Black Professionals in Tech Network

All Eligible Employees

Arranged by:

Humi Inc.

Administered by:

Underwritten by:

Chubb Life Insurance Company of Canada

SSQ Insurance Company Inc.

Industrial Alliance

Policy effective: ***November 1, 2020***
Policy amended: ***February 1, 2021***

Privacy Matters

GroupSource understands that your privacy is important. That is why we are taking this opportunity to confirm how we collect, use and protect personal information for you and your family.

Personal Information is information that can be used to explicitly identify you as an individual. When you apply for coverage, have a change in family status, job classification or earnings, personal information about you, your spouse and/or dependents may be collected. The type of personal information that we collect varies according to the benefits provided and may include:

- Full name and address
- Birth-date and gender
- Date of hire and earnings
- Beneficiaries and marital status
- Dependent's birth-date and relationship

This information is used to:

- verify eligibility for the group benefit program through your employer
- process claims accurately and efficiently
- provide accurate billing statements
- satisfy the conditions for additional or optional coverage
- perform insurance related functions

Sometimes it is necessary to collect personal health information, such as medical reports or clinical notes, to underwrite insurance coverage or so that complex claims may be adjudicated precisely and promptly. We do not share your medical information without your express consent. The medical information not collected directly from you may only be released directly through your physician.

GroupSource recognizes the sensitive nature of your personal information and has taken the necessary measures to protect its confidentiality and proper use. Only authorized personnel have access to your information. We do not collect, use or disclose your personal information without your consent, except where authorized by law. For example, when we receive a telephone inquiry, the information provided varies based on the caller's relationship to you, (e.g., plan administrator, a dependent, a service provider). After the caller has been screened for appropriate identification, only information pertaining to the status of the specific application, benefit or claim is shared. Your personal information is not used for any purpose other than that for which it is collected. Any and all statistical reports issued for plan administration purposes do not include any personal information.

You have the right to access your personal information. For information about access to your file, write directly to the Privacy Officer, GroupSource, #200, 5970 Centre Street SE, Calgary, Alberta T2H 0C1.

GroupSource is committed to protecting the confidentiality, accuracy and security of the personal information it collects and uses in the course of conducting business.

Puzzled about your benefits?

...let us put the pieces together.

This booklet gives only a brief outline of the plan and does not create or confer any rights. The exact terms of the plan are described in the policyholder's legal contract(s). In the event of a discrepancy between this booklet and the group contract(s), the terms of the contract(s) will be applicable.

Schedule of Benefits

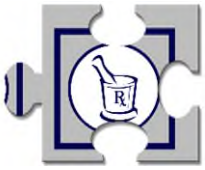
Life Benefits

Group Life
Accidental Death, Disease & Dismemberment
Dependent Life

Disability Benefits

Long Term Disability

Health Benefits



Prescription Drugs
Pay Direct Drug Card
Extended Health Care
Vision Care
Survivor Benefits
Emergency Travel Assistance
Employee and Family Assistance Program
Virtual Healthcare

Dental Benefits

Basic Services
Survivor Benefits

Optional Benefits

Optional Critical Illness

Spending Accounts

Lifestyle & Wellness Spending Account

Employee Classification

Class 001:	All Eligible Employees

Group Life
(underwritten by The Empire Life Insurance Company Group Policy GR009-001 / Policy # 780915)

All eligible Class 001	1 times annual earnings, rounded to the next higher $1,000 if not already a multiple of thereof
Maximum Benefit:	$500,000
No Evidence Limit:	Evidence of Insurability is required for amounts in excess of $190,000.
Coverage reduces:	50% at age 65
Coverage terminates:	at the earlier of retirement or age 70
Waiver of Premium:	To age 65 or prior retirement.
Own Occupation Period:	2 years from the start of any benefit period for the purposes of the "Total Disability" definition for the Waiver of Premium Benefit.
Elimination Period:	For the purposes of the Waiver of Premium Benefit. Injury 119 days Sickness 119 days

Accidental Death, Disease & Dismemberment
(underwritten by Chubb Life Insurance Company of Canada AB700338202)

All eligible Class 001	1 times annual earnings, rounded to the next higher $1,000 if not already a multiple of thereof
Non-evidence maximum: Overall maximum:	$190,000 $500,000
Coverage reduces:	50% at age 65
Coverage terminates:	at the earlier of retirement or age 70

Life Benefits

Dependent Life

(underwritten by The Empire Life Insurance Company Group Policy GR009-001 / Policy # 780915)

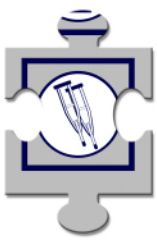
All eligible Class 001

Spouse and each dependent child:	Spouse: Child:	$5,000 $2,500
Coverage terminates:	Employee's termination under the policy or employee's age 70 whichever is earlier.	

Long Term Disability

(underwritten by The Empire Life Insurance Company Group Policy GR009-001 / Policy # 780915)

All eligible Class 001	66 2/3% of monthly earnings, rounded to the next highest $1 if not already a multiple thereof
No-Evidence Limit:	Evidence of Insurability is required for amounts in excess of $4,800.
Overall maximum:	$9,000
Elimination Period:	113 days of continuous disability
Benefits are payable to:	age 65 or prior recovery
Taxability of benefits:	benefits are taxable
Own Occupation Period:	2 years
Integration:	Primary CPP/QPP Benefits
Benefit Period:	Age 65
Survivor benefits:	3 months
Coverage terminates:	Age 65 less the Elimination Period or prior retirement.



Extended Health Care

(underwritten by The Empire Life Insurance Company Group Policy GR009-001 / Policy # 780915)

All eligible Class 001 and their eligible dependents

Prescription drugs (mandatory generic substitution): Pay direct drug card	100%
Hospital (semi-private):	100%
Professional and medical care coverages:	100%
Eligible medical equipment and supplies:	100%
Vision care (eye wear):	100%
Adult:	$250/24 consecutive months
Qualified dependent children younger than 18 years of age:	$250/12 consecutive months
Survivor benefits:	24 months

Emergency travel assistance
(underwritten by SSQ Insurance Company Inc. Policy # 1GJ70)

Coverage is provided for a maximum duration of 90 days with respect to any one Trip.

All eligible out of province emergency expenses are payable at 100% subject to the limitations described in the emergency travel assistance section of this booklet.

Coverage terminates:	at the earlier of retirement or age 70

Employee and Family Assistance Program
(provided by LifeWorks®)

LifeWorks® is an Employee and Family Assistance Program (EFAP) integrated with Work-Life Services. It is a full-service, bilingual program that combines confidential counseling and comprehensive work-life services to assist employees and their immediate families with personal problems and concerns.

LifeWorks Full-Service EFAP includes:

- In-person confidential counseling during the day, evening and on weekends, with no fixed limit on the number of short term counseling sessions
- Bilingual expert counselors available 24 hours a day, seven days a week via a toll-free number
- Referrals to a network of community resources
- Management and supervisor consultation

LifeWorks Work-Life Services include:

- Access to an extensive library of tip sheets, educational articles, DVD's, CD's, audiotapes and booklets that address a wide range of topics
- Referrals to community resources including childcare, eldercare, financial and legal support and educational resources
- Convenient access to thousands of pages of work-life information on English and French Web sites

Coverage terminates: at the earlier of retirement or age 70

Virtual Healthcare

(provided by Akira Virtual Healthcare ~ VHC)

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

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

Consult Fees

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

Dental Care

(underwritten by The Empire Life Insurance Company Group Policy GR009-001 / Policy # 780915)

All eligible Class 001 and their eligible dependents

Basic, endodontic and periodontal:	100%
Calendar year maximum:	$1,000 for basic, endodontic, periodontal services
Survivor benefits:	24 months

Benefits are paid in accordance with the current published Provincial Fee Schedule.

Coverage terminates:	at the earlier of retirement or age 70

Dental Benefits

Optional Critical Illness
(underwritten by Industrial Alliance Policy # 780915)

All eligible Class 001 and/or spouse	units of $5,000 to a minimum benefit of $10,000 And a maximum of $100,000
Eligible dependent children	$10,000 Your Dependent children are eligible from birth to age 22; or 25 (26 in the province of Quebec) if in full-time attendance at an accredited school as students.
Guaranteed Issue Limit	Up to $50,000 is available on a guaranteed issue basis – i.e. medical evidence is not required

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

Portability	Available for Employee and/or Spouse
Payment of Premium	Premiums are paid 100% by the employee by way of payroll deduction
Coverage terminates:	at the earlier of retirement or age 70

Lifestyle & Wellness Spending Account
(Company Sponsored Benefits Policy # 780915)

All eligible Class 001 and their eligible dependents

"Plan Year":	Calendar Year (January 1st to December 31st)
Allocation amount:	$500 per "plan year"
Eligible expenses:	refer to the Lifestyle & Wellness Spending Account section of this Booklet
Eligible dependents:	as defined under your standard group health and dental benefits program
One year carry-over:	of unused funds
Waiting period for new employees:	3 months
Amount of coverage for new employees:	full amount upon completion of waiting period
Grace period to submit claims following the end of the plan year:	60 days
Grace period for claims to be submitted following employee termination:	30 days
Coverage terminates:	at the earlier of retirement or age 70

Waiting Period For All Benefits

The waiting period for your plan is THREE MONTHS of continuous employment. You and your dependents have 31 days from the date you become eligible to apply for the group insurance. If you apply later than 31 days after your eligibility date, you and your dependents must provide Evidence of Insurability. The effective date of your coverage will be the date the Insurer approves the Evidence of Insurability.

Spending Accounts

General Provisions

Eligibility

You are eligible for coverage under this plan if you:

- are a permanent employee;
- have satisfied the Waiting Period;
- have not reached the coverage termination age of each respective benefit as specified in the Schedule of Benefits; and
- are Actively at Work for your employer at least 35 hours a week.

All persons to be insured under the Policy must:

- be legally entitled to be or to remain in Canada; and
- make their home and normally be present in their province of territory of residence in Canada; and
- be insured under a Government Health Plan.

Eligible Dependents

Dependents eligible for benefits include your spouse or common-law spouse (1 year(s) cohabitation) and your unmarried dependent children under the age of 22 years (25 years if attending school on a full time basis).

A common-law couple should publicly represent themselves to society as married. Upon written request, your common-law spouse will be eligible immediately if a child is born to you and your common-law spouse.

Dependants must reside in Canada to qualify for benefits. However, children who are temporarily residing in the United States because they are attending an accredited academic institution will also be eligible for benefits provided they are insured under a Government Health Insurance Plan.

You can only cover one spouse at a time. You must insure the same person for all spousal benefits provided under the policy

If a child becomes permanently mentally or physically handicapped before the age of 22 or while a full time student at an accredited educational institution, before age 25, the Insurer will continue coverage as long as the child is incapable of self-sustaining employment by reason of mental or physical handicap and is wholly dependent on you or your spouse for support and maintenance. Proof of the disabling condition must be provided to the Insurer within 31 days of the limiting age outlined above. Continuing proof of such disabling condition must be submitted to the Insurer as required.

Evidence of Insurability

If your written request for coverage is received within 31 days of being eligible, Evidence of Insurability will only be required for any amounts in excess of the respective No Evidence Limits, as specified on the Schedule of Benefits.

After you have become insured under the plan, if the No Evidence Limit is increased, your coverage will be held at the No Evidence Limit in effect prior to the increase if you previously provided Evidence of Insurability and the evidence provided resulted in coverage being declined.

Should your written request for coverage be received after 31 days of becoming eligible for coverage and the Policy is mandatory, premiums are payable from the date you became eligible. If however, the Policy is non-mandatory, you will be required to submit Evidence of Insurability for all insurance. Coverage will not become effective until evidence has been reviewed and approved. For further information, please contact the Administrator.

Coordination of benefits

If your plan includes Extended Health Care and/or Dental Care Benefits and if either you or your dependents are entitled to benefits under this plan and any other plan for the same expense, the amount payable will be co-ordinated and/or reduced under this plan to ensure the total amount payable under all plans does not exceed the amount of the expense incurred. For further information, please contact the Administrator.

Limitation of actions

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract (the Policy) is absolutely barred unless commenced within the time set out in the Insurance Act (for British Columbia, Alberta and Manitoba), the Limitations Act, 2002 (for Ontario), or other applicable legislation (for all other provinces and territories).

Termination of coverage

Your benefits will terminate whenever one of the following first occurs:

- termination of employment; or
- premiums are not submitted on your behalf; or
- the Policy is terminated; or

you no longer satisfy one or more of the eligibility requirements above.

Payment of Claims

Claim filing

If you wish to claim for any benefit, please see your employer who will provide you with the correct forms and explain how you should file a claim. You should save all bills and original receipts for medical expenses as they will be required for proof of claim.

Whenever possible, you should promptly submit the completed claim form and any actual bills or receipts (not photocopies). The Insurer should be notified within 31 days of any event which will give rise to a claim, or within 45 days whenever you are absent from work due to a disability.

Claim submission period

You have 90 days to submit the required proof of any death and disability claims. For dental and extended health claims, claim forms must be submitted within 365 days from the date the claim was incurred or within 90 days of Policy termination, whichever comes first.

Payment

Claims will be paid after the proof of claim is received. Any death benefit due will be paid to the named beneficiary, if living. Otherwise it will generally be paid to the estate. All other benefits will be paid as directed by you on the claim form. Please note: Under some circumstances, Extended Health Benefits may not be payable until the Government Health Insurance Plan concerned has paid its' yearly maximum. Check with the Administrator if you require further details.

Access to personal information

Subject to the exceptions established by applicable law, you may request access to your files containing personal information by contacting the Administrator.

Definitions

Here is a list of definitions of some terms that appear in this employee benefits booklet. Additional definitions appear within benefit description sections.

Actively at Work means any day you are actively at work performing all the usual and customary duties of your job for the scheduled number of hours for that day.

Evidence of Insurability means written health information provided to determine whether or not a person satisfies the Insurer's medical underwriting requirements.

Government Health Insurance Plan means the provincial or federal legislation and the regulations pursuant to such legislation, as amended from time to time, which provide government sponsored hospital, drug, dental or other medical care benefits for residents of Canada, including but not limited to provincial Dental Care Plans, provincial Health Insurance Plans, provincial Hospital Insurance Plans, provincial Medicare Plans, federal or provincial medical or dental care and services Acts, and the Canada Health Act.

Hospital means a facility, legally constituted as a hospital, which,

- is licensed as a hospital where such licensing laws exist and, in Canada, is approved by the province in which it is situated to provide insured hospital services in accordance with the Government Health Insurance Plan of such province, and
- is operated primarily to provide medical, diagnostic and surgical facilities for the care and treatment of sick and injured persons on an in-patient basis, and
- has a staff of one or more Physicians available at all times and provides twenty-four hour nursing service by graduate registered nurses, and
- is not principally a tuberculosis hospital or sanatorium, an institution for the mentally ill, a rest home, a nursing home, a home for the aged, an institution solely for the provision of custodial care or, other than incidentally, is not principally a medical facility which provides for the treatment of alcohol or drug addiction.

Insurer means the insurance company shown in Schedule of Benefits as the underwriter for the benefit.

No Evidence Limit means the amount of insurance you and your eligible dependant may obtain without providing Evidence of Insurability. At each rate re-calculation the Insurer may establish a new No Evidence Limit.

If at a date subsequent to the Policy Effective Date, the No Evidence Limit is increased, your coverage will be held at the No Evidence Limit in effect prior to the change, if you previously provided Evidence of Insurability that did not satisfy the Insurer's medical underwriting requirements.

Physician means a physician or surgeon or a specialist medical doctor duly qualified and legally licensed by the jurisdiction in which he operates, who prescribes and administers medical treatment and drugs professionally or performs surgery within the scope of his licence, and who specializes in a particular branch of medicine and who is neither insured for benefits under the Policy, nor related by blood or marriage to you.

Pregnancy/Parental Leave of Absence means any formal pregnancy or parental leave taken pursuant to Provincial or Federal Law or pursuant to mutual agreement between you and your employer.

Life Benefits

Amount of insurance

The amount of your Group Life Insurance coverage is described on the Schedule of Benefits page. You may be required to submit Evidence of Insurability. If you are, you will only be insured for the No Evidence Limit until the evidence is approved.

Death Benefit

The amount of life insurance for which you are covered will be payable upon your death to your last named beneficiary.

Appointment of beneficiary

Your beneficiary will be as designated in your individual application for group insurance, or, if applicable, as designated under your previous carrier's coverage. If your designation is carried over from your previous carrier's coverage we recommend you review the existing designation to ensure it reflects your current intention. The most recent designation will apply.

You may name anyone you please as your beneficiary, and you may change your beneficiary at any time, subject to the laws of your province by filing written notice with the Insurer. If you do not appoint a beneficiary or if your beneficiary predeceases you, the death benefit will be payable to your estate.

Waiver of premium

If you become Totally Disabled, as defined below, you may qualify to have your life insurance continue until you reach age 65 without payment of any premiums. To be eligible, you must be disabled before your 65th birthday or your retirement, whichever occurs first, and you must have been unable to work throughout the Elimination Period as shown in the Schedule of Benefits before the premium will be waived.

Total Disability/Totally Disabled means during the Elimination Period and the Own Occupation Period, if any, as shown on the Schedule of Benefits page, such a continuous state of incapacity resulting from injury or sickness that you will be completely prevented from performing the essential duties of your own occupation at your own or any workplace. After the expiration of the Own Occupation Period, if any, it means such a continuous state of incapacity resulting from injury or sickness that you will be completely prevented from engaging in any gainful occupation or from performing any work for remuneration or profit for which you are reasonably fitted by education, training or experience.

The availability of work will not be considered by the Insurer in assessing your Total Disability.

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

Living benefit

If you are under age 62 and suffer a terminal illness from which death is expected within 24 months and you have been approved for the Waiver of Premium Benefit above, you may qualify for a Living Benefit. A Living Benefit is an advance payment of a portion of the amount of your Basic Life coverage described on the Schedule of Benefits page.

The Living Benefit consists of 50% of the amount of your Group Life coverage to a maximum of $50,000.

Upon your death, the Death Benefit will equal the sum insured on your date of death less the Living Benefit paid and the interest accrued on the Living Benefit.

Conversion privilege

Should you leave your Employer's service while the Group Policy is in force or turn 65 years old, you may arrange to convert that portion of your Life Insurance, without medical examination, to an individual policy of any one of the standard level premium Life, Term to Age 65 or One Year Term plans then being issued by the Insurer, provided application for the converted policy is made within 31 days of termination of employment. The amount will be limited to the lesser of:

- the amount of your Group Life Insurance to a maximum of $200,000 (or the amount required by provincial legislation, if applicable); and
- the difference between your amount of Group Life Insurance in effect upon termination and the amount of life insurance for which you are or become eligible for within the 31 day conversion period.

Basic Accidental Death & Dismemberment Coverage

Coverage

The plan offers you full 24-hour protection against accidents, on or off the job, on business, on vacation, at home, regardless of your health history.

