Carrier 3 receives all relevant documents needed to establish proof of disability.

Health Benefits Coverage: Subject to the exceptions below with respect to certain travel benefits, Carrier 3 must receive proof of claim for all other Health Benefits within 15 months of the date the expense was incurred. Eligible expenses are considered to have been incurred on the date services were rendered or products were supplied.

Emergency Hospital and Medical Travel Coverage, and Referral Outside of Canada: Carrier 3 must receive proof of claim within 4 months of the date the expense was incurred to be eligible for maximum reimbursement under the benefit. Carrier 3 will accept claims up to 15 months from the

date the expense was incurred. However, in such circumstances, the claim may be subject to reductions for any amounts Carrier 3 would have been able to co-ordinate with the Participant's Government Health Care Coverage had the claim been submitted within the 4 month limitation period.

Claim Submitted After Policy Termination

If this policy has terminated, proof of claim must be received by Carrier 3:

- for disability benefits, within 6 months of the onset of disability or the time limit specified by applicable provincial legislation, whichever period is longer;
- for accidental death and dismemberment benefits or accidental damage to natural teeth, within 6 months following the termination date of this policy; or
- within 90 days following the termination date of this policy for all other benefits.

Right to Audit

Carrier 3 has the right, at any time, to inspect or audit the health and claim records of the Participant in relation to a claim for benefits. This right to inspect or audit applies to records held by Carrier 3 or in the files of Approved Providers and may be exercised by Carrier 3 or by a third party on behalf of Carrier 3.

Recovery of Overpaid Amounts

Carrier 3 has the right to recover from a Participant:

- any amount paid in error;
- any amount paid as a result of claims made by the Participant on the basis of fraudulent pretences or misrepresentations; or
- any amount paid that has resulted in overpayment to the Participant.

Carrier 3 has the right to reduce future benefit payments to the Participant until the excess amount is fully recovered.

Termination or Suspension of Benefit Payments

Carrier 3 may, without prior notice, suspend or terminate the rights and benefits of a Participant in the following circumstances:

- the discovery of a claims discrepancy or the initiation of a claim abuse investigation; or
- the filing of criminal charges or initiation of disciplinary action against the Participant by Carrier 3.

Carrier 3 also has the right to suspend or deny payment of a claim for any services or supplies prescribed, rendered or dispensed by a provider who is under investigation by a regulatory body or

by Carrier 3 or who has been charged with an offence in relation to the provider's conduct or practice.

Interest on Benefits Payable

No benefit amounts payable under this policy will bear interest, except for life benefits, if applicable.

Time Limitation to Dispute a Claim Decision

In the event Carrier 3 determines that benefits are not payable, the Participant has a right to appeal the decision by providing written notice to Carrier 3 within 30 days from the date of the written denial.

The time limitation to bring an action against Carrier 3 under this policy begins on the date of the initial written denial from Carrier 3 and extends until the expiry of the minimum limitation period prescribed by the applicable provincial legislation.

Every action or proceeding against Carrier 3 for the recovery of insurance money payable under the policy is absolutely barred unless commenced within the time set out in the Insurance Act or other applicable legislation.

Other Coverage

With the exception of travel, benefits under this policy will be co-ordinated with other health plans when the Participant has similar coverage elsewhere. Payment of travel benefits provided under this policy are limited to amounts that are in excess of coverage provided by any other plan, as specified in the *What Carrier 3 Will Pay* provision found under the *Travel Benefit* provisions of this policy.

The types of other plans that are potentially subject to co-ordination of benefits include any form of group, individual, family, creditor or saving insurance coverage that provides reimbursement for medical treatment, services or supplies and any Government Health Care Coverage.

Supplemental to Government Health Care Coverage

Unless otherwise agreed by Carrier 3, no payment will be made for any health care services or supplies payable or available under Government Health Care Coverage or administered by government funded hospitals, agencies or providers.

Carrier 3 will pay Eligible Expenses in excess of Government Health Care Coverage allowances only where permitted by provincial legislation.

Co-ordination of Benefits with Other Coverage

If a Participant is covered for Health Benefits under this policy and has similar coverage under another health plan, the benefits payable under this policy will be co-ordinated with the other plan in accordance with CLHIA guidelines. Co-ordination of benefits will be calculated to ensure that reimbursement from all sources does not exceed 100% of the cost incurred by the Participant.

Subrogation

Health Benefits

If a Participant is injured as a result of the actions of a third party:

- Carrier 3 will:
  - pay all Health Benefits to which the Participant is entitled under this policy; and
  - be subrogated to the Participant's rights of recovery with respect to such benefits, including the right to sue the third party in the name of the Participant; and
- the Participant will:
  - sign any documentation that is required to give effect to the subrogation rights of Carrier 3; and
  - not release the third party from liability without the prior written consent of Carrier 3 or take any other action that might jeopardize the rights of subrogation of Carrier 3. Any release signed by a Participant without the prior written consent of Carrier 3 will not bind Carrier 3.

