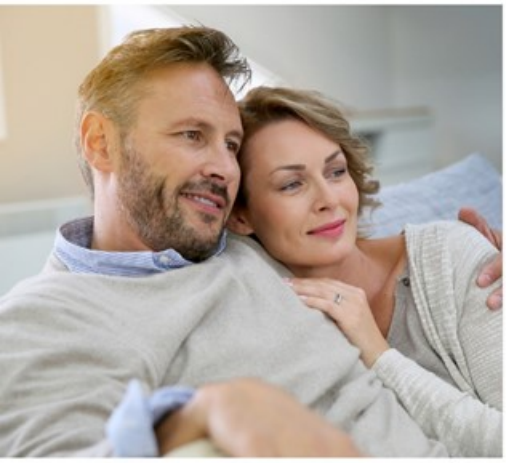

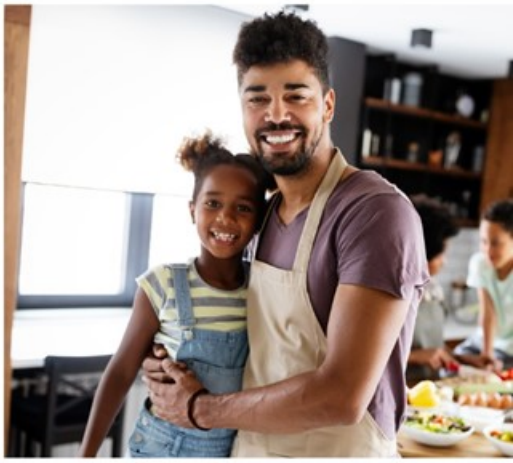

Your Group Benefits Booklet

Englobe
Harmonized Flex Plan

Seasonal and Regular Employees

Group Number:
91374

Updated Effective Date:
January 14, 2022

MEDAVIE BLUE CROSS™

Welcome to your Group Benefits Plan

Your group benefits coverage provides you with the peace of mind that you and your family are protected today and in the future, for health and medical expenses not available through the coverage provided by government.

This program is insured by Medavie Inc. (also known as Medavie Blue Cross) and Blue Cross Life Insurance Company of Canada, which together will be referred to as "Blue Cross" for convenience of reference.

Medavie Blue Cross insures all health benefits. All other benefits are insured by Blue Cross Life Insurance Company of Canada.

Blue Cross has been a trusted health services partner for individuals, employers and governments across Canada for over 60 years. Our core purpose is to help improve the health and well-being of people and their communities.

Our commitment to service, innovative solutions and technological expertise mean you can rest easy because at Blue Cross, we're always there for you.

About this Booklet

This booklet, together with your identification card, contains important information about your group benefits coverage. You should keep them in a safe place for future reference.

This booklet summarizes the important features of your group benefits coverage. It is prepared as information only, and does not, in itself, constitute an agreement. The exact terms and conditions of your group benefits coverage are described in the group policy held by your employer. In the event of a difference of wording from those of the group policy, the group policy will prevail, to the extent permitted by law.

Your booklet is divided into the following sections:

- **Summary of Benefits:** Outlines the main features of each benefit. It is important to read your Summary of Benefits along with the benefit details to ensure you fully understand your benefit coverage.

- **Coverage Details:** Contains important information regarding the eligibility requirements for your group benefits coverage. In addition, these details explain when your coverage begins and ends, plus other useful information that will help you take advantage of the coverage available to you.

- **Rights and Responsibilities under the Policy:** Outlines your responsibilities under the group policy, such as notifying your employer upon change in status, and your rights, for example your right to privacy.

- **How to Submit a Claim and Obtain More Information:** Additional information on the various options available to you for submitting claims and how you can obtain more information regarding your coverage.

- **Helpful Tips:** Throughout this booklet we have provided useful tips to help you better understand and get the most out of your group benefits.

Medavie Mobile App

Submit a claim, access an electronic version of your ID card, check coverage, find a health professional in your area, and much more! Visit **www.medaviebc.ca/app** for more information or to download the app.

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Appendix I: Voluntary Accidental Death and Dismemberment Insurance
The Accidental Death and Dismemberment group insurance program no. 1R685 is issued by SSQ Insurance Company Inc.
Appendix II: Critical Illness Insurance
The Critical Illness Insurance Group Policy no. 1R700 is issued by SSQ Insurance Company Inc.

Summary of Benefits

Member Life Benefit

Benefit Formula	1 time the annual Salary
Benefit Maximum	$725,000
Non-Evidence Limit	$725,000
Terminal Illness Benefit	Included
Benefit Reduction	The amount of coverage reduces by 50% at age 65
Termination	Retirement

Summary of Benefits

Optional Life Benefit

Benefit Formula	
Member Maximum	Units of $10,000 Maximum of $500,000
Spouse Maximum	Units of $10,000 Maximum of $500,000
Per Child Maximum	Units of $10,000 Maximum of $50,000
Non-Evidence Limit	Proof of health is required for all amounts of coverage
Termination	
Member	When the Member reaches age 65 or retires
Spouse	When the Member or Spouse reaches age 65 or when the Member retires
Child	When the Member reaches age 65 or retires

Summary of Benefits

Short Term Disability Benefit

Benefit Formula	70% of weekly Pre-Disability Salary
Benefit Maximum	$3,460/week
Non-Evidence Limit	Same as the Benefit Maximum
Elimination Period:	Calculated in Calendar days
Hospital	7 days
Outpatient surgery covered	7 days
Accident*	7 days
Illness	7 days
Benefit Period**	17 weeks
Taxable	Yes
Payment Basis	Calendar days
Integration with Canada Employment Insurance Commission (CEIC) Benefit	No
Supplemental Unemployment Benefit (SUB) Coverage	No
Termination**	Age 70 or retirement

*Total Disability beginning more than 30 days after an accident will be considered an illness.

**If the Short Term Disability Benefit is registered with the CEIC, the Benefit Period will not be less than the duration specified under the Employment Insurance Premium Reduction Program

Summary of Benefits

Long Term Disability Benefit

Option 1

Benefit Formula	53% of the first $2,400 of monthly Pre-Disability Salary, plus 38% of the next $2,100, plus 33% of the remainder, not exceeding the All Source Maximum
Benefit Maximum	$14,500/month
Non-Evidence Limit	$8,700/month
Elimination Period	17 weeks (119 days)
Benefit Period	To age 65 or retirement
Taxable	No
Integration of Benefits	Yes
All Source Maximum	85% of Pre-Disability Net Salary
Duration of Own Occupation	24 months
Cost-of-Living Adjustment	CPI adjustment to a maximum of 2%
Effective Date of Adjustment	This adjustment will become effective only after 3 years of disability
Termination	Age 65 less the Elimination Period or at retirement

Summary of Benefits

Long Term Disability Benefit

Option 2

Benefit Formula	58% of the first $2,400 of monthly Pre-Disability Salary, plus 46% of the next $2,100, plus 39% of the remainder, not exceeding the All Source Maximum
Benefit Maximum	$14,500/month
Non-Evidence Limit	$8,700/month
Elimination Period	17 weeks (119 days)
Benefit Period	To age 65 or retirement
Taxable	No
Integration of Benefits	Yes
All Source Maximum	85% of Pre-Disability Net Salary
Duration of Own Occupation	24 months
Cost-of-Living Adjustment	CPI adjustment to a maximum of 2%
Effective Date of Adjustment	This adjustment will become effective only after 3 years of disability
Termination	Age 65 less the Elimination Period or at retirement

Summary of Benefits

Drug Benefit

Option 1

Deductible	Not applicable
Reimbursement Level*	Not applicable
Method of Payment	Not applicable
Supplemental Coverage Offered to Participants in RAMQ Public Plan	Not applicable
Drug Formulary	Not applicable
Benefit Maximum	
Erectile Dysfunction Treatments	Not covered
Allergy Sera	Not covered
Varicose Vein Injections	Not covered
Substitution Provision	Not applicable
Days Supply	Not applicable
Termination	Not applicable

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

Summary of Benefits

Drug Benefit

Option 2

Deductible	None
Reimbursement Level*	Same as % used by RAMQ
Method of Payment	Pay Direct
Supplemental Coverage Offered to Participants in RAMQ Public Plan	Yes
Drug Formulary	Open Formulary
Benefit Maximum	
Erectile Dysfunction Treatments**	$250/calendar year
Allergy Sera	Included
Varicose Vein Injections	$20/visit
Substitution Provision	Mandatory Generic Substitution
Days Supply	100 days maximum supply (30 days supply may apply to some drugs)
Termination	When the Member retires

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

For the **Crandall division only.

Summary of Benefits

Drug Benefit

Option 3

Deductible	None
Reimbursement Level*	75%
Method of Payment	Pay Direct
Supplemental Coverage Offered to Participants in RAMQ Public Plan	Yes
Drug Formulary	Open Formulary
Benefit Maximum	
Erectile Dysfunction Treatments**	$250/calendar year
Allergy Sera	Included
Varicose Vein Injections	$20/visit
Substitution Provision	Mandatory Generic Substitution
Days Supply	100 days maximum supply (30 days supply may apply to some drugs)
Termination	When the Member retires

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

For the **Crandall division only.

Summary of Benefits

Drug Benefit

Option 4

Deductible	None
Reimbursement Level*	90%
Method of Payment	Pay Direct
Supplemental Coverage Offered to Participants in RAMQ Public Plan	Yes
Drug Formulary	Open Formulary
Benefit Maximum	
Erectile Dysfunction Treatments**	$250/calendar year
Allergy Sera	Included
Varicose Vein Injections	$20/visit
Substitution Provision	Mandatory Generic Substitution
Days Supply	100 days maximum supply (30 days supply may apply to some drugs)
Termination	When the Member retires

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

For the **Crandall division only.

Summary of Benefits

Extended Health Care

Option 1

Deductible	
Hospitalization	None
Vision Care	None
All Other Extended Health Care	None

	Reimbursement Level	Benefit Maximum	Accommodation
Hospitalization			
Hospital	Not covered	Not applicable	Not applicable
Convalescent Care/Physical Rehabilitation (combined)	Not covered	Not applicable	Not applicable
Medical Services and Supplies			
Ambulance Transportation	Not covered	Not applicable	
Nursing Care	Not covered	Not applicable	
Health Practitioners:	Not covered	**Maximum per Contract Year**	
Psychologist	Not covered	Not applicable	
Social worker	Not covered	Not applicable	
Chiropractor	Not covered	Not applicable	
Naturopath	Not covered	Not applicable	
Acupuncturist	Not covered	Not applicable	
Dietitian	Not covered	Not applicable	
Osteopath	Not covered	Not applicable	
Chiropodist	Not covered	Not applicable	
Podiatrist	Not covered	Not applicable	
Audiologist	Not covered	Not applicable	
Speech Therapist	Not covered	Not applicable	
Occupational Therapist	Not covered	Not applicable	
Physiotherapist/Athletic Therapist/ Rehabilitation Technician (combined)	Not covered	Not applicable	
Massage Therapist	Not covered	Not applicable	
Kinesitherapist	Not covered	Not applicable	
Orthotherapist	Not covered	Not applicable	
X-rays (Chiropractor)	Not covered	Not applicable	

Summary of Benefits

Extended Health Care

Option 1 (cont'd)

	Reimbursement Level	Benefit Maximum
Medical Services and Supplies		
Durable Medical Equipment	Not covered	Not applicable
Therapeutic devices	Not covered	Not applicable
Mobility Aids and Orthopedic Appliances	Not covered	Not applicable
Prostheses	Not covered	Not applicable
Diabetic Equipment	Not covered	Not applicable
Hearing Aids	Not covered	Not applicable
Custom Orthopedic Shoes	Not covered	Not applicable
Custom Made Foot Orthotics	Not covered	Not applicable
Diagnostic Tests	Not covered	Not applicable
Other Medical Services and Supplies	Not covered	Not applicable
Accidental Dental	Not covered	Not applicable
Vision Care		
Eye Examination	Not covered	Not applicable
Eyeglasses (Lenses and Frames)/Contact Lenses/ Eyeglasses (Lenses and Frames) or Contact Lenses related to cataract surgery/Laser Eye Surgery (combined)	Not covered	Not applicable
Intraocular lenses used in cataract surgery	Not covered	Not applicable
Termination	Not applicable	

Referral Outside of Canada or Outside of province of residence*	Not covered	Not applicable
Termination	Not applicable	

Summary of Benefits

Extended Health Care

Option 2

Deductible	
Hospitalization	None
Vision Care	None
All Other Extended Health Care	None

	Reimbursement Level	Benefit Maximum	Accommodation
Hospitalization			
Hospital	100%		Semi-private
Convalescent Care/Physical Rehabilitation (combined)	100%	$50/day to a maximum of 120 days/Contract Year	
Medical Services and Supplies			
Ambulance Transportation	Not covered		
Nursing Care	Not covered	Not applicable	
Health Practitioners:	Not covered	**Maximum per Contract Year**	
Psychologist	Not covered	Not applicable	
Social worker	Not covered	Not applicable	
Chiropractor	Not covered	Not applicable	
Naturopath	Not covered	Not applicable	
Acupuncturist	Not covered	Not applicable	
Dietitian	Not covered	Not applicable	
Osteopath	Not covered	Not applicable	
Chiropodist	Not covered	Not applicable	
Podiatrist	Not covered	Not applicable	
Audiologist	Not covered	Not applicable	
Speech Therapist	Not covered	Not applicable	
Occupational Therapist	Not covered	Not applicable	
Physiotherapist/Athletic Therapist/ Rehabilitation Technician (combined)	Not covered	Not applicable	
Massage Therapist	Not covered	Not applicable	
Kinesitherapist	Not covered	Not applicable	
Orthotherapist	Not covered	Not applicable	
X-rays (Chiropractor)	Not covered	Not applicable	

Summary of Benefits

Extended Health Care

Option 2 (cont'd)

	Reimbursement Level	Benefit Maximum
Medical Services and Supplies		
Durable Medical Equipment	Not covered	Not applicable
Therapeutic devices	Not covered	Not applicable
Mobility Aids and Orthopedic Appliances	Not covered	Not applicable
Prostheses	Not covered	Not applicable
Diabetic Equipment	Not covered	Not applicable
Hearing Aids	Not covered	Not applicable
Custom Orthopedic Shoes	Not covered	Not applicable
Custom Made Foot Orthotics	Not covered	Not applicable
Diagnostic Tests	Not covered	Not applicable
Other Medical Services and Supplies	Not covered	Not applicable
Accidental Dental	Not covered	Not applicable
Vision Care		
Eye Examination	Not covered	Not applicable
Eyeglasses (Lenses and Frames)/Contact Lenses/ Eyeglasses (Lenses and Frames) or Contact Lenses related to cataract surgery/Laser Eye Surgery (combined)	Not covered	Not applicable
Intraocular lenses used in cataract surgery	Not covered	Not applicable
Termination	When the Member retires	

Referral Outside of Canada or Outside of province of residence*	Not covered	Not applicable
Termination	Not applicable	

*Pre-authorization required.

Summary of Benefits

Extended Health Care

Option 3

Deductible	
Hospitalization	None
Vision Care	None
All Other Extended Health Care	None

	Reimbursement Level	Benefit Maximum	Accommodation
Hospitalization			
Hospital	100%		Semi-private
Convalescent Care/Physical Rehabilitation (combined)	100%	$50/day to a maximum of 120 days/Contract Year	
Medical Services and Supplies			
Ambulance Transportation	100%		
Nursing Care	75%	$10,000/Contract Year	
Health Practitioners:		**Maximum per Contract Year**	
Psychologist	75%	$500	
Social worker	75%	$500*	
Chiropractor	75%	$500*	
Naturopath	75%	$500*	
Acupuncturist	75%	$500*	
Dietitian	75%	$500*	
Osteopath	75%	$500*	
Chiropodist	75%	$500*	
Podiatrist	75%	$500*	
Audiologist	75%	$500*	
Speech Therapist	75%	$500*	
Occupational Therapist	75%	$500*	
Physiotherapist/Athletic Therapist/ Rehabilitation Technician (combined)	75%	$500*	
Massage Therapist	75%	$500*	
Kinesitherapist	75%	$500*	
Orthotherapist	75%	$500*	
X-rays (Chiropractor)	75%	$500*	

*Total combined maximum of $500 per Contract Year for: **Health Practitioners** (excluding Psychologist), **Eye Examination**, and the set of **Eyeglasses (Lenses and Frames)/Contact Lenses/ Eyeglasses (Lenses and Frames) or Contact Lenses following a cataract surgery/Laser Eye Surgery**

Summary of Benefits

Extended Health Care

Option 3 (cont'd)

	Reimbursement Level	Benefit Maximum
Medical Services and Supplies		
Durable Medical Equipment*	75%	1/month for rental, 1/5 Contract Years for approved purchase
Therapeutic devices*	75%	1/month for rental, 1/5 Contract Years for approved purchase
Mobility Aids and Orthopedic Appliances	75%	See benefit details
Prostheses	75%	See benefit details
Diabetic Equipment	75%	See benefit details
Hearing Aids	75%	$700/3 Contract Years
Custom Orthopedic Shoes	75%	1 pair/Contract Year
Custom Made Foot Orthotics	75%	1 pair/Contract Year
Diagnostic Tests	75%	$1,000/Contract Year
Other Medical Services and Supplies	75%	See benefit details
Accidental Dental	75%	Predetermination required
Vision Care		
Eye Examination**	75%	$150/12 consecutive months combined with Eyeglasses (Lenses/Frames)/Contact Lenses/ Eyeglasses (Lenses/Frames) or Contact Lenses related to cataract surgery/Laser Eye Surgery
Eyeglasses (Lenses/Frames)/Contact Lenses/ Eyeglasses (Lenses/Frames) or Contact Lenses related to cataract surgery/Laser Eye Surgery (combined)**	75%	$150/12 consecutive months (combined with Eye Examination)
Intraocular lenses used in cataract surgery	75%	Unlimited
Termination	When the Member retires	

Referral Outside of Canada or Outside of province of residence*	75%	$100,000/lifetime
Termination	When the Member retires	

*Pre-authorization required.

Total combined maximum of $500 per Contract Year for: **Health Practitioners (excluding Psychologist), **Eye Examination**, and the set of **Eyeglasses (Lenses and Frames)/Contact Lenses/ Eyeglasses (Lenses and Frames) or Contact Lenses following a cataract surgery/Laser Eye Surgery**

Summary of Benefits

Extended Health Care

Option 4

Deductible	
Hospitalization	None
Vision Care	None
All Other Extended Health Care	None

	Reimbursement Level	Benefit Maximum	Accommodation
Hospitalization			
Hospital	100%		Semi-private
Convalescent Care/Physical Rehabilitation (combined)	100%	$50/day to a maximum of 120 days/Contract Year	
Medical Services and Supplies			
Ambulance Transportation	100%		
Nursing Care	90%	$10,000/Contract Year	
Health Practitioners:		**Maximum per Contract Year**	
Psychologist	90%	$1,000	
Social worker	90%	$1,000*	
Chiropractor	90%	$1,000*	
Naturopath	90%	$1,000*	
Acupuncturist	90%	$1,000*	
Dietitian	90%	$1,000*	
Osteopath	90%	$1,000*	
Chiropodist	90%	$1,000*	
Podiatrist	90%	$1,000*	
Audiologist	90%	$1,000*	
Speech Therapist	90%	$1,000*	
Occupational Therapist	90%	$1,000*	
Physiotherapist/Athletic Therapist/ Rehabilitation Technician (combined)	90%	$1,000*	
Massage Therapist	90%	$1,000*	
Kinesitherapist	90%	$1,000*	
Orthotherapist	90%	$1,000*	
X-rays (Chiropractor)	90%	$1,000*	

*Total combined maximum of $1,000 per Contract Year for: **Health Practitioners** (excluding Psychologist), **Eye Examination**, and the set of **Eyeglasses (Lenses and Frames)/Contact Lenses/ Eyeglasses (Lenses and Frames) or Contact Lenses following a cataract surgery/Laser Eye Surgery**.

Summary of Benefits

Extended Health Care

Option 4 (cont'd)

	Reimbursement Level	Benefit Maximum
Medical Services and Supplies		
Durable Medical Equipment*	90%	1/month for rental, 1/5 Contract Years for approved purchase
Therapeutic devices*	90%	1/month for rental, 1/5 Contract Years for approved purchase
Mobility Aids and Orthopedic Appliances	90%	See benefit details
Prostheses	90%	See benefit details
Diabetic Equipment	90%	See benefit details
Hearing Aids	90%	$700/3 Contract Years
Custom Orthopedic Shoes	90%	1 pair/Contract Year
Custom Made Foot Orthotics	90%	1 pair/Contract Year
Diagnostic Tests	90%	$1,000/Contract Year
Other Medical Services and Supplies	90%	See benefit details
Accidental Dental	90%	Predetermination required
Vision Care		
Eye Examination**	90%	$300/12 consecutive months combined with Eyeglasses (Lenses/Frames)/Contact Lenses/ Eyeglasses (Lenses/Frames) or Contact Lenses related to cataract surgery/Laser Eye Surgery
Eyeglasses (Lenses/Frames)/Contact Lenses/ Eyeglasses (Lenses/Frames) or Contact Lenses related to cataract surgery/Laser Eye Surgery (combined)**	90%	$300/12 consecutive months (combined with Eye Examination)
Intraocular lenses used in cataract surgery	90%	Unlimited
Termination	When the Member retires	

Referral Outside of Canada or Outside of province of residence*	90%	$100,000/lifetime
Termination	When the Member retires	

*Pre-authorization required.

Total combined maximum of $1,000 per Contract Year for: **Health Practitioners (excluding Psychologist), **Eye Examination**, and the set of. **Eyeglasses (Lenses and Frames)/Contact Lenses/ Eyeglasses (Lenses and Frames) or Contact Lenses following a cataract surgery/Laser Eye Surgery**.

Summary of Benefits

Dental Benefit

Option 1

Deductible	N/A		
Fee Guide Schedule	N/A		
		Reimbursement Level	**Benefit Maximum**
Preventive Care		Not covered	N/A
Oral Exam and Diagnosis			N/A
Recall oral exams			N/A
Preventive Treatment			N/A
Polishing of teeth			N/A
Fluoride treatment			N/A
Scaling			N/A
Basic Care		Not covered	N/A
Endodontic Services			N/A
Periodontic Services			N/A
Root Planing/ Periodontic curettage (combined)			N/A
TMJ/Facial Pain			N/A
Major Restoration		Not covered	N/A
Restorative and Prosthodontic Services			N/A
Implants			N/A
Restorations over implants			N/A
Orthodontic Services		Not covered	N/A
Lowest Cost Alternative Benefit	N/A		
Termination	N/A		

Summary of Benefits

Dental Benefit

Option 2

Deductible	None		
Fee Guide Schedule	Current year/Province of Provider (Specialist and GP fee guide)		
		Reimbursement Level	**Benefit Maximum**
Preventive Care		60%	$700/Contract Year combined with Basic Care and Major Restoration
Oral Exam and Diagnosis			
Recall oral exams			1/9 consecutive months
Preventive Treatment			
Polishing of teeth			1/9 consecutive months
Fluoride treatment			1/9 consecutive months (Participants under age 16)
Scaling			1/9 consecutive months
Basic Care		60%	$700/Contract Year combined with Preventive Care and Major Restoration
Endodontic Services			Included
Periodontic Services			Included
Root Planing/ Periodontal Curettage			6 Units/Contract Year or 1 time/tooth/24 months
Major Restoration		50%	$700/Contract Year combined with Basic Care and Preventive Care
Restorative and Prosthodontic Services			See benefit details
Veneers			1/tooth/5 Contract Years
Implants			1/tooth/10 Contract Years
Restorations over implants			1/tooth/10 Contract Years
Orthodontic Services		Not covered	N/A
Lowest Cost Alternative Benefit	Inlays and crowns Restorations on posterior teeth (reduced to the cost of bonded amalgam) Bridgework		
Termination	When the Member retires		

Summary of Benefits

Dental Benefit

Option 3

Deductible	None		
Fee Guide Schedule	Current year/Province of Provider (Specialist and GP fee guide)		
		Reimbursement Level	**Benefit Maximum**
Preventive Care		75%	$1,000/Contract Year combined with Basic Care and Major Restoration
Oral Exam and Diagnosis			
Recall oral exams			1/9 consecutive months
Preventive Treatment			
Polishing of teeth			1/9 consecutive months
Fluoride treatment			1/9 consecutive months (Participants under age 16)
Scaling			1/9 consecutive months
Basic Care		75%	$1,000/Contract Year combined with Preventive Care and Major Restoration
Endodontic Services			Included
Periodontic Services			Included
Root Planing/ Periodontal Curettage			6 Units/ Contract Year or 1 time/tooth/24 months
Major Restoration		50%	$1,000/Contract Year combined with Preventive Care and Basic Care
Restorative and Prosthodontic Services			See benefit details
Veneers			1/tooth/5 Contract Years
Implants			1/tooth/10 Contract Years
Restorations over implants			1/tooth/10 Contract Years
Orthodontic Services		Not covered	N/A
Lowest Cost Alternative Benefit	Inlays and crowns Restorations on posterior teeth (reduced to the cost of bonded amalgam) Bridgework		
Termination	When the Member retires		

Summary of Benefits

Dental Benefit

Option 4

Deductible	None		
Fee Guide Schedule	Current year/Province of Provider (Specialist and GP fee guide)		
	Reimbursement Level		**Benefit Maximum**
Preventive Care	90%		$2,000/Contract Year combined with Basic Care and Major Restoration
Oral Exam and Diagnosis			
Recall oral exams			1/9 consecutive months
Preventive Treatment			
Polishing of teeth			1/9 consecutive months
Fluoride treatment			1/9 consecutive months (Participants under age 16)
Scaling			1/9 consecutive months
Basic Care	90%		$2,000/Contract Year combined with Preventive Care and Major Restoration
Endodontic Services			Included
Periodontic Services			Included
Root Planing/ Periodontal Curettage			6 Units/ Contract Year or 1 time/tooth/24 months
Major Restoration	60%		$2,000/Contract Year combined with Preventive Care and Basic Care
Restorative and Prosthodontic Services			See benefit details
Veneers			1/tooth/5 Contract Years
Implants			1/tooth/10 Contract Years
Restorations over implants			1/tooth/10 Contract Years
Orthodontic Services	50%		$2,000/lifetime (Participants under age 18)
Lowest Cost Alternative Benefit	Inlays and crowns Restorations on posterior teeth (reduced to the cost of bonded amalgam) Bridgework		
Termination	When the Member retires		

Summary of Benefits

Travel Benefit

Option 1 (Member Only)

Deductible	None
Reimbursement Level	100%
Coverage Duration	First 180 days of Trip outside province of residence
Stability Requirement	Participant must be Stable in the 90 days before the departure date
	Benefit Maximum
Emergency Hospital and Medical Travel Coverage	$5,000,000/Lifetime
Worldwide Travel Assistance	Yes
Termination	When the Member reaches age 80 or retires

Summary of Benefits

Travel Benefit

Option 2

Deductible	None
Reimbursement Level	100%
Coverage Duration	First 180 days of Trip outside province of residence
Stability Requirement	Participant must be Stable in the 90 days before the departure date
	Benefit Maximum
Emergency Hospital and Medical Travel Coverage	$5,000,000/Lifetime
Worldwide Travel Assistance	Yes
Termination	When the Member reaches age 80 or retires

Summary of Benefits

Travel Benefit

Option 3

Deductible	None
Reimbursement Level	100%
Coverage Duration	First 180 days of Trip outside province of residence
Stability Requirement	Participant must be Stable in the 90 days before the departure date
	Benefit Maximum
Emergency Hospital and Medical Travel Coverage	$5,000,000/Lifetime
Worldwide Travel Assistance	Yes
Termination	When the Member reaches age 80 or retires

Summary of Benefits

Travel Benefit

Option 4

Deductible	None
Reimbursement Level	100%
Coverage Duration	First 180 days of Trip outside province of residence
Stability Requirement	Participant must be Stable in the 90 days before the departure date
	Benefit Maximum
Emergency Hospital and Medical Travel Coverage	$5,000,000/Lifetime
Worldwide Travel Assistance	Yes
Termination	When the Member reaches age 80 or retires

Summary of Benefits

Health Spending Account Benefit

Deductible	None
Plan Administration	Reimbursement Upon Request (credits will be used to pay an HSA claim as directed by the Member on the claim form)
Credit Allocation frequency	On the first day of each Contract Year, the remaining Flex Dollars* are deposited to the Member Account
Benefit Details	
HSA Year	April 1 to March 31
Account Type	Credit Carry Forward
Grace Period for Active Members	90 days
Grace Period for Terminated Members	90 days
Termination	When the Member reaches age 70 or retires

* When a Member coverage takes effect after the beginning of the HSA year, the credits will be adjusted based on the number of months left before the end of the HSA year.