Eligibility

All active permanent employees of group clients of GroupSource. Benefit terminates as shown in the Schedule of Benefits.

Benefit amount

In the event of your death, the benefit amount is payable to the beneficiary you have named under your Group Life Insurance Plan or in the absence of such designation, to your Estate.

Benefits payable under the following section will be limited to only one policy in the event the benefits are contained in two or more policies issued to the Policyholder by Chubb Life *(not applicable to the Schedule of Losses, Exposure ,Disappearance and Conversion)*

Schedule of losses

Accidental death & dismemberment

If such injuries shall result in any one of the following specific losses within one year from the date of the accident, Chubb Life will pay the percentage of the benefit amount, based on the amount stated under the benefit amount section, however, that not more than one (the largest) of such benefits shall be paid with respect to injuries resulting from one accident.

	Percentage of benefit amount
Loss of Life	100%
Loss of Entire Sight of Both Eyes	100%
Loss of One Hand and One Foot	100%
Loss of Use of One Hand and One Foot	100%
Loss of One Hand and Entire Sight of One Eye	100%
Loss of One Foot and Entire Sight of One Eye	100%
Loss of Speech and Hearing in Both Ears	100%
Brain Death	100%
Coma	100%
Loss of Both Arms, Both Hands, Both Legs or Both Feet	200%
Loss of Use of Both Arms, Both Hands, Both Legs or Both Feet	200%
Quadriplegia	200%
Paraplegia	200%

Hemiplegia	200%
Loss of One Arm or One Leg	75%
Loss of Use of One Arm or One Leg	75%
Loss of One Hand or One Foot	75%
Loss of Use of One Hand or One Foot	75%
Loss of Entire Sight of One Eye	75%
Loss of Speech or Hearing in Both Ears	75%
Loss of Thumb and Index Finger of Same Hand	33 1/3%
Loss of Use of Thumb and Index Finger of Same Hand	33 1/3%
Loss of Four Fingers of Same Hand	33 1/3%
Loss of Hearing in One Ear	33 1/3%
Loss of All Toes of Same Foot	25%

"Loss" shall mean with respect to hand or foot, the actual severance through or above the wrist or ankle joint; with respect to arm or leg, the actual severance through or above the elbow or knee joint; with respect to eye, the total and irrecoverable loss of sight; with respect to speech, the total and irrecoverable loss of speech which does not allow audible communication in any degree; with respect to hearing, the total and irrecoverable loss of hearing which cannot be corrected by any hearing aid or device; with respect to thumb and index finger or four fingers, the actual severance through or above the metacarpophalangeal joints of the same hand (the joints between the fingers and the hand); with regard to toes, the actual severance through or above the metatarsophalangeal joints (the joints between the toes and the foot) of the same foot. If an Insured Person suffers complete severance of a hand, foot, arm or leg as described above, then Chubb Life will pay the amount specified in the Schedule of Losses even if the severed limb is surgically reattached, whether successful or not.

"Loss" as used with reference to quadriplegia (paralysis of both upper and lower limbs), paraplegia (paralysis of both lower limbs), and hemiplegia (total paralysis of upper and lower limbs of one side of the body), means the complete and irrecoverable paralysis of such limbs, provided such loss of function is continuous for 180 consecutive days and such loss of function is thereafter determined on evidence satisfactory to Chubb Life to be permanent.

"Loss of Use" shall mean the total and irrecoverable loss of function of an arm, hand, foot, leg or thumb and index finger of the same hand provided such loss of function is continuous for 12 consecutive months and such loss of function is thereafter determined on evidence satisfactory to Chubb Life to be permanent.

"Brain Death" means irreversible unconsciousness with total loss of brain function; and complete absence of electrical activity of the brain, even though the heart is still beating.

"Coma" means the Insured has been in a state of unconsciousness for a continuous period of at least 96 hours, during which external stimulation produced no more than primitive avoidance reflexes. A Physician who is certified as a neurologist must confirm diagnosis in writing.

All benefits that are payable at 200% of the Principal Sum are subject to an all policies combined maximum benefit amount of $1,000,000.

Repatriation benefit

When injuries result in loss of life of an Insured Person outside 150 kilometers from their city of permanent residence or outside Canada and the loss of life occurs within 365 days from the date of the accident, Chubb Life will pay the actual expense incurred for preparing the deceased for burial and shipment of the body to the city of residence of the deceased, but not to exceed $15,000.

Rehabilitation benefit

When injuries result in a payment being made by Chubb Life under any benefit excluding the Loss of Life Benefit, Chubb Life will also pay the reasonable and necessary expenses actually incurred up to a limit of $15,000 for special training of an Insured Employee provided:

- such training is required because of such injuries and in order for an Insured Employee to become qualified to engage in an occupation in which he or she would not have been engaged except for such injuries;
- expenses are to be incurred within 2 years from the date of the accident;
- no payment will be made for ordinary living, travelling, or clothing expenses.

Family transportation benefit

When injuries result in an Insured Person confinement as an in-patient in a hospital outside 150 kilometers from an Insured Person's city of permanent residence or outside Canada and requires personal attendance of a "Family Member" as recommended by the attending physician, in writing, Chubb Life will pay for the expense incurred by the member of the family, for the transportation by the most direct route by a licensed common carrier to an Insured Person, while confined, but not to exceed $15,000.

"Family Member" means spouse, parent or stepparent, child or stepchild or brother or sister, stepbrother or stepsister, brother-in-law or sister-in-law, mother-in-law or father-in-law, and son-in-law or daughter-in-law.

Spousal occupational training benefit

When injuries result in a payment being made by Chubb Life under the Loss of Life Benefit, Chubb Life will pay in addition the expenses actually incurred, within 365 days from the date of the accident, by the spouse of an Insured Employee for a formal occupation training program for the purpose of specifically qualifying such spouse to gain active employment in an occupation for which the spouse would otherwise not have sufficient qualifications. The maximum payable hereunder is $15,000.

Home alteration and vehicle modification benefit

In the event an Insured Person sustain an injury which results in a payment being made under the Schedule of Losses, excluding the Loss of Life Benefit, and such injury subsequently requires the use of a wheelchair to be ambulatory, Chubb Life will pay the reasonable and necessary expenses actually incurred within 365 days from the date of the accident for:

1. the one-time cost of alterations to an Insured Person's principal residence to make it wheelchair accessible and habitable; and
2. the one-time cost of modifications necessary to a motor vehicle utilized by an Insured Person to make the vehicle accessible or operable for an Insured Person.

Benefit payments herein will not be paid unless:

- home alterations are made by a person or persons experienced in such alterations and recommended by a recognized organization, providing support and assistance to wheelchair users; and
- vehicle modifications are carried out by a person or persons with experience in such matters and modifications are approved by the Provincial vehicle licensing authorities.

The maximum payable under both items 1 and 2 shall be 10% of an Insured Person's Principal Sum amount to a maximum of $50,000.

Day care benefit

If an Insured Person suffers a loss of life in a covered accident while the policy is in force, Chubb Life will pay, in addition to all other benefits payable under the policy a Day Care Benefit equal to the reasonable and necessary expenses actually incurred, subject to the lesser of 5% of an Insured Person's Principal Sum amount or a maximum of $5,000 per year, on behalf of any dependent child who is enrolled in a legally licensed day care centre on the date of the accident or who enrolls in a legally licensed day care centre within 365 days following the date of the accident.

The "Day Care Benefit" will be paid each year for 4 consecutive years, but only upon receipt of satisfactory proof that a child is enrolled in a legally licensed day care centre.

"Dependent Child" means the Employee's eligible unmarried natural, adopted, step child or common law child who is principally dependent on the Employee or the Employee's spouse for financial support.

Special education benefit

If an Insured Person suffers a loss of life in a covered accident while the policy is in force, Chubb Life will pay, in addition to all other benefits payable under the policy, a Special Education Benefit up to 5% of an Insured Person's Principal Sum amount, (subject to a maximum of $5,000 per year), on behalf of any dependent child who, on the date of the accident, is enrolled as a full-time student in any post-secondary institution of higher learning or was at the 12th grade level and subsequently enrolls as a full-time student in any post-secondary institution of higher learning within 365 days following the date of the accident.

The "Special Education Benefit" is payable annually for a maximum of 4 consecutive annual payments but only if the dependent child continues his or her education as a full-time student in an institution of higher learning.

Bereavement benefit

When injuries covered by the policy result in loss of life of an Insured Person within 365 days from the date of the accident, Chubb Life will pay the reasonable and necessary expenses actually incurred by the spouse and dependent children of an Insured Person for up to 6 sessions of grief counseling, by a "Professional Counsellor", subject to a maximum of $1,000.

"Professional Counsellor" means a therapist or counsellor who is licensed, registered or certified to provide such treatment.

In-Hospital confinement monthly income benefit

In the event an Insured Person sustains an injury which results in a payment being made under the Schedule of Losses, excluding the Loss of Life Benefit, and an Insured Person is hospital confined as an in-patient and is under the care of a legally qualified and registered physician or surgeon other than himself or herself, Chubb Life will pay for each full month, 1% of an Insured Person's Principal Sum amount, subject to a maximum amount of $2,500, or 1/30 of such monthly benefit for each day of partial month, retroactive to the 1st full day of such confinement but not to exceed 365 days in the aggregate for each period of hospital confinement.

"Hospital" as used herein means a legally constituted establishment which meets all of the following requirements: (1) operates primarily for the reception, care and treatment of sick, ailing or injured persons as in-patients; (2) provides 24 hour a day nursing service by registered or graduate nurses; (3) has a staff of one or more licensed physicians available at all times; (4) provides organized facilities for diagnosis and surgical facilities; and (5) is not primarily a clinic, nursing home or convalescent home or similar establishment nor, other than incidentally, a place for alcoholics or drug addicts.

"In-Patient" means a person admitted to a hospital as a resident or bed-patient and who is provided at least one day's room and board by the hospital.

Cosmetic disfigurement benefit

If an Insured Person suffers a third degree burn due to an accident, Chubb Life will pay a percentage of the Principal Sum depending on the area of the body which was burned according to the following table, subject to a maximum benefit payable of $25,000:

Body Part	**% of Principal Sum Payable**
Face, Neck, Head	100%
Hand & Forearm	25%
Either Upper Arm	15%
Torso (Front or Back)	35%
Either Thigh	10%
Either Lower Leg (below knee)	25%

In the event of a 50% surface burn, the % of benefit is reduced by 50%. This table only represents the maximum percent of the Principal Sum payable for any one accident. If the Insured suffers burns in more than one area as a result of any one accident, benefits will not exceed a maximum of $25,000.

Seat belt benefit

In the event an Insured Person sustains an injury which results in a payment being made under the Schedule of Losses, an Insured Person Principal Sum amount will be increased by 10% to a maximum of $25,000 if, at the time of the accident, an Insured Person was driving or riding in a vehicle and wearing a properly fastened seat belt. Due proof of seat belt use must be provided as part of the written proof of loss.

"Vehicle" means a private passenger car, station wagon, van, or jeep-type automobile.

"Seat Belt" means those belts that form a restraint system.

Identification benefit

In the event accidental loss of life is sustained by an Insured Person not less than 150 kilometers from an Insured Person's normal place of residence and identification of the body by an "Family Member" has been requested by the police or a similar governmental authority, Chubb Life will reimburse the reasonable expenses actually incurred by such member for:

- transportation by the most direct route to the city or town where the body is located; and
- hotel accommodation in such city or town, subject to a maximum duration of 3 days.

The reimbursement of such expenses incurred is subject to the accidental Loss of Life benefit being subsequently payable in accordance with the terms of the policy following the identification of the body as an Insured Person. The maximum amount payable will not exceed $15,000 for all such expenses.

Payment will not be made for board or other ordinary living, travelling or clothing expenses, and transportation must occur in a vehicle or device operated under a license for the conveyance of passengers for hire.

"Family Member" means spouse, parent or stepparent, child or stepchild, brother or sister, stepbrother or stepsister, brother-in-law or sister-in-law, mother-in-law or father-in-law, and son-in-law or daughter-in-law.

Psychological Therapy Benefit

When an injury to an Insured Person results in the Company making a payment under the Loss Schedule, the Company will increase the benefit amount payable up to a maximum of $5,000, for the reasonable and customary charges for treatment or counseling for Psychological Therapy as determined by a Physician and authorized by the Company.

Benefit payments herein will be paid until the earlier occurrence of one of the following:

- the maximum benefit amount has been paid; or
- two (2) years have elapsed from the date of the accident; or
- death of the Insured Person.

Psychological Therapy must be provided by a therapist or counsellor (other than yourself or a Member of the Immediate Family) who is licensed to provide such treatment, whether on an out-patient basis or while a patient is at a medical facility licensed to provide such treatment.

"**Reasonable and Customary**" means the lesser of:

- the usual charge made by Physicians or other health care providers for a given service or supply; or
- the charge the Company determine to be the prevailing charge made by the Physicians or other healthcare providers for a given service or supply in a geographical area where it is furnished; or
- the amount negotiated by the Company and the health care provider.

"**Physician**" means a doctor of medicine (other than yourself or a Member of the Immediate Family) licensed to practice medicine by:

- a recognized medical licensing organization in the locale where the treatment is rendered, provided he/she is a member in good standing of such licensing body; or
- a governmental agency having jurisdiction over such licensing in the locale where the treatment is rendered.

"**Member of the Immediate Family**" means a person at least eighteen (18) years of age, who is the Insured Person's son, daughter, father, mother, brother, sister, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, sister-in-law (all of the previous include natural, adopted and step relationships), spouse, grandson, granddaughter, grandfather or grandmother.

Funeral Expense

If an Insured Person suffers Injury resulting in Loss of Life for which the Company has paid the benefit set out in Coverage A, the Company will reimburse the person who has incurred the actual expenses pertaining to the cremation, burial or funeral expenses of the Insured Person.

Workplace Modification & Accommodation Benefit

If an Insured Person suffers accidental injury resulting in a covered loss (excluding loss of life) for which the Company has paid a benefit under Coverage A and which results and necessitates the use of special adaptive equipment and/or workplace modification in order to reasonably accommodate the Insured Person's return to active, full-time work with his or her employer, the Company shall pay the Insured Person's employer, upon the Insured Person's return to active, full-time work with the employer, the reasonable and necessary expenses actually incurred by the employer for such adaptive equipment and/or workplace modification provided:

- the employer agrees in writing with the Company to provide the special adaptive equipment and/or make modifications to the workplace for the purpose of making it accessible and adaptable to the needs of such Insured Person;
- the employer acknowledges in writing to the Company that the performance of the essential duties of such Insured Person's job may be altered;
- the proposed special adaptive equipment and/or workplace modification have been approved in advance of an expense being incurred by the employer for such equipment or modification.

The company shall be afforded the opportunity to examine the Insured Person to evaluate the appropriateness of the proposed modifications.

This benefit is payable only once in connection with accidental injuries and covered losses suffered by any one (1) Insured Person, regardless of the number of policies, providing coverage for a workplace modification and accommodation benefit, that may be issued by the Company to the Policyholder or the employer.

The maximum amount payable for this benefit for all accidental injuries resulting from one (1) accident is $5,000 for each Insured Person.

Critical Disease Benefit

Chubb Life will pay an amount equal to 10% of the principal sum, subject to a maximum benefit of $50,000, provided:

- the loss occurs prior to the insured person's 65th birthday;
- the insured person has been medically diagnosed with one of the covered Critical Diseases while insured under the policy; and
- the insured person has been Totally Disabled from the Critical Disease for at least 9 months. Benefits are limited to the first covered Critical Disease in the insured person's lifetime.

"**Critical Disease**" shall mean any one of the following diseases diagnosed after the insured person's effective date of coverage: Poliomyelitis, Parkinson's Disease, Huntington's Chorea, Multiple Sclerosis, Alzheimer's Disease, Type 1 Diabetes (Insulin Dependent), Amyotrophic Lateral Sclerosis (ALS), Peripheral Vascular Disease and Necrotizing Fasciitis.

"**Totally Disabled**" shall mean a disability resulting from the Critical Disease to the extent that the insured person:

- is under the regular care and following the prescribed treatment of a physician, and;
- is not engaged in any occupation or performing any work of any sort, for wage, remuneration, or profit; and
- is prevented from engaging in any occupation or performing any work of any sort, for wage, remuneration or profit, for which they are able or may become able, by means of education, training or experience.

Cancer Critical Illness Insurance Rider

Cancer Critical Illness Benefit (applicable to Insureds under age 70 only)

If the Insured, under age 70 is diagnosed with Cancer after the effective date or latest reinstatement date of coverage, and survives a period of 30 days following the date of such diagnosis, the Company will pay 5% of the AD&D Principal Sum up to a maximum of $10,000.

The Company will only pay the Cancer Critical Illness Benefit once.

Definitions

"***Cancer***" means a malignant tumor characterized by the uncontrolled growth and spread of malignant cells and invasion of tissue. This includes Leukemia, Hodgkin's Disease and invasive melanoma but does not include:

- Carcinoma in situ;
- Kaposi's Sarcoma or other Acquired Immune Deficiency Syndrome (AIDS) related cancers and cancer in the presence of human immunodeficiency virus (HIV);
- Skin cancer or melanoma that is not invasive and has not exceeded .75 millimeters in depth;
- Prostate cancer diagnosed as T1 N0 M0 or equivalent staging; or
- a recurrence or metastasis of a cancer which was originally diagnosed prior to the effective date of coverage.

A Physician certified as an oncologist must confirm the Cancer diagnosis in writing.

"***Pre-existing Condition***" means an injury or sickness for which the Insured received treatment or advice or a diagnosis, or for which treatment was required or recommended by a Physician during the 24 months immediately before the Insured's effective date of coverage or any increased amount of insurance coverage (not including increases caused by annual salary changes).

Limitations and Exclusions

In addition to General Limitations and Exclusions this Rider does not provide benefits for any injury or illness caused directly or indirectly by or contributed to by any of the following:

- injury or sickness, other than Cancer;
- a complication of Human Immunodeficiency Virus (HIV) infection or any variance thereof including Acquired Immune Deficiency Syndrome (AIDS) and AIDS related complex;
- the use, existence or escape of nuclear weapons, material or ionizing radiation from or contamination by radioactivity from any nuclear fuel or waste from the combustion of nuclear fuel;
- any Pre-existing Condition, except where coverage has been in effect for a period of 24 consecutive months following the Insured's effective date of coverage.

90 Day Cancer Exclusion

The Company will not pay the Cancer Critical Illness Benefit for a diagnosis of Cancer 90 days from the effective date of coverage or latest reinstatement date.

A Cancer diagnosed within the 90 Day Cancer Exclusion period does not void coverage under this policy however no benefits will be payable at any time for the diagnosed Cancer.

Critical Illness Insurance Rider (Four Covered Conditions)

Critical Illness Benefit (applicable to Insureds under age 70 only)

If the Insured is diagnosed with or meets the definition of an Insured Condition after the effective date or latest reinstatement date of coverage, and survives a period of 30 days following the date of diagnosis, the Company will pay 5% of the AD&D principal sum up to a maximum of $10,000.