If the amount recovered by the Participant or Carrier 3 from the third party is not sufficient to fully indemnify the Participant, the amount recovered, after deduction of the cost of recovery, will be divided between Carrier 3 and the Participant in proportion to which the loss was borne by them.

If the Participant receives, from any source, reimbursement of amounts that were paid by Carrier 3, the Participant must remit these amounts to Carrier 3.

Carrier 3 may require a Participant to sign an acknowledgement that they are bound by this provision.

Disability Benefits

If a Member becomes disabled as a result of the actions of a third party:

- Carrier 3 will:
  - assume liability for all disability benefit payments to which the Participant is entitled under this policy; and
  - where permitted by law, be subrogated to the Member's rights of recovery with respect to such benefits, including the right to sue the third party in the name of the Participant; and
- the Member will:
  - sign any documentation that is required to give effect to the subrogation rights of Carrier 3; and
  - not release the third party from liability without the prior written consent of Carrier 3 or take any other action that might jeopardize the rights of subrogation of Carrier 3. Any

release signed by the Member without the prior written consent of Carrier 3 will not bind Carrier 3.

If the Member initiates legal action or other claim with respect to:

- an incident or Accident that gave rise to, or prolonged, the payment of disability benefits; or
- the assumption of liability under a disability benefit plan,

the Member will include in their claim all losses for which benefit payments have been assumed by Carrier 3 and prosecute their claim with diligence and good faith.

On final disposition of any such legal action or claim, the Member will account to Carrier 3 as follows:

- Past Loss of Income: If the Member recovers an amount for income lost before the date their claim was resolved:
  - this amount, less any legal fees and disbursements incurred to recover this portion of the claim, is added to the amount of benefits the Member has received from Carrier 3;
  - the resulting sum is reduced by the Member's actual loss of Pre-Disability Salary (net of applicable income tax if the plan is non-taxable); and the resulting difference is payable to Carrier 3.
- Future Loss of Income: If the Member recovers an amount for future income loss, Carrier 3 will stop paying disability benefits until the number of weeks or months of benefits represented by that amount is exhausted. This number is calculated by dividing the amount recovered for future loss of income, less any legal fees and disbursements incurred to recover this portion of the claim, by the weekly or monthly benefit amount Carrier 3 was paying before resolution of the claim.
- Lump Sum Settlement: If the Member settles their claim for a lump sum amount without any apportionment for loss of income, the Member must immediately pay Carrier 3 the lesser of:
  - 75% of the net lump sum amount (i.e. the total lump sum amount less the legal fees and disbursements incurred to resolve the claim); or
  - an amount equal to the maximum disability benefits that would have been payable to the Member under the policy.

If the net lump sum is more than the total amount of disability benefits paid to the Member up to the date of settlement, no further benefits will be paid until the weekly or monthly benefits, which would have otherwise been payable after the date of settlement, in addition to the amounts already paid by Carrier 3 under this provision, equal 75% of the net lump sum amount.

Carrier 3 may require a Member to sign an acknowledgement that they are bound by this provision.

Carrier 3 may withhold or discontinue disability benefits if the Member refuses or fails to comply with any of the terms of this provision.

Administration Provisions

Communication to Members

The Policyholder is responsible for informing Members of their rights and obligations under this policy, including any changes to, or termination of, benefits.

The Policyholder must provide Members with materials approved by Carrier 3, such as application forms, claim forms and updated Member booklets.

Requirements for Providing Data

The Policyholder must, in a format agreed on by both parties, provide Carrier 3 with all information needed by Carrier 3 for administrative purposes including:

- completed and signed Member application forms;
- Member beneficiary designations and any subsequent beneficiary changes;
- all information needed to determine the premium and coverage amounts applicable to each Member;
- confirmation of any Member Salary increases within 30 days of the increase;
- the names and termination dates of Members whose employment is terminated; and
- the names of any Participants who no longer meet eligibility requirements. This information must be provided before the date the Participant is no longer eligible.

The Policyholder must ensure all information provided to Carrier 3 is accurate, complete and timely. Carrier 3 is not liable for any payments made as a result of inaccurate, incomplete or untimely information. Carrier 3 may recover from the Policyholder any payments made on that basis.

If the Policyholder fails to notify Carrier 3 that a Participant is no longer eligible for coverage, the Participant's coverage will not remain in force beyond the date they were no longer eligible for coverage, even if premiums have been paid for that Participant. Carrier 3 will refund any overpaid premiums, up to a maximum of 3 months.

Carrier 3 may request to review the Policyholder's Salary records or other files to verify Employee participation, amounts of coverage and premium amounts to be paid.

Misstatement of Age

Benefits and premiums are based on the actual age of the Participant at the time of the event resulting in a claim. If Carrier 3 discovers the age used is inaccurate, premiums and benefits will be

adjusted to correspond to the amounts that would have been provided if the age had not been misstated. If the Participant is not eligible for coverage due to age, the coverage will be voided and a fair adjustment of premiums between Carrier 3 and the Policyholder will be made for the time the coverage based on the misstated age was in force.