You and Your Dependents

Throughout this booklet we use several key terms when we refer to you and your Dependents:

- the terms that may refer to you are: Employee, Member and Participant;
- the terms that may refer to your Dependents are: Dependent, Spouse, Child and Participant.

Employee: A person who:

- resides in Canada; and
- works a minimum of 22 hours 30 per week for the employer.

Employees hired on a temporary or contractual basis are not eligible unless specified otherwise in the Summary of Benefits. For employees working outside of Canada on a regular basis, Blue Cross must be notified of any new destination in regions or countries that are not recommended by the Canadian government in order to maintain coverage.

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

Dependent: Your Spouse or Child.

Child: A person who:

- is a resident of Canada;
- is the natural or adopted child of the Member or Spouse, or the child over whom the Member or Spouse has been appointed as guardian with parental authority;
- is financially reliant on the Member or Spouse for care, maintenance and support;
- is not married or in a common law relationship; and
- meets one of the following criteria:
  a) is under age 21;
  b) is under age 26 and is attending an accredited educational institution, college or university on a full-time basis; or
  c) became mentally or physically disabled while a child as defined in (a) or (b) and has been continuously disabled since that time.

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

Change in Family Situation: one of the following major events:

- Marriage, beginning of a civil union;
- New common law partner;
- Birth or adoption of a first child;
- Separation, divorce or dissolution of a common law;
- Death of Spouse or Child;
- Last Dependent Child is no longer qualifies as a dependent.

Helpful Tip

You are responsible for enrolling your Dependents under the plan when they become eligible.

In addition, you are responsible for removing them when they no longer meet the definitions outlined here.

You can update your family or Dependent status directly online in your account at: **https://app.connect.medavie.bluecross.ca/Englobe**

Spouse: The person who:

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

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

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

Helpful Tip

A Member, Spouse and Child are all Participants under the policy.

Other Important Terms

Accident: A sudden, fortuitous and unforeseeable event that:

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

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

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

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

Helpful Tip

One of the eligibility requirements for coverage is that you be Actively at Work.

Activities of Daily Living: The following 5 activities:

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

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

Contract Year: The period of time beginning on the first day of April in a given year and ending on the last day of **March** the following year.

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

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

Key Terms

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

- Medically Necessary;
- usual, customary and reasonable, meaning that:
  - the amount charged is consistent with the amount typically charged by Health Practitioners or Approved Providers for similar services or supplies in the province in which the services or supplies are being purchased; and
  - the frequency and quantity in which services or supplies are purchased by the Participant are, in the opinion of Blue Cross in consultation with its health care consultants, consistent with the frequency and quantity that would usually be prescribed or needed for the Participant's condition;
- recommended or prescribed by a Physician or Health Practitioner who:
  - does not normally reside in the Participant's home;
  - is not the Participant's Family Member; and
  - is not the Participant's employer or co-worker;
- rendered or dispensed by an Approved Provider who:
  - does not normally reside in the Participant's home; and
  - is not the Participant's Family Member; and
- rendered or dispensed after the effective date and while the policy is in effect, unless otherwise specified.

Helpful Tip

Important: Blue Cross will only reimburse health expenses meeting these Eligible Expenses criteria.

Helpful Tip

Family member refers to a Participant's:

- Spouse;
- father or mother, or their spouse or common-law partner;
- children, or the children of the Participant's spouse or common-law partner;
- brothers and sisters;
- grandchildren; or
- grandparents.

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

An Eligible Expense is considered to be incurred on the date the service or supply was received by the Participant. Reimbursement for Eligible Expenses incurred outside of Canada will be limited to the amount that would have been reimbursed if the expense had been incurred in the Participant's province of residence, unless the benefit is restricted to in Canada only.

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

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

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

Helpful Tip

Blue Cross will only pay for Eligible Expenses that are Medically Necessary.

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

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

Re-enrolment Period: a period of limited duration which is held between February and March every two years, as of April 1, 2020.

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

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

Helpful Tip

If specified in the Summary of Benefits, your Salary may be used in calculating your life, accidental death and dismemberment and/or disability benefits. (if applicable)

Salary: A Member's regular earnings paid by the Employer, including overtime and any additional remuneration or incentives that are received by the Member on a regular basis. It does not include dividends or any irregular gains, such as bonuses and gratuities.

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

For Members assigned in a remote location where the normal work schedule is greater than 40 hours per week, the Salary is the Member's average earnings over the last year (12 months of employment) as indicated on their Canada Revenue Agency (CRA) taxation form. If the Member has not completed a year (12 months) of continued service, the Salary will be prorated.

In determining benefits, Salary will be the lesser of:

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

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

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

Who is Eligible for Coverage?

Category Seasonal Employees

You are eligible for coverage if you:

- meet the definition of Employee and are Actively at Work; and
- have worked 6 months during the **last 12 months.**

Category Regular Employees

You are eligible for coverage if you meet the definition of Employee and are Actively at Work.

All Categories of Employees

Your Dependents are also eligible for coverage if they meet the definition of Spouse or Child outlined above in the *Key Terms*.

To be eligible for coverage, you and your Dependents must be entitled to government health care coverage.

You must continue to work the minimum number of hours per week to maintain eligibility under the policy.

Do I Need to Supply Proof of Health to Obtain Coverage?

You generally do not need to provide proof of health to obtain group benefits coverage. However, proof of health must be submitted in the following circumstances:

- if the coverage for yourself or your Dependents exceeds the non-evidence limit specified in the Summary of Benefits;
- for all applications for the optional life benefit (if applicable); or
- if your application is received by Blue Cross more than 31 days after the date upon which you or your Dependent became eligible for coverage, with the following exceptions:
  - late applicants for dental benefits (if applicable); and
  - Quebec Participants who are late in applying for drug benefits do not need to submit proof of health for drug coverage.

Helpful Tip

Proof of health refers to statements or medical evidence about your health or the health of your Dependents.

Non-evidence limit refers to the amount of coverage for which you or your Dependents are eligible, without having to submit satisfactory proof of health.

The non-evidence limits for each benefit (if any) are specified in the Summary of Benefits.

How do I Enrol for Coverage?

Application Form

Once you receive an email from Blue Cross confirming your access to the online enrolment system, you can enrol for coverage. To obtain coverage, you must complete and submit online the application form and submit proof of health, if required for one of the reasons listed above.

The completed application form must be received by Blue Cross within 31 days of the date you or your Dependent become eligible for coverage.

Helpful Tip

If you do not enrol for coverage within 31 days of eligibility, you may be restricted when applying for benefits and your benefit levels may be reduced.

Can I Opt Out of Coverage for Certain Benefits?

You are not allowed to individually select the benefits you want under the policy. In addition, when you enrol for coverage you must also enrol all of your eligible Dependents, subject to the exceptions noted below:

- it is your choice whether or not to obtain coverage for optional benefits; and

- you are allowed to waive the health benefits coverage for yourself or your Dependents if you or your Dependents already have similar coverage under another group policy. In this case, you or your Dependents will again be eligible for health benefits if there is a change in your family status or if you or your Dependents' other coverage terminates for reasons outside of your control.

Helpful Tip

Health benefits may include: drug benefits, extended health care, dental benefits and/or travel benefits.

When Does My Coverage Begin?

Employees

Your coverage takes effect on the latest of the following dates:

- the effective date of the policy;
- the date you meet all of the eligibility requirements; or
- the date Blue Cross approves your proof of health, if required.

If you are not Actively at Work on the date you would have become eligible for coverage, your coverage begins on the date you resume being Actively at Work.

Dependents

Your Dependent's coverage takes effect on the latest of the following dates:

- the date you become eligible for coverage;
- the date they meet all of the eligibility requirements;
- the date Blue Cross approves their proof of health, if required; or
- the date following their discharge from hospital if they were hospitalized on the date they would have become eligible for coverage, unless:
  - they were covered under a Previous Policy, in which case their coverage begins on the effective date of the policy; or
  - they were born while this coverage is in force, in which case their coverage will be effective from their live birth, or for dependent life coverage, as specified in the dependent life Summary of Benefits (if applicable).

Helpful Tip

Previous Policy refers to a group insurance policy that provided coverage for you and your Dependents, and terminated within 31 days of the effective date of this group policy.

What Happens to my Coverage During Periods of Absence from Work?

Illness/Accident

If you are absent from work due to illness or accident, your group benefits coverage is retained. In such circumstances, please contact your group benefits administrator to discuss the maximum period your coverage will be retained.

Maternity Leave/Parental Leave

During a maternity or parental leave of absence, you have the choice to either retain or discontinue all coverage for the maximum period provided under the applicable legislation.

Your decision to retain or discontinue coverage must be made before the beginning of your leave of absence and this decision cannot be changed at a later date. If you decide to retain coverage, you must continue to pay your premium contributions (if any) for the whole duration of the absence.

If you are a Quebec Participant, you must at least retain drug coverage unless you benefit from drug coverage under another group plan.

Temporary Layoff/Authorized Leave of Absence/Disciplinary Suspension/Strike or Lockout

In such circumstances, please contact your group benefits administrator to discuss the benefits you must retain during such an absence and the maximum period these benefits will be retained.

How Can I Modify My Coverage?

Options changes during the Re-enrolment Period

You can modify your coverage during the Re-enrolment Period as defined in the **Definitions** section.

The requested changes then come into effect on April 1 of every second year following the Re-enrolment Period. However, insurance amounts for Optional Life Benefit and Long Term Disability Benefit are not increased unless the proof of health provided by the Member is approved.

For the Drug Benefit, Extended Health Care Benefit, Dental Care Benefit and Travel Benefit, the Member may increase his options as follows:

- Option 1 to Option 2;
- Option 2 to Option 3;
- Option 3 to Option 4.

Furthermore, the following are the only reductions possible:

- Option 4 to Option 3;
- Option 3 to Option 2;
- Option 2 to Option 1.

If you are not Actively at Work, because you are totally disabled, you remain insured under the same coverage that was in effect prior to the beginning of your disability, until the date you return Actively at work.

Upon your return to work, any request to modify his coverage must be submitted within 31 days of the date of the return to work. The modification will be in effect on the date you return Actively at work and your choice of coverage will be in effect up until the following March 31. If you have not made your choice during this period, the coverage you were under prior to your return to work will continue.

Option changes outside the Re-enrolment Period

You may choose to modify options upon a Change in Family Situation, provided that the modification request is submitted within 31 days following the Change in Family Situation. Modifications will take effect retroactively to the date of the Change in Family Situation. However, amounts for Optional Life and Long Term Disability will not be increased unless the proof of health provided by the Member is approved.

Your coverage will remain as is for modifications submitted after thirty-one (31) days following a Change in Family Situation.

If, at the time of a Change in Family Situation, you were not Actively at Work because you were totally disabled, you can modify:

- your choice of plan or your coverage status for Drug Benefit, Extended Health Care Benefit, Dental Care Benefit and Travel Benefit within 31 days following the Change in Family Situation;
- your other benefits within 31 days following your return actively at work.

When Does My Coverage End?

Coverage ends on the earliest of the date:

- the policy terminates;
- you or your Dependents no longer meet one or more of the eligibility requirements;
- your employment is terminated;
- you (or your Spouse in the case of optional life benefits, if applicable) reaches the termination age or termination date, if any, specified in the Summary of Benefits;
- you retire from the employer, unless otherwise specified in the Summary of Benefits;
- you die;
- you or your Dependents commit a fraudulent act against Blue Cross; or
- the policyholder defaults in payment of premiums.

Coverage for your Dependents will also terminate on the date your coverage terminates.

What Happens When Coverage Ends?

Right to Convert to Individual Coverage

Upon termination of coverage for certain benefits, you and your Dependents have the right to convert your group benefits coverage to an individual insurance policy, provided certain criteria are met.

The benefit details will specify if this conversion right applies to a particular benefit.

When conversion is available, the following terms and conditions apply:

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

Helpful Tip

The benefit of converting your group coverage is that you do so without having to provide proof of health.

Conversion premium rates will typically be higher than group premium rates currently paid.

Instead of converting your group coverage, you may prefer to apply for an individual plan, which will require Proof of Health.

What if I Have Coverage Elsewhere?

With the exception of the travel benefits provided under the travel benefit section of this booklet, Blue Cross will co-ordinate your group benefits coverage with other health plans when similar coverage is available. Co-ordination of benefits helps ensure you get the most out of your coverage, and also means you can receive up to, but no more than, 100% reimbursement for Eligible Expenses.

Government Health Care Coverage

Blue Cross will not pay for any health care services or supplies available under government health care coverage, or administered by government funded hospitals, agencies or providers. Blue Cross will only consider Eligible Expenses in excess of those provided under government health care coverage.

Helpful Tip

Blue Cross will help direct you to existing **government programs** whenever possible.

Other Health Plans

Do you take advantage of coverage under the other benefit plans available to you, such as your Spouse's? If not, you may be missing out on possible reimbursement of up to 100% of Eligible Expenses through a process called co-ordination of benefits.

Blue Cross applies co-ordination of benefits according to the guidelines of the Canadian Life and Health Insurance Association Inc. (CLHIA). Here are general rules:

Expenses for Yourself:

- You must first submit expenses incurred to this plan (where you are covered as a Member). The balance that has not been paid by this plan (if any) can then be submitted to the other plan where you are covered as a dependent (for example your Spouse's plan).
- If you are covered as a member under more than one group benefit plan, the plan that has covered you the longest pays first.

Helpful Tip

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

Expenses for Your Spouse:

- Your Spouse must submit any expenses incurred for themselves to their own group benefit plan (if any) first. The balance that has not paid by their plan (if any) can then be submitted to this plan.

Expenses for Your Child:

- If a Child is covered as a dependent by both you and your Spouse, you should submit their claim to the plan of the parent whose birthday comes first in the year.
- In the event of divorce or separation, the plan of the parent with whom the Child resides (the plan of the parent with custody of the Child) pays first.

Helpful Tip

For more information on Co-ordination of benefits (including examples), visit our website.

Purpose of Coverage

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

Advance Payment Due to Terminal Illness

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

- the Member submits a request to Blue Cross in writing;
- Blue Cross is satisfied, on the basis of medical evidence provided by the Member's attending physician, that the Member is suffering from a condition that is expected to result in the Member's death within 12 months of the date of the request; and
- the Member is less than age 65.

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

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

Payment of Claims

Beneficiary

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

Time Limit to Submit a Claim

Blue Cross must receive proof of claim as soon as is reasonably possible and in no event later than 12 months following the date of death.

Exclusions and Limitations

1. No payment of life insurance will be made following the death of a Member that results directly or indirectly of a war (declared or not), a civil war or an act of war or of terrorism or an epidemic, if the event occurs in a region or country for which the Government of Canada recommends its citizens avoid travel, whether essential or not. This exclusion does not apply in the following situations:
   a) In the case of Participants who are already in the region or country in question when the government recommendation was issued, provided that these persons take the necessary measures to comply to the government recommendation as soon as possible;
   b) In the case where the Government of Canada recommends its citizens avoid non-essential travel in the region or country in question and that the Member's death occurs while at work, at his residence in the country where his work is located, or in the travel area accessing or coming from his work.
2. No coverage will be provided to a Participant while performing duties as an active member in the armed forces of any country, unless coverage must be retained under the applicable provincial legislation.

Right to Convert to Individual Coverage

Eligibility for Conversion

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

This conversion option also applies to any scheduled reduction or termination of coverage that becomes effective at specified ages, without exceeding age 65.

Terms and Conditions of the Converted Policy

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

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

- during the 31-day period that the conversion option may be exercised, the amount of coverage available through this conversion option is continued without charge;
- the effective date of coverage under the individual life policy will be 31 days after the group coverage terminates;
- the individual life policy will not include any disability or other supplementary benefits;
- the individual life policy will be a 1-year term life policy that may be exchanged, before its expiry date, for 1 of the following 2 life policy options:
  - a non-convertible term life policy that provides level term coverage to age 65; or
  - a term to age 100 life policy that provides lifetime coverage with no non-forfeiture options;
- the maximum amount of coverage available under the individual life policy is the lesser of:
  - the amount of member life benefit coverage in effect on the termination date;
  - the amount of any scheduled reduction of the member life benefit coverage;
  - the amount of the reduction in coverage caused by any replacement policy that is issued to the Member within 31 days of the date of the termination;
  - $400,000 for residents of Quebec or $200,000 for residents outside of Quebec; and
- the coverage provided by the individual life policy cannot be less than:
  - the minimum amount that Blue Cross will normally issue for the type of policy selected; or
  - $10,000 for residents of Quebec.

Purpose of Coverage

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

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

Eligibility for Coverage

To be eligible for this benefit, the Member and Dependent must submit proof of health deemed satisfactory by Blue Cross.

Amount of Coverage

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

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

Payment of Claims

Beneficiary

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

Time Limit to Submit a Claim

Blue Cross must receive proof of claim as soon as is reasonably possible and in no event later than 12 months following the date of death.

Exclusions and Limitations

1) If the Member's or Dependent's death is a result of suicide, whatever the state of mind, and while an amount of optional life benefit has been in effect for less than 24 consecutive months, the payment for this amount of optional life benefit will be limited to the return of premiums.
2. No payment of life insurance will be made following the death of a Member that results directly or indirectly of a war (declared or not), a civil war or an act of war or of terrorism or an epidemic, if the event occurs in a region or country for which the Government of Canada recommends its citizens avoid travel, whether essential or not. This exclusion does not apply in the following situations:
    a) In the case of Participants who are already in the region or country in question when the government recommendation was issued, provided that these persons take the necessary measures to comply to the government recommendation as soon as possible;
    b) In the case where the Government of Canada recommends its citizens avoid non-essential travel in the region or country in question and that the Member's death occurs while at work, at his residence in the country where his work is located, or in the travel area accessing or coming from his work.
3. No coverage will be provided to a Participant while performing duties as an active member in the armed forces of any country, unless coverage must be retained under the applicable provincial legislation.

Right to Convert to Individual Coverage

Eligibility for Conversion

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

A Spouse residing in any province and a Child who is a resident of Quebec also have the right to purchase an individual life policy from Blue Cross if their optional life benefit coverage terminates for one of the following reasons:

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

Terms and Conditions of the Converted Policy

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

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

- during the 31 day period that the conversion option may be exercised, the amount of coverage available through this conversion option is continued without charge;
- the effective date of coverage under the individual life policy will be 31 days after the group coverage terminates;
- the individual life policy will not include any disability or other supplementary benefits;
- the individual life policy will be a 1-year term life policy that may be exchanged, prior to its expiry date, for 1 of the following 2 life policy options:
  - a non-convertible term life policy that provides level term coverage to age 65; or
  - a term to age 100 life policy that provides lifetime coverage with no non-forfeiture options;
- the maximum amount of coverage provided by the Member’s individual life policy is the lesser of:
  - the amount of member life benefit coverage plus optional life coverage in effect on the date of termination of the optional life benefit; and
  - $400,000 for residents of Quebec or $200,000 for residents outside of Quebec;
- the amount of coverage provided by the Member’s individual life policy cannot be less than the minimum amount that Blue Cross will normally issue for the type of policy selected, or $10,000 for residents of Quebec; and
- the amount of coverage provided by the Dependent’s individual life policy cannot be more than the amount of the Dependent’s optional life benefit, and for residents of Quebec, less than $5,000.

Purpose of Coverage

If a Member becomes Totally Disabled following an illness or accident, Blue Cross will pay the weekly amount specified in the Summary of Benefits, subject to the conditions outlined below.

Additional Definitions

The following definitions apply to this benefit, in addition to those found under the *Key Terms* provision of this booklet.

Benefit Period: The maximum number of weeks Blue Cross will pay benefits, as specified in the Summary of Benefits.

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

If the benefit is registered with the Canada Employment Insurance Commission (CEIC), the Elimination Period will not exceed 14 calendar days.

Hospitalization: Admission to a hospital as an inpatient for a minimum period of 1 overnight stay. If so specified in the Summary of Benefits, hospitalization will include outpatient surgery performed in a hospital or at a private surgical clinic if this surgery is or would have been covered under government health care coverage.

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

Total Disability or Totally Disabled: The complete and continuous inability of a Member to perform the regular duties of their own job as a result of illness or accident. Regular duties refers to those work related activities that are essential to performing a particular job.

The Member must be under the continuous care and Treatment of a physician and must not be working, other than in a rehabilitation program pre-approved by Blue Cross.

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

Payment of Benefits

When Benefit Payments Begin

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

If the Elimination Period is calculated in:

- calendar days, the benefit for each day of Total Disability will be equal to 1/7 of the weekly benefit; or
- working days, the benefit for each working day of Total Disability will be equal to 1/5 of the weekly benefit.

The calculation basis of the Elimination Period is specified in the Summary of Benefits.

Calculation of the Benefit Amount

Blue Cross calculates the weekly benefit amount in accordance with the following 2-step process:

Step 1. Blue Cross applies the benefit formula specified in the Summary of Benefits to obtain a weekly benefit amount (up to the benefit maximum specified in the Summary of Benefits);

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

a) any provincial automobile insurance plan in which benefits payable under Employment Insurance are not taken into account;
b) the Quebec Pension Plan or the Canada Pension Plan;
c) any fringe-benefits plan offered by the employer as defined by the Income Tax Act.

With respect to the subtraction of income amounts in Step 2:

- income amounts received for children are not included;
- if it appears to Blue Cross that there are income amounts to which the Member is eligible, Blue Cross may reduce benefits by these amounts even if the Member fails to apply for or exercise their right to such amounts;
- Blue Cross may estimate income amounts pending their actual award; and
- Blue Cross will calculate each reduction without taking into account any subsequent increases to the income amounts by way of cost-of-living adjustments.

When Benefit Payments End

Benefit payments end on the earliest of the date:

- the Member is no longer Totally Disabled;
- the Member fails to:
  - provide Blue Cross with satisfactory proof of continued Total Disability;
  - submit to an independent examination requested by Blue Cross; or
  - participate in any reasonable Treatment or rehabilitation program considered appropriate by Blue Cross;
- the Member reaches the termination age specified in the Summary of Benefits;
- the Member retires from the Employer;
- the Benefit Period expires;
- the Member engages in any occupation or employment other than a rehabilitation program pre-approved by Blue Cross;
- the Member refuses to accept any reasonable offer of modified duties or alternative employment from the employer; or
- the Member dies.

Time Limit to Submit a Claim

Blue Cross must receive proof of claim within 90 days of the expiry of the Elimination Period. If this 90-day time limit is not met for reasons Blue Cross considers unacceptable, the Elimination Period will begin on the date Blue Cross receives all relevant documents needed to establish proof of disability.

Helpful Tip

Proof of claim consists of 3 forms: Declaration of the Employee, Declaration of the employer and Declaration of the physician. Forms are available on our website.

Recurrent Disabilities

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

- the same or related causes within the first 2 weeks of the Member returning to work according to their normal work schedule; or
- different and unrelated causes and the Member did not fully recover from the first disability and did not return to work for at least a full day before the start of the recurrent disability.

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

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

Total Disability During Periods of Absence

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

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

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

Rehabilitation Program

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

- medical care, Treatment, diagnostic measures or prescribed medications;
- full-time work or part-time work; or
- a vocational assessment, training or re-training program for the purpose of rehabilitation.

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

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

Exclusions and Limitations

1. Benefits are not payable for any Total Disability that results from any of the following causes:

   a) participation in a criminal act or an attempt to commit a criminal act;
   b) any accident or injury occurring while operating a motor vehicle under the influence of any intoxicant or with a blood alcohol level in excess of the legal limit in the jurisdiction in which the accident occurred;
   c) attempted suicide or voluntary injury or illness, whatever the state of mind of the Member;
   d) medical care or treatment that is performed for cosmetic purposes only, unless it is required as a result of an Illness or Accident; or
   e) insurrection, the hostile action of the armed forces of any country or participation in any riot or civil commotion.