The Company will only pay the Critical Illness Benefit once notwithstanding that an Insured may be diagnosed with more than one of the Insured Conditions.

Definitions

"***Insured Conditions***" means Cancer, Heart Attack, Kidney Failure or Stroke.

"***Cancer***" means a malignant tumor characterized by the uncontrolled growth and spread of malignant cells and invasion of tissue. This includes Leukemia, Hodgkin's Disease and invasive melanoma but does not include:

- Carcinoma in situ;
- Kaposi's Sarcoma or other AIDS related cancers and cancer in the presence of human immunodeficiency virus (HIV);
- Skin cancer or melanoma that is not invasive and has not exceeded .75 millimeters in depth;
- Prostate cancer diagnosed as T1 N0 M0 or equivalent staging; or
- a recurrence or metastasis of a cancer which was originally diagnosed prior to the effective date of coverage.

A Physician certified as an oncologist must confirm diagnosis in writing.

"***Heart Attack***" means a 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.

Exclusions: No benefit will be payable under this condition for:

- elevated biochemical cardiac markers with a:
  - Troponin Level of less than 1
  - CK-Mb Level of less than 4, or
- ECG changes suggesting a prior myocardial infarction, which do not meet the Heart Attack definition as described above.

"***Kidney Failure***" means end stage renal disease due to chronic irreversible failure of both kidneys' ability to function, requiring the Insured to undergo regular hemodialysis, peritoneal dialysis, or renal transplantation. A Physician who is certified in nephrology must confirm diagnosis in writing.

"***Pre-existing Condition***" means an injury or sickness for which the insured received treatment or advice or a diagnosis, or for which treatment was required or recommended by a Physician during the 24 months immediately before the insured's effective date of coverage under this policy or any increased amount of insurance coverage (not including increases caused by annual salary changes).

"***Stroke***" means that the Insured has suffered a cerebrovascular incident, excluding transient ischemic attack (TIA), producing infarction of brain tissue due to thrombosis, hemorrhage from an intracranial vessel or embolization caused by an extracranial source. There must be evidence of permanent neurological deficit persisting for 30 consecutive days, supported by evidence that the deficit is resulting from the Stroke, confirmed in writing by a Physician who is certified as a neurologist.

Limitations and Exclusions

In addition to the General Limitations and Exclusions section of this policy the Critical Illness Insurance Rider (four Covered Conditions) coverage does not provide benefits for any injury or illness caused directly or indirectly by or contributed to by any of the following:

- injury or sickness, other than an Insured Condition;
- a complication of Human Immunodeficiency Virus (HIV) infection or any variance thereof including AIDS and AIDS related complex;
- the use, existence or escape of nuclear weapons, material or ionizing radiation from or contamination by radioactivity from any nuclear fuel or waste from the combustion of nuclear fuel;
- any Pre-existing Condition, except where coverage has been in effect for a period of 24 consecutive months following the Insured's effective date of coverage.

90 Day Cancer Exclusion

The Company will not pay for a Cancer diagnosed within 90 days from the effective date of coverage or latest reinstatement date.

A Cancer diagnosed within the 90 Day Cancer Exclusion period does not void coverage under this policy however no benefits will be payable at any time for the diagnosed Cancer.

Conversion privilege

On the date of termination of employment or during the 31-day period following termination of employment, an Insured Person may convert his or her insurance to an individual ACCIDENTAL DEATH and DISMEMBERMENT only insurance policy of Chubb Life. The individual policy will be effective either as of the date that the application is received by Chubb Life or on the date that coverage under the group policy ceases, whichever occurs later. The premium will be the same, as a person would ordinarily pay when applying for an individual policy at that time.

Exposure and disappearance

Loss resulting from unavoidable exposure to the elements shall be covered to the extent of the benefits afforded an Insured Person.

If the body of an Insured Person has not been found within one year of disappearance, stranding, sinking or wrecking of the conveyance in which an Insured Person was riding at the time of the accident, it shall be presumed, subject to all other conditions of the policy, that an Insured Person suffered a loss of life resulting from bodily injuries sustained in the accident covered under the policy.

General Limitations and Exclusions

This policy does not cover loss caused by or resulting from any one or more of the following:

- Intentionally self-inflicted injuries, suicide or any attempt thereat, while sane or insane;
- Declared or undeclared war or any act thereof;
- Travel or flight in any vehicle or device for aerial navigation; except to the extent such travel or flight is provided in the "Description of Hazards" section of this proposal.
- This insurance does not apply to the extent that trade or economic sanctions or other laws or regulations prohibit us from providing insurance, including, but not limited to, the payment of claims. All other terms and conditions of the policy remain unchanged.

Waiver of premium

If an Insured Employee, under age 65, becomes totally disabled for six consecutive months and an Insured Employee provides evidence of total disability satisfactory to Chubb Life Insurance, Chubb Life Insurance will then waive the payment of each premium which falls due with respect to an Insured Employee and any Insured Dependents. Subject to all the terms and conditions of the policy, waiver of any premium as herein provided will continue with respect to an Insured Employee until age 65 or earlier termination of the policy. If an Insured Employee ceases to be disabled and an Insured Employee returns to employment with the Policyholder and is a member of an eligible class, insurance with respect to an Insured Employee may be continued upon resumption of premium payments by an Insured Employee or the Policyholder.

If after 120 days, an Insured Employee receives approval of any long term disability claim provided under a policy of group insurance through the Policyholder, Chubb Life will then waive the payment of each Accidental Death and Dismemberment insurance premium subject to the terms stated above.

Recurrent disabilities

When an Insured Employee becomes totally disabled again from the same or related causes within six months of cessation of the Waiver of Premiums, then all such recurrences will be considered a continuation of the same disability and Chubb Life will waive the 6 month qualification period.

If the same disability recurs more than six months after cessation of the Waiver of Premiums, such disability will be considered a separate disability. Two disabilities which are due to unrelated causes are considered separate disabilities if they were separated by a return to work of at least one day.

Termination of waiver of premium

Waiver of Premiums will cease on the earliest of:

- the date an Insured Employee ceases to meet the policy's definition of totally disabled;
- the date an Insured Employee does not supply Chubb Life with appropriate medical evidence as deemed necessary by Chubb Life;
- the date an Insured Employee is no longer receiving regular, ongoing care and treatment of a Physician appropriate for the disabling condition, as determined by Chubb Life;
- the date an Insured Employee does not attend a medical, psychiatric, psychological, functional, educational and/or vocational examination evaluation by an examiner selected by Chubb Life;

- the date the policy terminates;
- the date an Insured Employee turns 65; or
- the date an Insured Employee dies.

Coverage during waiver of premium

While premiums are being waived, Basic Accidental Death and Dismemberment Insurance under the policy on an Insured Employee will continue to be in force. The amount of such insurance will be the amount of insurance that was in effect on the date of commencement of the disability, subject to any age reduction or termination shown in the policy.

"Totally Disabled or Total Disability" with respect to Waiver of Premium means disability resulting from injury or sickness which prevents engagement in an Insured Person's regular occupation for 6 consecutive months.

Continuance of coverage

If an Insured Employee is: (1) laid off on a temporary basis; (2) temporarily absent from work due to short-term disability; (3) on leave of absence, coverage shall be extended for a period of 12 months following the beginning of any such event subject to payment of premiums.

In the case of an Insured Employee who is on a maternal or paternal leave, coverage shall be extended in accordance with the maximum period provided under the applicable law following the beginning of any such event subject to payment of premiums.

If an Insured Employee assumes other occupational duties during the leave or lay-off period, no benefits shall be payable for a loss occurring during the performance of such other occupation.

Critical Illness Benefit

(Applicable to Insureds under age 70 only)

If, while coverage is in effect, an Insured Person is diagnosed with or meets the definition of Cancer, Heart Attack, Kidney Failure or Stroke, and survives for a period of 30 days following the date of diagnosis, Chubb Life will pay 5% of the Principal Sum up to a maximum of $10,000.

Chubb Life shall only be obligated to pay the Critical Illness Benefit once, notwithstanding that an Insured Person may be diagnosed with more than one of the covered illnesses.

Definitions

Cancer: means a malignant tumor characterized by the uncontrolled growth and spread of malignant cells and invasion of tissue. This includes Leukemia, Hodgkin's Disease and invasive melanoma but does not include:

- Carcinoma in situ
- Kaposi's Sarcoma or other AIDS related cancers and cancer in the presence of Human Immunodeficiency Virus (HIV)
- Skin cancer or melanoma that is not invasive and has not exceeded .75 millimeters in depth

- Prostate cancer diagnosed as TI N0 M0 or equivalent staging
- a recurrence or metastasis of a cancer which was originally diagnosed prior to the effective date of coverage

A Physician certified as an Oncologist must confirm diagnosis in writing.

***Heart Attack*:** means a 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.

Exclusions: No benefit will be payable under this condition for:

- elevated biochemical cardiac markers with a:
  - Troponin Level of less than 1
  - CK-Mb Level of less than 4, or
- ECG changes suggesting a prior myocardial infarction, which do not meet the Heart Attack definition as described above.

"***Kidney Failure***" means end stage renal disease due to chronic irreversible failure of both kidneys' ability to function, requiring the Insured to undergo regular hemodialysis, peritoneal dialysis, or renal transplantation. A Physician who is certified in nephrology must confirm diagnosis in writing.

"***Pre-existing Condition***" means an injury or sickness for which the insured received treatment or advice or a diagnosis, or for which treatment was required or recommended by a Physician during the 24 months immediately before the insured's effective date of coverage under this policy or any increased amount of insurance coverage (not including increases caused by annual salary changes).

"***Stroke***" means that the Insured has suffered a cerebrovascular incident, excluding transient ischemic attack (TIA), producing infarction of brain tissue due to thrombosis, hemorrhage from an intracranial vessel or embolization caused by an extracranial source. There must be evidence of permanent neurological deficit persisting for 30 consecutive days, supported by evidence that the deficit is resulting from the Stroke, confirmed in writing by a Physician who is certified as a neurologist.

Critical Illness Benefit Exclusions

In addition to the Exclusions section of this booklet this coverage does not provide benefits for any injury or illness caused directly or indirectly by or contributed to by any of the following:

- injury or sickness, other than an Insured Condition;
- a complication of Human Immunodeficiency Virus (HIV) infection or any variance thereof including AIDS and AIDS related complex;
- the use, existence or escape of nuclear weapons, material or ionizing radiation from or contamination by radioactivity from any nuclear fuel or waste from the combustion of nuclear fuel;
- any Pre-existing Condition, except where coverage has been in effect for a period of 24 consecutive months following the Insured's effective date of coverage.

90 Day Cancer Exclusion

The Company will not pay for a Cancer diagnosed within 90 days from the effective date of coverage or latest reinstatement date.

A Cancer diagnosed within the 90 Day Cancer Exclusion period does not void coverage under this policy however no benefits will be payable at any time for the diagnosed Cancer.

General Provisions

Beneficiary

An employee or any spouse has the right to name a beneficiary when he applies for insurance. It is understood that the beneficiary designation made under the Policyholder's Group Life Insurance Policy shall be recognized as the beneficiary under the policy, unless a further designation has been made that specifically identifies the policy. Failing such designation, all benefits will be paid to the estate of the insured person.

All other indemnities of the policy will be payable to the insured person.
An insured person can change his beneficiary at any time, where permitted by law. The Company assumes no responsibility for the validity of such designation or change of beneficiary.

The beneficiary designation made by the insured person (if any) under the replaced policy has been retained. The insured person should review the existing designation to ensure it reflects his/her current intention.

The policy contains a provision removing or restricting the right of the insured person to designate persons to whom or for whose benefit insurance money is to be payable.

Legal Actions

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the Insurance Act, Limitations Act, 2002 or other applicable legislation in the Insured's province of residence.

Change of Insurer

An insured person under a former policy may not be excluded from the new policy or be denied benefits solely because of a pre-existing condition limitation that was not applicable or that did not exist in the former policy, or because the person is not at work on the date of coming into force of the new policy.

The insured person and any claimant under the policy has the right, as determined by law applicable in the insured person's province of residence, to obtain a copy of his/her application, any written evidence of insurability (as applicable) and the Policy, on request, subject to certain access limitations.

How to Claim

In the event of a claim, claim forms can be obtained from the Plan Administrator.

Notice of claim must be given to Chubb Life within 30 days from the date of the accident, the beginning of the disability or after the survival period, and subsequent proof of claim must be submitted to Chubb Life within 90 days from the date of the accident or after survival period.

Failure to give notice of claim or furnish proof of claim within the time prescribed in the policy condition will not invalidate the claim if the notice or proof is given or furnished as soon as reasonably possible and if it is shown that it was not reasonably possible to give notice or furnish proof within the time so prescribed. In no event, will Chubb Life accept notice of claim beyond one year.

Dependent Life

Death benefit

This benefit insures your eligible dependents covered for Dependent Life for the amount of coverage shown on the Schedule of Benefits. If your spouse or one of your children die you will receive this amount.

Waiver premium

The premium payable under this Provision will be waived during the period for which the Group Life Insurance premium is waived due to your becoming Totally Disabled.

Conversion privilege

If your Dependant Life Insurance coverage under this benefit ceases because you are no longer eligible for insurance under the Policy, your spouse (and insured children, as required by provincial legislation, if applicable) may convert the amount of the Dependant Life Insurance benefit terminated without medical evidence, to an individual policy. This individual policy may be issued on any one of the standard level premium Life plans then being issued by the Insurer. Application for the individual policy must be made while the group policy is in force and within 31 days after the earlier of:

- the date you die, or
- the date you cease to be insured, or
- your spouse's 65th birthday.

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

Long Term Disability

Amount of monthly benefit and coverage

Long Term Disability Insurance provides you with regular income to replace salary or wages lost because of a lengthy disability due to an Injury or Sickness. The amount of your Long Term Disability Benefit, the date that benefits commence, and the maximum duration of benefits, are as indicated on the Schedule of Benefits page.

If you become disabled due to Injury or Sickness, the Insurer will pay you in accordance with the foregoing or until you recover, whichever occurs first. Benefits will be directly reduced by (i) the amount of any benefits you are entitled to under the Canada/Quebec Pension Plan as outlined on the Schedule of Benefits page (ii) any disability benefit you are entitled to under an automobile insurance plan deemed to be first payor of benefits, and, iii) any disability payment you are entitled to under any workplace safety legislation (e.g. Workplace Safety and Insurance Act, 1997) or similar legislation. Benefits may be further reduced to the extent that your income from all sources exceeds 85% of either:

- your pre-disability earnings if benefits are taxable as stated on the Schedule of Benefits; or
- your pre-disability Take-Home pay (i.e. income less income tax) if benefits are not taxable as stated on the Schedule of Benefits.

Other sources include CPP/QPP, any other group or franchise insurance plan providing benefits for disability, any salary continuation, retirement or disability plan of the employer, any workplace safety legislation (e.g. Workplace Safety and Insurance Act, 1997, or similar legislation), any other government-sponsored insurance or pension plan, or any salary replacement cash dividend income received from the employer while receiving Long Term Disability benefits from the Insurer, if your Monthly Earnings includes salary replacement cash dividend income.

Definition of disability and earnings

Benefits paid under this plan are taxable if your employer pays any portion of the premium for this benefit.

Total Disability means during the Elimination Period and the Own Occupation Period shown on the Schedule of Benefits page, such a continuous state of incapacity resulting from Injury or Sickness that you will be completely prevented from performing the essential duties of your own occupation, at your own or any workplace. After the expiration of the Own Occupation Period, if any, it means such a continuous state of incapacity resulting from Injury or Sickness that you will be completely prevented from engaging in any gainful occupation or from performing any work for remuneration or profit for which you are reasonably fitted by education, training or experience. In no event will any benefits be paid for any period in which you are not under the continuing care of an appropriate licensed physician qualified to treat the specific ailment or if you fail to cooperate and participate in an appropriate treatment program satisfactory to the Insurer, unless the payment of benefits in such circumstances has been pre-arranged by the Insurer.

The availability of work will not be considered by the Insurer in assessing your Total Disability.

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

Accident shall mean a single, sudden, violent, unintended, unexpected, external event that causes a disability, independent of any other cause.

Injury means accidental bodily injury sustained by you, while this Provision is in force, which directly and independently of all other causes results, within 90 days of the date of the Accident, in Total Disability as hereinafter defined.

Sickness means any illness or disease not specifically excluded elsewhere in this Provision, which causes Total Disability as defined below, while this Provision is in force. Any disability which is caused by, or is contributed to by, accidental bodily injury and which commences more than 90 days after the date such Injury is sustained, will be deemed to be resulting from Sickness. Any infection, other than a pyogenic infection, occurring through and at the time of an accidental cut or wound, will also be deemed to be as resulting from Sickness.

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

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

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

Earnings mean your regular monthly rate of income received from your employer excluding commissions, overtime pay, bonuses, dividends or other special allowances.

Subject to approval by the Insurer, Earnings will also include the average monthly commission and/or bonus received from your employer over the preceding 2 calendar year(s). If applicable, commission and/or bonus will be verified by your employer and the Insurer will be provided with satisfactory T4 and/or T4A forms.

Any changes in Earnings must be submitted in writing by your Employer to our Head Office as your insured benefit is based on Earnings reported to our Head Office prior to the date of disability, and will determine the amount of disability benefit you will receive if you become disabled.

Take-home Pay means your Earnings less the federal and provincial income taxes payable on such income.

Elimination Period means the initial period of your continuous Total Disability during which no Long Term Disability Benefit is payable. The duration of the Elimination Period is shown on the Schedule of Benefits.

Waiver premium

If you are receiving benefits, premiums for the Long Term Disability Benefit will be waived.

Your responsibilities

During any period of Total or Partial Disability, you must make reasonable efforts to:

- facilitate recovery from the Injury or Sickness that caused the Total Disability,
- participate in any reasonable Medical Care and/or rehabilitation program,
- accept any reasonable offer of modified duties from your employer,
- return to your own occupation, or prepare to return to work in another occupation if it becomes apparent that you will not be able to return to your own occupation, and
- obtain any benefits that may be available from other sources.

If you fail to comply with any of these responsibilities, the Insurer may withhold or discontinue benefits.

Recurrence of disability

If you return to active full-time employment, and while the Policy is in force you again become disabled within 180 days due to the same cause, the benefits will commence immediately without any further waiting period. If such disability commences after 180 days of active full-time employment, the second disability will be subject to a new waiting period before you can again receive benefits.

Rehabilitation

If you receive Long Term Disability benefits you may be required to participate in a rehabilitation program to assist you in returning to gainful employment, either to your pre-disability occupation or to another occupation. Benefit payments will only be reduced by half of the income received from the program.

The decision to approve or discontinue a rehabilitation program will be made solely by the Insurer, which is under no obligation to approve or continue rehabilitation.

Any Long Term Disability Benefit payable may be further reduced so that the income received from such rehabilitation program together with the total income received from all sources does not exceed 100% of your Indexed Pre-Disability Earnings.