Administration Provisions

Clerical Errors

A clerical or technical error will not influence the rights of Carrier 3 or any person having a beneficial interest in the coverage under this policy. If such error is discovered:

- the amount of coverage will be that which would have been in force had there been no such error; and
- a fair adjustment of contributions between Carrier 3 and the Policyholder will be made.

Beneficiary

Unless otherwise designated, all benefits are payable to the Member.

Death Benefits

Benefits payable as a result of the Member’s death will be paid to the Member's last designated beneficiary or beneficiaries.

Subject to the provisions of the law, the beneficiary is the person designated by the Member on their application form. The Member may change their beneficiary by submitting a signed written declaration to Carrier 3.

If 2 or more beneficiaries are designated (other than alternatively) without any specification as to how the death benefit will be divided, the benefit payable will be divided equally among the designated beneficiaries.

If a designated beneficiary dies before the Member, the Member must designate a new beneficiary. If the Member dies before designating a new beneficiary, the deceased beneficiary’s share will be payable:

- to any surviving beneficiaries in equal shares; or
- if there is no surviving beneficiary, to the Member or the Member’s personal representative.

If a Member dies and a beneficiary has not been named in writing, the death benefit will be payable to the Member's estate.

Previous Group Insurance Policy

If this policy replaces a previous group insurance policy that contained a life benefit, the Summary of Benefits specifies whether or not the beneficiary designations for the life benefit under the previous group insurance policy are continued under this policy.

Policy Provisions

Policy Amendments

This policy can be amended in the following manners:

 at any time by the written agreement of the Policyholder and Carrier 3; or by unilateral decision of Carrier 3:

- on any renewal date by giving 31 days written notice to the Policyholder; or
- on the effective date of a change in legislation or a change to any governmentsponsored plan or program that entails a change in benefits payable under this policy.

The Policyholder is deemed to have agreed to an amendment proposed by Carrier 3 if the written proposed amendment is signed by an authorized representative of the Policyholder or if premiums are paid within 60 days after the Policyholder is given a copy of the proposed amendment.

Policy Termination

Termination by the Policyholder

The Policyholder may terminate the policy at any time by giving written notice to Carrier 3. The policy will terminate on the last day of the month in which the notice reaches Carrier 3 or on any later date specified in the notice.

Termination by Carrier 3

Carrier 3 may terminate the policy:

- on any renewal date by providing written notice to the Policyholder at least 31 days before this date, in which case the termination will take effect at 12:01 a.m. on the renewal date; or
- at any time, subject to 31 days written notice, if the Policyholder is in violation of any terms of the policy, including the failure to meet the participation requirements outlined in the policy.

Participation Requirements

Carrier 3 may terminate the policy at any time, subject to 31 days written notice, if the participation of eligible Employees does not reach the percentage outlined in the Summary of Benefits.

When assessing the participation percentage, Employees who have waived coverage for Health Benefits because of similar coverage under another group policy are still considered as participating in the policy.

Policy Provisions

Member Rights on Policy Termination or Replacement

This policy will be administered according to all applicable legislation and CLHIA guidelines dealing with the continuation of coverage following policy termination and the replacement of group coverage.

Exceptions under the Policy

Carrier 3 will not waive its rights or make an exception under this policy based on having previously waived, delayed or made an exception to the enforcement of its rights.

Application of Provisions

The provisions listed under Definitions, *Coverage* provisions, *Waiver of Premium* provisions, *Premium* provisions, *Claim* provisions, *Administration* provisions and *Policy* provisions apply to each benefit under this policy unless the meaning attributed to a defined term or provision is inconsistent or incompatible with the meaning attributed to the same term or provision within the benefit provisions. In the event of incompatibility, the meaning set out in the benefit provisions will prevail.

Non-Participation

This policy will not participate in a distribution of the surplus or profits of Carrier 3.

Assignment

A Participant or beneficiary is not allowed to assign any interest in the coverage or benefits provided under this policy. In certain circumstances, however, Carrier 3 may permit assignment to an Approved Provider.

Legal Currency

All payments and sums referred to in this policy are payable in Canadian currency.

Conformity with Existing Laws

Any provision of this policy that is in conflict with any applicable provincial or federal law of the Member's province of residence is considered automatically amended to conform to the minimum requirements of that law.

Privacy of Information

Both Carrier 3 and the Policyholder agree that the collection, use, disclosure and retention of personal information undertaken in the course of administering this policy will be in accordance with the provisions of applicable privacy legislation.

Policy Provisions

The Entire Policy

This policy is being issued on the basis of the information provided in the Policyholder's application for coverage and any individual Employee's applications, if applicable.

This policy constitutes the entire policy and replaces all prior agreements and understandings between the parties, whether written or verbal, with respect to this subject matter. Any amendment to this policy must be in writing and made in accordance with the *Policy Amendments* provision of this policy.