2. Benefits are not payable for any Total Disability that results, directly or indirectly, of a war (declared or not), a civil war or an act of war or of terrorism or an epidemic, if the event occurs in a region or country for which the Government of Canada recommends its citizens avoid travel, whether essential or not.

   This exclusion does not apply in the following situations:

   a) In the case of Participants who are already in the region or country in question when the government recommendation was issued, provided that these persons take the necessary measures to comply to the government recommendation as soon as possible;
   b) In the case where the Government of Canada recommends its citizens avoid non-essential travel in the region or country in question and the Member becomes Totally Disabled while at work, at his residence in the country where his work is located, or in the travel area accessing or coming from his work.

3. Benefits are not payable during any periods in which the Member:
   a) receives compensation under a workers' compensation board/commission or any program of a similar nature;
   b) is eligible for benefits from the Canada Employment Insurance Commission (CEIC) if the Summary of Benefits specifies that this benefit is integrated with CEIC benefit and there is no Supplemental Unemployment Benefit (SUB) coverage;
   c) receives maternity or parental benefits under any provincial or federal law or takes maternity or parental leave in accordance with any provincial or federal law or any agreement between the Member and the employer, subject to the following exception:
      – benefits will be payable during the health-related portion of the maternity leave when required by applicable law or legislation, provided coverage has been retained for the Member. The health-related portion of the maternity leave will be considered to be the normal post-natal recovery period deemed reasonable and appropriate by Blue Cross;
   d) is absent from Canada for any reason, unless Blue Cross agrees in writing, in advance, to pay benefits during the period; or
   e) is imprisoned in a correctional facility, community residence or while under house arrest by order of a criminal court.

Purpose of Coverage

If the Member becomes Totally Disabled following an illness or accident, Blue Cross will pay up to the maximum amount specified in the Summary of Benefits, subject to the conditions outlined below.

Additional Definitions

The following definitions apply to this benefit, in addition to those found under the *Key Terms* provision of this booklet.

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

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

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

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

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

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

Total Disability or Totally Disabled: During the Elimination Period and for the Own Occupation Duration specified in the Summary of Benefits, a Member is Totally Disabled for the purposes of this benefit if the Member is completely and continuously unable to perform the regular duties of their own occupation as a result of illness or accident.

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

- would earn 60% or more of the Member's Pre-disability Salary; and
- is reasonably qualified or may so become by training, education or experience.

Regular duties refers to those work related activities that are essential to performing a particular occupation.

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

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

Helpful Tip

If you are performing **modified work duties** for at least 6 months before applying for long term disability benefits, these modified work duties constitute your own occupation for purposes of assessing Total Disability.

Payment of Benefits

When Benefit Payments Begin

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

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

Calculation of the Benefit Amount

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

> **Helpful Tip**
>
> The long term disability benefit you receive, when added to any other disability income to which you are entitled, cannot exceed the All Source Maximum listed in the Summary of Benefits.

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

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

a) the Quebec Pension Plan or the Canada Pension Plan;
b) any workers' compensation board/commission;
c) any automobile insurance bureau, if applicable;
d) the Canada Employment Insurance Commission (CEIC) ; or
e) any federal or provincial law or legislation;

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

Additional Sources of Income means:

a) any of the following income amounts payable to the Member, as a result of their current or subsequent disability, under one of the following plans:
   i. any fringe-benefits plan offered by the employer as defined by the Income Tax Act;
   ii. any plan under which the Member is covered as a member of an association; or
   iii. any fringe-benefits plan set up according to any provincial or federal law, including the disability payments from any of the plans specified in Step 2; and
   iv. any plan under which the Member is covered as a member of an association; and
b) any income amounts payable to the Member under any retirement or pension plan funded in whole or in part by the Employer. This includes the Quebec Pension Plan or Canada Pension Plan if the application for retirement benefits is made following the date of Total Disability.

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

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

Cost-of-Living Adjustment

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

When Benefit Payments End

Benefit payments end on the earliest of the date:

- the Member is no longer Totally Disabled;

- the Member fails to:
  - provide Blue Cross with satisfactory proof of continued Total Disability;
  - submit to an independent examination requested by Blue Cross; or
  - participate in any reasonable Treatment or rehabilitation program considered appropriate by Blue Cross;
- the Member reaches the termination age specified in the Summary of Benefits;
- the Benefit Period expires;
- the Member engages in any occupation, employment or volunteer work other than a rehabilitation program pre-approved by Blue Cross;
- the Member refuses to accept any reasonable offer of modified duties or alternative employment from the employer; or
- the Member dies.

Time Limit to Submit a Claim

Blue Cross must receive proof of claim within 90 days of the expiry of the Elimination Period.

If this 90-day time limit is not met for reasons Blue Cross considers unacceptable, the Elimination Period will begin on the date Blue Cross receives all relevant documents needed to establish proof of disability.

Helpful Tip

Proof of claim consists of 3 forms: Declaration of the Employee, Declaration of the employer and Declaration of the physician. Forms are available on our website.

Recurrent Disabilities

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

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

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

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

Total Disability During Periods of Absence

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

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

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

Rehabilitation Program

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

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

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

- the Member's Total Disability will not be considered to have ended simply because they undertook a rehabilitation program;
- if the Member becomes Totally Disabled again while participating in a rehabilitation program, the terms and conditions of this benefit will apply as if the Member had remained Totally Disabled for the full duration of the rehabilitation program;
- the Benefit Period continues despite participation in the rehabilitation program; and
- during the rehabilitation program, monthly benefits will be reduced by 50% of the remuneration received by the Member from such a program and will further be reduced as necessary to ensure that the Member's total income from all sources does not exceed 100% of the Member's Pre-Disability Salary.

Exclusions and Limitations

1. Benefits are not payable for any Total Disability that results, directly or indirectly, from any of the following causes:

   a) participation in a criminal act or an attempt to commit a criminal act, regardless of whether charges are laid or a conviction is obtained;
   b) any accident or injury occurring while operating a motor vehicle under the influence of any intoxicant or with a blood alcohol level in excess of the legal limit in the jurisdiction in which the accident occurred;
   c) attempted suicide or voluntary injury or illness, whatever the state of mind of the Member;
   d) medical care or treatment that is not Medically Necessary or that is performed for cosmetic purposes only; or
   e) insurrection, the hostile action of the armed forces of any country or participation in any riot or civil commotion.

2. Benefits are not payable for any Total Disability that results, directly or indirectly, of a war (declared or not), a civil war or an act of war or of terrorism or an epidemic, if the event occurs in a region or country for which the Government of Canada recommends its citizens avoid travel, whether essential or not.

   This exclusion does not apply in the following situations:

   a) In the case of Participants who are already in the region or country in question when the government recommendation was issued, provided that these persons take the necessary measures to comply to the government recommendation as soon as possible;
   b) In the case where the Government of Canada recommends its citizens avoid non-essential travel in the region or country in question and the Member becomes Totally Disabled while at work, at his residence in the country where his work is located, or in the travel area accessing or coming from his work.

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

   a) receives maternity or parental benefits under any provincial or federal law or takes maternity or parental leave in accordance with any provincial or federal law or any agreement between the Member and the employer, subject to the following exception:
      - benefits will be payable during the health-related portion of the maternity leave when required by applicable law or legislation, provided coverage has been continued for the Member. The health-related portion of the maternity leave will be considered to be the normal post-natal recovery period deemed reasonable and appropriate by Blue Cross;
   b) is absent from Canada for any reason, unless Blue Cross agrees in writing, in advance, to pay benefits during the period; or
   c) is imprisoned in a correctional facility or community residence or while under house arrest by order of a criminal court.

Purpose of Coverage

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

Additional Definitions

The following definitions apply to this benefit, in addition to those found under the *Key Terms* provision of this booklet.

Eligible Drug: A drug that is:

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

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

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

- are considered pharmaceutical equivalents by Health Canada;
- contain the same active ingredients; and
- are administered in the same way.

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

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

What Blue Cross Will Pay

Blue Cross will pay Eligible Expenses subject to the following terms and conditions:

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

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

- diabetic supplies, including test strips, lancets, needles, syringes, continuous glucose monitoring (CGM) sensors;
- viscosupplementation injections;
- preparations and compounds if their main ingredient is an Eligible Drug; and
- prescribed Eligible Drugs that appear on the following drug formulary:
  - **Open Formulary:** List of all Life-Sustaining Drugs and Eligible Drugs that require a prescription by law. This list is not subject to the Medication Advisory Panel decisions.

Special Authorization

Certain Eligible Drugs require prior or ongoing authorization by Blue Cross to qualify for reimbursement. The criteria to be met for Special Authorization are established by Blue Cross and may include requiring the Participant to participate in related patient support programming.

Helpful Tip

Your group benefits plan provides you with immediate access to most Eligible Drugs.

Certain Eligible Drugs require Special Authorization before your prescription is covered.

How does the Special Authorization process affect my claim?

The first time you present a prescription for an Eligible Drug on the Special Authorization list your pharmacist will indicate the need for Special Authorization.

You can request a Special Authorization Prescription Drug Form from your pharmacy, your employer, the nearest Blue Cross customer information centre or from our website. You must complete the patient section of the form, have your physician complete and sign the remaining portion and mail your completed form to the nearest Blue Cross office.

Your request will be confidentially reviewed by a health care professional according to the payment criteria established. When all the required information is received by Blue Cross, the standard turn-around time for Special Authorization decisions is 7 to 10 working days.

Helpful Tip

To print a copy of our Special Authorization Prescription Drug Form, visit our website.

You will receive confirmation in writing regarding the decision on your Special Authorization request. If your request is approved, this confirmation will include the effective date and duration of your approval.

Any fees associated with completing this form or obtaining additional medical information are your responsibility.

Substitution Provision

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

Helpful Tip

A generic drug and its brand name equivalent are considered to be Interchangeable Drugs. Health Canada imposes the same standards and tests on generic drugs as it does on brand name drugs. Generic drugs are effective and safe, while often being less expensive.

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

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

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

Payment of Claims

How Payments are Made

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

Reimbursement: The Participant will pay the full cost of the prescription to the Approved Provider at the time of purchase. Blue Cross will reimburse any Eligible Expenses on receipt of proof of payment from the Participant.

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

If the Participant submits to Blue Cross a paid-in-full prescription drug receipt, Blue Cross will only reimburse the amount that would have been paid to the Approved Provider if the claim had been submitted electronically.

Deferred Payment: At the time of purchase, the Approved Provider submits the Participant's claim to Blue Cross electronically to verify eligibility. The Participant pays the full amount charged by the Approved Provider and Blue Cross will reimburse the portion of the Participant's claim covered by this benefit when a specified dollar amount or a time-period threshold has been reached.

If the Participant submits to Blue Cross a paid-in-full prescription drug receipt, Blue Cross will reimburse only the amount that would have been reimbursed if the claim had been submitted electronically.

Time Limit to Submit a Claim

Blue Cross must receive proof of claim within 12 months of the date the Eligible Expense was incurred.

Helpful Tip

If you have a Pay Direct or Deferred Payment plan, always have your drugs submitted electronically via the Approved Provider. This will ensure you don't end up paying more out-of-pocket than you should.

Helpful Tip

If you pay up front and submit your claim for reimbursement, you may end up with surprise out-of-pocket expenses if your pharmacist charged you more than would have been permitted by the Blue Cross system.

Exclusions and Limitations

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

a) antihistamines;
b) smoking cessation aids;
c) vaccines;
d) vitamins;
e) weight loss treatments;
f) natural health products, homeopathic and naturopathic products, herbal medicines and traditional medicines, nutritional and dietary supplements;
g) fertility treatments;
h) erectile dysfunction treatments (except for the **Crandall** division);
i) hair growth stimulants;
j) services, treatment or supplies that:
    i. are not Medically Necessary;
    ii. are for cosmetic purposes only;
    iii. are elective in nature; or
    iv. have experimental or investigative indication;
k) procedures related to drugs injected by a Health Care Professional in a private clinic;
l) drugs that Blue Cross determines are intended to be administered in hospital, based on the way they are administered and the condition the drug is used to treat;
m) expenses that are covered under any government health care coverage or charges payable under a workers' compensation board/commission, any automobile insurance bureau or any other similar law or public plan;
n) services, treatment or supplies the Participant receives free of charge;
o) charges that would not have been incurred if no coverage existed; or
p) drugs that are eligible under the travel benefit provided by the group policy (if applicable).

Helpful Tip

Shop around for the best price for your prescription drugs.

For the same prescription, the price can vary depending on where you go, even among stores in the same chain.

Right to Convert to Individual Coverage

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

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

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

Minimum Requirements for Drug Coverage in Quebec

This provision applies to Quebec Participants.

Act Respecting Prescription Drug Insurance

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

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

Out-of-pocket Maximum per Calendar year

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

Participants Age 65 Years and Over

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

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

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

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

Exception: If the Summary of Benefits specifies this benefit is supplemental to the RAMQ public drug plan coverage, the following expenses are eligible, subject to the Deductible and the reimbursement level mentioned in the Summary of Benefits:

- the Deductible and coinsurance paid by the Quebec Participant under the RAMQ public drug plan; and
- reimbursement for any Eligible Drug that is not included in the RAMQ public drug plan but is covered under this benefit.

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

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

Purpose of Coverage

(If covered under the option chosen, as per the Summary of Benefits)

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

Helpful Tip

Blue Advantage® offers savings to Blue Cross members on medical, vision care and many other products and services from participating providers across Canada.

To receive savings, present your Blue Cross identification card and mention **Blue Advantage®** to any participating provider prior to processing your transaction.

A list of participating providers and discounts is available at **www.blueadvantage.ca**.

Additional Definitions

The following definitions apply to this benefit, in addition to those found under the *Key Terms* provision of this booklet.

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

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

Convalescent Care Facility: A public establishment that provides convalescent care to patients who are under the direct care of a physician at all times. The establishment must be licensed by the appropriate government body and must provide 24 hour nursing care services.

Convalescent Care Facilities do not include rest homes, nursing homes, retirement homes, residential and long term care centres, drug addiction or alcohol treatment centres or facilities intended for custodial care.

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

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

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

Physical Rehabilitation Facility: A public establishment that provides physical rehabilitation care to patients with physical impairments or disabilities who do not require Acute Care, but who need continued medical supervision directed toward the restoration of functional ability and quality of life. The establishment must be licensed by the appropriate government body.

Physical Rehabilitation Facilities do not include rest homes, nursing homes, retirement homes, residential and long term care centres, facilities intended for custodial care or drug addiction and alcohol treatment centres.

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What Blue Cross Will Pay

Blue Cross will pay Eligible Expenses subject to the following terms and conditions:

- payment is limited to the reimbursement level and benefit maximums specified below and/or in the Summary of Benefits;
- the Member must pay the Deductible, if any, specified in the Summary of Benefits; and
- payment is limited in accordance with the Limitations and Exclusions provision of this benefit.This benefit covers the expenses explicitly listed in the following categories, provided they also meet the definition of Eligible Expenses under the Key Terms provision of this booklet.

Hospitalization

Hospital: Room accommodation when a Participant is admitted to a Hospital as an inpatient for Acute Care. The type of room eligible for coverage is specified in the Summary of Benefits.

Convalescent Care/Physical Rehabilitation: Room accommodation when a Participant is admitted to a Convalescent Care Facility or a Physical Rehabilitation Facility within 14 days of their discharge from a Hospital where they received Acute Care.

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

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

Medical Services and Supplies

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

This coverage excludes inter-Hospital transfers.

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

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

Helpful Tip

Before receiving nursing services you should obtain pre-approval from Blue Cross by contacting the toll-free number on your Blue Cross identification card.

Charges for the services of a personal support worker in the Participant's home may also be eligible if the Participant is under the active care of a nurse or requires home care for recuperation after a discharge from Hospital. Personal support workers offer essential services related to the 5 Activities of Daily Living.

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

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

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

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

Helpful Tip

Ask your Health Practitioner if they are a Blue Cross Approved Provider before you obtain service or supplies to avoid unexpected out-of-pocket expenses.

This coverage excludes:

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

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

- manual or electric wheelchair, including cushions and inserts;
- industrial hospital bed, including mattress and safety side rails;
- equipment for the administration of oxygen, percussor, suction pump, bi-level positive air pressure (BiPAP), continuous positive airway pressure (CPAP), BiPAP and CPAP accessories and ventilator;
- insulin pump for the Treatment of type 1 diabetes;
- compression pump;
- apnea monitor;
- non union bone stimulator;
- mist tent;
- incontinence pads;
- incontinence briefs; and
- disposables (Attends, Depends)

Helpful Tip

You must obtain pre-approval from Blue Cross before purchasing durable medical equipment or prostheses. This will ensure you don't end up with significant and unexpected out-of-pocket expenses.

Therapeutic devices:

Expenses to rent the following therapeutic devices:

- MPC device;
- cardiac pacemaker;
- bi-osteogene system;
- renal dialysis machine;
- UVB; and
- other therapeutic devices.

The purchase of **durable medical equipment or therapeutic devices** requires pre-approval from Blue Cross, otherwise it may be ineligible for payment in whole or in part.

If there is a long-term need for **equipment or device** due to extended illness or disability, Blue Cross may, at its discretion, approve the purchase of these items. If such purchase is approved, the rental or approved purchase of a second piece of similar equipment or device is limited to once every 5 consecutive Contract Years.

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

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

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

Prostheses: Charges for the following prosthetic appliances:

- standard artificial limbs or myoelectric limbs to a maximum of 1 per limb per lifetime. A $10,000 maximum applies to myoelectric limbs;
- residual limb socks (stump socks);
- artificial eyes to a maximum of 1 per eye per lifetime;
- artificial nose to a maximum of 1 per lifetime;
- breast prosthesis when needed following a mastectomy to a maximum of 1 per breast per 2 Contract Years; and

- wigs when hair loss is due to an underlying pathology or its Treatment to a maximum of $300 per lifetime.

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

This coverage excludes:

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

Diabetic Equipment: Charges for glucometer or other equipment approved by Blue Cross that performs similar functions. The equipment must be used for the Treatment and control of diabetes.

Insulin pumps are eligible under the durable medical equipment benefit.

Hearing Aids: Charges for the purchase and repair of hearing aids when prescribed by an otorhinolaryngologist or otologist or recommended by an audiologist to a combined maximum for both ears.

Exception**:** for a Participant less than age 21 who requires a hearing aid for each ear, the benefit maximum specified in the Summary of Benefits is per ear.

This coverage excludes batteries and exams.

Custom Orthopedic Shoes and Foot Orthotics: Charges for:

- the purchase and repair of custom made orthopedic shoes or prefabricated orthopedic shoes with permanent modifications to accommodate, relieve or remedy a mechanical foot defect or abnormality provided that:
  - the shoes have been prescribed by an attending physician, orthopedic surgeon, physiatrist, rheumatologist or chiropodist/podiatrist;
  - the Participant provides a copy of a biomechanical or gait analysis from the prescribing Health Practitioner; and
  - the shoes are dispensed by an Approved Provider of orthopedic shoes;
- custom made foot orthotics to accommodate, relieve or remedy a mechanical foot defect or abnormality providing that:
  - they have been prescribed by an attending physician, an orthopedic surgeon, physiatrist, rheumatologist or chiropodist/podiatrist; and
  - they are dispensed by an Approved Provider of custom made foot orthotics.

Helpful Tip

For more information on which expenses qualify under your orthopedic shoes and orthotics coverage, visit our website. www.medaviebc.ca/benefitupdates.

This coverage excludes the purchase and repair of:

- pre-fabricated orthopedic shoes without permanent modifications; or
- extra-depth shoes.

Diagnostic Tests: Charges for the following diagnostic tests when provided by a laboratory approved by Blue Cross:

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

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

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

- allergy testing materials to a maximum of $50 per Contract Year;
- purchase of an artificial larynx to a maximum of 1 per lifetime;
- burn pressure garments;
- graduated compression garments (including stockings) to a maximum of 2 pairs per Contract Year;
- intrauterine contraceptive device (IUD) to a maximum of $75 per 2 Contract Years;
- ostomy supplies, catheters and catheterization supplies;
- oxygen;
- spacing devices to a maximum of 1 per Contract Year;
- insulin pump supplies;
- speech aid equipment for persons who do not have oral communication ability, when approved by a qualified speech therapist and authorized by the attending physician, to a maximum of $500 per lifetime;
- sleeves for lymphedema to a maximum of 2 per Contract Year;
- surgical brassieres to a maximum of 2 per Contract Year; and
- purchase and rental of a transcutaneous electrical nerve stimulator (TENS) device.

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

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

To be eligible for coverage, Treatment must be:

- required as a result of a direct accidental blow to the mouth or a fractured or dislocated jaw that requires setting;
- incurred while covered for accidental dental benefits with the Employer; and
- performed within 12 months (1 year) of the date of the accident or dislocation, unless the Participant has been approved by Blue Cross for deferred Treatment due to the Participant's age.

This coverage excludes accidental damage to teeth that occurs while eating.

Helpful Tip

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

Vision Care

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

Lenses, Frames, Contact Lenses and Laser Eye Surgery: Charges for the following products and services are eligible when prescribed by an ophthalmologist or optometrist:

- corrective eyeglasses (frames and lenses) and contact lenses;
- eyeglasses following a cataract surgery;
- contact lenses following a cataract surgery;
- laser eye surgery; and
- intraocular lenses used in cataract surgery.

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

Referral Outside Canada or Outside the Province of Residence

When an attending physician refers a Participant outside of Canada or outside the province of residence for medical services not available in Canada and in his province of residence, Blue Cross will cover the portion of expenses listed below which exceed those covered by the Participant's government health care coverage.

Hospital Services: Charges for:

- hospital room accommodation;

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

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

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

To be eligible for coverage under this category, all expenses must be pre-approved by Blue Cross and the Participant's government health care coverage must agree to cover a portion of the expenses.

Specific Exclusions and Limitations

Expenses associated with the following services, treatment or supplies are not eligible for reimbursement:

a) referral outside Canada for services available in Canada;
b) referral outside the province of residence for services available in the province of residence of the Participant;
c) health care services or treatments unavailable in Canada or in the province of residence of the Participant due to waiting lists;
d) health care services or treatments that physicians in Canada have refused to perform;
e) services, treatment or supplies that are experimental or investigative;
f) services provided while the Participant is not under the active Treatment of a physician; and
g) any expenses relating to any Pre-Existing Condition, as defined below.

Pre-Existing Condition: An illness:

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

Payment of Claims

How Payments are Made

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

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

How Eligible Expenses are Calculated

Reimbursement of an Eligible Expense is calculated as follows:

Step 1. Blue Cross will apply any applicable usual, customary and reasonable limits. The Eligible Expense will be equal to the lesser of the actual expense and the usual, customary and reasonable charges for the service or supply;
Step 2. Blue Cross will subtract the Deductible (if any);
Step 3. the Reimbursement Level percentage will be applied to the remainder of the Eligible Expense;

Step 4. the result is the amount payable by Blue Cross, subject to any Benefit Maximums applicable.

Time Limit to Submit a Claim

Blue Cross must receive proof of claim within 12 months of the date the Eligible Expense was incurred.

Exclusions and Limitations

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

a) services, treatment, articles or supplies that are not mentioned in the categories of Eligible Expenses listed in this benefit;
b) health care covered under any government health care coverage or charges payable under any occupational health and safety board, automobile insurance bureau or other similar law or public plan;
c) health care that was covered under any government health care coverage or charges payable under a workers' compensation board/commission, automobile insurance bureau or other similar law or public plan, when this benefit was issued but has since been modified, suspended or discontinued;
d) services, treatment or supplies that the Participant receives free of charge;
e) charges that would not have been incurred if no coverage existed;
f) services, treatment or supplies that are:
    i. not Medically Necessary;
    ii. for cosmetic purposes only;
    iii. elective in nature; or
    iv. experimental or investigative.
g) all services relating to family planning (except for intrauterine contraceptive devices (IUDs)), including artificial insemination, laboratory fees or other charges incurred in relation to infertility treatment, regardless of whether or not infertility is considered to be an illness;
h) charges that are eligible under the travel benefit provided by the group policy (if applicable);
i) services or supplies normally intended for recreation or sports;
j) extra supplies that are spares or alternates;
k) charges for missed appointments or the completion of forms;
l) medical examinations or routine general checkups;
m) mileage or delivery charges to or from a Hospital or Health Practitioner; or
n) services or expenses incurred as a result of:
    i. attempted suicide or voluntary injury or illness, whatever the state of mind of the Participant;
    ii. insurrection, war (declared or not), the hostile action of the armed forces of any country or participation in any riot or civil commotion; or
    iii. participation in a criminal act or attempt to commit a criminal act, regardless of whether charges are laid or conviction is obtained.

Right to Convert to Individual Coverage

A Participant who is no longer eligible for coverage under this benefit may convert their group coverage to a similar individual extended health care plan provided by Blue Cross. Individual policies issued under this conversion option are subject to the terms and conditions specified in the *Right to Convert to Individual Coverage* found under the *Coverage Details* of this booklet.

Purpose of Coverage

(If covered under the option chosen, as per the Summary of Benefits)

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

> **Helpful Tip**
>
> Blue Cross limits its payments to the amount listed in the fee guide specified in the Summary of Benefits.
>
> Before starting your Treatment, ask your dentist if they follow the provincial fee guide.

Additional Definition

The following definition applies to this benefit, in addition to those found under the *Key Terms* provision of this booklet.

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

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

- the fee guide in effect where Treatment is rendered; or
- the fee guide specified by this plan;

each incident of service is considered 1 Unit, regardless of its duration.

What Blue Cross Will Pay

Blue Cross will pay Eligible Expenses subject to the following terms and conditions:

> **Helpful Tip**
>
> You are responsible for paying any expenses in excess of the fee guide listed in the Summary of Benefits. This is important to consider, since it can directly impact your out-of-pocket expenses.