Indexed Pre-Disability Earnings means:

In the first year of your disability the average of:

- Monthly Earnings, if the Long Term Disability Benefit is taxable, or
- Take-home Pay if the Long Term Disability Benefit is non-taxable,

during the 12 month period immediately prior to commencement of Total Disability.

After the first year of your disability:

- the previous year's Indexed Pre-Disability Earnings will be increased on each anniversary of the date of disability only if you are participating in a paid return to work program approved by the Insurer.

The amount of each annual increase will equal the lesser of (a) the rate of the annual increase in the annual Consumer Price Index as published by Statistics Canada (or similar index published by a government agency succeeding Statistics Canada) for the preceding calendar year or (b) 10 percent.

Any expenses associated with a rehabilitation program approved by the Insurer, other than normal employment expenses such as transportation, will be paid by the Insurer as long as the Insurer approves the expenses in advance. Expenses will not be covered if the Insurer notifies you that the rehabilitation program is no longer approved or that it will no longer accept previously approved expenses

If you cease to be available, co-operate or participate in a rehabilitation program approved by the Insurer, you will no longer be entitled to Long Term Disability Benefits. If you are not participating in a rehabilitation program because of a change in your medical status, the Insurer will require medical evidence documenting how your inability to continue with the rehabilitation program is due to a covered Injury or Sickness.

Partial disability

Partial Disability occurs when, as a result of your Total Disability, you:

- are able to perform one or more, but not all of the essential duties of your own occupation on a full-time or part-time basis; or
- are able to perform all of the essential duties of your own occupation on a part-time basis; and
- still require the regular attendance of a Physician; and
- earn greater than 15% of your Indexed Pre-Disability Earnings.

Payment and duration of the partial disability benefit

Payment of a Partial Disability Benefit will be made if (i) Partial Disability (for the same or related cause) follows a period of Total Disability equal to the Elimination Period shown on the Schedule of Benefits, plus one day or more, and (ii) you earn more than 15% of your Indexed Pre-Disability Earnings.

The Partial Disability Benefit will be equal to the Long Term Disability Benefit less 50% of the income earned during the same period and is payable only during the Own Occupation Period shown on the Schedule of Benefits.

Any Long Term Disability Benefit payable may be further reduced so that the income received from all sources does not exceed 100% of your Indexed Pre-Disability Earnings.

Survivor benefit

A survivor benefit will be paid in a lump sum to your beneficiary if you die while receiving benefits under the Policy provided that your current disability has continued for a period of six months beyond the Elimination Period indicated on the Schedule of Benefits and your Long Term Disability premiums are being waived.

You may appoint a beneficiary at the time you submit your Long Term Disability claim; however, if a beneficiary is not appointed at that time, the Survivor Benefit will be paid to the last recorded beneficiary for any other death benefits that may be payable under the Policy.

This benefit will be equal to the Long Term Disability Benefit times the number of months indicated on the Schedule of Benefits.

Limitations

- No Long Term Disability Benefit is payable for disabilities that result from Substance Abuse, unless you are receiving and complying with continuous treatment for such Total Disability from a rehabilitation centre, a provincially designated institution, or you are actively involved in and following a program of rehabilitation which is supervised by a Physician and approved by the Insurer.
- No Long Term Disability Benefit is payable for any period during which you are serving a sentence for a criminal offence and are confined in a prison or other place of detention including but not limited to, a hospital, mental institution, a halfway facility or private residence (under house arrest).

Pre-existing conditions

No benefit is payable if, during the first 12 months of Long Term Disability coverage under the Policy, total disability results from a pre-existing condition. A pre-existing condition is one for which you received Medical Care by a Physician or other health care professional, or for which medication (either prescription or non prescription) was recommended by a Physician or other authorized health care professional, during the 90 day period immediately prior to the effective date of your insurance

The Insurer reserves the right to request clinical notes and records from your primary care Physician or any other health care professional who provided Medical Care to you.

Generally, the twelve month period will have to be fully satisfied from the reinstatement date upon reinstatement of coverage. However, if the reinstatement immediately follows a leave of absence or lay-off of which the Insurer has been notified in advance, then the periods before and after the leave of absence or lay-off will be combined to satisfy the twelve month requirement.

Exclusions

No benefit is payable if your disability results directly or indirectly from:

- suicide, attempted suicide, or intentional self-inflicted injury;
- the voluntary or intentional inhalation or administration of drugs, poison, poisonous substances, gas or fumes;
- insurrection, war, invasion, enemy acts, civil war, rebellion, revolution, military power, usurped power or hostilities of any kind, whether war is declared or not;
- any armed conflict or service in the armed forces;

- voluntary participation in a riot or any disturbance of the public order;
- the participation in, or attempt to participate in, a criminal offence, under any applicable law whether or not convicted with such offence;
- treatments rendered for cosmetic purposes (as determined by the Insurer) except when such treatment is necessitated by accidental Injury; or
- the operation of a Motorized Vehicle while your ability to drive is impaired as a direct result of Substance Abuse or while your drug or alcohol levels exceed the maximum levels allowable by law in the jurisdiction where the Accident occurred.

For any disability incurred prior to or during a Pregnancy/Parental Leave of Absence, the Elimination Period may commence or continue during the period:

- of formal Pregnancy or Parental Leave taken pursuant to Provincial or Federal law or pursuant to mutual agreement between you and your Employer; or
- for which Employment Insurance pregnancy or parental benefits are paid; or
- commencing on the earlier of the elected date of a formal Pregnancy or Parental Leave or the delivery date; however,

no payment will commence or continue until the later of the completion of the Elimination Period and the scheduled return to work date.

No benefits commence or continue during any period you are not a resident of Canada for a minimum of 6 months in any 12 month period.

Extended Health Care

General description of this coverage

In this section, **you** means the employee and all eligible dependents covered for Extended Health Care benefits. To qualify for Extended Health Care coverage you and your dependents must be covered by the Government Health Insurance Plan in your province of residence.

All Allowable Expenses covered under the Extended Health Care Benefit provision must represent Reasonable and Customary Treatment of your Medically Diagnosed Condition.

Allowable Expenses are the lesser of the actual charges and the Reasonable and Customary Expenses for covered services and supplies.

Reasonable and Customary Expenses are the lowest of:

- representative prices in the area where the service or supply was provided;
- prices shown in any applicable professional association fee guide; and
- maximum prices established by law.

Reasonable and Customary Treatment is systematic treatment that is generally accepted and recognized by the Canadian medical profession as effective, appropriate and essential treatment and is of a nature, intensity, frequency and duration essential to the diagnosis or management of the Medically Diagnosed Condition involved.

A Medically Diagnosed Condition is a sickness or an injury, which has been diagnosed according to a generally accepted classification system including but not limited to an x-ray. MRI, bone scans, biopsy, CT scan, psychometric testing including MMPI-2, or haematological or ultrasonic test.

Reimbursement for eligible expenses incurred outside your province of residence will be made in Canadian funds, based on the rate of exchange in effect on the last date the services were rendered. Refer to the Schedule of Benefits for any deductible, co-payment or maximum benefit amounts applicable.

An expense must be claimed for the calendar year in which the expense is incurred. You incur an expense on the date the service is received or the supplies are purchased or rented.

The calendar year is from January 1 to December 31.

Deductible

The deductible as indicated in the Schedule of Benefits is the portion of claims that you are responsible for paying. After the deductible has been paid, claims will be paid up to the percentage of coverage (co-insurance) indicated in the Schedule of Benefits.

Pre-Determination of Allowable Expenses

In the event Allowable Expenses for you are likely to exceed five hundred dollars ($500), a detailed treatment plan must be submitted before any treatment, other than necessary emergency treatment, commences.

You will then be advised of the estimated amount payable for the Allowable Expense. This pre-determination of benefits is valid for 1 year from the date provided. In order for benefits to be paid, you must be eligible for coverage under the Policy on the date the expense is actually incurred.

If this pre-determination is not obtained, the only obligation will be to reimburse you for the claim on the basis of the recommendations that would have been made if the pre-determination request had been submitted.

Prescription drugs

Coverage includes the cost of drugs that are, by law, only available with a prescription as long as they are prescribed by a physician, dentist, pharmacist or other authorized healthcare professional, where applicable based on provincial legislation, and are obtained from a licensed pharmacist.

Where a generic alternative is available, the payment will be reduced to reflect the cost of the lowest priced generic alternative.

Drugs that must be injected, including vitamins, insulin and allergy extracts are covered. Oral contraceptives are covered. Immunization vaccines are covered if they require a prescription.

Drugs that do not require a prescription by law are covered if they are:

- listed in the current Compendium of Pharmaceuticals and Specialties and;
- prescribed by a Physician and;
- categorized as life sustaining drugs.

Drugs for the treatment of infertility are covered up to a lifetime maximum of two thousand five hundred dollars ($2,500) for each covered person.

For the above items, the Insurer will only pay for quantities that can reasonably be used in a three month period. If coverage is terminated, quantities will be limited to a one month supply.

The Insurer will not pay for the following, even when prescribed:

- Specialty Drugs that are listed on the provincial drug programs. Specialty Drugs NOT listed on the provincial program may be covered by the drug plan subject to clinical evaluation and meeting special authorization criteria.
- fees for the administration of any injectable drugs, including but not limited to serums, vaccines, vitamins, insulin, and allergy extracts.
- hair growth stimulants.

- drugs dispensed by a Physician, Dentist or clinic or by a non-approved Hospital pharmacy.
- treatments for weight loss, including drugs, proteins and food or dietary supplements.
- erectile dysfunction medication.
- any drug that does not have a drug identification number as defined by the Food and Drugs Act, Canada.
- any drug prescribed for treatment of a medical condition that is not an approved indication by the manufacturer.
- experimental drugs, proprietary or patent medicines registered under the Food and Drugs Act, governed by Health Canada.
- drugs dispensed during treatment as an in-patient in Hospital.
- drugs that are considered cosmetic or for personal hygiene purposes, whether or not prescribed for a medical reason.
- drugs which would have been payable by the provincial plan if proper application had been made.
- homeopathic or natural products.

Medical services and supplies

The Insurer will cover Reasonable and Customary charges for the eligible services and supplies described below. Medical supplies are covered when prescribed by a Physician for Reasonable and Customary Treatment of a Medically Diagnosed Condition. For supplies available on a rental basis, the Insurer will, at its discretion, cover the rental cost or the cost of purchase. The services of a licensed optometrist, ophthalmologist or dentist do not require a physician's order.

Ambulance

Ambulance services, including air ambulance services are covered if a licensed ambulance company provides them. Transportation must be to the nearest Hospital where Reasonable and Customary Treatment is available. There is no coverage if you are not transported to a Hospital. When required for medical reasons, transfer from one Hospital to another may be covered. Where medically necessary, the fee for one person to attend you when being transported will be covered.

Dental accident

Expenses for the repair or replacement of whole, functioning, sound, natural teeth where damage has resulted from a direct accidental injury which occurs while you are covered but not when caused by an object intentionally placed in the mouth.

Prior to beginning dental treatment, details of the accident, relevant x-rays, pre-accident condition of the teeth, plan treatment and cost must be submitted to the Insurer. Approval of a treatment plan (except for emergency treatment required to alleviate pain) must be obtained from the Insurer prior to starting a course of treatment. These services must start within 100 days after the accident and be completed within 12 months of the accident and must be the least expensive that will provide professionally adequate treatment. Coverage is limited to the fee stated in the current Provincial Dental Fee Schedule for a general practitioner in the province where you live at the time that treatment is received. Expenses for the treatment of temporomandibular joint dysfunction (TMJ) or orthodontic services are not covered under this provision.

Diabetic supplies

The following diabetic supplies are covered:

- insulin syringes.
- Novolin-Pens or similar insulin injection devices using a needle.
- test strips.
- blood letting devices, including platforms and lancets.
- insulin infusion sets, not including infusion pumps.

The following diabetic equipment is covered up to a combined maximum of four thousand dollars ($4,000) per person per calendar year:

- Continous Glucose Monitor
- Sensors (maximum 36/calendar year)
- Transmitters (maximum 2/calendar year)

Diagnostic services

Coverage is provided for the charges in excess of the Government Health Insurance Plan for diagnostic laboratory and x-ray expenses performed by a properly licensed lab technician. No benefits will be payable for services provided by a Physician in the course of the private practice of medicine.

Eye exams

Eye exams performed by a licensed ophthalmologist or optometrist are covered up to a maximum of sixty dollars ($60) per person over 24 consecutive months, provided no portion of the cost is covered under your provincial health care plan.

Hearing aids

Coverage includes charges for the cost of, installation and repair (excluding batteries or routine maintenance of) hearing aids. Hearing aid batteries, tubing and ear molds provided at the time the hearing aid is purchased are covered. The maximum amount payable is five hundred dollars ($500) per person over a 60 consecutive month period. Audiology is not covered.

Home nursing care

The Insurer covers home nursing care provided in Canada. Nursing care is care that:

- requires the skills and training of a professional nurse; and
- is provided by a professional nurse who is not a member of your family.

Coverage is limited to the minimum number of hours and level of skill needed to provide each essential nursing service. Applicable licensing restrictions will be recognised in determining the level of skill needed. A professional nurse is a graduate registered nurse, licensed practical nurse, registered nursing assistant, or certified nursing assistant. The maximum amount payable per calendar year is ten thousand dollars ($10,000).

Pre-determination of home nursing care benefits

To establish the amount of coverage available under this provision before home nursing begins, you must apply for a pre-determination of benefits.

A pre-determination of benefits is an assessment provided by the Insurer that identifies:

- the type of nurse that will be covered;
- the number of hours to be covered per day or week; and
- the estimated duration of coverage.

To receive a pre-determination of benefits, you must submit a letter from your attending Physician containing:

- a description of the current Medically Diagnosed Condition and prognosis;
- a list of the required nursing services and their frequency;
- an indication of the level of skill required to perform the required services, meaning those of a graduate registered nurse, licensed practical nurse, registered nursing assistant, certified nursing assistant or other practitioner;
- the number of hours of care required per day or week; and
- an estimate of the length of time care will be required.

No benefits will be paid for companionship, counselling services, supportive care (bathing, dressing, feeding), child-care duties or house-keeping duties, or for nursing care for Medically Diagnosed Conditions where significant improvement or deterioration is unlikely within the next 12 months. This is considered Chronic Care.

Hospital accommodation

The Insurer will cover hospital charges for room and board in the province where you live. The deductible does not apply to these expenses.

Benefit for hospital services outside Canada are payable only as provided under the Emergency Travel Assistance benefit.

The Insurer will also cover the cost of room and board in a convalescent hospital if this care has been ordered by a physician as long as:

- it immediately follows at least 3 or more days of in-patient hospitalization, for a Medically Diagnosed Condition that required acute care.
- it represents acute, convalescent or palliative care.

Medically Diagnosed Conditions are considered related when they exist simultaneously or they arise from the same or related cause.

Convalescent Hospital accommodation is limited to a maximum of 180 days, for treatment of an illness due to the same or related causes. For purposes of this benefit, a **Convalescent Hospital** is a facility licensed to provide convalescent care and treatment for sick or injured patients on an in-patient basis. Nursing and medical care must be available 24 hours a day. It does not include a nursing home, rest home, home for the aged or chronically ill, sanatorium or a facility for treating alcohol or drug abuse.

Medical equipment

The initial charges for the following medical equipment required as a result of a Medically Diagnosed Condition:

- crutches, casts, trusses and canes.
- glucometers prescribed by a medical physician, up to a lifetime maximum of seven hundred dollars ($700) per person.
- orthopaedic braces. Braces are wearable, orthopaedic appliances that rely on a rigid material such as metal or hard plastic to hold parts of the body in the correct position. Elastic supports and foot orthotics are not considered braces. Dental braces are not considered a covered Extended Health Care expense. Replacement braces are 1 every 60 consecutive months.
- splints, including shoes attached to a splint. Intra-oral splints are not covered.
- surgical elastic stockings / pressure gradient hose to a maximum of 2 pairs per calendar year.
- IUD when inserted by a physician

Medical and hospitalization expenses for pre-authorized care received outside the province of residence

Coverage is provided for you, as long as you are also covered by the Government Health Insurance Plan in your province of residence. Expenses described below that are incurred in order to obtain medical care outside the province of residence, provided that the Government Health Insurance Plan in question agrees to cover part of the cost and that such expenses are pre-approved:

- hospitalization in a hospital where you receive curative treatment.
- professional fees of a physician for medical, surgical or anaesthetic care other than fees for dental care.
- transportation and accommodation expenses paid by you.
- expenses incurred for medications, X-rays and laboratory analyses.

The coverage applies to expenses that exceed the benefits payable by the Government Health Insurance Plan of any Canadian province.

Orthopaedic shoes and foot orthotics

Coverage is provided for foot orthotics or orthopaedic shoes when prescribed by a Podiatrist, Pedorthist, Chiropodist or Orthopaedic surgeon for the treatment of a Medically Diagnosed Condition. Benefits are provided for:

- custom-made foot orthotic inserts for shoes that are specially designed and molded for you. The maximum amount payable is two hundred and fifty dollars ($250) per 24 consecutive months.
- custom-made and custom-fitted orthopaedic shoes that are specially designed and fitted for you. Coverage is also provided for modifications to orthopaedic shoes. The maximum amount payable is two hundred and fifty dollars ($250) per 24 consecutive months.

Ostomy supplies

The following colostomy and ileostomy supplies are covered:

- irrigation sets, bags, deodorants, adhesives and skin creams.
- charges for catheters, catheterization supplies and urinary kits are also covered under this provision.

Oxygen and equipment

When ordered by a Physician in connection with the treatment of a Medically Diagnosed Condition, charges for the provision of oxygen and the equipment needed for its administration are covered.

Paramedical practitioners services

Charges for out-of-hospital services of the following Practitioners, when treating a Medically Diagnosed Condition are covered when provided in Canada. Only one treatment per practitioner is covered per day, per covered person. The Insurer will cover up to a maximum of five hundred dollars ($500) per person in a calendar year for each category of paramedical specialists listed below, to a combined maximum of one thousand dollars ($1,000) for single and three thousand dollars ($3,000) for family and couple per calendar year:

- Acupuncturist - treatment by a Licensed Acupuncturist.
- Chiropractor - treatment of muscle and bone disorders, including diagnostic x-rays.
- Clinical Counsellors/Psychologist/Psychoanalyst/Psycho-therapist/Psychiatrist/Social Worker - treatment by a Clinical Counsellor, Registered or Chartered Psychologist, Psychoanalyst, Psycho-therapist, Psychiatrist or Registered Social Worker.
- Massage Therapist - treatment by a Registered Massage Therapist for muscle, tissue and joint disorders.
- Naturopath - treatment by a Licensed Naturopath (naturopathic remedies and/or supplements are excluded).
- Osteopath - treatment of musculoskeletal disorders, including diagnostic x-rays.
- Physiotherapist - treatment by a Registered Physiotherapist.
- Podiatrist/Chiropodist - treatment of foot disorders, including diagnostic x-rays.
- Speech Therapist - treatment by a Licensed Speech Therapist for speech impairments.