- payment of all Eligible Expenses is limited to the reimbursement level and benefit maximums specified below and/or in the Summary of Benefits;
- the Member must pay the Deductible, if any, specified in the Summary of Benefits;
- the amount of the Eligible Expense to which the reimbursement level applies is the lesser of:
  - the expense actually incurred by the Member; or
  - the fee amounts specified in the dental fee guide approved by Blue Cross (the applicable guide and annual edition are specified in the Summary of Benefits);
- the Eligible Expenses for laboratory fees are limited to 50% of the provider fee suggested in the fee guide;
- if one or more forms of alternative Treatment exist, payment is limited to the cost of the least expensive Treatment that will meet the Participant's basic dental needs. This limitation applies to the benefits specified as Lowest Cost Alternative Benefit in the Summary of Benefits;
- Eligible Expense must have been performed by:
  - a licensed dentist;
  - a licensed denturist when the services are within the scope of their profession; or
  - a licensed dental hygienist under the supervision of a licensed dentist or independently where permitted by provincial legislation; and
- payment is limited in accordance with the Limitations and Exclusions provision of this benefit.

This benefit covers the expenses explicitly listed in the following categories, provided they also meet the definition of Eligible Expenses under the *Key Terms* provision of this booklet.

Preventive Care

Helpful Tip

If a dental procedure is required as a result of an accident, it is considered as an extended health care expense rather than a dental benefit expense.

Oral Examinations and Diagnosis: Charges for:

- complete or general oral examination to a maximum of 1 per 24 consecutive months;
- complete periodontal examination to a maximum of 1 per 24 consecutive months;
- recall examination to the maximum specified in the Summary of Benefits;
- examination for children under the age of 10 not covered by the public plan to a maximum of 1 per 12 consecutive months;
- emergency oral examination; and
- limited or specific oral examination to a maximum of 2 per Contract Year.

X-rays: Charges for:

- complete series films to a maximum of 1 per 24 consecutive months;
- panoramic film to a maximum of 1 per 24 consecutive months;
- intra-oral :
  - periapical;
  - occlusal; and
  - bitewings to a maximum of 2 procedures per Contract Year;
- sialography;
- radiopaque dyes; and
- x-ray related to temporo-mandibular articulation/services related to myofascial pain.

Laboratory Tests and Examinations: Charges for:

- bacterial culture;
- biopsy of soft oral tissue;
- biopsy of hard oral tissue;
- cytological examination;
- diagnostic casts; and
- case presentation/plan with patient.

Preventive Treatment: Charges for:

Helpful Tip

Scaling refers to removal of plaque, calculus, and stains from teeth.

- polishing of teeth to the maximum specified in the Summary of Benefits;
- fluoride treatment (limited to Participants under the age of 16) to the maximum specified in the Summary of Benefits;
- oral hygiene instruction to a maximum of 1 Unit per lifetime;
- pit and fissure sealants (limited to Participants under the age of 18);
- scaling to the maximum specified in the Summary of Benefits; and
- mouthguard to a maximum of 1 per 12 consecutive months.

Space maintainers: Limited to Participants under age 18.

Correction of oral habits:

- fixed or removal appliances (limited to Participants under the age of 18);
- appliances to control oral habits;
- myofunctional evaluation (limited to Participants under the age of 18) to a maximum of 1 per 24 consecutive months;
- patient motivation (limited to Participants under the age of 18) to a maximum of 1 per lifetime; and
- myotherapy (limited to Participants under the age of 18) to a maximum of 1 per lifetime

Basic Care

Restorations: Charges for:

- amalgam, acrylic, silicate or composite restorations on anterior and posterior teeth;
- retentive pins;
- pulp capping;
- recementation of inlays/onlays or crowns to a maximum of 2 per tooth per contract year;
- recementation of veneers to a maximum of 2 per tooth per Contract Year; and
- removal of inlays/onlays or crowns.

> **Helpful Tip**
> **Restorations** (fillings) refer to dental material used to restore the function and integrity of a tooth.

Endodontic Services: Charges for:

- pulpotomy;
- pulpectomy;
- root canal therapy;
- endodontic surgery;
  - apicoectomy;
  - retrofilling; and
  - other surgeries;
- bleaching (endodontically treated teeth);
- apexification.

> **Helpful Tip**
> **Endodontic** Services refer to treatment of infected root canals and tissues surrounding the root of the tooth.

Periodontic Services: Charges for:

- periodontal surgery;
- provisional splinting;
- management of acute infections;
- desensitization;
- periodontal curettage and root planning to a combined maximum of 6 Units per Contract Year or 1 per tooth per 24 months;
- occlusal adjustments to a maximum of 8 Units per Contract Year; and
- other adjunctive periodontal services.

> **Helpful Tip**
> **Periodontic Services** refers to prevention, diagnosis and treatment of gum diseases.

Removable Denture Adjustments: Charges for:

- repairs;
- adjustments;
- rebasing, relining and remaking;
- prophylaxis and polishing;
- obturator palatal.

Oral Surgery: Charges for:

- removal of teeth and roots;
- surgical exposure and movement of teeth;
- surgical incision, excision and drainage of tumours or cysts;
- frenectomy (surgical alteration of the frenum);
- removal, reduction or remodelling of bone or gum tissue; and
- post-surgical care.

General adjunctive services: Charges for:

- anesthesia (related to surgery);
- temporary dressing for the emergency relief of pain; and
- finishing restorations.

Major Restoration

Extensive Restorations: Charges for:

- gold foil restoration;
- inlays;
- onlays;
- crowns: Charges for single restorations only (including pre-fabricated steel or plastic restorations), for teeth damaged due to caries or traumatic injury; and
- veneers.

Inlays, onlays and crowns are eligible to a combined maximum of 1 per tooth per 5 Contract Years.

Other Restorative Services: Charges for:

- cast post;
- prefabricated metal post;
- supplement for bonded fillings to a maximum of 2 per Contract Year; and
- supplement for crown manufacturing.

Prosthodontic Services: Charges for:

- complete and partial dentures to a maximum of 1 per 5 Contract Years;
- bridgework to a maximum of 1 per tooth per 5 Contract Years;
- retentive bar to be fixed to caps;
- implants to a maximum of 1 per tooth per 10 Contract Years;
- final restorations over implants (i.e. crown-supported implant, implant-supported bridge and dentures supported by implants) to a maximum of 1 per tooth per 10 Contract Years;
- implant related services;
- missing teeth clauses;
- construction and insertion of an initial permanent denture or bridgework if necessary due to the extraction of at least 1 natural tooth while covered under this benefit; and
- replacement of an existing denture or bridge with a permanent denture or bridge so long as:
  - the appliance is necessary due to the extraction of at least 1 natural tooth that occurred while covered under this benefit; and
  - the existing appliance is at least 5 years old.

Helpful Tip

Prosthodontic Services refers to diagnosis, treatment, rehabilitation and maintenance of oral function, comfort, appearance and health, for patients with clinical conditions associated with missing or deficient teeth.

Orthodontic Services

Charges for:

- orthodontic examinations: complete orthodontic examination;
- orthodontic examinations: specific orthodontic examination to a maximum of 1 per 12 consecutive months;
- removable appliances for tooth guidance (limited to Participants under the age of 18);
- fixed or cemented appliances (braces),
- retention appliances;
- comprehensive treatment; and
- x-ray of hand and wrist.

Helpful Tip

Orthodontic Services refers to treatment to correct abnormal arrangement of teeth and/or jaws.

Payment of Claims

How Payments are Made

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

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

Time Limit to Submit a Claim

Blue Cross must receive proof of claim within 12 months of the date the Eligible Expense was incurred.

Predetermination for Claims over $500

If the total cost of any Treatment is expected to exceed $500, the Member must submit to Blue Cross, before the Treatment begins, a detailed Treatment plan outlining the type of Treatment to be provided and the amounts to be charged.

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

Date of Treatment

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

Exclusions and Limitations

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

a) services, treatment, articles or supplies that are not mentioned in the categories of Eligible Expenses listed in this benefit;
b) services, treatment or supplies covered by any government health care coverage or charges payable under a workers' compensation board/commission, automobile insurance bureau or other similar law or public plan;
c) dental care that was covered under any government health care coverage or charges payable under a workers' compensation board/commission, automobile insurance bureau or other similar law or public plan, when this benefit was issued but has since been modified, suspended or discontinued;
d) services, treatment or supplies the Participant receives free of charge;
e) charges that would not have been made if no coverage had existed;
f) anti-snoring or sleep apnea devices;
g) services rendered by a dental hygienist but not administered under the supervision of a dentist, except in provinces where such supervision is not legally required;
h) services, treatment or supplies that are:
    i. not Medically Necessary (except for Preventive Care services);
    ii. for cosmetic purposes only; or
    iii. experimental or investigative;
i) services or expenses incurred as a result of:
    i. attempted suicide or voluntary injury or illness, whatever the state of mind of the Participant;
    ii. insurrection, the hostile action of the armed forces of any country or participation in any riot or civil commotion; or
    iii. participation in a criminal act or attempt to commit a criminal act, regardless of whether charges are laid or conviction is obtained;

j) expenses incurred following a war (declared or not), a civil war or an act of war or of terrorism or an epidemic, if an event entitling to benefits arises in a region or country for which the Government of Canada recommends its citizens avoid travel, whether essential or not. This exclusion does not apply in the following situations:
   i. In the case of Participants who are already in the region or country in question when the government recommendation was issued, provided that these persons take the necessary measures to comply to the government recommendation as soon as possible;
   ii. In the case where the Government of Canada recommends its citizens avoid non-essential travel in the region or country in question and if an event entitling to benefits arises while the Member is at work, at his residence in the country where his work is located, or in the travel area accessing or coming from his work.

k) expenses incurred after the termination date of the Participant's coverage, even if a detailed treatment plan was submitted and accepted by Blue Cross before this date;

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

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

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

o) extra supplies that are spares or alternates; or

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

Purpose of Coverage

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

Additional Definitions

The following definitions apply to this benefit, in addition to those found under the *Key Terms* provision of this booklet.

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

- an injury resulting from an accident;
- a new medical condition which begins during the Trip; or
- a medical condition that existed prior to the Trip provided that it is stable.

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

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

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

Hospital: A facility that:

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

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

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

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

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

What Blue Cross Will Pay

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

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

Emergency Hospital and Medical Travel Coverage

Blue Cross will pay the Eligible Expenses listed in this section if:

- they are incurred as a result of an Emergency;
- the Participant is covered by government health care coverage when the Emergency occurs; and
- Blue Cross is satisfied the expense is necessary to stabilize the Participant's medical condition.

Helpful Tip

Make sure to bring your Blue Cross identification card with you when you travel.

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

Physician Fees: Fees charged for physician or surgeon services.

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

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

This coverage excludes nursing fees for custodial care.

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

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

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

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

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

a) of damage to natural teeth that occurs as a result of a direct accidental blow to the mouth;
b) that is necessary to repair a fracture or reposition a dislocation of the jaw resulting from an accident; or
c) that is needed to relieve pain caused by an Emergency other than those listed in (a) or (b).

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

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

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

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

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

If returning on a commercial aircraft, coverage includes:

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

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

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

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

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

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

Meals and Accommodation: The cost of commercial accommodation and meals when the Participant’s travel is delayed due to an Emergency illness or injury of the Participant or Travel Companion. The medical reason for the delay must be verified by the attending physician. The maximum reimbursement is $150 per Participant per day for a maximum of 20 days (up to a total maximum of $3,000 per Incident).

All costs must be supported by receipts from commercial organizations.

Worldwide Travel Assistance

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

Medical Assistance

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

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

General Assistance

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

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

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

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

Payment of Claims

How Payments are Made

The Participant will pay the full cost of any Eligible Expense at the time of purchase. Blue Cross will then reimburse any Eligible Expenses on receipt of proof of payment from the Participant.

In certain circumstances and with pre-approval by Blue Cross, Blue Cross may approve payment directly to the service provider.

Time Limit to Submit a Claim

Emergency Hospital and Medical Travel Coverage: Blue Cross must receive proof of claim within 4 months of the date the expense was incurred to be eligible for maximum reimbursement under the benefit.

Blue Cross will accept claims up to 12 months from the date the expense was incurred. However, in such circumstances, the claim may be subject to reductions for any amounts Blue Cross would have been able to co-ordinate with the Participant's government health care coverage had the claim been submitted within the 4-month limitation period.

Exclusions and Limitations

Exclusions Applicable to all Travel Benefit Claims

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

a) the Participant fails to communicate with Blue Cross in the event of medical consultation or hospitalization following an injury or illness;
b) expenses are incurred beyond the coverage duration period specified in the Summary of Benefits;
c) the purpose of the Trip is primarily or incidentally to seek medical advice or treatment, even if this Trip is on the recommendation of a physician;
d) expenses have already been paid or are eligible for refund from a third party;
e) expenses are incurred while travelling in a country (or a specific region of a country) for which there is a Government of Canada travel warning, when such travel warning was issued before the departure date and the loss or expense is related to the reason for which the travel warning was issued; or
f) expenses are incurred as a result of:
    i. participation in a criminal act or attempt to commit a criminal act, regardless of whether charges are laid or conviction is obtained;
    ii. an illness or injury that occurred while operating a vehicle under the influence of any intoxicant or with a blood alcohol level that was proven to be in excess of the legal limit in the jurisdiction in which the accident occurred;
    iii. an injury or illness resulting from intentional non-compliance with the medical treatment or therapy that has been prescribed;
    iv. attempted suicide or voluntary injury or illness, whatever the state of mind of the Participant; or
    v. insurrection, the hostile action of the armed forces of any country or participation in any riot or civil commotion; or
g) expenses are incurred following a war (declared or not), a civil war or an act of war or of terrorism or an epidemic, if an event entitling to benefits arises in a region or country for which the Government of Canada recommends its citizens avoid travel, whether essential or not. This exclusion does not apply in the following situations:
    i. In the case of Participants who are already in the region or country in question when the government recommendation was issued, provided that these persons take the necessary measures to comply to the government recommendation as soon as possible;
    ii. In the case where the Government of Canada recommends its citizens avoid non-essential travel in the region or country in question and if an event entitling to benefits arises while the Member is at work, at his residence in the country where his work is located, or in the travel area accessing or coming from his work.

Specific Exclusions and Limitations

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

a) expenses for any care, treatment, surgery, products or services that:
    i. are not incurred as a result of an Emergency;
    ii. are not Medically Necessary;
    iii. are performed for cosmetic purposes only;
    iv. are not required for the immediate relief of acute pain and suffering; or
    v. could be delayed until the Participant's return to Canada;
b) expenses incurred due to pregnancy or pregnancy complications that occur within 8 weeks of the expected date of delivery; or
c) expenses incurred due to an Emergency that occurs while participating in:
    i. a sport for remuneration;
    ii. a motor vehicle or speed contest of any kind; or
    iii. any Extreme Sport, defined as an activity with a high level of inherent danger and which often involves speed, height, a high level of physical exertion, highly specialized gear or spectacular stunts.

Purpose of Coverage

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

Helpful Tip

You should first submit any eligible medical expenses to any other health plan. Any remaining balance can be processed through your HSA.

Additional Definition

The following definition applies to this benefit, in addition to those found under the *Key Terms* provision of this booklet.

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

What Blue Cross Will Pay

Blue Cross will pay eligible medical expenses based upon Canada Revenue Agency guidelines. Eligible medical expenses include deductible amounts, co-payment amounts, and amounts exceeding plan maximums, as well as expenses which are not covered by any applicable group policy, individual policy, government health care coverage, or any other private program.

HSA Credits

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

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

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

HSA credit allocation may only change in the case of a Life Event or a change in the employment status. In such circumstances, allocated credits could be adjusted following a Life Eventles or the HSA termination, as specified in the Summary of Benefits.

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

- marriage or common law union;
- birth or adoption of a child;
- divorce or legal separation;
- dependent no longer meets eligibility criteria; or
- death of a Dependent.

If a Member’s coverage is terminated, the Policyholder may adjust the credits allocated to the HSA for that HSA year. The Policyholder must promptly notify Blue Cross of the adjusted amount of credits.

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

Payment of Claims

How Payments are Made

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

Helpful Tip

View your HSA balance through the Medavie Mobile App or the Member Centre at www.medaviebc.ca

Carry Forward Type

Credit Carry Forward

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

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

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

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

Exclusions and Limitations

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

a) expenses incurred by Members and (CRA) Dependents prior to the effective date of this benefit or following termination, in accordance with this policy;
b) over the counter medications that can be acquired without the intervention of a Health Professional, such as vitamins, minerals, and herbal remedies; or
c) services, treatment or supplies that:
    i. are not Medically Necessary;
    ii. are for cosmetic purposes only; or
    iii. are elective in nature.

Common Eligible Expenses			
Attendant Care(requires certification of need from physician)	• Services provided in Home, Retirement Home, Nursing Home or Group Home	• Includes Fees from: - Personal Care Worker - Registered Nurse - Respite Care	• Includes Fees for: - Food Preparation - Housekeeping - Laundry Services
Dental Services (excluding teeth whitening and cosmetic veneers)	• Diagnostic Services (x-rays) • Dentures • Orthodontic	• Preventive Services, such as: - Recall Examinations - Polishing - Application of Fluoride	
Diagnostic Services*	• Diagnostic laboratory, radiological tests and scans		
Drugs	• Drugs requiring a prescription and/or dispensed by a pharmacist, physician or practitioner*	• Fertility Treatments • Flu Shots • Insulin* • Liver Extract Injections*	• Smoking Cessation Drugs* • Vaccines • Vitamin B12 Injections*
Facility Care (excluding television rentals and phone fees)	• Convalescent care home • Hospital • Nursing home	• Psychiatric facility • Substance abuse facility	
Medical Devices and Services*	• Air Conditioners (required for severe chronic ailment, disease or disorder) • Artificial Eyes and Limbs • Blood Transfusion Fees • Breast Prosthesis • Cochlear Implants • Crutches • Diabetic Supplies	• Electronic Bone Healing Devices • Electronic Speech Synthesisers • Hearing Aids • Heart Monitoring Devices • Needles and Syringes • Ostomy Supplies • Oxygen Equipment	• Physician Fees • Prosthetics • Repairs to Eligible HSA Devices • Respirators • Scooters • Trusses • Walkers • Wheelchairs (excluding accessories)
Medical Practitioner Services	• Acupuncturist • Athletic Therapist • Audiologist • Chiropodist/Podiatrist • Chiropractor • Dental Hygienist • Dentist	• Dietician • Homeopath • Massage Therapist** • Naturopath • Occupational Therapist • Osteopath • Personal Care Worker*	• Physiotherapist • Psychiatrist • Psychologist • Registered Nurse • Social Worker • Speech Therapist
Medical Transportation Services	• Ambulance Services • Bone Marrow Transplant Charges (patient and donor), such as transportation charges and meals and expenses	• Meals and Transportation Expenses, when patient transportation is required (plus one attending person - if required)	• Organ Donor Charges (patient and donor), such as transportation charges and meals and expenses
Miscellaneous	• Health and Dental Plan Premiums (private insurance)	• Home or Vehicle Modifications, when required for disabled persons	• Seeing Eye Dog Miscellaneous Charges
Rehabilitative Training	• Lip Reading	• Sign Language	
Vision Care	• Contact Lenses • Eye Examinations	• Laser Eye Surgery	• Prescription Lenses and Frames

*Prescription required

**For Therapeutic massage services only

Common Ineligible Expenses			
Adoption Fees	• Adoption Fees		
Cosmetic Procedures (aimed at purely enhancing appearance)	• Augmentations • Botox Injections • Liposuction	• Hair Replacement Procedures and Supplies (ex. hair plugs, hair extensions)	• Laser Hair Removal • Tattoo Removal • Teeth Whitening
Cosmetics and Hygiene Products	• Contact Lens Solution • Lotions and Creams	• Make-up • Sunscreen	• Toothpaste
Dietary Supplements	• Food (except when required for enteral feeding)	• Minerals and Supplements	• Meal Replacements
Esthetic Massage Therapy	• Aromatherapy Massage	• Body Wraps	
Fees for missed appointments	• Fees for missed appointments		
Health Programs	• Weight loss program fees		
Home Appliances	• Air Conditioners • Air Purifiers	• Dehumidifiers • Fans	• Humidifiers (except when required for CPAP machines)
Hot Tubs and Saunas	• Hot Tubs	• Saunas	
Life and Disability Plan Premiums	• Life and Disability Plan Premiums		
Over the counter medications	• Acid Controllers • Allergy Medications • Cough and Cold Items	• Creams and Lotions • Digestive Aids • Herbal Remedies	• Pain Relievers • Smoking Cessation Products • Vitamins
Personal Response Systems	• Lifeline Services	• Health Line Services	
Shoes	• Off the shelf	• Athletic	
Sports Equipment	• Treadmills		

What Are My Responsibilities Under the Policy?

Keeping Your Employer Informed

It is your responsibility to provide your employer with a completed and signed application form, including accurate information on your family status, as well as your beneficiary designation(s). You must complete the group benefits application form within 31 days from the date you become eligible for coverage.

To ensure coverage is kept up-to-date for you and your Dependents, it is important to report any changes to your employer within 31 days of the change. Failure to do so could result in the need for proof of health before your requested change in coverage takes place. Changes that must be reported to your employer include:

- Adding/removing a Dependent
- Status updates of a Dependent student
- Change in marital status
- Change of beneficiary
- Application for benefits previously waived

Helpful Tip

It is very important to maintain up-to-date beneficiary designations.

When insurance money is paid to the estate, it may be subject to creditor claims and estate taxes.

However, when a beneficiary is named, this person receives the entire benefit tax free, regardless of what debts may be owed by the deceased.

You can change your beneficiary by filling out a beneficiary designation form available through your employer or on our website.

Beneficiary Designations

Unless otherwise designated, all benefits are payable to you.

Death Benefits

Benefits payable as a result of your death will be paid to your last designated beneficiary or beneficiaries.

Subject to the provisions of the law, the beneficiary is the person(s) you have designated on your group benefits application form. You may change your beneficiary by submitting a signed written declaration to Blue Cross.

If you designate 2 or more beneficiaries (other than alternatively) without any specification as to how the death benefit will be divided, the benefit payable will be divided equally among the designated beneficiaries.

If your beneficiary predeceases you, you must designate a new beneficiary.

If you die and a beneficiary has not been named in writing, the death benefit will be payable to your estate.

Providing Proof of Claim

You must submit your claims for Eligible Expenses within the applicable time limitations outlined under each benefit. Proof of claim must be provided in writing and in a form considered acceptable by Blue Cross.

Blue Cross must approve your proof of claim and may require you to provide additional information and/or require you to undergo a medical examination by a physician or Health Professional as often as deemed necessary. Blue Cross reserves the right to suspend or deny a claim until you have submitted the additional information requested to process the claim.

Costs associated with providing proof of claim are your responsibility.

Helpful Tip

Your proof of claim must be submitted in either English or French. If the original proof of claim is in a language other than English or French, you are responsible for any costs associated with translating your proof of claim.

Submitting Claims After Your Group Policy Terminates

If the group policy has terminated, you must submit proof of claim to Blue Cross:

- for disability benefits, **within 6 months** of the onset of disability or the time limit specified by applicable provincial legislation, whichever period is longer;

- for accidental damage to natural teeth, within 6 months following the termination date of this group policy; or
- **within 90 days** following the termination date of this group policy for all other benefits.

Recovering Damages From a Third Party (Subrogation)

If you have the right to file legal action against a third party (individual or corporate body) for a loss relating to any claim submitted under this group benefits plan, Blue Cross is entitled to acquire your rights for recovering damages for any portion of the loss that has been paid by Blue Cross.

You must sign and return the necessary documents to facilitate this process and you must do everything that is required of you to protect your rights to recover damages from the third party.

Reporting Health Insurance Fraud

Health insurance fraud is the intentional act of submitting false, deceiving or misleading information for the purpose of financial gain.

Whether fraud schemes are committed on a small or large scale, fraud can lead to significant financial losses to the benefit plan and result in higher premiums and decreased coverage. Blue Cross is committed to protecting the integrity of our benefit programs for our policyholders and members by monitoring and resolving any abusive or fraudulent activity.

Helpful Tip

Health care fraud in Canada is estimated to cost between $2 billion and $12 billion annually.

How You Can Help

As a group plan member, you can help us eliminate fraudulent abuse of your plan:

- keep your identification card, policy number, member identification number and related information confidential and secure;
- carefully review your receipts for products and services claimed to ensure:
  - you understand the charges billed; and
  - the charges reflect the services received.

If you are unclear about any of the charges on your receipt, ask your provider to explain the charges to you:

- carefully review your Explanation of Benefits claim statements (EOB) for any discrepancies in services received compared to services claimed;
- never sign a blank claim form;
- from time to time, we send member verification questionnaires to confirm treatments and other related information. If you receive one of these questionnaires, please complete it and return it promptly. These questionnaires make an essential contribution to our fraud deterrence efforts.

Helpful Tip

If you suspect health care fraud, please refer it to Blue Cross through one of the following confidential methods:

Toll free:
1-877-412-8809

StopFraud@medavie.bluecross.ca

www.medavie.bluecross.confidenceline.net

What Are My Rights Under the Policy?

Privacy

In the course of providing customers with quality health, life and travel coverage, Blue Cross acquires and stores certain personal information about its clients and their dependents.

Protecting the confidentiality of client information is fundamental to the way we do business. Our staff takes our privacy policies and procedures very seriously.

What is personal information?

Personal information includes details about an identifiable individual and may include name, age, identification numbers, income, employment data, marital and dependent status, medical records, and financial information.

How is Your Personal Information Used?

Your personal information is necessary for Blue Cross to process your application for coverage under its health, life and travel plans. Your personal information is used to provide the services outlined in your group policy of which you are an eligible Member, to understand your needs so that we can recommend suitable products and services, and to manage our business.

To Whom Could This Personal Information be Disclosed?

Helpful Tip

For more information on our privacy protection practices, please visit our website.

Depending on the type of coverage you carry with us, release of selected personal information to the following may be necessary in order to provide the services outlined in the group policy of which you are an eligible member:

- other Canadian Blue Cross organizations in order to administer your benefit plan if you reside outside the Atlantic Provinces, Quebec or Ontario;
- specialized health care professionals when required to assess benefit eligibility;
- government and regulatory authorities in an emergency situation or where required by law ;
- Blue Cross Life Insurance Company of Canada and other third parties, on a confidential basis, when required to administer the benefits outlined in your contract or the group policy of which you are an eligible member; or
- the plan member in any contract under which you are a participant.