Prosthetic equipment

Charges for the following standard prosthetic equipment are covered:

- artificial limbs, including repairs; stump socks (maximum 5/calendar year).
- artificial eyes, including rebuilding and polishing.
- external breast prostheses /mastectomy forms (maximum of 2/calendar year) and surgical bras (maximum of 6/calendar year).

Coverage for myoelectic prosthesis will be reimbursed only to the amount allowed for the cost of standard prosthesis. Prior approval by the Insurer is required.

Reimbursements for covered prosthetic equipment is subject to the lifetime maximum aggregate amount of ten thousand dollars ($10,000).

Smoking cessation aids

Coverage for nicotine patches (with your doctor's referral) and prescribed drugs are covered to a lifetime maximum of five hundred dollars ($500) for each covered person.

Speech aids

Coverage includes speech aids, such as bliss boards and laryngeal speaking aids, when no alternative method of communication is possible. The maximum amount payable in a covered person's lifetime is one thousand dollars ($1,000).

Therapeutic equipment

Coverage includes charges for the rental of (or at the Insurer's option, the purchase of) therapeutic medical equipment when medically necessary (in the Insurer's opinion), and is considered Reasonable and Customary Treatment and is prescribed as the result of a Medically Diagnosed Condition. Therapeutic shall mean:

- tending to cure or to restore health,
- pertaining to healing,
- treatment that is remedial, or
- having or exhibiting healing powers.

Reimbursements for covered therapeutic equipment is subject to the lifetime maximum aggregate amount of ten thousand dollars ($10,000).

To establish the amount of coverage available under this provision you must apply for a pre-determination of benefits. If the pre-determination is not obtained, the Insurer's only obligation will be to reimburse the claim on the basis of the recommendations that would have been made if the pre-determination request had been submitted.

Wheelchairs, walkers and hospital beds

Coverage is provided for non-motorized wheelchairs or walkers, including Reasonable and Customary Charges for repairs. Special wheelchairs necessary to permit independent participation in daily living are included. Special wheelchair features required primarily for participation in sports are not covered. Prior approval by the Insurer is required.

Coverage is provided for standard hospital beds. Electric and air-fluidized hospital beds are not covered. Prior approval by the Insurer is required.

Wigs and hair pieces

Coverage is provided for wigs or hairpieces following traumatic surgery, cancer treatments or for the diagnosis of alopecia universalis. The maximum amount payable in a lifetime is five hundred dollars ($500) per covered person.

What is not covered

The Insurer will not pay for the costs of:

- services or supplies not specifically listed as covered;
- services or supplies payable in whole or in part under any legislation, except for user fees and extra billing if the legislation allows the user fees and extra billing.
- services or supplies to the extent that their costs exceed the reasonable and usual rates in the locality where the services or supplies are provided.
- care, services or supplies utilized as treatment of lifestyle choices, as determined by the Insurer.
- rest cures, travel for health reasons or examinations for the use of a third party.
- services provided in a health spa, psychiatric or chronic care hospital or chronic care unit of a general hospital.
- equipment that the Insurer considers ineligible (examples of this equipment are orthopaedic mattresses, exercise equipment, air-conditioning or air-purifying equipment, vaporizers, whirlpools, humidifiers, home modification items, and equipment used to treat seasonal affective disorders).
- drugs, injectables, supplies or appliances which are experimental or which are not approved by the Health Protection Branch of Health & Welfare Canada for use in Canada.
- services or supplies which are primarily for cosmetic purposes.
- charges for dental care due to an accident which occurred prior to your effective date of coverage.
- charges for completion of forms or other documentation or charges incurred for failing to keep a scheduled appointment or transfer of medical files.
- additional, duplicate or replacement appliances or devices, except where the replacement is required because the existing appliance can no longer be made serviceable due to normal wear and tear, or as the result of a pathological change, unless prior approval in writing is obtained from the Insurer.
- services provided by an individual who resides with you.
- services provided by an individual who is related to you in one of the following ways: spouse, son, daughter, father, mother, brother, sister.

The Insurer will not pay benefits when the claim is for an illness resulting from:

- the hostile action of any armed forces, insurrection or participation in a riot or civil commotion, whether or not war was declared.
- participation in a criminal offence.

The Insurer will also not pay benefits when compensation is available under a Workers' Compensation Act, Criminal Injuries Compensation Act or similar legislation.

When and how to make a claim

To make a claim, complete the claim form that is available from your employer.
Please note: Handwritten receipts without an official business stamp or label will not be accepted. Cash register receipts will not be accepted.

In order for you to receive benefits, the claim must be submitted no later than 90 days after the earlier of:

- the end of the benefit year during which you incur the expenses, or
- the termination of your Extended Health Care coverage for any reason.

Upon completion, please mail the claim form and original receipts to:

GroupSource
#200, 5970 Centre Street S.E.
Calgary, Alberta T2H 0C1

Telephone: 403-228-1644
Toll-free: 1-888-547-MYGS (6947)

Vision Care

The charges for the purchase or repairs of lenses, frames, sunglasses or contact lenses are covered as long as they are required to correct vision and are prescribed and dispensed by a licensed Ophthalmologist, Optometrist or Optician. The maximum vision care amount payable is indicated in the Schedule of Benefits.

The charges for laser eye surgery required to correct vision, are covered when prescribed by a licensed Optometrist or Ophthalmologist and performed by a licensed Ophthalmologist. The maximum payable is equal to double the available vision care benefit once per lifetime.

The available vision care benefit means the benefit amount as described in the Schedule of Benefits.

There is no coverage for any service or supply that does not provide for the correction of one's vision. Magnifying glasses, safety glasses, whether prescription or not, are not covered. Expenses covered by the Worker's Compensation Board or any government plan of any kind are not covered.

Survivor Health Benefit

If you die while covered by this plan, coverage for your dependents will continue, without premiums, until the earlier of the following:

- the period indicated in the Schedule of Benefits after the date of your death.
- the date the person would no longer be considered your dependent under this plan if you were still alive.
- the date the benefit provision under which the dependent is covered terminates.
- the date your dependent obtains alternate coverage under any other group insurance plan, as an Employee or Dependent.
- the date this policy terminates.

Emergency Travel Assistance

This travel health insurance policy provides benefits for expenses incurred on a non-elective Emergency basis for Accident, Sickness or Disease that first occurs when you and/or your eligible dependents are vacationing or travelling for other than health reasons, outside your Province of Residence.

Coverage is limited to a maximum of 90 consecutive days per trip. If you are in the Hospital on the 90th day, benefits will be paid provided treatment for the Injury or Sickness is continuous. However, no benefits will be payable under the sections entitled "Medical reimbursement expense benefit" and "Emergency dental treatment benefit" for expenses incurred after you are no longer confined as an inpatient in a Hospital or 12 months from the first day of hospitalization, whichever occurs first.

Definitions

For the purpose of this Emergency Travel Assistance benefit, the following definitions apply:

Accident means any unlooked for mishap or untoward event which is not expected or designed.

Accommodation means lodging in the vicinity of the Hospital where the Insured Person is confined.

Airfare means the regular fare charged for an economy class seat on a regular flight by a domestic or international scheduled air carrier, which holds an operating certificate issued by Transport Canada or by a similar governmental authority having jurisdiction over such air carrier in the country of its certification.

Disease means any unhealthy condition of the body or any part thereof occurring while this policy is in force as to the Insured Person whose disease is the basis of claim and for which expenses are incurred during the course of a Trip outside the province of Residence.

Emergency means unexpected and not pre-planned.

Employee means an active employee who is under the termination age as indicated in the Schedule of Benefits.

Injury means bodily injury caused by an Accident occurring while this policy is in force as to the Insured Person whose injury is the basis of claim and resulting directly and independently of all other causes in loss covered by this policy provided such injury is sustained and for which expenses are incurred during the course of a Trip outside the province of Residence. In no event shall Injury mean Sickness or Disease howsoever caused unless caused by an Accident.

Member of the Immediate Family means a person at least 18 years of age, who is the son, daughter, father, mother, brother, sister, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, sister-in-law, (all of the above include natural, adopted or step relationship), spouse, grandson, granddaughter, grandfather or grandmother of the Insured Person.

Physician means a doctor of medicine (other than the Insured Person or a Member of the Immediate Family) who is licensed to practise medicine by a recognized medical licensing organization in the locale where the treatment is rendered, provided he is a member in good standing of such licensing body; or a governmental agency having jurisdiction over such licensing in the locale where the treatment is rendered.

Sickness means an impairment of normal physiological function and includes illness and infections, occurring while this policy is in force as to the Insured Person whose sickness is the basis of claim and for which expenses are incurred during the course of a Trip outside the province of Residence.

Spouse means an individual who satisfies the eligibility requirements listed under **Who qualifies as your dependent** in the General Provisions section of this employee benefit booklet.

Travelling Companion means a person who is sharing the same booked accommodation with the Insured Person.

Trip means travel, which commences on the date of departure from your province of Residence and continues until the return date to your province of Residence, subject to a maximum duration of 90 consecutive days.

When and how to make a claim

When major emergencies occur outside of Canada, telephone or ask the physician or hospital administration to telephone AXA Assistance at the numbers shown on your travel membership card. **AXA Assistance must be notified within 48 hours of an emergency. Claims may be reduced if contact is not made with 48 hours of admission to hospital**. The following information will be required:

- the name of the person calling, telephone # and relationship to you.
- your name, location, ID # and Policy # as shown on the travel membership card.
- name, location and telephone # of hospital and treating physician.
- written notice of loss must be submitted by you or on your behalf to the Insurer within 30 days of occurrence.
- send notice to GroupSource #200, 5970 Centre Street S.E., Calgary, Alberta T2H 0C1.

For eligible expenses which you pay for yourself while outside your province of residence:

- collect detailed receipts and include the medical diagnosis for each receipt submitted, and,
- complete a SSQ Insurance Company Inc. Out-of-Country claim form (available from GroupSource).
- provide translation for claims in languages other than English or French.
- submit all claims within 90 days of occurrence.
- send claims to:

GroupSource
#200, 5970 Centre Street S.E.
Calgary, Alberta T2H 0C1

Telephone: 403-228-1644
Toll-free: 1-800-661-6195

Failure to submit your claim within the time provided will not invalidate any claim, if it is shown not to have been reasonably possible to give such notice during such time and that notice was given as soon as was reasonably possible, but in no event later than one year after the date of the loss. If any time limitation specified in this policy for giving notice of claim, or submitting proof of loss, or undertaking legal action is less than that permitted by law of the province in which you are residing at the time of loss, then the time limitation will not be less than that provided for by such provincial law.

Legal action will not be taken to recover benefits under this policy until 60 days after proof of loss has been submitted to the Insurer. Thereafter, the claimant will be limited to a one year period (3 years in the province of Quebec) during which legal action may be taken.

Payments

Unless otherwise indicated, all benefits, including those payable for your spouse and/or dependent children, will be paid to you or at your direction. All moneys payable under this policy are payable in the lawful money of Canada.

Evacuation benefit

If, as a result of Injury, Sickness or Disease, you require any of the following evacuations:

- transportation by any conveyance (other than ground ambulance) licensed to carry passengers for hire, including air ambulance, from the place of Accident, Sickness or Disease to the nearest Hospital that is equipped to provide the required treatment (or medical facility or doctor's clinic, when warranted) provided the evacuation is recommended by the attending Physician and approved by the Insurer.
- transportation to your province of Residence by any conveyance (other than ground ambulance) licensed to carry passengers for hire, including air ambulance provided the evacuation is recommended by the attending Physician and approved by the Insurer and the attending Physician certifies in writing that your medical condition after receiving treatment (including diagnostic testing) warrants the return to your province of Residence for further treatment or to recover.
- transportation to your province of Residence in the event you are confined as an inpatient in a Hospital and under the Regular Care and Attendance of a Physician, thus preventing you from returning to your province of Residence on the original scheduled return flight, provided the return ticket is non-changeable and non-refundable.

The Insurer will pay the reasonable and necessary transportation expenses actually incurred by you including any related medical services and supplies.

The Insurer will also pay the reasonable and necessary expenses actually incurred by a medical attendant or one (1) Immediate Family Member, who accompanied you, for a round trip Airfare plus Accommodation and board. All covered expenses incurred by the medical attendant or Immediate Family Member are subject to a maximum amount of two thousand dollars ($2,000).

The total maximum amount payable under this section will not exceed twenty-five thousand dollars ($25,000) as a result of any one (1) Accident, Sickness or Disease.

Emergency dental treatment benefit

When Injury to whole and sound teeth, due to a force or blow external to the mouth, requires treatment, replacement or x-rays by a legally qualified dentist or oral surgeon, and you consult with the dentist or oral surgeon within 30 days from the date of the Accident, the Insurer will pay the reasonable and necessary expenses actually incurred. For the purposes of this policy, capped or crowned teeth will be considered whole and sound. The maximum amount payable as a result of any one accident is two thousand dollars ($2,000).

Any payments made under this section will be in accordance with the current Fee Guide for General Practitioners published by the Dental Association in your province of Residence.

Family transportation and accommodation benefit

If, as a result of Injury or Sickness, you sustain loss of life or are confined as an inpatient in a Hospital for at least 4 consecutive days and under the Regular Care and Attendance of a Physician, the Insurer will pay the reasonable and necessary expenses actually incurred by:

- any other Insured Person or Travelling Companion who remained with you during your hospitalization, which prevented them from returning to their province of Residence on the original scheduled return date, provided the return Fare is non-changeable and non-refundable, for their board, Accommodation and transportation by the most direct route back to their normal place of Residence, subject to the cost of one way Fare; or
- a Member of the Immediate Family or a Family representative for board, Accommodation and one return Fare for transportation by the most direct route to and from the normal place of Residence to where you are confined if you had been travelling unaccompanied by a Family Member at the time you became hospitalized.

Reimbursement of transportation expenses under this section is limited to 75% of the cost of the Fare. If transportation occurs in a motorized vehicle other than one operated under a license for the conveyance of passengers for hire, then reimbursement of transportation expenses will be limited to a maximum of twenty five cents ($.25) per kilometre travelled.

Expenses for board and Accommodation will be paid at fifty dollars ($50) per day, subject to the following maximum duration:

- if you are confined in a Hospital and whether or not loss of life occurs, to a maximum of 20 consecutive days of hospitalization.
- if you sustain loss of life, up to a maximum of 5 consecutive days.

The total maximum amount payable under this section by the Insurer to you or on your behalf will not exceed two thousand dollars ($2,000) for any one Injury, Sickness or Disease.

Fare means the regular fare charged for:

- an economy class seat on a regular flight by a domestic or international scheduled air carrier,
- a coach seat on a passenger train,
- a regular seat on a passenger bus, or
- an economy class seat on a boat,

where each of these carriers must hold an operating certificate issued by Transport Canada or by a similar governmental authority having jurisdiction over such carrier in the country of its certification.

Medical reimbursement expense benefit

When by reason of Injury, Sickness or Disease, you require medical or surgical treatment and incur eligible expenses as described in this section, the Insurer will reimburse the reasonable and necessary charges for following services or supplies:

- Hospital charges including those for room and board, up to and including the semi-private accommodation level, subject to a maximum duration of 12 months.
- Hospital charges for out-patient services when medically required.
- expenses for the services of a Nurse ordered or prescribed by a Physician, provided the Nurse does not ordinarily reside with you. The maximum payable per Accident, Sickness or Disease is five thousand dollars ($5,000).
- charges for prescription drugs, sera and vaccines, obtainable only upon a written prescription by a Physician or legally qualified dentist and dispensed by a registered pharmacist or Physician, but excluding any charges made for the administration of injectable drugs, sera and vaccines, subject to a dispensing maximum of a 30 day supply.
- expenses charged for the services of a licensed professional physiotherapist for physiotherapy treatment ordered or prescribed by a Physician, provided such physiotherapist does not ordinarily reside with you and is not a Member of your Immediate Family. The maximum amount payable per Accident, Sickness or Disease is one thousand dollars ($1,000).
- expenses for a licensed ground ambulance service or, when recommended by a Physician, by any other conveyance licensed to carry passengers for hire, to or from the nearest Hospital which is equipped to provide the required treatment, subject to a maximum of five thousand dollars ($5,000) per Accident, Sickness or Disease.
- expenses incurred for the following:

    - blood plasma, whole blood or oxygen, including the administration thereof.
    - x-rays and laboratory examinations which are required for diagnostic purposes.
    - artificial limbs, eyes or other prosthetic appliances, subject to a maximum of two thousand dollars ($2,000) per calendar year.

- rental or purchase of casts, cervical collars, crutches, trusses, splints and braces (except dental braces and splints).
- rental of a wheelchair, an iron lung and other durable medical equipment for temporary therapeutic treatment, subject to a maximum of five thousand dollars ($5,000) per Accident, Sickness or Disease.

- expenses for medical care and treatment rendered or surgical procedures performed by a Physician.
- expenses for the services of a licensed anaesthetist when recommended by a Physician.
- expenses for the services of any of the following licensed practitioners, provided such practitioner does not ordinarily reside with you and is not a member of your Immediate Family. The maximum payable is three hundred dollars ($300) per specialty per Accident, Sickness or Disease (such services do not require the recommendation of a Physician except as indicated below):

  - Chiropractor
  - Osteopath
  - Chiropodist or podiatrist
  - Massage Therapist on the recommendation of a Physician
  - Speech therapist
  - Licensed psychologist

Expenses for diagnostic x-rays and laboratory tests ordered by a chiropractor, osteopath, chiropodist or podiatrist will be allowed as expenses under the services of such practitioners, subject to a maximum of one x-ray per practitioner per Accident, Sickness or Disease.

The total amount payable under this policy for all Medical Reimbursement Expense Benefits as a result of all Injuries caused by any one Accident or as the result of any one Sickness or Disease, will not exceed the Maximum Limit of Indemnity of two million dollars ($2,000,000).

Return of vehicle benefit

If, as the result of Injury, Sickness or Disease, the attending Physician certifies in writing that you have become disabled and are unable to continue the Trip by means of driving the owned or rented motorized vehicle, the Insurer will pay the reasonable and necessary expenses actually incurred for the return of such vehicle by a commercial agency to your normal place of Residence or the rental agency, as the case may be. The maximum amount payable to you or on your behalf will not exceed five hundred dollars ($500) for any one Accident, Sickness or Disease.

Repatriation benefit

This benefit applies to loss of life, sustained as a result of your Injury, Sickness or Disease, more than 50 kilometres from your normal place of Residence.

Up to three thousand dollars ($3,000) will be reimbursed towards the reasonable and necessary expenses actually incurred for the transportation of a deceased person to the first resting place (including but not limited to a funeral home or the place of interment) in the vicinity of the normal place of Residence of the deceased. This includes charges for the preparation of the body for such transportation. The benefit will be payable to the person who actually incurred the expenses.