We do not provide or sell personal information about you to any outside company for use in marketing and solicitation. Personal information about you or your Dependents is not released to a third party without permission unless necessary to fulfil the services Blue Cross is contracted to provide to you.

By becoming a Blue Cross customer or filing a claim for benefits, you are agreeing to allow your personal information to be used and disclosed in the manner outlined above.

Disputing a Claim Decision

In the event Blue Cross determines that benefits are not payable, you have the right to appeal the decision by providing written notice to Blue Cross within 30 days from the date of the written denial.

The time limitation to bring an action against Blue Cross under the group policy begins on the date of the initial written denial from Blue Cross and runs until the expiry of the minimum limitation period as prescribed by the applicable provincial legislation.

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

Copy of the Group Policy

Where legislated, you have the right to request a copy of your application for benefits and any written statements or other record provided to Blue Cross as proof of your health. You may also request, with reasonable notice, a copy of the contract for insured benefits.

The Rights of Blue Cross Under the Policy

Right to Audit

Blue Cross has the right, at any time, to inspect or audit the health and claim records of a Participant in relation to a claim for benefits.

Helpful Tip

The right to inspect or audit applies to records held by Blue Cross or Approved Providers.

Recovery of Overpaid amounts

Blue Cross has the right to recover from a Participant:

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

If the excess amounts cannot be recovered, Blue Cross has the right to reduce future benefit payments to the Participant until the excess amount is fully recovered.

Termination or Suspension of Benefit Payments

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

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

Blue Cross also has the right to suspend or deny payment of a claim for any services or supplies prescribed, rendered or dispensed by a provider who is under investigation by a regulatory body or by Blue Cross or who has been charged with an offence in regards to the provider's conduct or practice.

How to Obtain a Claim Form

Health benefit claim forms can be obtained from any one of the following sources:

- the plan member website (see instructions below);
- one of our Quick Pay locations;
- your group benefits administrator; or
- our Customer Information Contact Center at the toll-free number listed below.

All claim forms for life or disability benefits can be obtained through your group benefits administrator.

Helpful Tip

Instead of a cheque by mail, get reimbursement directly to your bank account by signing up for direct deposit. It's fast, and convenient. Visit our website to register.

How to Submit a Claim

Blue Cross offers several convenient options to quickly and efficiently submit your health benefit claims:

- **Provider eClaims**
  For Approved Providers who have registered to submit claims to Blue Cross through our electronic claims submission service, our e-claim service allows approved health care professionals to instantly submit claims at the time of service. This eliminates the need for you to submit your claim to Blue Cross and means you only pay the amount not covered under your group benefits plan (if any).

- **Member eClaims**
  You can quickly and easily submit your health, drug, dental and Health Spending Account claims (as applicable) through our secure plan member website. Simply take or scan a digital image of your paid-in-full receipts and submit it through the applicable link on our plan member website.

- **Mobile App**
  Filing a claim has never been quicker or easier! Submit your claims through the Medavie Mobile app and have your reimbursement deposited directly to your bank account.

  Visit **www.medaviebc.ca/app** for more information or to download the app.

- **Quick Pay®**
  Quick Pay® is a unique service of Blue Cross. Through Quick Pay, you may submit all your dental, drug and extended health care claims and receive immediate adjudication and reimbursement.

  Quick Pay provides you with an opportunity to discuss how the claim was adjudicated, Coordination of Benefits, subrogation or other details of your benefit program. You meet face-to-face with a customer service representative equipped to answer your questions.

  To find the Blue Cross office or Quick Pay location nearest you, visit our website at **www.medaviebc.ca/ouroffices**.

- You can also mail your completed claim form to the nearest Blue Cross office.

You can submit your claims for **life or disability benefits** to Blue Cross by:

- mail, fax or scan to the address indicated on the applicable claim form;
- dropping the form off at one of our Quick Pay locations; or
- providing them to your group benefits administrator.

Plan Member Website

The plan member website is a secure, user-friendly website that is available 24 hours a day, seven days a week. The website provides additional information regarding your coverage and other useful options including:

- **Coverage inquiry:** Detailed information about your group benefits plan;
- **Forms:** Printable versions of Blue Cross forms;
- **Requests for new identification cards;**
- **Addition/updating of banking information** for direct deposit of claim payments;
- **Member statements:** view claims history for you and your Dependents;
- **Record of payments:** view transactions issued to yourself or the service provider;
- **Submit claims** electronically.

Helpful Tip

For security reasons, the plan member website is for your use only. Dependents and other family members will not have access to the site.

To register for the plan member website, visit **www.medaviebc.ca** and log in.

Blue Cross Contact Information

For more information about your group benefits coverage or the plan member website, please contact our Customer Information Contact Center toll free at:

Atlantic Provinces: 1-800-667-4511
Ontario: 1-800-355-9133
Quebec: 1-888-588-1212
From Anywhere in Canada: 1-888-873-9200

Alternatively, you can email your question(s) to **inquiry@medavie.bluecross.ca**. or visit our website at **www.medaviebc.ca**.

Helpful Tip

Have your group policy number and identification number ready when you call for questions regarding your coverage.

Connect with Blue Cross

Like us on Facebook at **facebook.com/MedavieBlueCross**

Follow us on Twitter at @**MedavieBC**

My Good Health®

My Good Health is a secure, interactive web portal that provides valuable health information and tools for managing your health. You can create your own health profile and use it to map personal goals using My Good Health resources.

Blue Cross is proud to help point your way to healthier living. Go to **medaviebc.mygoodhealth.ca** and simply follow the instructions to register for your free account!

APPENDIX I

VOLUNTARY ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

SSQ INSURANCE COMPANY INC.

VOLUNTARY ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

for Employees of
EnGlobe Corp.

EFFECTIVE DATE: **April 1st, 2016**

POLICY Nº **1R685**

This Booklet/Certificate is an important document.
Please keep it in a safe place.

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This booklet is an outline of SSQ Insurance Company Inc.'s Accidental Death and Dismemberment insurance program offered to Employees of the Policyholder. It is designed to help you learn more about the coverage offered under this insurance program. This booklet should be kept for future reference.

The Accidental Death and Dismemberment #1R685 group insurance program's Master Application, endorsements and attached papers, if any, and the entire contract of insurance, all referred to hereafter as the "Policy", set forth the terms and conditions of the insurance program. All rights and obligations are determined in accordance with the Policy, not this booklet. For exact provisions of coverage offered, please contact your Human Resources department.

SSQ Financial Group

Values in the right place

INTRODUCTION

What is Accidental Death and Dismemberment insurance?

Accidental Death and Dismemberment insurance offers the financial protection needed in case of an accident to help alleviate financial setbacks for you and your loved ones. Accidental Death and Dismemberment coverage provides payment in the event of an accident resulting in death or serious injury. The amount that is paid will depend upon the type of injury.

Who needs Accidental Death and Dismemberment insurance?

Everyone should plan for their financial security because accidents happen. According to Statistics Canada (2006), unintentional injury is the 5th leading cause of death in Canada. Nowadays, few people set money aside for emergency needs, so this coverage provides you with protection when it is most needed. Not only does Accidental Death and Dismemberment coverage help lighten the financial burden you or your family may experience due to an accident, but most importantly, it will provide you with a peace of mind.

Why should you consider Accidental Death and Dismemberment insurance?

Because no one is immune to accidents, Accidental Death and Dismemberment insurance is perceived as a valuable addition to any group insurance plan. Accidents happen and their impact may be devastating to you and your loved ones. Recovery from an accident may take a while and may cost you more than you'd expect. That is why it is beneficial to make Accidental Death and Dismemberment insurance a part of your group insurance plan, as it provides necessary resources when they are most needed.

What are the advantages of your coverage?

With our group Accidental Death and Dismemberment insurance, you benefit from:

- Comprehensive coverage
- Extensive list of benefits
- 24-hour, year round and worldwide coverage
- Efficient claims service
- Coverage may be used to complement your company group life, health or disability insurance

Definitions – for a better comprehension of this booklet

Wherever used in this booklet:

- "Accident" means a sudden and unexpected mishap or event in which an Insured Person is involved and which directly results in an Injury to the Insured Person.
- "Accommodation" means lodging at a hotel, motel, inn, bed and breakfast or other like establishment as well as food reasonably required during the lodging, provided however that no indemnity will be paid for lodging at a private residence or for food not consumed as meals by the person seeking reimbursement of expenses.
- "Brain Damage" means irreversible physical damage to the brain causing complete incapacity of performing all the substantial and material functions and activities normal to everyday life.
- "Burn" means a condition which a Physician has determined to be a 3rd degree burn.
- "Comatose" means being in a state of total unconsciousness from which the person cannot be aroused. A Comatose person is unresponsive to any external stimuli and continuously requires the use of life support systems.
- "Commencement of Total Disability" means the date of commencement of the Insured Person's Total Disability, as determined by a Physician, which date must be subject to the satisfaction of the Insurer that, on that date, the Insured Person has met all criteria for Total Disability.
- "Common Accident" means a single Accident or multiple Accidents occurring within the same twenty-four (24) hour period.
- "Daily Indemnity" means one-thirtieth of one percent (1/30 of 1%) of the Insured Person's Principal Sum, subject to a maximum monthly indemnity of two thousand and five hundred dollars ($2,500).

- "Day-Care Centre" means a facility, which is run according to the law, including laws and regulations applicable to day-care facilities, and which provides care and supervision for children in a group setting on a regular basis. A Day-Care Centre will not include a hospital, the child's home or school if the only care at such school is provided during normal school hours while the Dependent Child is attending school from grades one (1) through twelve (12).
- "Day of Hospitalization" means a necessary Period of Hospitalization in a Hospital as an inpatient for which a full day's room and board is charged.
- "Dependent Child" means a natural child, adopted child, stepchild or child with who is in a parent-child relationship with you. The child must be dependant upon you for maintenance and support and:
  (1) under 21 years of age; or
  (2) under 25 years of age (26 in the province of Quebec) and in attendance at an Institution for Higher Learning on a full-time basis; or
  (3) no matter his age on the date of the claim, have been struck with a Functional Disability while satisfying the criteria under paragraphs (1) or (2) above. Proof of existence of this Functional Disability, including the determination by a Physician that the disability exists and when it occurred, must be presented to the Insurer within 31 days after the child reaches the age at which he would otherwise no longer qualify as a Dependent Child under paragraph (1) or (2) above. Thereafter, the Insurer may periodically require that other proof be submitted establishing to its satisfaction that the Functional Disability still exists and that the child otherwise meets the definition of Dependent Child, failing which, the Insurer may determine that the child no longer qualifies as a Dependent Child under the Policy.

  The Dependent Child will be covered from birth, provided such child is born alive.

  “Employee” means an active, full-time and permanent employee of the Policyholder. The Employee of the Policyholder must be under the age of seventy (70) and reside in Canada. The Employee is designated by the terms “you” and “your” for the purposes of this booklet.
- "Employee Only Plan" means a plan which provides insurance to the Employee only.
- "Employee and Family Plan" means a plan which provides insurance to the Employee and his/her Spouse and/or Dependent Children.
- "Fare" means the regular fare charged for:
  (1) an economy class seat on a regular flight by a domestic or international scheduled air carrier;
  (2) a coach seat on a passenger train;
  (3) a regular seat on a passenger bus;
  (4) an economy class accommodation on a boat.

  Each of those carriers must hold a current and valid certificate issued by Transport Canada or, if subject to regulation in another country by a similar governmental authority having jurisdiction in that country.
- "Functional Disability" means an irreversible and serious limitation of a person’s physical or mental capacity or of their skills that prevents the person from living independently.

  “Hemiplegia” means the permanent Paralysis and functional loss of use of upper and lower limbs on the same side of the body.
- "Hospital" means an institution licensed as a hospital within the jurisdiction in which it operates. To qualify under this definition, a hospital must be an active treatment hospital open at all times for the care and treatment of sick and injured persons, have a staff of one (1) or more Physicians available at all times, provide twenty-four (24) hour nursing service by graduate registered nurses and have organized facilities for diagnostics and surgery. A facility which is primarily a clinic, rest home, nursing home, convalescent hospital or similar establishment is not a Hospital. For the purposes of this definition, a Hospital will include a facility or part of a facility used for rehabilitative care.
- “Immediate Family Member” means a person at least eighteen (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, uncle, aunt, nephew, niece, grandson, granddaughter, grandfather, grandmother (all of the above include natural, adopted or step relationships) or the spouse of an Insured Person.
- “Injury” means bodily injury caused by an Accident occurring while the Policy is in force as to the Insured Person whose loss is the basis of claim and resulting directly and independently of all other causes in loss covered under the Policy, twenty-four (24) hours a day, anywhere in the world but in no event shall Injury mean Sickness or Disease howsoever caused unless caused by an Accident.
- "Institution for Higher Learning" means and is limited to universities, colleges, CEGEPs and professional or vocational schools.
- “Insurer”, “We”, “Us” means SSQ Insurance Company Inc.

- “Insured Person” means you, or your insured Spouse or your insured Dependant Children, while meeting the Spouse and Dependent Child definition criteria presented in this section, and before the date of individual coverage termination.
- "Intoxicated" and "Under the Influence of Drugs" means that the driver has a blood alcohol content and/or is impaired due to the use of alcohol, narcotics or other drugs such that he could be subject to proceedings under provincial, state or federal law, even if he has not been subject to such proceedings.

  “Loss of Life” means the death of the Insured Person.
- “Loss” means:
  (a) as used with reference to a hand or foot, the complete and irrecoverable severance through or above the wrist or ankle joint, but below the elbow or knee joint;
  (b) as used with reference to an arm or leg, the complete and irrecoverable severance through or above the elbow or knee joint;
  (c) as used with reference to a thumb, the complete and irrecoverable severance of one (1) entire phalanx of the thumb;
  (d) as used with reference to a finger, the complete and irrecoverable severance of two (2) entire phalanges of the finger;
  (e) as used with reference to toes, the complete and irrecoverable severance of one (1) entire phalanx of the big toe and irrecoverable severance of all phalanges of the other toes;
  (f) as used with reference to an eye, the irrecoverable loss of the entire sight thereof, and determined by a Physician to be irrecoverable;
  (g) as used with reference to speech, the complete and irrecoverable loss of the ability to utter intelligible sounds, and determined by a Physician to be irrecoverable;
  (h) as used with reference to hearing, the complete and irrecoverable loss of hearing, and determined by a Physician to be irrecoverable.
- “Loss of Use” means a total incapacity to use part of the body, which has been continuous for twelve (12) consecutive months and was determined by a Physician to be permanent at the end of such period.
- "Motorized Vehicle" means a passenger car, van, jeep-type automobile, sports utility vehicle (SUV), any truck-type automobile, truck, ambulance, or any type of motorized vehicle used by municipal, provincial or federal police forces.
- “Paralysis” means the loss of ability to move all or part of the body.
- “Paraplegia” means the permanent Paralysis and functional loss of use of both lower limbs of the body.
- "Period of Hospitalization" means a single uninterrupted confinement in a Hospital or several successive confinements in a Hospital as a result of the same Accident, provided each such confinement is separated by a period of less than ninety (90) consecutive days and all such confinements occur within seven hundred and thirty (730) days of the date of the Accident.
- “Physician” means an individual who is legally licensed to practice medicine and provide treatment within the scope of his licence by:
  (a) a recognized medical licensing organization in the jurisdiction where the treatment is rendered, provided he is a member in good standing of such licensing body, or
  (b) a governmental agency having jurisdiction over such licensing where the treatment was rendered.

  The Physician must not ordinarily reside in the Insured Person's residence. The Physician must not be an Insured Person, an Immediate Family Member or business associate of an Insured Person.
- “Policy” means Policy #1R685 as well as the attached Master Application, any endorsements and attached papers.
- “Policyholder” means EnGlobe Corp..
- “Principal Sum” means the amount indicated in Item 3 of the Master Application as being applicable to the Insured Person and stated on the Insured Person's most recently signed individual enrollment card on file with the Policyholder, if any.
- “Quadriplegia” means the permanent Paralysis and functional loss of use of both upper and lower limbs of the body.
- "Regular Care and Attendance" means observation and treatment to the extent necessary under existing and recognized standards of medical practice.
- "Seat Belt" means a belt that forms a restraint system in a Motorized Vehicle.

  For the purposes of this definition, a Seat Belt includes infant and child restraint systems used in Motorized Vehicles and the restraining belts which are part of a stretcher used in the transportation of sick or injured persons by ambulance.
- “Sickness or Disease” means the alteration of a person’s state of health resulting from internal or external cause(s), creating objectively verifiable symptoms and/or signs, and revealing itself by the impairment of physiological or mental functions.

- “Specific Loss” means Loss of Life, Loss, Loss of Use, Quadriplegia, Paraplegia or Hemiplegia, all as defined in this section of this booklet.
- "Spouse" means an individual under the age of seventy (70):
  (a) to whom you are legally married or in a civil union with; or
  (b) with whom you have continuously cohabited in a conjugal relationship for a minimum of one (1) year immediately before the date of the event insured against.

  However, when the individual is the biological or adoptive mother or father of at least one of your children and is cohabitating with you, the individual shall be deemed a Spouse from the date of birth or adoption of that child, if that date precedes the end of the period of one year of cohabitation.

  Only one (1) individual will qualify as your Spouse. If you are legally married or in a civil union but are also cohabiting with an individual as described under Item (b) above, you may elect in writing, which one of the individuals will qualify as a Spouse under the Policy. This election must be filed with the Policyholder. The Insurer will not be bound by an election not filed before the occurrence of the event insured against. If an election is not filed, the Spouse will be the individual to whom you are legally married or in a civil union with.
- "Total Disability" or "Totally Disabled" means or directly refers to a continuous state of incapacity preventing the Insured Person from performing all of the usual and customary duties of his occupation.

  An Insured Person will be deemed Totally Disabled only if he does not receive any income from any occupation after the Commencement of Total Disability, directly or indirectly, except in the context of a rehabilitation program approved by the Insurer.

  For a Total Disability to be recognized, the state of the Insured Person must require Regular Care and Attendance by a Physician or an appropriate specialist. Proof of Regular Care and Attendance must be satisfactory to the Insurer.
- "Transportation" means conveyance from one place to another by private or public Motorized Vehicle, bus, train, boat, ferry, airplane or helicopter.

Throughout this booklet, the male pronoun will be construed as the feminine when the person is a female.

DETAILS OF THE PROGRAM

Eligibility

The Accidental Death and Dismemberment insurance program is available to Employees of the Policyholder and their dependents (Spouse and Dependent Children).

As an active, full-time and permanent Employee of the Policyholder, you are eligible under the Accidental Death and Dismemberment insurance program if you are under the age of seventy (70) and residing in Canada. If you are absent from active work for any reason other than bona fide vacation or maternity/parental leave, you will only become eligible upon return to active work.

Your Spouse is eligible for coverage if he or she is under the age of seventy (70) and meets the Spouse definition as presented under the section of this booklet entitled "Definitions – for a better comprehension of this booklet".

Any of your children who meet the definition of Dependent Child as presented under the section of this booklet entitled "Definitions – for a better comprehension of this booklet" are also eligible for coverage.

Note: If you are legally married but also cohabiting with an individual please refer to the Spouse definition for more information.

Coverage Amounts

Voluntary program

The Accidental Death and Dismemberment insurance program is a voluntary coverage program for you, you and your Spouse or you and your dependents (Spouse and Dependent Children) **without having to provide any evidence of insurability**.

The amounts of the Principal sum for you, your Spouse or your dependents (your Spouse and Dependent Children) may vary depending on your employee classification :

Employees and Spouses– $10,000 minimum, in units of $10,000, up to a maximum of $500,000.

Dependent Children– $10,000 minimum, in units of $10,000, up to a maximum of $50,000.

Note: Only 1 family plan may be purchased if You and Your Spouse both work for the Policyholder. Your Spouse can be covered as an employee under the Employee Only Plan and as a dependent under the Employee & Family Plan, but the amount of Principal Sum under the employee coverage will be limited to the difference between $500,000 and the amount of Principal Sum under the spouse coverage.

How much does the insurance cost?

Premiums are payable by monthly payroll deduction. Here are somes examples:

Principal Sum Selected	Employee	Spouse	Children
$ 10,000	$0.16	$0.16	$0.16
$ 50,000	$0.80	$0.80	$0.80
$ 100,000	$1.60	$1.60	n/a
$ 150,000	$2.40	$2.40	n/a
$ 200,000	$3.20	$3.20	n/a

An exemple

If you select $200,000 of coverage for yourself, $100,000 for your spouse and $50,000 for your dependent Children, y our payroll deduction per month would be:

	Principal Sum	Premium
Employee	$ 200,000	$ 3.20
Spouse	$100,000	$ 1.60
Each Child	$50,000	$ 0.80

Total: $ 5.60

Note: Provincial sales tax on insurance premium must be added.

Enrolment and Effective Date of Individual Coverage

Voluntary program

Enrollment

If you wish to adhere to the voluntary Accidental Death and Dismemberment insurance program, you must complete and send the Policyholder a signed enrollment card or complete the online enrollment.

Effective date of individual coverage

With respect to an Employee who sends an enrollment card or completes an online enrollment, or for whom an enrollment card is sent:

- on or before the effective date of the policy;
- after the effective date of the policy, on the first of the month following or coincident with the date the enrollment card is received by the Policyholder.

With respect to Spouse and/or Dependent Child:

- on the effective date of the your coverage;
- on the date the Spouse and/or Dependent Child becomes eligible if eligible after the effective date of your coverage;

Individual Coverage Termination

Your coverage terminates on the earliest of the following dates:

- the date the Policy is terminated;
- the premium due date if the Policyholder fails to pay the required premium, except as the result of an inadvertent error;
- the premium due date coincident with or following the date you reach seventy (70) years of age;the premium due date coincident with or following the date you give notice of cancellation to the Policyholder.
- the premium due date coincident with or following the date you cease to be an active Employee of the Policyholder on account of leave of absence, lay-off, maternity/parental leave, disability, resignation, dismissal, pension or retirement, except as provided under the following sections of this booklet:

  Waiver of Premium

  Continuation of Coverage During Approved Leaves

  Extension of Coverage

Coverage for your insured Spouse and/or Dependent Child terminates on the earliest of the following dates:

- the date such person ceases to satisfy the criteria for definition of "Spouse" or "Dependent Child" as presented under the section of this booklet entitled "Definitions – for a better comprehension of this booklet";
- the date your coverage is terminated except as provided under the "Extension of Family Coverage" section of this booklet.

This insurance program may be cancelled by the Policyholder by mailing to the Insurer written notice stating the date on which such cancellation will be effective. The program may also be cancelled by the Insurer by mailing to the Policyholder at the address shown in the Policy, written notice stating when, not less than thirty (30) days prior to the anniversary date of the policy, the date on which such cancellation will be effective. The mailing of such notice as aforesaid will be sufficient proof of notice and the effective date of cancellation stated in the notice will become the end of the Policy period. Delivery of such written notice either by the Policyholder or by the Insurer will be equivalent to mailing.

PROGRAM BENEFITS

Specific Loss Accident Indemnity

When, within three hundred and sixty-five (365) days after the date of an Accident, an Insured Person suffers an Injury from such Accident which results in a Specific Loss listed below, the Insurer will pay an indemnity as indicated below:

Loss of

Life	The Principal Sum
The entire sight of both eyes	The Principal Sum
Speech and hearing in both ears	The Principal Sum
One hand and the entire sight of one eye	The Principal Sum
One foot and the entire sight of one eye	The Principal Sum
The entire sight of one eye	Three-Fourths of the Principal Sum
Speech	Three-Fourths of the Principal Sum
Hearing in both ears	Three-Fourths of the Principal Sum
Hearing in one ear	Two-Fifths of the Principal Sum
All toes of one foot	One-Third of the Principal Sum

Loss or Loss of Use of

Both hands	The Principal Sum
Both feet	The Principal Sum
One hand and one foot	The Principal Sum
One arm	Four-Fifths of the Principal Sum
One leg	Four-Fifths of the Principal Sum
One hand	Three-Fourths of the Principal Sum
One foot	Three-Fourths of the Principal Sum
The thumb and index finger or at least four fingers of one hand	Two-Fifths of the Principal Sum

Paralysis of

Both upper and lower limbs (Quadriplegia)	Two Times the Principal Sum
Both lower limbs (Paraplegia)	Two Times the Principal Sum
The upper and lower limbs of one side of body (Hemiplegia)	Two Times the Principal Sum

However, in the case of Quadriplegia, Paraplegia and Hemiplegia, if the Insured Person dies within ninety (90) days after the date of the Accident, the indemnity payable by the Insurer will be limited to the Principal Sum.

Indemnity provided under this section for all Specific Losses sustained by an Insured Person as the result of any one (1) Accident will not exceed the following:

(a) the Principal Sum, with the exception of Quadriplegia, Paraplegia and Hemiplegia; or

(b) with respect to Quadriplegia, Paraplegia and Hemiplegia, two times the Principal Sum, provided that the Insured Person lives longer than ninety (90) days after the date of the Accident.

Under this section, in no event will the Insurer pay more than two times the Principal Sum as the result of the same Accident, regardless of the combination of losses suffered.

Covered Accidental Death and Dismemberment Benefits

Surgical Reattachment Benefit

If an Injury sustained by an Insured Person results in the complete severance of the Insured Person's limb or appendage or part of either a limb or appendage, and if such severed limb, appendage or part is then surgically reattached to that Insured Person within three hundred and sixty-five (365) days after the date of the Accident resulting in such Injury, then the Insurer will pay an indemnity to such Insured Person as follows:

(1) Whether or not the Insured Person regains use of the severed limb, appendage or part, the Insurer will pay an indemnity equal to 50% of the indemnity that would have been payable under the section of this booklet entitled "Specific Loss Accident Indemnity" for the Loss of such limb, appendage or part, if the surgical reattachment had not been performed.

(2) If, after the reattachment of the severed limb, appendage or part and within three hundred and sixty-five (365) days after the date of the Accident resulting in such Injury, the Insured Person suffers a total, irrecoverable and permanent Loss of Use of such reattached limb, appendage or part, the Insurer will pay an indemnity as provided under the section of this booklet entitled "Specific Loss Accident Indemnity" for Loss of Use of such limb, appendage or part, less any amount(s) paid or payable under the Surgical Reattachment Benefit section shown under item (1) above.

(3) If, after the reattachment of the severed limb, appendage or part and within three hundred and sixty-five (365) days after the date of the Accident resulting in such Injury, such reattachment fails and the limb, appendage or part must be amputated, the Insurer will pay an indemnity as provided under the section of this booklet entitled "Specific Loss Accident Indemnity" for the Loss of such limb, appendage or part less any amount(s) paid or payable under this Surgical Reattachment Benefit section, under items (1) and (2).

Indemnity payable under this section and the section of this booklet entitled "Specific Loss Accident Indemnity" for any one (1) Insured Person as the result of any one (1) Accident will not exceed the Principal Sum.

Repatriation Benefit

In the event an Insured Person suffers a Loss of Life resulting from Injury more than fifty (50) kilometres from that Insured Person's normal place of residence and indemnity for such loss becomes payable under the section of this booklet entitled "Specific Loss Accident Indemnity", the Insurer will pay the reasonable and necessary expenses actually incurred for the transportation of the body of the deceased Insured Person to a resting place (including but not limited to a funeral home or the place of interment) in proximity to the normal place of residence of the deceased Insured Person, including charges for the preparation of the body for such transportation, not to exceed, in the aggregate, the amount of fifteen thousand dollars ($15,000) for all such expenses paid under this section as a result of one (1) Accident.

The indemnity payable under this section will be payable to the person who actually incurred the expenses.

The amount payable under this section will be co-ordinated with any amount which is paid or payable for a same or similar benefit provided under any other policies issued to the Policyholder by the Insurer.

Education Benefit

In the event you or your insured Spouse suffers a Loss of Life resulting from an Injury and indemnity for such loss becomes payable under the section of this booklet entitled "Specific Loss Accident Indemnity", the Insurer will pay the reasonable and necessary tuition fees for any Dependent Child who, on the date of or within the following three hundred and sixty-five (365) days of the Insured Person's death, is enrolled or enrolls as a full-time student in any Institution for Higher Learning, up to the lesser of the following amounts:

(a) five percent (5%) of such deceased Insured Person's Principal Sum; or

(b) five thousand dollars ($5,000),

for each year (up to five (5) consecutive years) per Dependent Child during which such Dependent Child remains enrolled as a full-time student in an Institution for Higher Learning.

The total maximum payable under this section will not exceed five thousand dollars ($5,000) per year per Dependent Child.

The indemnity will be paid each year upon receipt of proof satisfactory to the Insurer that the Dependent Child is enrolled as a full-time student in an Institution for Higher Learning. Payment will not be made for expenses incurred prior to the Loss of Life of such Insured Person, nor for room, board, books or other living, travelling or clothing expenses.

The indemnity payable under this section will be payable to the person who actually incurred the expenses.

The amount payable under this section will be co-ordinated with any amount which is paid or payable for a same or similar benefit provided under any other policies issued to the Policyholder by the Insurer.

Day-Care Benefit

In the event you or your insured Spouse suffers a Loss of Life resulting from an Injury and indemnity for such loss becomes payable under the section of this booklet entitled "Specific Loss Accident Indemnity", the Insurer will pay the reasonable and necessary expenses actually incurred for Day-Care Centre attendance for any Dependent Child under thirteen (13) years of age at the date of the Insured Person's death and who on the date of or within the following three hundred and sixty-five (365) days after such Insured Person's death, is enrolled or enrolls in a Day-Care Centre, to the lesser of the following amounts:

(a) five percent (5%) of such deceased Insured Person's Principal Sum; or

(b) five thousand dollars ($5,000),

for each year (up to five (5) consecutive years) per Dependent Child during which such Dependent Child remains enrolled in a Day-Care Centre.

The total maximum payable under this section will not exceed five thousand dollars ($5,000) per year per Dependent Child.

The indemnity will be paid each year upon receipt of satisfactory proof that the Dependent Child is enrolled in a Day-Care Centre, but payment will not be made for expenses incurred prior to the Loss of Life of such Insured Person, nor for room, board or other ordinary living, travelling or clothing expenses.

The indemnity payable under this section will be payable to the person who actually incurred the expenses.

The amount payable under this section will be co-ordinated with any amount which is paid or payable for a same or similar benefit provided under any other policies issued to the Policyholder by the Insurer.

If none of the Insured Person's Dependent Children satisfy the above requirements or the requirements as shown under the section entitled "Education Benefit", the Insurer will pay to your beneficiary the lesser of the following amounts:

(a) five percent (5%) of the deceased Insured Person's Principal Sum; or

(b) two thousand and five hundred dollars ($2,500),

under only one (1) of the policies issued by the Insurer.

Rehabilitation Benefit

In the event you suffer a Specific Loss resulting from an Injury and indemnity for such loss becomes payable under the section of this booklet entitled "Specific Loss Accident Indemnity" and such Injury requires that you participate in a rehabilitation program in order to be qualified to engage in an occupation in which you would not have engaged except for such Injury, the Insurer will pay the reasonable and necessary expenses that you actually incurred for such program within three (3) years after the date of such loss. Payment will not be made for room, board or other ordinary living, travelling or clothing expenses.

Payment by the Insurer for the total of all expenses that you incurred under this section will not exceed fifteen thousand dollars ($15,000) as the result of any one (1) Accident.

The amount payable under this section will be co-ordinated with any amount which is paid or payable for a same or similar benefit provided under any other policies issued to the Policyholder by the Insurer.

Workplace Modification and Accommodation Benefit

In the event you suffer a Specific Loss resulting from an Injury and indemnity for such loss becomes payable under the section of this booklet entitled "Specific Loss Accident Indemnity" and you require special adaptive equipment and/or workplace modification in order to reasonably accommodate your return to active work with the Policyholder, the Insurer will pay the reasonable and necessary expenses actually incurred by the Policyholder for such equipment and/or modification provided:

(1) The Policyholder agrees in writing to provide the special adaptive equipment and/or make modifications to the workplace for the purpose of making it accessible and adaptable to your needs; and

(2) The Policyholder acknowledges in writing that the performance of the essential duties of your job would be compromised in the absence of such modification or accommodation; and

(3) The proposed special adaptive equipment and/or workplace modification have prior written approval by the Insurer.

The Insurer has the right to have you examined by a professional of its choice to evaluate the appropriateness of the proposed modifications and/or equipment.

The indemnity under this section will be paid to the Policyholder once you have returned to active work with the Policyholder and the Insurer has been provided with written proof of the expenses incurred. The benefit is not payable if the Policyholder does not incur any cost in providing the special adaptive equipment and/or the workplace modification.

Payment by the Insurer for the total of all expenses incurred by the Policyholder under this section will not exceed five thousand dollars ($5,000) as a result of any one (1) Accident.

The amount payable under this section will be co-ordinated with any amount which is paid or payable for a same or similar benefit provided under any other policies issued to the Policyholder by the Insurer.

Occupational Training Benefit

In the event you suffer a Loss of Life resulting from an Injury and indemnity for such loss becomes payable under the section of this booklet entitled "Specific Loss Accident Indemnity", the Insurer will pay the reasonable and necessary expenses actually incurred within the following three (3) years after the date of such loss by your Spouse who engages in a formal occupational training program in order to become specifically qualified for active employment in an occupation for which he would not otherwise have sufficient qualifications. Payment will not be made for room, board or other ordinary living, travelling or clothing expenses.

Payment by the Insurer for the total of all expenses incurred by your Spouse under this section will not exceed fifteen thousand dollars ($15,000).

The indemnity payable under this section will be payable to the person who actually incurred the expenses.

The amount payable under this section will be co-ordinated with any amount which is paid or payable for a same or similar benefit provided under any other policies issued to the Policyholder by the Insurer.

Enhanced Child Benefit

In the event an insured Dependent Child suffers a Specific Loss resulting from an Injury and indemnity for such loss becomes payable under the section of this booklet entitled "Specific Loss Accident Indemnity", the Insurer will pay double the applicable indemnity with exception of Loss of Life.

This section is not applicable if the insured Dependent Child dies as a result of the Injury or from any cause within ninety (90) days after the date of the Accident.

Permanent Total Disability Indemnity

In the event you suffer an Injury resulting in Total Disability within three hundred and sixty-five (365) days after the date of the Accident causing such Injury, provided such Total Disability was continued over a period of twelve (12) consecutive months following Commencement of Total Disability and is permanent at the end of this period, the Insurer will pay the Principal Sum, less any amount paid or payable as the result of the same Accident under the section of this booklet entitled "Specific Loss Accident Indemnity".

Family Transportation Benefit

In the event an Insured Person suffers a Specific Loss resulting from an Injury and indemnity for such loss becomes payable under the section of this booklet entitled "Specific Loss Accident Indemnity" and such Insured Person is under the Regular Care and Attendance of a Physician, the Insurer will pay the reasonable and necessary expenses actually incurred by one (1) Immediate Family Member or family representative for Transportation to the bedside of such Insured Person by the most direct route from the normal place of residence of the Immediate Family Member or family representative, Accommodation in the vicinity, and return to the normal place of residence of such Immediate Family Member or family representative by the most direct route if the Insured Person had been travelling unaccompanied by an Immediate Family Member. Payment will not be made for other ordinary living, travelling or clothing expenses.

The Insurer will not pay any indemnity under this section unless such Insured Person is confined as an inpatient in a Hospital located more than fifty (50) kilometres from his normal place of residence.

Reimbursement of Transportation expenses under this section is limited to the cost of a single return trip to the bedside of the Insured Person while in Hospital. More than one form of conveyance may be used for the Transportation if necessary, but the indemnity paid will be limited to the Fare or Fares reasonably required for a single return trip. If Transportation occurs in a Motorized Vehicle other than one operated under a license for the conveyance of passengers, then reimbursement of Transportation expenses will be limited to a maximum of thirty-five cents ($0.35) per kilometre travelled for such return trip.

The total maximum amount payable under this section by the Insurer will not exceed fifteen thousand dollars (15 000$) as a result of any one (1) Accident.

The indemnity payable under this section will be payable to the person who actually incurred the expenses.

The amount payable under this section will be co-ordinated with any amount which is paid or payable for a same or similar benefit provided under any other policies issued to the Policyholder by the Insurer.

Identification Benefit

In the event an Insured Person suffers a Loss of Life resulting from an Injury and indemnity for such loss becomes payable under the section of this booklet entitled "Specific Loss Accident Indemnity" and the police or similar governmental authority requires identification of the Insured Person’s body, the Insurer will pay the reasonable and necessary expenses actually incurred by one (1) Immediate Family Member or family representative for Transportation to the location of the Insured Person’s body by the most direct route from the normal place of residence of the Immediate Family Member or family representative, Accommodation in the vicinity, and return to the normal place of residence of such Immediate Family Member or family representative by the most direct route, if, at the time of death, the Insured Person had been travelling unaccompanied by an Immediate Family Member. Payment will not be made for other ordinary living, travelling or clothing expenses.

The Insurer will not pay any indemnity under this section unless the Insured Person’s body is located more than fifty (50) kilometres from the Insured Person’s normal place of residence.

Reimbursement of Transportation expenses under this section is limited to the cost of a single return trip to identify the deceased Insured Person. More than one form of conveyance may be used for the Transportation if necessary, but the indemnity paid will be limited to the Fare or Fares reasonably required for a single return trip. If Transportation occurs in a Motorized Vehicle other than one operated under a license for the conveyance of passengers, then reimbursement of Transportation expenses will be limited to a maximum of thirty-five cents ($0.35) per kilometre travelled for such return trip.

The total maximum amount payable under this section by the Insurer will not exceed fifteen thousand dollars (15 000$) as a result of any one (1) Accident.

The indemnity payable under this section will be payable to the person who actually incurred the expenses.

The amount payable under this section will be co-ordinated with any amount which is paid or payable for a same or similar benefit provided under any other policies issued to the Policyholder by the Insurer.

Common Disaster Benefit

In the event you and your insured Spouse both suffer a Loss of Life resulting from an Injury and indemnity for such losses becomes payable under the section of this booklet entitled "Specific Loss Accident Indemnity" as a result of a Common Accident, the indemnity for such Loss of Life applicable to your insured Spouse will be increased up to your Principal Sum amount, but in no event will the amount payable under the Policy exceed, in the aggregate, one million dollars ($1,000,000).

Seat Belt Benefit

In the event an Insured Person suffers a Specific Loss resulting from an Injury and indemnity for such loss becomes payable under the section of this booklet entitled "Specific Loss Accident Indemnity", the Insurer will pay an additional indemnity equal to ten percent (10%) of the applicable indemnity payable under the section of this booklet entitled "Specific Loss Accident Indemnity", subject to a maximum of fifty thousand dollars ($50,000), if at the time of the Accident causing such Injury, the Insured Person was driving or riding in a Motorized Vehicle and wearing a properly fastened Seat Belt.

At the time of the Accident, the driver of the Motorized Vehicle must hold a current and valid driver's license of a rating authorizing him to operate such Motorized Vehicle and neither be Intoxicated nor Under the Influence of Drugs.

Proof of Seat Belt use to the satisfaction of the Insurer must be provided as part of the written proof of loss.

Home Alteration and/or Vehicle Modification Benefit

In the event an Insured Person suffers a Specific Loss listed below resulting from an Injury:

(1) Loss of both feet or legs; or

(2) Loss of Use of both feet or legs; or

(3) Quadriplegia, Paraplegia or Hemiplegia,

and indemnity for such loss becomes payable under the section of this booklet entitled "Specific Loss Accident Indemnity" and such Insured Person requires the use of a wheelchair, as result of such loss, in order to be ambulatory, the Insurer will pay the reasonable and necessary expenses actually incurred by the Insured Person within three (3) years following the date of Loss for home alteration and/or vehicle modification as provided under this section.

To be covered under this section, the alteration or modification must enable the Insured Person to access his residence and/or his vehicle in a wheelchair and must be approved, where required by law, by licensing authorities.

The total maximum amount payable under this section by the Insurer will not exceed fifteen thousand dollars ($15,000) as a result of any one (1) Accident.

The amount payable under this section will be co-ordinated with any amount which is paid or payable for a same or similar benefit provided under any other policies issued to the Policyholder by the Insurer.

Hospital Indemnity

In the event an Insured Person suffers a Specific Loss resulting from an Injury and indemnity for such loss becomes payable under the section of this booklet entitled "Specific Loss Accident Indemnity" and such Injury requires the Insured Person to stay in a Hospital and under the Regular Care and Attendance of a Physician for at least four (4) consecutive days, the Insurer will pay a Daily Indemnity provided such Period of Hospitalization is necessary for the treatment of such Injury. Such Daily Indemnity will be paid from the first (1st) Day of Hospitalization, but in no event for more than three hundred and sixty five (365) days per Accident.

Notwithstanding anything contained to the contrary in the Policy, a Period of Hospitalization which becomes necessary for the treatment of an Injury which resulted in a Specific Loss will be covered in accordance with the terms of this section, provided such Period of Hospitalization commences:

(1) within three hundred and sixty-five (365) days after the date of the Accident causing such Injury; and

(2) while this Insured Person's individual coverage under the Policy is in force.

Such Daily Indemnity will be calculated as payable from the first (1st) Day of Hospitalization, provided the Insured Person is hospitalized for at least four (4) consecutive days.

Only one (1) Period of Hospitalization will be payable for all Injuries sustained by the Insured Person as the result of one (1) Accident.

Cosmetic Disfigurement Benefit

In the event an Insured Person suffers a Burn resulting from an Injury, the Insurer will pay an indemnity determined by multiplying the applicable Area Classification Factor, as shown in the Cosmetic Burn Indemnity Schedule below, by the percentage of body surface actually burned subject to the Maximum Allowable Percentage for Body Surface Burned as stipulated in the Cosmetic Burn Indemnity Schedule times the Principal Sum.

The Maximum Allowable Percentage for Body Surface Burned, as shown in the following Cosmetic Burn Indemnity Schedule, is based on one hundred percent (100%) of the specific body part that was burned. The attending Physician will determine the actual percentage applicable to each burn.

If an Insured Person suffers a Burn or Burns to more than one (1) body part as a result of any one (1) Accident, indemnities payable for all such Burn or Burns will not exceed one hundred percent (100%) of the Insured Person's Principal Sum.

Cosmetic Burn Indemnity Schedule

Body Part	Area Classification Factor	Maximum Allowable Percentage for Body Surface Burned
Face, Neck, Head	11	9.0%
Hand & Forearm (Right)	5	4.5%
Hand & Forearm (Left)	5	4.5%
Upper Arm (Right)	3	4.5%
Upper Arm (Left)	3	4.5%
Torso (Front)	2	18.0%
Torso (Back)	2	18,0%
Thigh (Right)	1	9.0%
Thigh (Left)	1	9.0%
Lower Leg - below knee (Right)	3	9.0%
Lower Leg - below knee (Left)	3	9.0%

In the event indemnities are payable under this section and any of the sections entitled "Specific Loss Accident Indemnity", "Permanent Total Disability Indemnity", "Comatose Benefit" or "Brain Damage Benefit", the total amount payable under all such sections will not exceed one hundred percent (100%) of the Insured Person's Principal Sum or, in the case such indemnities include an indemnity for Paralysis, two hundred percent (200%) of the Insured Person's Principal Sum.

Escalation Benefit

In the event an Insured Person suffers a Specific Loss resulting from an Injury and indemnity for such loss becomes payable under any of the sections of this booklet entitled "Specific Loss Accident Indemnity", "Permanent Total Disability Indemnity", "Comatose Benefit" or "Brain Damage Benefit" of the Policy, the Insurer will pay one percent (1%) of such indemnity, for each year your individual coverage has remained continuously in force under the Policy without interruption, subject to a total maximum of five percent (5%) of such indemnity, based on the Principal Sum approved by the Insurer for this Insured Person at the time of the Accident or, if such approval was not required, the Principal Sum, as to this Insured Person, stated on your most recently signed enrollment card on file with the Policyholder at the time of the Accident.

The number of years your individual coverage remained in force will be counted as follows:

(1) if you become insured on or before the effective date of this benefit, one year will be counted on the first anniversary date of this benefit and one (1) year will be added on each subsequent anniversary date thereafter; or

(2) if you become insured after the effective date of this benefit, one year will be counted on the first anniversary date of your insurance under the Policy and one (1) year will be added on each such subsequent anniversary date thereafter.

An Insured Person who discontinues his coverage and subsequently re-applies for coverage will be considered as a person becoming insured for the first (1st) time in the year he re-applies for coverage.

Comatose Benefit

In the event a Physician determines that an Insured Person has become Comatose as a result of an Injury, the Insurer will pay an indemnity equal to the amount of the Principal Sum less any other amount paid or payable under the section of this booklet entitled "Specific Loss Accident Indemnity" as the result of the same Accident, provided:

(1) The Insured Person becomes Comatose within three hundred and sixty five (365) days after the date of the Accident; and

(2) The Insured Person has been Comatose for at least six (6) consecutive months.

Aircraft Coverage

Insurance provided under the Policy includes coverage for loss when such loss results from Injury sustained while and as a result of the Insured Person:

(a) riding as a passenger, and not as a pilot, operator or member of the crew, in or on any aircraft having a current and valid certificate of airworthiness and being piloted by a person who then holds a current and valid pilot's license of a rating authorizing him to pilot such aircraft.

(b) riding as a passenger, and not as a pilot, operator or member of the crew, in or on any aircraft operated by the Canadian Armed Forces or by a similar military service of any duly constituted governmental authority of any other recognized country.

(c) boarding or alighting from or being struck by any aircraft.

However, coverage is excluded from Injury sustained while and as a result of riding in or on any aircraft owned, operated, leased or chartered by or on behalf of the Policyholder.

Exposure and Disappearance Coverage

In the event an Insured Person undergoes unavoidable exposure to natural elements and, as a direct result, suffers a Specific Loss for which indemnity would have been payable under the section of this booklet entitled "Specific Loss Accident Indemnity" if it had been caused by an Accident, the Insurer will pay the amount specified for the same loss as in the section of this booklet entitled "Specific Loss Accident Indemnity".

In the event an Insured Person is not found within one (1) year following the date of the disappearance or sinking or wrecking of the conveyance in which he was riding at the time of such disappearance or sinking or wrecking and under such circumstances as would otherwise be covered under the section of this booklet entitled "Specific Loss Accident Indemnity", it will be presumed the Insured Person suffered a Loss of Life resulting from an Injury at the time of such disappearance, sinking or wrecking.

Brain Damage Benefit

In the event an Insured Person suffers Brain Damage as a result of an Injury, the Insurer will pay the Principal Sum, less any other amount paid or payable under the section of this booklet entitled "Specific Loss Accident Indemnity" as the result of the same Accident, provided:

(1) The Insured Person incurs Brain Damage within one hundred and twenty (120) days from the date of the Accident; and

(2) The Insured Person is hospitalized as a result of Brain Damage at least seven (7) of the first one hundred and twenty (120) days of the Injury; and

(3) A Physician determines and the Insurer is satisfied that the Insured Person has evidence of Brain Damage for at least six (6) consecutive months.

Extension of Coverage

Your individual coverage will be continued for a period of up to twelve (12) months if your employment has been terminated by the Policyholder provided such continuation of coverage is required by any applicable provincial or federal employment law or by a severance package agreement that you received from the Policyholder and payment of premium is continued. Under such conditions, individual coverage with respect to your insured Spouse and/or insured Dependent Children will also continue, provided payment of premium is continued.

This extension of coverage will terminate at 12:01 a.m., Standard Time, on the first (1st) day of the month following either the completion of the twelve (12) month period or the date you return to work in any capacity, whichever is earlier.

Extensions of coverage for periods in excess of twelve (12) months may be granted, provided written request is submitted by the Policyholder to the Insurer.

The coverage which is provided as a result of extension under this section will be subject to the terms and provisions of the Policy which were in effect as of the date of termination of employment, including any provision providing for reductions in amounts of insurance.

Notwithstanding anything contained to the contrary in the Policy, in no event will indemnities payable for any event insured against which occurs while coverage is being continued under this clause exceed the amount that would have been payable to you at the date of termination of employment.

Extension of Family Coverage

In the event of your death from any cause, individual coverage under the Policy will be continued for your insured Spouse and/or insured Dependent Children for a period of six (6) months, without payment of premium.

Indemnities which become payable as a result of coverage being extended under this section will be paid to your insured Spouse, except in the event of the Loss of Life of your insured Spouse, where indemnity for such loss will be paid to the estate of your insured Spouse.

In the event you do not have an insured Spouse, indemnities payable with respect to your insured Dependent Children will be payable as follows:

(a) If your Child is a minor and the loss is not the Loss of Life of your Child, all indemnities payable will be paid in trust to the legal guardian of your Child.

(b) If your Child is not a minor and the loss is not the Loss of Life of that Child, all indemnities payable will be paid to your Child.

(c) Regardless of the age of your Child, the indemnity payable in the event of the Loss of Life of your Child will be paid to the estate of your Child.

This extension of coverage will terminate at 12:01 a.m., Standard Time, on the first (1st) day of the month following the completion of a six (6) month period which began on the date of your death.

The coverage which is provided as a result of extension under this section will be subject to the terms and provisions of the Policy that were in effect as of the date of your death, including any provision providing for reductions in amounts of insurance.

Notwithstanding anything contained to the contrary in the Policy, in no event will indemnities payable for any event insured against which occurs while individual coverage is being continued under this section exceed the amount that would have been payable to the Insured Person prior to the date of your death.

Continuation of Coverage during Approved Leaves

Individual coverage under the Policy will be continued for you and your insured Spouse and/or your insured Dependent Children during any of the following:

- your approved leave of absence;
- your temporary lay-off;
- your maternity/parental leave; or
- your disability leave,

provided payment of premium is continued.

This continuation of coverage will terminate at 12:01 a.m., Standard Time:

(1) with respect to any leave of absence approved by the Policyholder, on the first (1st) day of the month following the completion of a twelve (12) month period that started on the date such approved leave of absence began or on the date you return to work in any capacity for the Policyholder or any other employer, including self-employment, whichever is earlier. Continuation of coverage for periods in excess of twelve (12) months may be granted, provided written request is submitted by the Policyholder to the Insurer;

(2) with respect to any temporary lay-off approved by the Policyholder, on the first (1st) day of the month following the completion of a six (6) month period that started on the date such approved temporary lay-off began or on the date you return to work in any capacity for the Policyholder or any other employer, including self-employment, whichever is earlier. Continuation of coverage for periods in excess of six (6) months may be granted, provided written request is submitted by the Policyholder to the Insurer;

(3) with respect to strike, on the thirty-first (31st) day following the commencement of the strike;

(4) with respect to any maternity/parental leave approved by the Policyholder, on the date you return to work in any capacity for the Policyholder or any other employer, including self-employment; and

(5) with respect to any disability leave approved by the Policyholder, on the date you reach seventy (70) years of age, qualify under the Waiver of Premium section of this booklet or return to work in any capacity, whichever is earlier.

The coverage which is provided as a result of continuation under this section will be subject to the terms and provisions of the Policy that were in effect as of the date of commencement of the leave, including any provision providing for reductions in amounts of insurance.

Notwithstanding anything contained to the contrary in the Policy, in no event will indemnities payable for any event insured against which occurs while individual coverage is being continued under this section exceed the amount that would have been payable to you at the date of commencement of your leave.

Waiver of Premium

When, under the Policyholder's basic group life insurance policy, your life insurance coverage is extended under a waiver of premium provision as the result of total disability resulting from a Sickness or Disease, from a Sickness or Disease related to pregnancy, from an Injury or from an Accident, coverage under the Policy will also be extended and waiver of premium granted. Premiums with respect to your insured Spouse and insured Dependent Children, if any, will also be waived whenever your premiums are waived.

Premiums will continue to be waived until the earliest of the following dates:

(a) the date the Policy is terminated; or

(b) the date you reach seventy (70) years of age; or

(c) the date the you cease to be totally disabled; or

(d) the date you fail to provide proof satisfactory to the Insurer of the continuance of total disability within ninety (90) days of request of such proof or refuse to submit to a medical examination requested by the Insurer.

The coverage which is continued under this section is subject to the terms and provisions of the Policy which are in effect on the date prior to the commencement of total disability, including any provision providing for reductions in amounts of insurance or any indemnity.