Exclusions and limitations

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

- suicide or intentionally self-inflicted Injury.
- declared or undeclared war or any acts thereof; perpetration of acts of terrorism; participation in a riot, insurrection or civil commotion.
- active full-time, part-time or temporary service in the armed forces of any country.
- pregnancy, childbirth, except complications thereof which will be treated as any other Sickness.
- a Trip undertaken by the Insured Person for the purpose of obtaining medical treatment, assessment or consultation.
- participation in any professional athletics.
- participation in acrobatic or stunt flying and any racing or speed contests.

This policy does not cover any of the following supplies or services or costs thereof:

- expenses covered under any government hospital, medical, dental or health care insurance plan, whether payable or not, or expenses for which insurance is prohibited by law.
- medical examinations for the use of a third party, cosmetic surgery and dental services other than those required as a result of an accident.
- oral contraceptives and patent medicines.
- charges for experimental drugs not approved by Drugs Directorate, Health Protection Branch of Health and Welfare Canada.
- charges for any experimental medical treatments.
- services for which no charge would ordinarily be made if there was no insurance coverage.
- expenses incurred for treatment or surgery which medically could be delayed until the Insured Person has returned to his province of Residence.
- medical expenses for treatment or surgery which the Insured Person elects to have rendered or performed outside his province of Residence, following Emergency treatment for or diagnosis of a medical condition which (on medical evidence) would not prevent the Insured Person from returning to his province of Residence prior to such treatment or surgery.

The following limitations to the coverage provided under this policy will apply:

- coverage for each Trip begins when an Insured Person leaves the border of his province of Residence or if travelling by aircraft, when such aircraft takes off in his province of Residence, provided insurance is in force as to such Insured Person in accordance with the effective date of individual insurance.
- coverage for each Trip terminates when an Insured Person crosses the border of his province of Residence when returning from a Trip or if travelling by aircraft, when such aircraft lands in his province of Residence or 90 days following the date of departure from his province of Residence, whichever is earlier.
- all expenses must be incurred on a non-elective Emergency basis outside your Province of Residence and are in excess of expenses payable under any individual, group or government sponsored hospital or medical reimbursement plan.
- in consultation with the attending Physician, the Insurer reserves the right to transfer an Insured Person to another Hospital or to return an Insured Person to his province of Residence for necessary treatment. In the event the Insured Person refuses to comply, the Insurer will no longer be liable for further expenses incurred, which are relating to the condition causing the treatment, after the proposed transfer date.

Non duplication

Any benefits normally payable under any other insurance policy or plan that duplicate benefits payable under this policy will be co-ordinated with this policy to the extent that the aggregate reimbursement does not exceed the total expenses incurred.

The Insurer may, at its discretion, require from the Insured Person an assignment of all right of recovery against any other party for loss to the extent that payment is made hereunder.

The AXA Assistance Program

SSQ Insurance Company Inc., in co-operation with AXA Assistance, agrees to provide the AXA Assistance Program to persons insured (hereinafter referred to as Member) under Policy # 1GJ70.

The following emergency services will be provided while the Member is travelling or stationed away from his normal place of Residence:

- 24 hour worldwide medical information and assistance including pre-trip information such as local English-speaking doctors and phone numbers for local hospitals.
- medical monitoring during treatment and ongoing updates to family and/or employer.
- arrangements for emergency medical evacuation to the nearest facility capable of providing the required medical care.
- special assistance on medically supervised emergency transportation.
- hospital deposit guarantee after verification of insurance coverage.
- dispatch of a doctor or specialist if condition cannot be adequately assessed to evaluate the need for evacuation.
- access to legal referrals.
- assistance in obtaining bail bond services.
- access or referral to interpreter services.
- assistance in making travel arrangements for family member to join disabled Member, for the return of minor children to their normal place of Residence.
- emergency message transmission between the family and/or employer.
- assistance in obtaining replacements of lost or stolen travel documents such as passport, credit cards, etc.
- assistance in making arrangements for the return of vehicle to the rental agency or the current principal Residence.

If a Member becomes ill or injured, call one of the numbers shown on the membership card and be prepared to give the following information:

- the name of the person calling, telephone # and relationship to the Member.
- the Member's name, location, ID # and Policy # as shown on the membership card.
- the condition of the Member and nature of the emergency.
- name, location and telephone # of hospital.
- name, location and telephone # of treating physician.

AXA Assistance will help the ill or injured Member to get the care needed. However, neither SSQ Insurance Company Inc. nor AXA Assistance will be responsible in any way for the availability, unavailability, quantity, quality or results of any medical services or treatment received or for the failure to obtain such services or treatment.

AXA Assistance must be notified within 48 hours of an emergency, or when reasonably possible following an emergency. Claims may be reduced if contact is not made with AXA Assistance within 48 hours of admission to Hospital.

SSQ Insurance Company Inc. will provide each employee with a membership card which shows the telephone #'s to call. Service is available 24 hours a day, 365 days a year for any medical, travel or personal emergency. The membership card also shows a toll-free # to call for pre-trip medical referrals or additional information.

This service is available provided Policy # 1GJ70 remains in force with SSQ Insurance Company Inc.

Employee & Family Assistance Program

LifeWorks is an Employee and Family Assistance Program (EFAP) and work-life/wellbeing resource designed to help you and your dependents with a variety of issues, concerns, or questions. The program is an employee benefit and provided at no additional cost to you by your employer.

LifeWorks is confidential support and services for work, life, family, health, money, and everything in between. The program includes:

- 24/7 access to expert consultants for work-life advice, information, and resources
- access to counselling
- referrals to community supports
- a secure desktop website full of practical wellbeing content
- mobile app for iPhone or Android.

You can access LifeWorks 24 hours a day, seven days a week, 365 days a year, by toll-free number, online at login.lifeworks.com, or by mobile app, for support related to:

- **Life:** Stress/Overload, Anxiety, Depression, Grief/Loss, Community Resources
- **Family:** Parenting, Separation/Divorce, Blended Families, Caring for Older Adults, Education
- **Money:** Saving/Investing, Debt Management, Estate Planning/Wills, Home Buying/Renting
- **Work**: Work Relationships, Job Stress/Burnout, Managing People
- **Health**: Fitness/Nutrition, Sleep, Addiction/Recovery, Smoking Cessation

Contact LifeWorks toll-free, 24/7: 1.833.300.9511

Service en Français :1 833.237.5117; TTY: 1.877.371.9978

Online: login.lifeworks.com
(User ID: groupsource, Password: wellness)

AKIRA
Virtual Healthcare (VHC)

Virtual Healthcare (VHC)

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

What is Virtual Healthcare?

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

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

How to Access Virtual Healthcare

First You will need to enroll in the VHC Solution. Go to www.akirahealth.ca/signup/groupsource and follow the enrollment process. You will need your Policy # and Certificate # from Your oneCard. Once enrolled, You will be given a user ID and password and have access to the VHC Solution.

Mobile app

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

Consult Fees

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

For questions, regarding the VHC Solution, please either visit Akira at **www.akirahealth.ca** or contact Akira at **support@akirahealth.ca.**

Dental Care

General description of this coverage

In this section, **you** means the employee and all eligible dependents covered for Dental Care benefit.

Dental Care coverage pays for eligible expenses that are incurred for dental procedures provided by a licensed dentist, denturist and dental hygienist while you are covered by this group plan. Dental treatment is both described and assessed according to the Canadian Dental Association Uniform System of Coding and List of Services.

For each dental procedure, the Insurer will only cover Reasonable and Customary Expenses. Payments are based on the current Provincial Fee Schedule, published in the province where you live at the time treatment is received. No benefits are payable for any dental treatment where there is no identifiable fee in the fee schedule, or any service designated as a "visit fee".

Reasonable and Customary Expenses are the lowest of representative prices in the area where the services are provided, prices shown in any applicable professional association fee guide and maximum prices established by law.

The calendar year is from January 1 to December 31.

Alternate benefit

Where there are two or more courses of eligible treatment available to adequately correct a dental condition, reimbursement may be based on the cost of the least expensive treatment that provides adequate care. Professional dental concepts of treatment and dental plan liabilities are not necessarily the same. The Alternate Benefit clause is in no way an attempt to change a treatment plan. The choice of treatment is a matter for agreement solely between the patient and the dentist.

If you receive any temporary dental service, it will be included as part of the final dental procedure used to correct the problem and not as a separate procedure.

An expense must be claimed for the calendar year in which the expense is incurred. Allowable expenses are considered to be incurred when treatment is completed, other than orthodontic treatment. Orthodontic expenses are considered to be incurred on a periodic basis throughout the course of treatment.

Deductible

The deductible, as stated in the Schedule of Benefits, is the portion of claims you are responsible for paying. After the deductible has been paid, claims will be paid up to the percentage of coverage under this plan, to the amount indicated in the current Dental Fee Guide in the province in which you reside.

Preauthorization

You should submit an estimate, before the work is done, for any major treatment or any procedure that will likely cost more than $500. To submit an estimate, you need to send a completed dental claim form that shows the detailed treatment that the dentist is planning and the cost. Both you and the dentist will have to complete parts of the claim form. Your dentist may be

requested to submit any relevant x-rays. the Insurer will advise you how much of the planned treatment is covered. This way you will know how much of the cost you will be responsible for before the work is done.

Basic Dental Services

Your dental benefits include procedures used to help prevent dental problems. They are procedures that a dentist performs regularly to help maintain good dental health.

Oral examinations

You are covered for the following oral examinations:

- 1 complete or new patient examination every 36 months, if the dentist is changed, provided the plan has not paid for an exam in the past 6 months. A complete examination includes complete examination and charting of the hard and soft structures, periodontal charting, pulp vitality tests, recording history, treatment planning, case presentation and consultation with the patient.
- 1 recall or specific examination every 6 months. Recall and specific examinations include a complete examination of the hard and soft structures, checking occlusion, pulp vitality tests and consultation with the patient.
- emergency examinations which include an evaluation for acute pain or infection, and pulp vitality tests.
- 1 specialty examination per specialty every 12 months. Specialty examinations include general or specific examinations for periodontics, oral surgery, prosthodontics and endodontics.

X-rays

You are covered for all the following x-rays:

- 4 bitewing x-rays once in a 6 month period. A bitewing x-ray is a routine check-up x-ray used to detect decay in molar teeth.
- 1 complete series of x-rays or 1 panorex every 36 months. A complete set of x-rays is 10-14 individual x-rays, including bitewings, showing all the teeth in the mouth. A panorex is a large panoramic view of the entire mouth.
- x-rays of single teeth, called periapical x-rays.
- occlusal x-rays.
- extra oral x-rays.
- tomography x-rays.

Laboratory

Laboratory charges directly related to your covered dental services will be considered at the same level of co-insurance as the covered dental procedure and will not exceed the Reasonable and Customary Expenses amount of the eligible dentist’s fee.

Limitations & exclusions

No dental benefits will be paid for:

- expenses that private insurers are not permitted to cover by law.
- the replacement of dental appliances that are lost, misplaced or stolen.
- services or supplies payable by Worker's Compensation or a Third Party or that you are entitled to without charge or for which a charge is made only because you have insurance coverage.
- procedures, appliances or restorations used to increase vertical dimension, repair or restore teeth damaged or worn due to attrition or vertical wear.
- services or supplies associated with:
    - treatment performed for cosmetic purposes only.
    - congenital defects or developmental malformations or replacement of congenitally missing teeth.
    - bacteriological tests or smears.
- services of an experimental nature or at the medical research stage.
- services or supplies not specifically listed as covered.
- miscellaneous services:
    - nutritional counselling, dental plaque control.
    - charges for completing claim forms or pre-determinations.
    - treatment planning.
    - consultations, other than with specialists.
    - travel expenses, broken appointments or communication costs.
    - supplies usually intended for sport or home use (ex. mouth guards).
- expenses arising from war, insurrection, civil commotion, acts of terrorism, voluntary participation in a riot, or active duty as a member of any branch of the armed forces.
- services provided by an individual who resides with you.
- services provided by an individual who is related to you in one of the following ways: spouse, son, daughter, father, mother, brother, sister.

Benefits after termination

No benefits are payable for dental expenses incurred after the date your insurance terminates under the Policy.

When and how to make a claim

To make a claim, complete the claim form that is available from your employer. The dentist will have to complete a section of the form. The Insurer may require that you provide the dentist's statement of the treatment received, pre-treatment x-rays and any additional information that is considered necessary.

In order to receive benefits, your claims must be submitted no later than 12 months after the services are received.

If your Dental coverage terminates for any reason, you must submit, within 90 days, any claims incurred prior to the termination date. Dental claims submitted after the 90 days will not be considered.

Upon completion, please mail the original claim form to:

GroupSource
#200, 5970 Centre Street S.E.
Calgary, Alberta T2H 0C1

Telephone: 403-228-1644
Toll-free: 1-888-547-MYGS (6947)

Cleaning

You are covered for teeth cleaning (up to and including 1 time units of polishing) once every 6 months.

Topical fluoride treatment

You are covered for fluoride treatments once every 6 months.

Oral hygiene instruction

You are covered for instruction on how to brush and floss once every 6 months.

Space maintainers and maintenance

You are covered for this procedure when a dentist has removed a primary tooth and an appliance is used to maintain the space for a permanent tooth.

This procedure includes the design, separation, fabrication, insertion, cementation, removal and 6 month follow-up care.

Caries, trauma and pain control

You are covered for sedative fillings to reduce pain when the procedures are performed on a day separate from any other restorative procedure.

This procedure includes local anaesthesia, removal of decay or removal of existing restoration, occlusal adjustment, pulp cap and placement of a sedative filling.

Fillings

You are covered for amalgam fillings (silver) and composite (tooth coloured) fillings on front and back teeth for restoring natural tooth surfaces.

Pre-fabricated metal or plastic restorations

Your dependent children under 16 are covered for pre-fabricated metal or plastic restorations, including stainless steel crowns.

Pit and fissure sealant

This is a coating put on top of any pits or cracks in teeth to prevent cavities from forming. Your dependent children under 16 are covered for one application on any one bicuspid or molar only, in any 24-month period.

Endodontics

Endodontics is root canal therapy and root canal fillings and treatment of disease of the pulp tissue. Root canal therapy for permanent and primary teeth is limited to one course of treatment per tooth. Re-treatment will be considered only if the original therapy fails after the first 24 months and has not been reimbursed by the Insurer. If re-treatment is payable it will be considered as if it were the initial treatment.

Periodontics

Periodontics is the treatment of soft tissue and bone surrounding and supporting the teeth.

Scaling means removing calcium deposits above and below the gum line.

Root planing is the final smoothing of rough tooth surfaces and removing any remaining calcium deposit.

You are covered for up to 10 time units of scaling and root planing combined in a calendar year.

Occlusal adjustments and equilibration are limited to 10 time units combined per calendar year.

Periodontal appliance includes impression, insertion and adjustments within 6 months of insertion.

Temporomandibular joint (TMJ) disorders

The hinge joint of the jaw is called the temporomandibular joint or TMJ. You are covered for certain TMJ procedures up to a lifetime maximum of $1000.

Related surgical services

You are covered for minor surgical procedures, simple extractions and post-surgical care. Complicated extractions including impacted and residual roots are also covered. Reasonable and Customary Expenses for general anaesthesia in conjunction with covered surgical procedures are covered. Any charges for facility fees or other related expenses are not covered.

Repairing, relining or rebasing dentures

Repairing dentures means fixing broken or damaged dentures.

Relining dentures means adding material so that the dentures fit properly.

Rebasing dentures means fitting dentures with a new base.

You are covered for repairs, relining and rebasing of removable denture teeth once every 12 months.

Addition of teeth to a denture is covered provided the additional teeth are required to replace teeth that were lost, extracted or fractured after the effective date of your coverage under the Policy. Denture cleaning and polishing charges are not covered.

Survivor Dental Benefit

If you die while covered by this plan, coverage for your dependents will continue, without premiums, until the earlier of the following:

- the period indicated in the Schedule of Benefits after the date of your death.
- the date the person would no longer be considered your dependent under this plan if you were still alive.
- the date the benefit provision under which the dependent is covered terminates.
- the date your dependent obtains alternate coverage under any other group insurance plan, as an Employee or Dependent.
- the date this policy terminates.

Protector Series™
Optional Critical Illness

What is Critical Illness Insurance?

Critical illness insurance may provide the funds and the means to preserve your quality of life, protect personal assets and allow the freedom and flexibility to choose the kind of health care you want.

Critical Illness Insurance is designed to provide the Insured person with a lump sum payment up to $100,000 in the event this person is diagnosed with a critical illness covered and survives at least 14 days following this diagnosis. Among other advantages, the benefits are not limited by the person's ability to work or by full recovery. In the event you should receive such a diagnosis, the benefit is paid directly to you – and you are free to choose how to use it!

General Information

Thank you for choosing the Optional Group Critical Illness insurance plan for you and your family. This booklet outlines the features and benefits of your coverage. The complete details of coverage, limitations and exclusions are in the policy, which you may request a copy of. If there are variations between the information in this booklet and the specifications of the policy, the ones in the policy will prevail.

Having a copy of this booklet does not mean you are covered under the policy. You must enrol for coverage, be approved by us and maintain your coverage as laid out in the details of the policy. From time to time the policy may be updated and you will receive written notification of any changes that affect your coverage.

Please keep your information current with us too by reporting any changes to GroupSource. This includes changes in:

- Contact information (home address, email address, phone number)
- Family status, such as birth of a child, adoption, marriage or divorce
- Smoking status (premium rates are different for non-smokers and smokers)
- Payment information (update credit card, bank account details, etc.)

Some terms we use throughout this booklet are:

- "You" refers to an individual eligible for coverage as the primary insured under this policy
- "We" or "us" refers to Industrial Alliance
- "The policy" refers to the group critical illness insurance policy issued by us to GroupSource on behalf of Payroll Deduction Sponsoring Group clients of GroupSource
- "GroupSource" refers to GroupSource, the company supporting us with the administration of the policy.

Please read this booklet as coverage is subject to exclusions, including, without limitation, an exclusion relating to Pre-Existing Conditions and Covered Condition Exclusions.

If you have any questions about your coverage you may find the answers on our website or by contacting your group benefits administrator.

Benefit Features

If you, your spouse or your dependent children are Diagnosed with a Covered Condition as defined in the policy while insured under the policy and survive, you may be eligible to receive a lump sum payment. The Benefit Amount of the payment is determined by the Face Amount of insurance you are approved and paying premiums for.

Face Amount means the dollar amount of insurance coverage.

Benefit Amount is the dollar amount that could be paid for certain Covered Conditions.

Covered Conditions are the medical conditions or events that the policy covers, as described in the policy. The definitions, limitations and exclusions are in Section 7 of this booklet.

Survival Period is 14 days after the date of Diagnosis, except where modified in the policy.

Diagnosis means the medical Diagnosis (including diagnostic measures) of someone insured by the policy, with a Covered Condition as defined by the policy. Coverage is subject to a pre-existing condition limitation. The details can be found in Section 4 of this booklet.