Notwithstanding anything contained to the contrary in the Policy, in no event will indemnities payable for any event insured against which occurs while coverage is being continued under this section exceed the amount that would have been payable, if any, to the Insured Person at the date prior to your commencement of total disability.

The Insurer has the right to request proof of total disability or the continuation thereof from time to time, as the Insurer may reasonably require. Failure to provide proof satisfactory to the Insurer may result in termination of this "Waiver of Premium" section.

Conversion to an Individual Insurance Contract

In the event your coverage is terminated because:

(a) you cease to be an active Employee of the Policyholder on account of resignation, dismissal, retirement or failure to return to work for the Policyholder following a period of total disability; or

(b) you cease to be an eligible person under the Policy; or

(c) the period of extension of your coverage as provided in the "Extension of Coverage" section ends,

if you have not reached the age of seventy (70), you may make a written application to the Insurer within thirty-one (31) days of said termination to obtain an individual accident policy. On reception of such application, the Insurer will, without evidence of insurability, issue an individual accident policy to the applicant.

However, conversion will not be possible if the Policy is terminated at the time of the application.

The benefits provided will be set out in a Specific Loss Accident Indemnity schedule available from the Insurer at the time of conversion, and the amount of insurance that may be converted will not exceed the lesser of:

(a) the amount of insurance then in effect on the date of termination; or

(b) a total aggregate amount of two hundred and fifty thousand dollars ($250,000) for all such conversions.

Premiums for such an individual accident policy being issued in compliance with the aforementioned condition will be calculated at the Insurer's rates then in force for your attained age at the date of conversion. Premiums will be payable annually in advance and the accident policy will be issued on an annually renewable basis.

Premium Payment

Premiums for your coverage are fully paid by you, using the means of payroll deductions.

Indemnity Payment and Beneficiaries

Indemnity payable in the event of your Loss of Life will be paid to the beneficiary or beneficiaries designated in writing by you on your most recently signed enrollment card or beneficiary designation card on file with the Policyholder, on your most recently signed enrollment card or beneficiary designation card on file with the Policyholder, or, if there is no such beneficiary designation, such indemnity will be paid to your estate. All other indemnities payable, including those payable for your insured Spouse and/or insured Dependent Children, will be paid to you, with the exception of indemnities payable under the following sections of this booklet, for which, indemnity will be paid to the person who actually incurred the expenses giving rise to the indemnity:

- Repatriation Benefit
- Education Benefit
- Day-Care Benefit
- Workplace Modification and Accommodation Benefit
- Occupational Training Benefit
- Family Transportation Benefit
- Identification Benefit
- Home Alteration and/or Vehicle Modification Benefit

Aggregate Limit of Indemnity

The Insurer's aggregate limit of indemnity for all indemnities payable as a result of any one (1) Accident is $50,000,000. In the event said limit of indemnity for any one (1) Accident is insufficient to pay the full amount of indemnity for each Insured Person, then the amount payable for each Insured Person will be in the proportion that the limit of indemnity for any one (1) Accident bears to the total amount of indemnity that would have been payable, not taking into consideration such limit of indemnity.

This section only applies to indemnities payable under the following sections of this booklet:

- Specific Loss Accident Indemnity
- Enhanced Child Benefit
- Permanent Total Disability Indemnity
- Brain Damage Benefit
- Comatose Benefit

Exclusions

No benefit will be paid for any loss, fatal or non-fatal, caused or contributed to by:

- self-inflicted injuries, suicide or attempted suicide, whether the Insured Person was sane or insane;
- war whether declared or undeclared, and whether or not the Insured Person was actually participating therein;
- civil commotion, riot, insurrection, armed conflict if the Insured Person was participating therein;
- the Insured Person's service, whether as a combatant or non-combatant, in the armed forces of any country;
- the Insured Person riding as a passenger or otherwise in any vehicle or device for aerial navigation, other than as provided in the section of this booklet entitled "Aircraft Coverage";
- medical treatment or surgery on the Insured Person, except if the medical treatment or surgery was needed because of an Accident.

IN THE EVENT OF A CLAIM

Notice of Claim

Written notice of Injury on which claim is based must be given to the Insurer within thirty (30) days after the date of the Accident resulting in such Injury.

Such notice must be given in writing by or on behalf of the Insured Person, his beneficiary or the person who is entitled to the indemnity under the Policy, as the case may be, to the Insurer at 2020 University Street, Suite 1800, Montreal (Quebec), H3A 2A5, or to any Regional Office of the Insurer or to any authorized agent of the Insurer, with particulars sufficient to identify the Insured Person whose loss is the basis of such notice.

Failure to give such notice within the time provided in the Policy will not invalidate any claim if it is shown not to have been reasonably possible to give such notice during such time and that such notice was given as soon as was reasonably possible, but in no event later than one (1) year after the date of the Accident.

Claim Forms

The Insurer, upon receipt of such notice, agrees to furnish to the claimant such forms as are usually furnished by it for filing proof of loss. If such forms are not so furnished within fifteen (15) days after the Insurer’s receipt of such notice, the claimant will be deemed to have complied with the requirements of the Policy as to proof of such loss upon submitting, within the time fixed in the Policy for filing proofs of loss, written proof covering the occurrence, character and extent of the loss for which claim is made.

Proof of Loss

Written proof of loss must be furnished to the Insurer within ninety (90) days after the date of Accident resulting in such loss. Failure to furnish such proof within such time will not invalidate any claim if it is shown not to have been reasonably possible to furnish such proof during such time and that such proof was furnished as soon as was reasonably possible, but in no event later than one (1) year after the date of the Accident.

Physical Examination and Autopsy

The Insurer will have the right and opportunity to examine, at its own expense, the person of the Insured Person whose loss is the basis of claim under the Policy, where and so often as it may reasonably require while it determines the validity of a claim hereunder, and in the case of death, the right and opportunity to require an autopsy where it is not forbidden by law.

Payment of Claims

All indemnities provided in the Policy for loss will be paid after customary proof of loss satisfactory to the Insurer has been given in accordance with the requirements of the Policy. With respect to Insured Persons of the Policyholder for whom premium is paid in Canadian funds, all monies payable under the Policy are payable in the lawful money of Canada. With respect to Insured Persons of a Policyholder who pay the premium in U.S. funds, all moneys payable under the Policy are payable in the lawful money of the United States of America.

Legal Actions

Legal action will not be taken to recover indemnities under the Policy until sixty (60) days after proof of loss has been submitted to the Insurer in accordance with the requirements of the Policy. Thereafter, the claimant must take any legal action based on the Policy within a one (1) year period [three (3) years in the province of Quebec] following submission of a proof of loss to the Insurer.

FREQUENTLY ASKED QUESTIONS

1. Who is eligible for Accidental Death and Dismemberment coverage?

You are eligible under the program if you are a Canadian resident and an active, full-time and permanent Employee under the age of seventy (70).

Your Spouse is also eligible for coverage if he or she is under the age of seventy (70) [refer to definition list for details].

Your Dependent Child, under the age of 21 or under 25 years of age if attending an Institution for Higher Learning on a full-time basis (26 in Quebec) is also eligible for coverage [refer to definition list for details].

2. When does individual coverage take effect?

With respect to an Employee who sends an enrollment card or completes an online enrollment, or for whom an enrollment card is sent:

- on or before the effective date of the policy;
- after the effective date of the policy, on the first of the month following or coincident with the date the enrollment card is received by the Policyholder.

With respect to Spouse and/or Dependent Child:

- on the effective date of the your coverage;
- on the date the Spouse and/or Dependent Child becomes eligible if eligible after the effective date of your coverage.

3. Who receives the Principal Sum insured upon death of the Insured Person?

The Principal Sum will be paid to the beneficiary or beneficiaries designated in writing by you on your most recently signed enrollment card or beneficiary designation card on file with your Program administrator, or if there is no such beneficiary designation, the sum insured will be paid to your estate.

4. Who can change the beneficiary and how can this be done?

You have the right to change your designated beneficiary or beneficiaries. Please contact your Human Resources department for details.

5. How are premiums paid?

Premiums for your coverage are fully paid by you, using the means of payroll deductions.

6. Are Accidental Death and Dismemberment benefit indemnities and Principal Sum taxable?

No, Accidental Death and Dismemberment insurance proceeds and the Principal Sum are not taxable.

7. How do I file a claim?

Filing a claim is a very simple process.

You must notify your Program administrator of your claim, either in writing or verbally, as soon as you suffer the Injury on which the claim is based, as such notice must be given in writing to the Insurer within thirty (30) days after the date of the Accident resulting in such Injury. In the event that you are unable to give such notice, your beneficiary or beneficiaries or the person entitled to an indemnity under your coverage, may notify your Program administrator on your behalf.

The Insurer, upon receipt of the above-mentioned notice, will send claim forms to your Program administrator. These claim forms constitute the written proof of loss and must be completed and returned to the Insurer within ninety (90) days after the date of Accident resulting in such loss.

Your claim will be reviewed and processed, on average, within ten (10) business days from the date the completed claim forms are received by the Insurer.

8. Can I cancel my Accidental Death and Dismemberment coverage?

You may cancel your Accidental Death and Dismemberment coverage at any moment by giving notice of cancellation to the Policyholder.

9. Where can I obtain more information?

You can obtain more information by communicating with your Human Resources department.

APPENDIX II

CRITICAL ILLNESS INSURANCE

SSQ INSURANCE COMPANY INC.

CRITICAL ILLNESS INSURANCE

for Employees of
EnGlobe Corp.

EFFECTIVE DATE: **1st of April 2016**

POLICY No. **1R700**

This Booklet/Certificate is an important document.
Please keep it in a safe place.

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This booklet is an outline of SSQ Insurance Company Inc. Critical Illness Insurance Plan offered to the Employees of EnGlobe Corp. and their dependents (Spouses and Dependent Children). It is designed to help you learn more about the coverage offered under this Plan. This booklet should be retained for reference.

The Critical Illness Insurance Group Policy no. **1R700**, its endorsements and attached papers, if any, and the entire contract of insurance, all referred to hereafter as the "Policy", sets forth the terms and conditions of the Insurance Plan. All rights and obligations are determined in accordance with the Policy, not this booklet. For exact provisions of coverage offered, please contact your Human Resources department.

Throughout this booklet, the male pronoun will be construed as the feminine when the person is a female.

NOTICE OF NEW FILE

File and Personal Information

In order to maintain the confidentiality of information concerning the persons it insures, the Insurer opens an insurance file to hold personal information about the application for insurance and any insurance claims made.

With the exception of certain cases provided for under applicable legislation, access to insured persons' files is restricted to those employees, legal agents and service providers who must consult these files for the purpose of contract management, inquiries or underwriting, in addition to reinsurers and any other person you may authorize. The Insurer keeps these insurance files in its offices.

All persons insured with SSQ Insurance Company Inc. have the right to consult the information contained in their file and, if necessary, to have any errors or inaccuracies corrected, free of charge, by making a written request to the attention of the Insurer's Personal Information Protection Officer at the following address: SSQ, Life Insurance Company Inc., 2525 Laurier Boulevard, P.O. Box 10500, Station Sainte-Foy, Quebec QC G1V 4H6. However, the Insurer may charge fees for transcribing, reproducing or sending this information. The person making the request for information will be informed beforehand of the approximate amount that will be charged.

Legal Agents and Service Providers

The Insurer may exchange information of a personal and confidential nature with its reinsurers, legal agents and service providers only for the purpose of allowing them to carry out the tasks they are assigned. The Insurer's legal agents and service providers must comply with SSQ's Personal Information Protection Policy.

When you enrol in a group insurance plan, and also when you make a claim, you are actually giving your consent that the Insurer and its legal agents and service providers may use your personal information for the above-mentioned purposes. It is understood that not giving this consent would compromise the management of your insurance coverage and the quality of the services the Insurer can offer you.

For more information, consult the SSQ Personal Information Protection Policy available at ssq.ca.

INTRODUCTION

What is Critical Illness Insurance?

Critical Illness Insurance can provide the funds and 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.

It is designed to provide a lump sum payment in the event that the individual is diagnosed for the first time with a given covered Critical Illness while the insurance is in force and survives at least 14 days following the diagnosis. Among the many advantages of this coverage, payment of benefits is not limited by your ability to work or even by a full recovery. Should you receive a critical illness diagnosis, the benefit is paid directly to you and you are **free to choose how to use the amount you receive.**

Why is Critical Illness Insurance important?

Research has shown that a significant number of Canadians will face the challenge of a critical illness. Consider the following:

40% of Canadian women and 45% of men will develop cancer during their lifetimes.

On average, 3,300 Canadians will be diagnosed with cancer every week.

There are an estimated 70,000 heart attacks each year in Canada. One heart attack every 7 minutes.

More than 50,000 strokes occur in Canada each year. That's one stroke every 10 minutes.

75% of stroke victims survive the initial event.

Approximately 1,000 new cases of multiple sclerosis are diagnosed in Canada each year.

Source: Heart and Stroke Foundation, Canadian Cancer Society and Multiple Sclerosis Society of Canada

Critical illnesses are diagnosed everyday. Although healthy lifestyle choices can help protect against some health risks, a critical illness or condition can strike anyone at any time. Thanks to advances in modern medicine however, Canadians are enjoying longer and healthier lives. As survival rates improve, the need for Critical Illness Insurance, to help provide financial support throughout the recovery process is becoming more and more important.

A Critical Illness Insurance benefit can help you:

obtain the appropriate care where and when you decide

cover medical expenses not covered under your provincial health care plan

focus on your recovery process by funding a leave of absence or time off to take care of a family member

compensate for reduced family earnings and face increased costs, by using the benefit to pay for:

- medical bills or private nursing care
- mortgage payments or rent
- debt or other financial liabilities
- child care
- hired domestic help
- home or vehicle modifications

What are the advantages of your coverage?

With your Critical Illness Insurance, you benefit from:

coverage up to $20,000 for you, up to $20,000 for your spouse, and up to $ 25,000 for your dependent children, tax-free, without having to answer any medical questions or provide any evidence of insurability;

affordable coverage thanks to our competitive group rates;

premium payments by way of payroll deductions;

continued protection even if your health has diminished while covered under the Plan – even after having received a critical illness benefit, you and your insured spouse may still be covered under the Insurer's Critical Illness coverage!

GENERAL DEFINITIONS

"Critical Illness" means a deterioration of health or bodily disorder which, while the individual's insurance is in force, leads to an initial Diagnosis of one of the illnesses or medical conditions covered under the insurance or to a covered surgery, according to the following list of Critical Illnesses. In addition, for the Diagnosed illness to be recognized as a Critical Illness for the purposes of the plan, the Diagnosis must be made by a Specialist and confirm that it meets the criteria indicated in the "Definitions of Covered Illnesses" section. For any covered surgery, a Specialist must confirm that it is medically necessary.

1. Aortic surgery
2. Aplastic anemia
3. Bacterial meningitis
4. Benign brain tumour
5. Blindness
6. Cancer (life-threatening)
7. Coma
8. Coronary angioplasty
9. Coronary artery bypass surgery
10. Crohn's disease requiring surgery
11. Deafness
12. Dementia, including Alzheimer's disease
13. Dilated cardiomyopathy
14. Ductal carcinoma in situ of the breast
15. Fulminant viral hepatitis
16. Heart attack
17. Heart valve replacement or repair
18. Hip replacement surgery
19. Kidney failure
20. Knee replacement surgery
21. Liver failure of advanced stage
22. Loss of independent existence
23. Loss of limbs
24. Loss of speech
25. Major organ failure on waiting list
26. Major organ transplant
27. Motor neuron disease
28. Multiple sclerosis
29. Muscular dystrophy
30. Occupational HIV infection
31. Paralysis
32. Parkinson's disease and specified atypical Parkinsonian disorders
33. Primary pulmonary hypertension

34. Progressive systemic sclerosis
35. Severe burns
36. Severe rheumatoid arthritis
37. Stage 1A malignant melanoma
38. Stage A (T1a or T1b) prostate cancer
39. Stroke
40. Systemic lupus erythematosus

Any Critical Illness or health problem which is not defined in the present document is not covered according to this benefit and therefore, no benefit is payable in respect of such illness.

"Critical Illness" with respect to an Insured Dependent Child means one of the following illnesses, conditions or surgical operations which, while the individual's insurance is in force, leads to an initial Diagnosis of one of the illnesses or medical conditions covered under the insurance or to a covered surgery, according to the following list of Critical Illnesses. In addition, for the Diagnosed illness to be recognized as a Critical Illness for the purposes of the plan, the Diagnosis must be made by a Specialist and confirm that it meets the criteria indicated in the "Definitions of Covered Illnesses" section. For any covered surgery, a Specialist must confirm that it is medically necessary.

1. Benign brain tumour
2. Blindness
3. Cancer (life-threatening)
4. Cerebral palsy
5. Coma
6. Congenital heart disease requiring surgery
7. Cystic fibrosis
8. Deafness
9. Down's syndrome
10. Kidney failure
11. Loss of speech
12. Major organ failure on waiting list
13. Major organ transplant
14. Mental deficiency
15. Muscular dystrophy
16. Paralysis
17. Severe burns
18. Spina bifida cystica

Any Critical Illness or health problem which is not defined in the present provision is not covered according to this benefit and therefore, no benefit is payable in respect of such illness.

"*Dependent Child*" means a natural child, adopted child, stepchild or child otherwise in a parent-child relationship with the Insured Employee. The child must be unmarried and dependent upon the Insured Employee for maintenance and support, reside in Canada and:

(1) be under 21 years of age; or

(2) be under 25 years of age (26 in the Province of Quebec) and in attendance at an Institution for Higher Learning on a full-time basis; or

(3) no matter his age on the date of the claim, be residing with the Insured Employee or Insured Spouse and be suffering from a severe, incurable and chronic physical or mental disability that began while the child met the conditions indicated in (1) or (2) above in this definition, and have remained continuously disabled since that date; the disability must render the child incapable of pursuing any gainful activity. The Insurer may require medical evidence of such as it seems necessary.

The Dependent Child will be covered from birth provided such child is born alive.

"Diagnosis" or *"Diagnosed"* refers to the determination by a Specialist, using tests or other diagnostic methods, that the Insured Person has a specific illness covered under the Policy. The Diagnosis of any covered illness must be made in Canada or the United States by a Specialist licensed to practice in Canada or the United States. Furthermore, his area of practice must include the area of medicine directly related to the illness in question.

"Employee" means a salaried employee of the Policyholder who is under the age of seventy (70) and resides in Canada, and whose usual place of work is in Canada.

"Institution for Higher Learning" means and is limited to universities, colleges, CEGEPs and professional or vocational schools.

"Insured" means an individual whose coverage under the Policy is in force.

"Insured Employee" means an Employee whose coverage under the plan is in force.

"Irreversible" means a condition of the Insured where the prognosis cannot be improved by medical or surgical treatment at the time of Diagnosis. However, when the prognosis could be improved by medical or surgical treatment but would impose, in the opinion of the Insured's Physician, a risk to the Insured's health that would outweigh the expected benefit(s) of such treatment, the condition is then also considered as Irreversible for the purpose of this definition.

"Life Support" means the Insured is under the regular care of a licensed Physician for nutritional, respiratory and/or cardiovascular support when Irreversible cessation of all functions of the brain has occurred.

"Physician" means an individual who is legally licensed to practice medicine in Canada or the United States and provides treatment within the scope of his licence. The Physician must not ordinarily reside with the Insured. The Physician must not be the Insured, a relative of or business associate of the Insured.

"Pre-existing Condition" means:

- the existence of symptom(s) within a twenty-four (24) month period preceding the Insured's effective date of individual coverage which would cause a reasonably prudent person to seek Diagnosis, care or treatment; or
- an illness or condition for which the Insured, during twenty-four (24) months prior to the effective date of his individual coverage, incurred medical expenses, received medical treatment, took prescribed or non-prescribed drugs or consulted a Physician.

"Principal Sum" means the amount of insurance applicable to the Insured and stated on the Insured Employee's most recently signed individual enrollment card on file with the Policyholder, if any.

"Specialist" means a licensed Physician who has been trained in the specific area of medicine relevant to the covered Critical Illness for which benefit is being claimed, and who has been certified by a specialty examining board. In the absence or unavailability of a Specialist, and as approved by the Insurer, a condition may be Diagnosed by a qualified Physician practising in Canada or the United States. The Specialist must not ordinarily reside with the Insured. The Specialist must not be the Insured, a relative of or business associate of the Insured.

"Spouse" means an individual under the age of seventy (70) who resides in Canada and:

(1) who is legally married to or in a civil union with the Insured Employee; or

(2) with whom the Insured Employee has continuously cohabited in a conjugal relationship for a minimum of one (1) year immediately before the date of the event insured against.

However, if an individual is the biological or adoptive mother or father of at least one of the children of the Insured Employee and is cohabiting with the Insured Employee, the individual shall be deemed to be a Spouse from the date of birth or adoption of that child, if that date precedes the end of the period of one (1) year of cohabitation.

Only one (1) individual qualifies as the Spouse of any Insured Employee. If the Insured Employee is legally married or in a civil union but is also cohabiting with an individual as described under Item (b) above, the Insured Employee may elect in writing which one of the individuals will qualify as a Spouse under the Policy. This election must be filed with the Policyholder. The Insurer will not be bound by an election not filed before the occurrence of the event insured against. If an election is not filed, the Spouse will be the individual to whom the Insured Employee is legally married or in a civil union.

"Surgery" means that the Insured undergoes medically necessary surgery performed on the written advice of a Specialist. The Surgery must be performed by a Physician in Canada or the United States.

"Survival Period" means the fourteen (14) days following the date of Diagnosis or fourteen (14) days following the date of Surgery if applicable, except where otherwise specified under the present document. The Survival Period does not include days on Life Support as defined in this section. The Insured must be alive at the end of the Survival Period and must not have experienced Irreversible cessation of all functions of the brain.

For those conditions which have a qualifying period, for example ninety (90) days for Bacterial meningitis and Paralysis, the Survival Period runs concurrently with that condition's qualifying period.

ENROLMENT

Enrolment in this plan is on a voluntary basis.

ELIGIBILITY

- All active Employees of the Policyholder
- Spouses of all active Employees
- Dependent Children of all active Employees

If an Employee is absent from active work for any reason other than maternity or parental leave or vacation or other paid leave, such Employee will only become eligible upon return to active work. Dependent Children become eligible only when the Employee or Spouse enrols in the plan.

COVERAGE AMOUNTS

Critical Illness Insurance is a voluntary group coverage for you, your Spouse and your Dependent Children.

You have the option to buy an amount of principal sum in units of $ 10,000 up to a maximum of $ 250,000, subject to the terms of premium payment indicated in the "*Coverage Payment*" section.

Your Spouse has option to buy an amount of principal sum in units of $ 10,000 up to a maximum of $ 250,000, subject to the terms of premium payment indicated in the "*Coverage Payment*" section.

You can enroll your Dependent Children for coverage in units of $5,000 up to a maximum of $ 25,000 of principal sum, each, without having to provide any evidence of insurability.

With regard to evidence of insurability, you may request an amount of coverage equal or less than the guaranteed issue amount of $ 20,000 and your Spouse may request an amount of coverage equal or less than the guaranteed issue amount of $ 20,000 without having to answer medical questions or having to present evidence of insurability. However, if you or your Spouse wishes to request an amount of coverage greater than the guaranteed issue amount, you and/or your Spousemust submit to the Insurer satisfactory evidence of insurability.

EVIDENCE OF INSURABILITY AND EFFECTIVE DATE OF INSURANCE

Required evidence of insurability

Evidence of insurability to the satisfaction of the Insurer is required when the requested amount exceeds the Guaranteed Issue Amount. It is also required when the request is received by the Policyholder more than thirty-one (31) days after one of the following events:

a. the Effective Date of the Policy;

b. the person's date of eligibility;

c. a Life Event.

Life Events

At the time of any Life Event listed hereafter, the eligible persons may enrol in the plan subject to the provisions of this "Evidence of Insurability and Effective Date of Insurance" section. For the purposes of this insurance, Life Events that give rise to a new eligibility period without evidence of insurability are the following: marriage; civil union; cohabitation for one year; birth or adoption of a first child.

For coverage obtained without evidence of insurability

Coverage as to each eligible Employee or Spouse becomes effective on the latest of the following dates:

a. the Effective Date of the Policy with respect to a request received by the Policyholder on or prior to the Effective Date of the Policy;

b. the date the Employee returns to active full-time work if such Employee is absent from full-time work on the Effective Date of the Policy for any reason other than: vacation or other paid leaves; maternity leaves; parental leaves;

c. the first day of the month coincident with or next following the date of eligibility of the Employee or the Spouse with respect to an Employee or a Spouse who becomes eligible after the Effective Date of the Policy.

Coverage as to each eligible Dependent Child becomes effective on the latest of the following dates:

a. the effective date of the Employee's or Spouse's insurance hereunder;

b. the date the Dependent Child becomes eligible with respect to those who become eligible after the effective date of the Employee's or Spouse's insurance;

c. the date the enrolment of the eligible person is completed.

For coverage that can be obtained only upon approval of evidence of insurability by the Insurer

Coverage as to each eligible person becomes effective on the later between the Effective Date of the Policy and the first day of the month coincident with or next following the date of approval of evidence of insurability, if approved by the Insurer. However, Dependent Children coverage cannot become effective before the Employee's or Spouse's coverage.

DEFINITIONS OF COVERED ILLNESSES

Other illnesses are also covered under this plan. They are defined under section "Complementary Benefit in Case of Certain Illnesses".

"**Aortic Surgery**"

means 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 refers to the thoracic and abdominal aorta but not its branches.

Exclusion: No benefit will be payable under this condition for any of the following: angioplasty; intra-arterial procedures; percutaneous trans-catheter procedures; non-surgical procedures.

"**Aplastic anemia**"

means 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 (1) of the following:

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

"**Bacterial meningitis**"

means a definite Diagnosis of meningitis, confirmed by cerebrospinal fluid showing growth of pathogenic bacteria in culture, resulting in neurological deficit documented for at least ninety (90) days from the date of Diagnosis.

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

"**Benign brain tumour**"

means 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).