Face Amount of Insurance

You, your spouse and your dependent children may apply for coverage under the policy.

Face Amount	You	Your Spouse	Dependent children
Minimum available	$10,000	$10,000	$10,000
Maximum available	$100,000	$100,000	$10,000
Amount available without medical information	$50,000	$50,000	$10,000
Units of coverage	$5,000	$5,000	

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

Covered Conditions

Covered Conditions are the medical conditions or events that the policy covers. These contain definitions, limitations and exclusions, which can be found in the Covered Condition Definitions Section of this booklet. If you and your spouse are insured by the policy, you may be covered for the following conditions, as defined by the policy, at 100% of the Face Amount:

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

As well as the early diagnosis benefit Covered Conditions, as defined by the policy, at 10% of the Face Amount:

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

If your dependent children are insured by the policy they may be covered for the following conditions, as defined by the policy, at 100% of the Face Amount:

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

Charitable Donation When we determine that a first claim is payable to you or your spouse under this policy, the person claiming may designate a not-for-profit charitable organization to receive a one-time charitable donation of $500. If a first time claim is payable to a dependent child, you may designate the not-for-profit charitable organization

Early Diagnosis Benefit The early Diagnosis benefit Covered Conditions are medical conditions with a Benefit Amount equal to 10% of the Face Amount. Children are not covered for this benefit.

Multiple Event Coverage Coverage for you or your Spouse does not terminate with the payment of a first claim under the policy. Coverage may continue as long as the person claiming continues to meet the eligibility requirements and premium is paid according to the terms and conditions of the policy. You and your spouse may claim for up to 4 covered conditions at 100% of your Face Amount. It's called multiple event coverage and you can claim once in each of these categories:

- **Category 1** Life Threatening Cancer
- **Category 2** Aortic Surgery, Coronary Artery Bypass Surgery, Heart Attack (Myocardial Infarction), Heart Valve Replacement or Repair, and Stroke
- **Category 3** Blindness, Deafness, Loss of Limb, Loss of Speech, Occupational HIV, Severe Burns
- **Category 4** Aplastic Anemia, Bacterial Meningitis, Benign Brain Tumour, Coma, Dementia including Alzheimer's Disease, Kidney Failure, Loss of Independent Existence, Motor Neuron Disease, Multiple Sclerosis, Major Organ Transplant, Major Organ Failure on Waiting List, Paralysis and Parkinson's Disease.

The Benefit Amount for multiple event Covered Conditions is 100% of the Face Amount. It may be claimed for up to 4 Covered Conditions, with one claim in each of the 4 categories. Subsequent Diagnoses must be made 90 days or more after the date the prior covered condition was Diagnosed. Once a benefit has become payable, you will not be covered under the policy for another claim that is, in our opinion:

- caused by, or contributed to, has spread from or has occurred as result of the same Covered Condition;
- directly or indirectly associated with, or is likely to have been caused by, a Covered Condition that you have already claimed under the policy; or
- for a claim for another Covered Condition within the same multiple event Covered Condition category as a Claim that has already been paid under the policy.

Children are not covered for this benefit.

Reinstatement Benefit for Cancer

If you or your spouse has a benefit amount paid under the policy as a result of a Cancer Covered Condition, your or your spouse's eligibility to claim for a future Cancer Covered Condition will be restored:

- if the person claiming continues to meet the eligibility requirements of the policy;
- premium is paid in accordance with the terms and conditions of the policy; and
- the definition of Cancer Recurrence is met.

Cancer Recurrence is defined as a subsequent Diagnosis of the Insured Person with Cancer, provided that:

- after the payment date of an initial Cancer Claim, the Insured Person has not received any treatment relating directly or indirectly to the previous Cancer Diagnosis within the 60-month period that follows the payment date (treatment does not include preventative medications and follow-up visits to the doctor); and
- the Insured Person does not have any new signs, symptoms or deliberate or incidental findings, during that 60-month period, for which they sought medical investigation, consultation to investigate and or diagnose, Diagnosis, treatment, care, medication or medical advice, or for which there were symptoms that should have caused an individual to seek the same relating to a Diagnosis of Cancer; and
- the successive Diagnosis has been made while the Insured Person is covered under the policy, and prior to the coverage termination date

For the purpose of this Reinstatement Benefit, the treatment of a Non-Life-Threatening Cancer will be considered as treatment for Cancer. This benefit is available to you and your spouse, not to dependent children.

Who can be covered

You, your spouse and your dependent children may be insured under the policy. You and spouse may apply for coverage for yourselves. Only you may apply for coverage for your children. You must have coverage yourself in order to cover your children.

You are eligible if you meet eligibility requirements for group benefits and qualify for coverage as the primary insured under a Sponsoring Group's benefit plan and are:

- less than 65 years of age;
- actively at work on the date you apply for coverage; and
- a full-time resident of Canada.

Actively at Work means you perform all the functional and crucial duties of your job for a full workday at the location where your job duties are normally performed. You are considered Actively at Work on any day that is not your regular scheduled workday (e.g. vacation or holiday), as long as you meet this definition on the immediately preceding scheduled work day and you are not confined to hospital on the date you apply for coverage. Members on maternity leave are considered Actively at Work**.**

Your spouse is eligible for coverage if he or she:

- is less than 65 years of age;
- is a full-time resident of Canada; and
- is legally married to you, or has been living with you in a role like that of a marriage partner continuously for the immediately preceding 12-month period; or
- is in a civil union with you as defined by the Civil Code of Quebec; or
- is in a registered domestic partnership with you in Nova Scotia; or
- is the biological or adoptive father or mother of at least one of your children.

Only one spouse will be eligible for insurance under the policy.

Your dependent child is eligible for coverage if they are:

- your natural or adopted children or stepchildren;
- wholly dependent on you for support;
- either under 22 years of age; or under 25 years of age (26 in the province of Quebec) and in full-time attendance at an accredited school as students;
- unmarried residents of Canada;
- not employed on a full-time basis; and
- not eligible for insurance as an employee under this or any other group policy.

We may ask you to provide proof of the status of your dependents.

Dependent child coverage extends to all of your eligible dependent children. If you apply and are approved subsequent children are automatically insured at the same Face Amount.

When are you eligible

If you meet the eligibility requirements you will be considered eligible on the latest of the following dates:

	You	Your Spouse	Dependent children
The policy effective date	✓	✓	✓
The date you become eligible under the policy	✓	✓	✓
The date your dependent first applies for and is approved for coverage as a dependent		✓	✓
For insurance amounts above the non-evidence maximum, the date the person is approved for coverage	✓	✓	

When is medical evidence required

You and/or your spouse must answer a short medical questionnaire:

- if you apply for a Face Amount above the "amount available without medical questions", or
- if you apply for coverage for any person after they have been eligible for benefits for more than 31 days.

When does coverage start

If you and your dependents are eligible and apply for coverage under the policy, it will be effective on the latest of the following dates:

	You	Your Spouse	Dependent children
The policy effective date	✓	✓	✓
The 1st of the month following the date coverage is approved	✓	✓	✓
The date your dependent becomes eligible under the policy		✓	✓

A person cannot be insured by the policy as both a member and as a spouse or as a dependent child.

Life Event

A life event refers to one of the following events while you are insured by the policy:

- you marry (including common-law) or divorce;
- your child is born;
- you adopt a child; or
- your spouse or child dies.

You may request an increase in coverage under the policy within 31 days of a life event without providing medical information, up to the maximum available without medical questions. If you do not apply within this period of time, your coverage remains unchanged. To increase your coverage after 31 days have passed one of the life events stated above, medical information will be required. A face amount increase without new medical information will be effective on the 1st of the month following the latest of the following dates:

	You	Your Spouse	Dependent children
The date additional coverage is approved	✓	✓	✓
The date of the life event	✓	✓	✓

When does coverage terminate

Coverage terminates on the earliest of the following dates:

	You	Your Spouse	Dependent children
The date the policy terminates	✓	✓	✓
The date we receive your request for the cancellation of insurance in respect of an insured person (in writing)	✓	✓	✓
The last day for which any required premium has been paid	✓	✓	✓
The date of entry into the armed forces of any country on a full-time basis	✓	✓	✓
The date the maximum amount payable under the benefit plan has been paid	✓	✓	✓
Your 70th birthday	✓		✓
Your Spouse's 70th birthday		✓	
The date your Spouse ceases to qualify as a dependent spouse under the policy (please see definition in section "Who can be covered?")		✓	

The date your Child ceases to qualify as a dependent child under the policy (please see definition in section "Who can be covered?")	✓

Portability Privilege

If your coverage under the policy terminates following the end of your relationship with your Sponsoring Group, you are eligible to transfer it to another voluntary group critical illness policy we set up for this purpose without providing medical information.

The portability privilege will also be triggered upon the death of the Member for all insured dependents who meet the eligibility requirements of the policy and continue to pay premiums.

If you are eligible to transfer your coverage GroupSource will contact you to initiate your transfer.

This benefit is available to you, your spouse and your dependent children that are insured by the policy as long as you complete the necessary forms online that GroupSource will provide to you for this purpose, within 60 days of your date of termination.

The Portability Privilege is not available if your coverage under the policy terminates because:

- you entered the armed forces of any country on a full-time basis;
- you reached the age of 70 years; or
- you received the maximum amount payable for your benefit plan.

Pre-Existing Condition Limitation

What is a pre-existing condition

A pre-existing condition refers to a medical condition, whether diagnosed or not, for which the insured person sought medical investigation, medical care or services, diagnosis, treatment, including diagnostic measures, medication or medical advice, or

for which there were symptoms, signs or evidence that should have caused an individual to seek medical care or services, diagnosis, treatment, including diagnostic measures, medication or medical advice.

What is the pre-existing condition limitation

No Benefit Amount will be payable for a pre-existing condition that existed within 24-month prior to the starting date of your continuous coverage which is determined under the policy, if a Covered Condition is Diagnosed within 24 months of the starting date of coverage.

What if I had coverage before?

We will use the following starting date of your coverage to determine when the pre-existing condition limitation applies.

	Starting Date
If you were not insured for group critical illness before	The effective date of your insurance under the policy
For the amount and Covered Conditions covered under your prior critical illness policy that terminated within 31 days of the effective date of the policy	The effective date of your insurance under a prior policy
For any new Covered Conditions or increase in Face Amount not covered by the prior policy.	The effective date of your insurance under the policy
For any new Covered Conditions or increase in Face Amount of insurance	The effective date of the policy amendment that reflects the change

Restriction: **Recognition of prior coverage will not apply if that coverage was terminated by you voluntarily or because you breached the terms or conditions of your prior coverage**.

Premium Rates

You and your spouse will be charged premiums based on your respective:

- Age
- Gender
- Face Amount
- Smoking Status

Rates are grouped into 5-year age bands. The month you have a birthday that brings you in to the next 5-year age band, GroupSource will automatically adjust your premium rate to the new age band.

Smokers do pay more for their insurance coverage than non-smokers, so if there is a change in your smoking status please let GroupSource know.

Dependent children are covered at a single rate regardless of the number children covered under the policy.

We have the right to set new premium rates when the terms of the policy are changed. This includes legislative changes resulting in changes to:

- the liability for provision of benefits; or
- the taxability of premiums or benefits.

We also have the right to set new premium rates once in any 12-month period when there is no change to the terms of the policy

No premium rate may be increased unless we notify you at least 60 days before the increase.

Currency

All payments under the policy are made in Canadian dollars.

Grace Period

The grace period refers to the 31 days after the actual due date of your premium payment. We will continue your coverage in force during the grace period and if your premium is received during this time it is not considered late. If we do not receive your full payment before the grace period ends, your coverage will automatically terminate as of the premium due date for which premiums were not paid.

Claim information

To receive a claim payment under the policy:

You, your spouse or a dependent child, may make a claim under the policy if the claimant is insured for the relevant benefit on the date of Diagnosis.

- The Covered Condition meets the criteria and medical definition as defined in the policy.
- No policy exclusions or limitation apply (The exclusions and limitations are included in Section 7).
- The Diagnosis must be made by a physician licensed and practicing in Canada in a specialty that is customarily consulted for Diagnoses relating to the applicable Covered Condition. If the Diagnosis is made outside of Canada, we reserve the right to request confirmation by a physician licensed and practicing in Canada.
- We must be notified in writing within 30 days of the date of Diagnosis or surgery being claimed for using a form provided by us for this purpose.
- An initial claim notification form is available by contacting GroupSource Benefit Solutions.
- We must receive sufficient evidence and/or documentation documenting the Diagnosis of the Covered Condition, as defined in the Policy, that we regard as necessary for us to make a determination on your claim. If we require additional information we will refer the claimant to an independent physician at our expense. If we do not receive all of the information we require we may not be able to make a favourable decision on the claim.

Payment of a claim

Approved claims are payable to the insured adult person making the claim. There is no beneficiary designation under the policy. If a dependent child has an approved claim, the benefit will be payable to you. If the claimant is no longer living at the time payment is made, the benefit will be paid to his or her estate subject to the survival period being met.

The certificate we issued to you when you were approved under this policy will show the Face Amount of coverage you purchased. The Benefit Amount payable is based on this amount.

Right to appeal

If all or any part of a claim is denied, you may send us a request to review the denial within 6 months after receiving notice of this decision. We will review the request and notify you of the outcome regarding your appeal within a reasonable time upon receipt of all required information.

Legal action may not start less than 60 days after proof of claim has been submitted as required by the policy or longer than the time limit set out in applicable legislation.

Covered Condition Definitions

Aplastic Anemia is defined as a definite Diagnosis of a chronic persistent bone marrow failure, confirmed by biopsy, which results in anemia, neutropenia and thrombocytopenia requiring blood product transfusion, and treatment with at least one of the following:

- marrow stimulating agents;
- immunosuppressive agents; or
- bone marrow transplantation.

The Diagnosis of Aplastic Anemia must be made by a Specialist.

Aortic Surgery is defined as the undergoing of surgery for disease of the aorta requiring excision and surgical replacement of any part of the diseased aorta with a graft. Aorta means the thoracic and abdominal aorta but not its branches. The surgery must be determined to be Medically Necessary by a Specialist.

Exclusion: No benefit will be payable under this Covered Condition for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

Autism is defined as an organic defect in brain development characterized by failure to develop communicative language or other forms of social communication, with the Diagnosis confirmed by a specialist before the third birthday.

Bacterial Meningitis is defined as a definite Diagnosis of meningitis, confirmed by cerebrospinal fluid showing growth of pathogenic bacteria in culture, resulting in neurological deficit(s) documented for at least 90 days from the Date of Diagnosis. The Diagnosis of Bacterial Meningitis must be made by a Specialist.

Exclusion: ***No benefit will be payable under this condition for viral meningitis.***

Benign Brain Tumour is defined as a definite Diagnosis of a non-malignant tumour located in the cranial vault and limited to the brain, meninges, cranial nerves or pituitary gland. The tumour must require surgical or radiation treatment or cause Irreversible objective neurological deficit(s). The Diagnosis of Benign Brain Tumour must be made by a Specialist.

Exclusion: No benefit will be payable under this Covered Condition if, within the first 90 days following the later of:

- the Effective Date of Coverage, or
- the date of the last reinstatement of the Claimant's coverage, the Claimant has any of the following:
  - signs, symptoms, evidence or investigations that lead to a Diagnosis of Benign Brain Tumour (covered or excluded under the Policy), regardless of when the Diagnosis is made; or
  - a Diagnosis of Benign Brain Tumour (covered or excluded under the Policy).

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

Exclusion: No benefit will be payable under this Covered Condition for pituitary adenomas less than 10 mm.

Blindness is defined as a 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.

Cancer (Life-Threatening) is defined as a definite Diagnosis of a tumour, which must be characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. Types of cancer include carcinoma, melanoma, leukemia, lymphoma, and sarcoma. The Diagnosis of Cancer must be made by a Specialist.

Exclusion: No benefit will be payable under this Covered Condition if, within the first 90 days following the later of (i) the Effective Date of Coverage or (ii) the date of the last reinstatement of the Claimant's coverage, the Claimant has any of the following:

- signs, symptoms or investigations that lead to a Diagnosis of Cancer (covered or excluded under the Policy), regardless of when the Diagnosis is made; or
- a Diagnosis of Cancer (covered or excluded under the Policy).

Medical information about the Diagnosis and any signs, symptoms or investigations leading to the Diagnosis must be reported to us within 6 months of the date of the Diagnosis. If this information is not provided within this period, us has the right to deny any Claim for Cancer or any critical illness caused by any Cancer or its treatment.

Exclusion: No benefit will be payable for the following:

- lesions described as benign, pre-malignant, uncertain, borderline, non-invasive, carcinoma in-situ (Tis), or tumours classified as Ta;
- malignant melanoma skin cancer that is less than or equal to 1.0 mm in thickness, unless it is ulcerated or is accompanied by lymph node or distant metastasis;
- any non-melanoma skin cancer, without lymph node or distant metastasis;
- prostate cancer classified as T1a or T1b, without lymph node or distant metastasis;
- papillary thyroid cancer or follicular thyroid cancer, or both, that is less than or equal to 2.0 cm in greatest diameter and classified as T1, without lymph node or distant metastasis;
- chronic lymphocytic leukemia classified less than Rai stage 1; or
- malignant gastrointestinal stromal tumours (GIST) and malignant carcinoid tumours, classified less than AJCC Stage 2.

For purposes of the Policy, the terms Tis, Ta, T1a, T1b, T1 and AJCC Stage 2 are to be applied as defined in the American Joint Committee on Cancer (AJCC) cancer staging manual, 7th Edition, 2010.

For purposes of the Policy, the term Rai staging is to be applied as set out in KR Rai, A Sawitsky, EP Cronkite, AD Chanana, RN Levy and BS Pasternack: Clinical staging of chronic lymphocytic leukemia. Blood 46:219, 1975.

Cancer (Non-Life-Threatening) includes:

- *Ductal Carcinoma in Situ of Breast*, which is defined as the Diagnosis of non-life-threatening ductal carcinoma in situ of the breast, confirmed by biopsy.
- *Early Stage Lymphocytic Leukemia*, which is defined as the Diagnosis of chronic lymphocytic leukemia classified less than Rai stage 1.
- *Early Stage Thyroid Cancer*, which is defined as the Diagnosis of papillary thyroid cancer or follicular thyroid cancer, or both, that is less than or equal to 2.0 cm in greatest diameter and classified as T1, without lymph node or distant metastasis.
- *GIST (Gastrointestinal Stromal Tumour),* which is defined as the Diagnosis of malignant gastrointestinal stromal tumours (GIST) and malignant carcinoid tumours, classified less than AJCC Stage 2.
- *Stage A (T1a or T1b) Prostate Cancer*, which is defined as the Diagnosis of prostate cancer classified as T1a or T1b, without lymph node or distant metastasis.
- *Stage 1A Malignant Melanoma,* which is defined as the Diagnosis of malignant melanoma skin cancer that is less than or equal to 1.0 mm in thickness, unless it is ulcerated or is accompanied by lymph node or distant metastasis.

Exclusion: No benefit will be payable under this Covered Condition if, within the first 90 days following the later of:

- the Effective Date of Coverage, or
- the date of the last reinstatement of coverage, the Claimant has any of the following:
  - signs, symptoms or investigations that lead to a Diagnosis of Cancer (covered or excluded under the Policy), regardless of when the Diagnosis is made; or
  - a Diagnosis of Cancer (covered or excluded under the Policy).

Cerebral Palsy is defined as a definitive Diagnosis of cerebral palsy, a non-progressive neurological defect characterized by spasticity and in coordination of movements.

Coma is defined as a definite Diagnosis of a state of unconsciousness with no reaction to external stimuli or response to internal needs for a continuous period of at least 96 hours, and for which period the Glasgow coma score must be 4 or less. The Diagnosis of Coma must be made by a Specialist.

Exclusion: No benefit will be payable under this Covered Condition for:

- a medically induced Coma;
  - a Coma which results directly from alcohol or drug use; or
  - a Diagnosis of brain death.

Congenital Heart Disease is defined as any one or more Diagnosis(es) from the following lists of heart conditions that are Covered Conditions:

List A

- Total Anomalous Pulmonary Venous Connection
- Transposition of The Great Vessels
- Atresia of any heart valve
- Coarctation of The Aorta
- Single Ventricle
- Hypoplastic Left Heart Syndrome
- Double Outlet Left Ventricle
- Truncus Arteriosus
- Tetralogy of Fallot
- Eisenmenger Syndrome
- Double Inlet Ventricle
- Hypoplastic Right Ventricle
- Ebstein's Anomaly

The Covered Conditions described in List A will be covered commencing from the date of birth. The Diagnosis of any of the Covered Conditions in List A must be made by a Specialist who is a qualified pediatric cardiologist, and supported by appropriate cardiac imaging.

List B

- Pulmonary Stenosis
- Aortic Stenosis
- Discrete Subvalvular Aortic Stenosis
- Ventricular Septal Defect
- Atrial Septal Defect

The Covered Conditions described in List B will be covered only when open heart Surgery is performed for correction of the Covered Condition following the date of birth. The Diagnosis of any of the Covered Conditions in this List B must be made by a Specialist who is a qualified pediatric cardiologist, and supported by appropriate cardiac imaging. The Surgery must be recommended by a Specialist who is a qualified pediatric cardiologist and performed by a Specialist who is a cardiac surgeon in Canada.

List B Exclusion: Trans-catheter procedures such as balloon valvuloplasty or percutaneous Atrial Septal Defect closure are excluded.

General Congenital Heart Disease Exclusion: All other congenital cardiac conditions not specifically described in List A or List B are not Covered Conditions and are excluded.

Coronary Angioplasty is defined as the undergoing of an interventional procedure to unblock or widen a coronary artery that supplies blood to the heart to allow an uninterrupted flow of blood. The procedure must be determined to be medically necessary by a specialist.

Coronary Artery Bypass Surgeryis defined as the undergoing of heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass graft(s). The surgery must be determined to be Medically Necessary by a Specialist.

Exclusion: No benefit will be payable under this Covered Condition for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

Cystic Fibrosis is defined as a definitive Diagnosis of cystic fibrosis with evidence of chronic lung disease and pancreatic insufficiency.

Deafness is defined as a definite Diagnosis of the total and Irreversible loss of hearing in both ears, with an auditory threshold of 90 decibels or greater within the speech threshold of 500 to 3,000 hertz. The Diagnosis of Deafness must be made by a Specialist.

Dementia, including Alzheimer's Disease is defined as a definite Diagnosis of dementia, which must be characterized by a progressive deterioration of memory and at least one of the following areas of cognitive function:

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

The Insured Person must exhibit:

- 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.

The Diagnosis of Dementia must be made by a Specialist.

Exclusion: No benefit will be payable under this Covered Condition for affective or schizophrenic disorders, or delirium. For the purposes of the policy, reference to the Mini Mental State Exam is to Folstein MF, Folstein SE, McHugh PR, Journal of Psychiatric Research 1975;12(3):189.

Down's Syndrome is defined as a definitive Diagnosis of Down's Syndrome supported by chromosomal evidence of Trisomy 21.

Heart Attack is defined as a definite Diagnosis of the death of heart muscle due to obstruction of blood flow that results in a 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.

Exclusion: No benefit will be payable under this Covered Condition for:

- 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; or
- diagnosis or working diagnosis of Heart Attack without the supporting cardiac-biochemical markers diagnostic of myocardial infarction and new ECG changes consistent with a heart attack as defined in this Policy.

Heart Valve Replacement or Repair is defined as the undergoing of surgery to replace any heart valve with either a natural or mechanical valve or to repair heart valve defects or abnormalities. The surgery must be determined to be Medically Necessary by a Specialist.

Exclusion: No benefit will be payable under this Covered Condition for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

Kidney Failure is defined as a definite Diagnosis of chronic Irreversible failure of both kidneys to function, as a result of which regular hemodialysis, peritoneal dialysis or renal transplantation is initiated. The Date of Diagnosis is the date of the Insured Person's initiation into the transplant program. The Diagnosis of Kidney Failure must be made by a Specialist.

Loss of Independent Existence is defined as a definite Diagnosis of the total and permanent inability to perform, by oneself, at least 2 of the following 6 Activities of Daily Living for a continuous period of at least 90 days with no reasonable chance of recovery. The Diagnosis of Loss of Independent Existence must be made by a Specialist.

Activities of Daily Living are:

- 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 is defined as a definite Diagnosis of the complete severance of two or more limbs at or above the wrist or ankle joint as the result of an Accident or medically required amputation. The Diagnosis of Loss of Limbs must be made by a Specialist.

Loss of Speech is defined as a definite Diagnosis of the total and Irreversible loss of the ability to speak as the result of physical Injury or Sickness for a period of at least 180 days. The Diagnosis of Loss of Speech must be made by a Specialist.

Exclusion: No benefit will be payable under this Covered Condition for all psychiatric-related causes.

Major Organ Failure on Waiting List is defined as a definite Diagnosis of the Irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be Medically Necessary. To qualify under Major Organ Failure on Waiting List, the Insured Person must become enrolled as the recipient in a recognized transplant centre in Canada or the United States of America that performs the required form of transplant surgery. The Date of Diagnosis is the date of the Insured Person's Enrolment in the transplant centre. The Diagnosis of the major organ failure must be made by a Specialist.

Major Organ Transplant is defined as a definite Diagnosis of the Irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be Medically Necessary. To qualify under Major Organ Transplant, the Insured Person must 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. The Date of Diagnosis is the date of the Insured Person's Enrolment in the transplant centre. The Diagnosis of the major organ failure must be made by a Specialist.

Motor Neuron Disease is defined as a definite Diagnosis of one of the following: amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease), primary lateral sclerosis, progressive spinal muscular atrophy, progressive bulbar palsy, or pseudo bulbar palsy, and is limited to these conditions. The Diagnosis of Motor Neuron disease must be made by a Specialist.

Multiple Sclerosis is defined as a 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.

Muscular Dystrophy is defined as a definitive Diagnosis of muscular dystrophy, characterized by well-defined neurological abnormalities, confirmed by electromyography and muscle biopsy.

Occupational HIV Infection is defined as a definite Diagnosis of infection with Human Immunodeficiency Virus (HIV) resulting from an Accident causing Injury during the course of the Insured Person's normal occupation which exposed the Claimant to HIV contaminated body fluids.

The Injury from Accident leading to the infection must have occurred after the later of the Effective Date of Coverage or the Effective Date of the last reinstatement of the Claimant's coverage.

Payment under this Covered Condition requires satisfaction of all of the following:

- the Injury from Accident must be reported to us within 14 days of the Accident causing the Injury;
- a serum HIV test must be taken within 14 days of the Injury from Accident and the result must be negative;
- a serum HIV test must be taken between 90 days and 180 days after the accidental Injury from Accident and the result must be positive;
- all HIV tests must be performed by a duly licensed laboratory in Canada or the United States of America; and
- the Injury from Accident must have been reported, investigated and documented in accordance with current Canadian or United States of America workplace guidelines.

The Diagnosis of Occupational HIV Infection must be made by a Specialist.

Exclusion: No benefit will be payable under this Covered Condition if:

- the Claimant has elected not to take any available licensed vaccine offering protection against HIV;
- a licensed cure for HIV infection has become available prior to the Injury from Accident; or
- HIV infection has occurred as a result of any Injury not from Accident including, but not limited to, sexual transmission and intravenous (IV) drug use.

Paralysis is defined as a definite Diagnosis of the total loss of muscle function of two or more limbs as a result of Injury or Sickness to the nerve supply of those limbs, for a period of at least 90 days following the precipitating event. The Diagnosis of Paralysis must be made by a Specialist.

Parkinson's Disease and Specified Atypical Parkinsonian Disorders Parkinson's Disease is defined as a definite Diagnosis of primary Parkinson's disease, a permanent neurologic condition which must be characterized by bradykinesia (slowness of movement) and at least one of: muscular rigidity or rest tremor. The Claimant 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 Specialist who is a neurologist.

Exclusions: No benefit will be payable under this Covered Condition if, within the first year following the later of: (i) the Effective Date of the policy or (ii) the date of the last reinstatement of the Claimant's coverage, the Claimant 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 us within 6 months of the date of the Diagnosis. If this information is not provided within this period, us has the right to deny any Claim for Parkinson's Disease, Specified Atypical Parkinsonian Disorders or any Covered Condition caused by Parkinson's Disease or Specified Atypical Parkinsonian Disorders or its treatment.

Exclusion: No benefit will be payable under this Covered Condition for any other type of parkinsonism.

Severe Burns is defined as a definite Diagnosis of third-degree burns over at least 20% of the body surface. The Diagnosis of Severe Burns must be made by a Specialist.

Stroke (Cerebrovascular Accident) is defined as a definite Diagnosis of an acute cerebrovascular event caused by intracranial 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.

Exclusion: No benefit will be payable under this Covered 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.

Type 1 Diabetes Mellitus (Juvenile Diabetes) is defined as the Diagnosis of type 1 diabetes mellitus, characterized by absolute insulin deficiency and continuous dependence on exogenous insulin for survival. The Diagnosis must be made by a Specialist who is a qualified pediatrician or endocrinologist licensed and practising in Canada, and there must be evidence of dependence on insulin for a minimum of 3 months.

Dependent Child Critical Illness Exclusions

- Where a Child is born within 10 months of the Effective Date of Child Insurance, and such Child is diagnosed with any Dependent Child Covered Condition within those 10 months, no benefit will be payable for such Dependent Child Covered Condition.
- No benefit will be payable for any Cancer tumour in the presence of the human immunodeficiency virus (HIV).

General Exclusions for Adult and Dependent Child Covered Conditions

- No benefit will be payable if any of the Pre-Existing Condition Limitations apply.
- No benefit will be payable if the Covered Condition is diagnosed during the Pre-Existing Condition Period if the Covered Condition is directly or indirectly related to a Pre-Existing Condition. Once the Pre-Existing Condition Exclusion Period in respect of the Insured Person making the Claim has expired, this exclusion will not apply, except in the case of fraud.
- No benefit will be payable for a Covered Condition Diagnosed while the Insured Person is not covered under this policy.
- No benefit will be payable if the Insured Person's condition was either directly or indirectly caused by, contributed to, resulted from or was in any way associated with one or more of the following:
  - attempted suicide or self-inflicted Injury or Sickness, while sane or not sane;
  - committing or attempting to commit a criminal offence,
  - the use of alcohol or any medications or drugs, other than taken as prescribed by a Physician;
  - insurrection, riot, civil commotion, hostilities of any kind, war (whether declared or not), or active service in the armed forces of any country;

- any Accident, Injury or Sickness caused by hazardous activities such as, but not limited to: professional sports, underwater activities including scuba and snuba diving; parachuting; hang gliding; B.A.S.E. jumping; cliff diving; bungee jumping; mountaineering; motor vehicle racing or speed competition on land and/or water;
- injuries sustained while operating a motor vehicle, either while under the influence of any intoxicant or if the Insured's blood contained more than 80 milligrams of alcohol per 100 millilitres of blood at the time of the injury;
- medical care which is not Medically Necessary or which is cosmetic in nature (the donation of an organ or tissue will be considered as Medically Necessary care); or
- any specific exclusions relating to any given Condition as set out within the definition for that Covered Condition in this Article.

- No benefit will be payable if the Claimant fails to seek treatment in order to avoid the Pre-Existing Condition Period limitations or other conditions and restrictions of this policy.
- No benefit will be payable if, within 90 days following the later of the Effective Date of Coverage or date of Reinstatement of Coverage, if:
  - a diagnosis of cancer is made or the Insured Person has any signs, symptoms or investigations that lead to a Diagnosis of cancer (covered or excluded under this benefit), regardless of when the Diagnosis is made; or
  - a diagnosis of benign brain tumour is made or the Insured Person has any signs, symptoms or investigations that lead to a Diagnosis of benign brain tumour (covered or excluded under this benefit), regardless of when the Diagnosis is made.

Privacy Policy

We agree that the collection, use, disclosure and retention of personal information in connection with the policy will be done in accordance with the provisions of applicable privacy legislation and our Privacy Statement. We collect, use and disclose the personal information to process enrolments and, if such enrolments are approved, to provide and administer the relevant product(s) to you. This includes investigating and assessing claims and creating and maintaining our records.

You may exercise certain rights of access and correction of information with respect to your file by sending us a request in writing.

We do limit access to personal information in such files to:

- Our employees who have a need to know;
- People we approve who need it to perform their duties;
- People that you have granted access to; and/or
- People authorized by law.

For questions about our personal information policies and practices refer to www.ia.ca/privacy-policy or contact our Privacy Officer at:

Privacy Officer
iA Financial Group
1080 Grande Allée West
PO Box 1907, Station Terminus
Québec (Québec) G1K 7M3
Email: PrivacyOfficer@ia.ca

Lifestyle & Wellness Spending Account

What is a Lifestyle & Wellness Spending Account?

A Lifestyle & Wellness Spending Account (LWSA) is similar to a bank account in which your employer allocates a pre-determined amount of money that you can use to pay for wellness-related activities and items not covered by your group benefit plan or provincial health plan. Your LWSA may be used to reimburse a wide range of expenses that support your overall health and wellness—everything from a fitness club membership to weight loss programs may be eligible.

Claims paid from your LWSA are considered taxable income, which means the amount of benefits you use will be reported on the T4 or T4A prepared annually by your employer.

Who is covered?

You may use the LWSA to reimburse expenses for yourself and your eligible dependents, as defined in the General Provisions section of this booklet. Your eligible dependents are covered under your Lifestyle & Wellness Spending Account at the same time you become eligible.

What is covered?

Your Lifestyle & Wellness Spending Account may be used to reimburse you for a wide range of expenses focused on enhancing your overall health and wellness. The scope of eligible benefits is very broad, and it is up to your employer to specify the items allowed to be reimbursed. Please refer to the list of "Eligible Expenses" outlined in this booklet.

Your Lifestyle & Wellness Spending Account amount

Your employer allocates a defined amount of money to your LWSA. Please refer to the Schedule of Benefits for your allocation amount. This amount is pro-rated for new employees as outlined in the Schedule of Benefits.

Your LWSA will reimburse you for 100% of eligible expenses provided that the balance in your account exceeds the amount of the expense. If you submit a claim and do not have sufficient funds in your account, you will be reimbursed up to the maximum available in your account at that time.

Claims submission and utilization of funds

Your LWSA program runs on a "plan year" as defined in the Schedule of Benefits. Any expenses that were not reimbursed during the "plan year" due to insufficient funds become ineligible at the end of the "plan year." Claims must be submitted in the "plan year" that they were incurred; **failure to do so renders these claims ineligible under your LWSA.**

If you have any funds remaining in your account at the end of your "plan year," they will be rolled-over into the next "plan year." However, those funds must be used within the following 12 months or they are forfeited and returned to the company.

How to claim

You should first determine if expenses are eligible under Canada Revenue Agency (CRA) regulations. If they are, these expenses should be claimed first under your insured Extended Health Care plan or Health Spending Account (if applicable). If you have a wellness-related expense that is not eligible under any other plan, but is listed in the Eligible Expenses in this booklet, you should submit a claim to your LWSA.

To claim a wellness expense, attach the original receipt to a completed Lifestyle & Wellness Account Claim Form and submit for reimbursement. **Your receipt must clearly indicate the applicable item or service**.

When to claim

Only expenses incurred during your "plan year" will be eligible for reimbursement. Claims must be submitted within 60 days after your "plan year" ends.

Leave of Absence

If you are on an approved leave of absence for longer than 30 days, your employer *may* choose to extend your LWSA benefits for a maximum of 30 days. In this case, your LWSA will terminate at midnight of the 30th day of your leave. All eligible claims must be submitted within 30 days from the date your LWSA coverage ceased.

Termination of coverage

Lifestyle & Wellness Spending Account benefits will terminate on the earlier of the following dates:

- the date you reach the benefit termination age as indicated in the Schedule of Benefits.
- the date you cease to be a member of an eligible class.
- the date you retire.
- the date the Master Policy terminates.
- the date you die.

Your dependent coverage terminates on the earlier of the following dates:

- the date your coverage ends.
- the date your dependent no longer meets the definition of an eligible dependent.

If coverage terminates, all eligible claims incurred prior to your termination date must be submitted within 30 days from your date of termination.

Eligible LWSA expenses

The following list provides examples of Lifestyle and Wellness-related expenses eligible under this benefit.

Education & Personal Development

- Tuition fees
- Books and supplies
- Professional membership dues/fees
- Conferences/classes of special interest

Finance

- Contribution to an RRSP Plan administered by Employer
- Estate planning

Fitness

- Activity tracker
- Fitness/health and wellness app subscriptions
- Fitness club or gym membership including registration fees for classes
- Cost of fitness equipment and attire

Green Living

- Transit passes
- Home energy assessment
- High efficiency furnace and/or hot water system
- Solar panels

Health Services

- Paramedical practitioner services
- Medical equipment
- Alternative medicine and therapies
- Parental and baby care products & services
- DNA testing
- Personal care products
- Weight management
- Stress management

Sports & Recreation

- Club/course memberships, fees, tickets or passes
- Registration fees
- Cost of sport/hobby equipment
- Cost of outdoor activity equipment

Work-Life Balance

- Childcare/Daycare
- Elder care
- Home office equipment
- Ergonomic assessment and equipment

Pets

- Daycare/boarding
- Training classes
- Pet health care fees
- Pet products and services

Please note that the above are examples only. Please submit any other Wellness-related expenses for assessment.

Ineligible LWSA Expenses

The following list itemizes expenses that are not eligible for the LWSA:

- Any expenses for which you were reimbursed or are entitled to be reimbursed under an Extended Health Care benefits plan, Health Savings Account, provincial health care, etc.;
- Services provided by a family member.