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

In addition, no benefit will be payable under this condition if one of the following occurred to the Insured Person within the first ninety (90) days following the last time the Insured Person's coverage under this benefit became effective:

- signs, symptoms or investigations that lead to a Diagnosis of benign brain tumour (covered or not), regardless of when the Diagnosis was made; or
- a Diagnosis of benign brain tumour (covered or not).

Restriction: This medical information as described above must be reported to the Insurer within six (6) months of the date of the Diagnosis. If this information is not provided within this period, the Insurer has the right to deny any claim for Benign brain tumour or any Critical Illness caused by any benign brain tumour or by its treatment.

"**Blindness**"

means 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.

"**Cancer**" **(life-threatening)**

means a definite Diagnosis of a tumour characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. The following types of cancer are included: carcinoma, melanoma, leukemia, lymphoma and sarcoma.

Exclusion: No benefit will be payable under this condition for any of the following:

- lesions described as benign, pre-malignant, uncertain, borderline or non-invasive, carcinoma in situ (Tis) or tumors 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;
- malignant gastrointestinal stromal tumours (GIST) and malignant carcinoid tumours, classified less than the American Joint Committee on Cancer (AJCC) stage 2.

In addition, no benefit will be payable under this condition if one of the following occurred to the Insured Person within the first ninety (90) days following the last time the Insured Person's coverage under this benefit became effective:

- signs, symptoms or investigations that lead to a Diagnosis of Cancer (covered or not), regardless of when the Diagnosis was made; or
- a Diagnosis of cancer (covered or not).

Restriction: This medical information as described above must be reported to the Insurer within six (6) months of the date of the Diagnosis. If this information is not provided within this period, the Insurer has the right to deny any claim for Cancer or any Critical Illness caused by any Cancer or by its treatment.

References: For the 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. Also for the 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

"**Cerebral palsy**"

means the definite Diagnosis of a chronic disorder that appears in the first few years of life, caused by damage to the motor areas of the brain, characterized by varying degrees of limb weakness, involuntary movements and speech problems.

"**Coma**"

means 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 ninety six (96) hours, and for which period the Glasgow coma score must be four (4) or less.

Exclusion: No benefit will be payable under this condition for any of the following:

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

"**Congenital heart disease requiring surgery**"

means the definite Diagnosis of any serious cardiac malformation present at birth, for which corrective surgery has been performed.

"**Coronary artery bypass surgery**"

means the undergoing of heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass graft(s).

Exclusions: No benefit will be payable under this condition for any of the following: angioplasty; intra-arterial procedures; percutaneous trans-catheter procedures or non-surgical procedures.

"**Cystic fibrosis**"

means the definite Diagnosis of a genetic disease affecting the sweat and mucous glands particularly in the lungs and digestive system, characterized by excess production of thick mucous leading to chronic progressive respiratory disease and nutritional problems.

"**Deafness**"

means 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.

"**Dementia, including Alzheimer's disease**"

means the 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);
- 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 following is also required:

- dementia of at least moderate severity, which must be evidenced by a Mini 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 six (6) month period.

Exclusion: No benefit will be payable under this condition for affective or schizophrenic disorders, or delirium.

"**Dilated cardiomyopathy**"

means a condition of impaired ventricular function resulting in significant physical impairment of at least Class III of the New York Heart Association Classification of Cardiac Impairment. The Diagnosis of dilated cardiomyopathy must be confirmed by echocardiographic abnormalities demonstrating new abnormal cardiac function with a persistent low ejection fraction (less than 40%) for at least 3 months.

New York Heart Association Class III cardiomyopathy impairment means that the patient is comfortable at rest and is symptomatic during less than ordinary daily activities despite the use of medication and dietary adjustment, with evidence of abnormal ventricular function on physical examination and laboratory studies.

Exclusion: No benefit will be payable under this condition for ischemic and toxic causes (including alcohol, prescription and non-prescription drug use) of dilated cardiomyopathy.

"**Down's syndrome**"

means the definite Diagnosis of a congenital condition caused by an extra copy of chromosome 21, primarily characterized by varying degrees of mental retardation, though other defects, particularly congenital heart disease, may be present.

"**Fulminant viral hepatitis**"

means a definite Diagnosis of a sub-massive to massive necrosis of the liver caused by any virus leading precipitously to liver failure. Payment under this condition requires satisfaction of all of the following:

(a) a rapidly decreasing liver size as confirmed by abdominal ultrasound;
(b) necrosis involving entire lobules, leaving only a collapsed reticular framework to include histology, if available;
(c) rapidly deteriorating liver function tests;
(d) deepening jaundice.

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

- chronic hepatitis; or
- liver failure caused by alcohol, toxins and/or drugs.

"**Heart attack**"

means a definite Diagnosis of the death of heart muscle due to obstruction of blood flow, that results in:

Rise and fall of biochemical cardiac markers to levels considered diagnostic of myocardial infarction, with at least one (1) 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.

Exclusions: No benefit will be payable under this condition for any of the following:

- elevated biochemical cardiac markers as a result of an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty, in the absence of new Q waves; or
- ECG changes suggesting a prior myocardial infarction, which do not meet the heart attack definition as described above.

"**Heart valve replacement or repair**"

means the undergoing of Surgery to replace any heart valve with either a natural or mechanical valve or to repair heart valve defects or abnormalities.

Exclusion: No benefit will be payable under this condition for any of the following: angioplasty; intra-arterial procedures; percutaneous trans-catheter procedures; non-surgical procedures.

"**Kidney failure**"

means a definite Diagnosis of chronic Irreversible failure of both kidneys to function, as a result of which regular haemodialysis or peritoneal dialysis is required, or renal transplantation initiated.

"**Liver failure of advanced stage**"

means a definite Diagnosis of Liver failure due to cirrhosis and resulting in all of the following:
(a) Permanent jaundice;
(b) Ascites;
(c) Encephalopathy.

Exclusion: No benefit will be payable under this condition for any liver failure secondary to alcohol or drug use (except those taken as prescribed by a Physician).

"**Loss of independent existence**"

means a definite Diagnosis of the total inability to perform, by oneself, at least two (2) of the following six (6) Activities of Daily Living for a continuous period of at least ninety (90) days with no reasonable chance of recovery.

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.
- Feeding - the ability to consume food or drink that already has been prepared and made available, with or without the aid of assistive devices.

"**Loss of limbs**"

means a definite Diagnosis of the complete severance of two (2) or more limbs at or above the wrist or ankle joint as the result of an accident or medically required amputation.

"**Loss of speech**"

means a definite Diagnosis of the total and Irreversible loss of the ability to speak as the result of physical injury or disease, for a period of at least 180 days.

Exclusion: No benefit will be payable under this condition for all psychiatric related causes.

"**Major organ failure on waiting list**"

means a definite Diagnosis of the Irreversible failure of the heart, both lungs, liver or bone marrow, and for which transplant 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 that performs the required form of transplant Surgery. For the purposes of the Survival Period, the date of Diagnosis is the date of the Insured Person's enrollment in the transplant centre.

"**Major organ transplant**"

means a definite Diagnosis of the Irreversible failure of the heart, both lungs, liver or bone marrow, and transplantation must be medically necessary. To qualify under Major organ transplant, the Insured Person must undergo a transplantation procedure as the recipient of a heart, lung, liver or bone marrow, and limited to these entities.

Exclusion: No benefit will be payable under this condition for any organ transplant other than those described above.

"**Mental deficiency**"

means the definite Diagnosis of an intellectual deficiency, as demonstrated by an intelligence quotient (IQ) on standardized testing of less than 70.

"**Motor neuron disease**"

means a definitive Diagnosis of one (1) 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.

"**Multiple sclerosis**"

means a definite Diagnosis of at least one (1) of the following:
- two (2) or more separate clinical attacks, confirmed by magnetic resonance imaging (MRI) of the nervous system, showing multiple lesions or demyelination; or
- well-defined neurological abnormalities lasting more than six (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 (1) month apart.

"**Muscular dystrophy**"

means a definite Diagnosis of all of the following:
(a) Clinical presentation including skeletal muscle weakness, muscle pain and myotonia;
(b) Characteristic electromyography changes;
(c) Muscle biopsy confirming Diagnosis of muscular dystrophy.

"**Occupational HIV infection**"

means a definite Diagnosis of infection with Human Immunodeficiency Virus (HIV) resulting from accidental injury during the course of the Insured Person's normal occupation, which exposed the person to HIV contaminated body fluids. The accidental injury leading to the infection must occur while this coverage is in force.

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

(a) The accidental injury must be reported to the Insurer within fourteen (14) days of the accidental injury;
(b) A serum HIV test must be taken within fourteen (14) days after the accidental injury and the result must be negative;
(c) A serum HIV test must be taken between ninety (90) days and one hundred and eighty (180) days after the accidental injury and the result must be positive; the Insured Person must survive at least fourteen (14) days following the date of this second serum HIV test;
(d) All HIV tests must be performed by a duly licensed laboratory in Canada or the United States;
(e) The accidental injury must have been reported, investigated and documented in accordance with current Canadian or United States workplace guidelines.

Exclusion: No benefit will be payable under this condition if:

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

"**Paralysis**"

means a definite Diagnosis of the total loss of muscle function of two (2) or more limbs as a result of injury or disease to the nerve supply of those limbs, for a period of at least ninety (90) days following the precipitating event.

"**Parkinson's disease and specified atypical Parkinsonian disorders**"

Parkinson's disease means a definite Diagnosis of primary Parkinson's disease, a permanent neurologic condition which is characterized by bradykinesia (slowness of movement) and at least one of: muscular rigidity or rest tremor.

Specified atypical Parkinsonian disorders (SAPD) means a definite Diagnosis of progressive supranuclear palsy, corticobasal degeneration, or multiple system atrophy.

The Diagnosis of Parkinson's disease or specified atypical Parkinsonian disorder must be made by a neurologist. In all cases, the Insured Person condition must exhibit objective signs of a 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.

Exclusion: No benefit will be payable under this condition for any other type of Parkinsonism.

In addition, no benefit will be payable under Parkinson's disease or specified atypical Parkinsonian disorders if one of the following occurred to the Insured Person within the year following the last time the Insured Person's coverage under this benefit became effective:

- signs, symptoms or investigations that lead to a Diagnosis of Parkinson's disease or atypical Parkinsonian disorders or any other type of Parkinsonism, regardless of when the Diagnosis was made; or
- a Diagnosis of Parkinson's disease, atypical Parkinsonian disorders or any other type of Parkinsonism.

Restriction: This medical information as described above must be reported to the Insurer within six (6) months of the date of the Diagnosis. If this information is not provided during this period, the Insurer has the right to deny any claim for Parkinson's disease or specified atypical Parkinsonian disorder or any Critical Illness caused by Parkinson's disease or Parkinsonian disorders or by their treatments.

"**Primary pulmonary hypertension**" **(idiopathic pulmonary arterial hypertension and familial pulmonary arterial hypertension)**

means a definite Diagnosis of primary pulmonary hypertension with a substantial right ventricular enlargement confirmed by investigations including cardiac catheterization, resulting in permanent Irreversible physical impairment to the degree of at least Class IV of the New York Heart Association Classification of Cardiac Impairment.

The New York Heart Association Classification of Cardiac Impairment (source: *Current Medical Diagnosis and Treatment-39th Edition*) states the following about Class IV:

"Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest."

Exclusion: No benefit will be payable under this condition for any other type of pulmonary arterial hypertension.

"**Progressive systemic sclerosis**"

means a definite Diagnosis of Progressive systemic scleroderma with systemic involvement of the heart, lungs or kidneys. The Diagnosis must be unequivocally supported by clinical and serological evidence and with biopsy results when available.

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

- Localized scleroderma (linear scleroderma or morphea); or
- Eosinophilic fasciitis; or
- CREST syndrome.

"**Severe burns**"

means a definite Diagnosis of third degree burns over at least 20% of the body surface.

"**Spina bifida cystica**"

means the definite Diagnosis of a congenital defect caused by failure of the spine to close properly allowing the spinal cord and its protective covering (meninges) to protrude through the skin, characterized by varying degrees of the following:

(a) hydrocephalus;
(b) paralysis;
(c) bowel problems; and
(d) bladder problems.

Exclusion: No benefit will be payable under this condition for Spina Bifida Occulta.

"**Stroke**"

means a definite Diagnosis of an acute cerebrovascular event caused by intra-cranial thrombosis or haemorrhage, or embolism from an extra-cranial source, with:

- acute onset of new neurological symptoms; and
- new objective neurological deficits on clinical examination;

persisting for more than thirty (30) days following the date of Diagnosis.

These new symptoms and deficits must be corroborated by diagnostic imaging testing.

Exclusion: No benefit will be payable under this condition for any of the following:

- transient ischaemic attacks; or
- intracerebral vascular events due to trauma; or
- lacunar infarcts which do not meet the definition of stroke as described above.

COMPLEMENTARY BENEFIT IN CASE OF CERTAIN ILLNESSES (APPLICABLE TO AN INSURED EMPLOYEE AND INSURED SPOUSE)

In addition to the Critical Illnesses described under section "Definitions of Covered Illnesses", the following illnesses, as defined hereunder, are covered under the Complementary Benefit in Case of Certain Illnesses.

1. Coronary angioplasty
2. Crohn's disease requiring surgery
3. Ductal carcinoma in situ of the breast

4. Hip or knee replacement surgery
5. Severe rheumatoid arthritis
6. Stage A (T1a or T1b) prostate cancer
7. Stage 1A malignant melanoma
8. Systemic lupus erythematosus

"**Coronary angioplasty**"

means 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.

"**Crohn's disease requiring surgery**"

means the unequivocal Diagnosis of Crohn's disease confirmed by results of typical endoscopy and histopathology findings. Also, the Insured must exhibit intra-abdominal or anal abscesses or fistulas, or intestinal obstruction or perforation, or intractable disease not responding to non-surgical management. In addition, symptoms must have persisted despite optimal non-surgical therapy and a surgical intervention including at least one bowel segment resection must be medically necessary.

"**Ductal carcinoma in situ of the breast**"

means the Diagnosis of this illness, as confirmed by biopsy.

"**Hip or knee replacement surgery**"

means an open Surgery resulting in the total prosthetic replacement of either the hip or the entire knee (known as total knee replacement), subject to the following:

- For hip replacement to qualify under this insurance, the femoral stem must be replaced. Also, this procedure should be performed in both total arthroplasty and hemiarthroplasty (both monopolar and bipolar).
- For knee replacement to qualify under this insurance, all three compartments of the knee (medial, lateral and patellofemoral) must be replaced.

Exclusions: No benefit will be payable under this condition for arthroscopic treatment of joint surfaces or revision of previous total hip or knee replacements.

"**Severe rheumatoid arthritis**"

means the definite Diagnosis of severe seropositive rheumatoid arthritis, that must involve widespread joint destruction affecting at least 3 large joints (these are shoulders, elbows, hips, knees, and ankles), as well as 3 small joints (these are metacarpophalangeal joints, proximal interphalangeal joints, thumb interphalangeal joints, joints of the wrists and second through fifth metatarsophalangeal joints). The Diagnosis must be confirmed by clinical and radiological evidence of joints destruction and deformity.

"**Stage A (T1a or T1b) prostate cancer**"

means the definite Diagnosis of this illness, as confirmed by pathological examination of prostate tissue.

"**Stage 1A malignant melanoma**"

means the Diagnosis of a melanoma less than or equal to 1.0 mm in thickness, not ulcerated and without Clark level IV or V invasion. The Diagnosis of this illness must be confirmed by biopsy.

"Systemic lupus erythematosus"

means the definite Diagnosis of systemic lupus erythematosus, that must involve renal system which requires corticosteroid treatment for a continuous period of six (6) months and permanent impairment of kidney function tests that show Glomerular Filtration Rate (GFR) below 30mL/min/1.73m^2. In addition, a positive ANA test must be present.

Exclusions: No benefit will be payable under this condition for any other forms of lupus, such as discoid lupus and those forms with only hematological and joint involvement.

If the Insured Employee or Insured Spouse is Diagnosed with one of the illnesses indicated previously in this section while his coverage is in force and subject to the conditions of the "Survival Period" section and the limitations specified in the "Re-Entry Conditions" section, the Insurer will pay the Insured Employee or the Insured Spouse:

(1) 10% of the Principal Sum, subject to a maximum of $25,000, for the following conditions:
- Coronary angioplasty
- Ductal carcinoma in situ of the breast
- Stage A (T1a or T1b) prostate cancer
- Stage A malignant melanoma

The payment of the Complementary Benefit in Case of Certain Illnesses in group (1) above comes in addition to the Principal Sum and can only be paid once in a lifetime, in accordance with the limitations specified in the "Re-Entry Conditions" section.

(2) 10% of the Principal Sum, subject to a maximum of $10,000, for the following conditions:
- Crohn's disease requiring surgery
- Severe rheumatoid arthritis
- Systemic lupus erythematosus

The payment of the Complementary Benefit in Case of Certain Illnesses in group (2) above comes in addition to the Principal Sum and can only be paid once in a lifetime, in accordance with the limitations specified in the "Re-Entry Conditions" section.

(3) 10% of the Principal Sum, subject to a maximum of $10,000, for the following conditions:
- Hip replacement surgery
- Knee replacement surgery

The payment of the Complementary Benefit in Case of Certain Illnesses in group (3) above comes in addition to the Principal Sum and can only be paid once in a lifetime, in accordance with the limitations specified in the "Re-Entry Conditions" section.

CANCER RECURRENCE BENEFIT (APPLICABLE TO AN INSURED EMPLOYEE AND INSURED SPOUSE)

The Insurer will pay a Principal Sum amount if the Insured Employee or Insured Spouse is Diagnosed a subsequent time with Cancer and that more than sixty (60) months have passed since the previous Cancer Diagnosis and no treatment relating directly or indirectly to Cancer has been received within that sixty (60) month period (treatment does not include preventive medications and follow up visits to the doctor).

The subsequent Diagnosis must be made while coverage is in force.

MULTIPLE EVENT COVERAGE (APPLICABLE TO AN INSURED EMPLOYEE AND INSURED SPOUSE)

If an Insured Employee or Insured Spouse is Diagnosed with a covered Critical Illness for which the Principal Sum (or 10% of the Principal Sum under the Complementary Benefit in Case of Certain Illnesses) has been paid and is then Diagnosed with another covered Critical Illness, the Insurer will pay a Principal Sum amount (or 10% of the Principal Sum thereof under the Complementary Benefit in Case of Certain Illnesses) subject to the limitations specified in the "Re-Entry Conditions" section.

To give rise to a benefit payment under Multiple Event Coverage, the subsequent Diagnosis must be made ninety (90) days or more after the date another covered condition was Diagnosed.

SECOND MEDICAL OPINION SERVICE

Any Insured who is Diagnosed with a covered Critical Illness while enrolled in the insurance program is offered access to **AXA Assistance's Second Medical Opinion** program.

This program allows the Insured to obtain a second medical opinion from a highly qualified practitioner. It provides a thorough medical review that rigorously analyzes the Insured's file to confirm the initial Diagnosis and make recommendations on appropriate treatment.

If you or your insured Spouse or insured Dependent Child have been Diagnosed with a covered Critical Illness, simply call: **1-877-266-6550** in order to benefit from AXA Assistance's Second Medical Opinion program.

RE-ENTRY CONDITIONS (APPLICABLE TO AN INSURED EMPLOYEE AND INSURED SPOUSE)

If a benefit amount has already been received for a covered Critical Illness of an Insured Employee or Insured Spouse, coverage continues for that person, provided payment of premium is continued. Subsequent benefit payments are subject to the "Re-entry Exclusions Appendix" of this insurance.

CONDITIONS FOR PAYMENT

When an Insured is Diagnosed with a covered Critical Illness and the required Survival Period is completed, the Insurer shall pay the Principal Sum, unless otherwise provided under the contract and subject to all of the conditions and limitations of this Policy.

BENEFICIARY

Amounts payable under this Critical Illness benefit will be payable to the Insured Employee or to the Insured Spouse if the latter is the one who is Diagnosed with the Critical Illness.

However, accrued benefits, if any, unpaid at the time of the beneficiary becoming unable to legally receive payment of benefits will be paid to the beneficiary's estates.

With respect to the Insured Dependent Child, the Principal Sum payable in the event of a Critical Illness will be payable to the Insured Employee.

TERMINATION OF COVERAGE

Coverage of an Insured will immediately terminate on the earliest of the following dates:

A) With respect to an Insured Employee:

1. the date the Policy is terminated;
2. the premium due date if the Policyholder fails to pay the required premium, except as the result of an inadvertent error;
3. the premium due date coincident with or following the date the Insured Employee reaches seventy (70) years of age;
4. the premium due date coincident with or following the date the Insured Employee ceases to be an active Employee of the Policyholder on account of leave of absence, lay-off, maternity or parental leave, disability, resignation, dismissal, pension or retirement, except as provided under the following sections:
   - Waiver of Premium
   - Continuation of Coverage during Approved Leaves
   - Extension of Coverage
5. the date the Insured Employee dies;

6. the premium due date coincident with or following the date the Insured Employee gives notice of cancellation to the Policyholder.

B) With respect to an Insured Spouse:
   1. the date such person ceases to satisfy the criteria for definition of "Spouse" as presented in the Policy;
   2. the premium due date coincident with or following the date the Insured Spouse reaches seventy (70) years of age;
   3. the date the Insured Employee's insurance coverage is terminated.

C) With respect to an Insured Dependent Child:
   1. the date such person ceases to satisfy the criteria for definition of "Dependent Child" as presented in the Policy;
   2. the date the Principal Sum payment has been paid;
   3. the date the Insured Employee's insurance coverage is terminated.

CONVERSION OF GROUP COVERAGE TO AN INDIVIDUAL INSURANCE CONTRACT

In the event an Insured Employee's or Insured Spouse's coverage is terminated because:

a. the Insured Employee ceases to be an active Employee of the Policyholder on account of resignation, dismissal, retirement or failure to return to work for the Policyholder following a period of total disability; or

b. the Insured Employee ceases to be an eligible person under the plan; or

c. the period of extension of coverage ends,

the Insured Employee or Insured Spouse who has not yet reached the age of sixty-five (65) may make a written application to the Insurer within thirty-one (31) days of said termination to obtain an individual Critical Illness policy. On reception of such application, the Insurer will, without evidence of insurability, issue an individual Critical Illness policy to the applicant that will consist of 4 illnesses [Cancer (life-threatening), Coronary artery bypass surgery, Heart attack and Stroke].

However, conversion will not be possible if the Policy is terminated at the time of the application. An Insured Employee or Insured Spouse may only convert if he has never received a benefit payment and has never received a payment under the "Complementary Benefit in Case of Certain Illnesses" section in the past.

The amount of insurance that may be converted will not exceed the lesser of:

a. the amount of insurance then in effect on the date of termination; or

b. a total aggregate amount of one hundred thousand dollars ($100,000) for all such conversions by any Insured.

Premiums for such individual Critical Illness policy being issued in compliance with the aforementioned condition will be calculated at the Insurer's rates in force for the attained age of such Insured at the date of conversion. Premiums will be payable annually in advance and the Critical Illness policy will be issued on an annually renewable basis.

WAIVER OF PREMIUM

The Insurer will waive the Insured Employee's premium in the following circumstances:

A) If the Insured Employee has Life Insurance with waiver of premium provisions or Long Term Disability (LTD) Insurance and becomes totally disabled while covered under both this Critical Illness Insurance and the Life or LTD Insurance:

   From the first day of the month following the date the Insured Employee becomes entitled to waiver of premium under the Life or LTD Insurance.

B) If the Insured Employee has no Life Insurance with waiver of premium provisions and no Long Term Disability (LTD) Insurance and becomes totally disabled while covered under this Critical Illness Insurance:

From the first day of the month following six (6) consecutive months during which injury or sickness totally disables and prevents this Insured Employee from engaging in each and every gainful occupation for which he is or may become reasonably qualified by reason of his education, training or experience.

Notice of such disability must be submitted to the Insurer within twelve (12) months of the onset of total disability and due proof of disability must be submitted to the Insurer within three (3) months following the date notice was given.

Premiums with respect to the Critical Illness Insurance of the Insured Spouse and Insured Dependent Children, if any, will also be waived whenever the Insured Employee's premiums for Critical Illness Insurance are waived.

Premiums will continue to be waived until the earliest of the following dates:

a. the date the Critical Illness Insurance is terminated;

b. the date the Insured Employee reaches sixty-five (65) years of age;

c. the date the Insured Employee ceases to be totally disabled; or

d. the date the Insured Employee fails to provide proof satisfactory to the Insurer of the continuance of total disability within ninety (90) days of request of such proof or refuses to submit to examination.

The coverage which is continued under this clause will be subject to the terms and provisions of this document in effect as of the date of commencement of disability, including any provision providing for reductions in amounts of insurance.

Notwithstanding anything contained to the contrary in this document, in no event will benefits payable for any Diagnosis which occurs while coverage is being continued under this clause exceed the amount of insurance that would have been payable to the Insured at the date of commencement of disability.

The Insurer will have the right to request proof of the continuance of total disability, and may also require the disabled Insured Employee to submit to examination by the Insurer's medical advisor from time to time, as the Insurer may reasonably require.

CONTINUATION OF COVERAGE DURING APPROVED LEAVES

Coverage under the Policy can be continued for an Insured Employee and his Insured Spouse and/or his Insured Dependent Children during any approved leave of absence, temporary lay-off, maternity or parental leave or disability leave of the Insured Employee, provided payment of premium is continued.

This continuation of coverage will terminate at 12:01 a.m., Standard Time:

1. with respect to any leave of absence approved by the Policyholder, on the first (1st) day of the month following the completion of a twelve (12) month period that started on the date such approved leave of absence began or on the date the Insured Employee returns to work in any capacity for the Policyholder or any other employer, including self-employment, whichever is earlier. Continuation of coverage for periods in excess of twelve (12) months may be granted, provided written request is submitted by the Policyholder to the Insurer;

2. with respect to any temporary lay-off approved by the Policyholder, on the first (1st) day of the month following the completion of a six (6) month period that started on the date such approved temporary lay-off began or on the date the Insured Employee returns to work in any capacity for the Policyholder or any other employer, including self-employment, whichever is earlier. Continuation of coverage for periods in excess of six (6) months may be granted, provided written request is submitted by the Policyholder to the Insurer;

3. with respect to strike, on the thirty-first (31st) day following the commencement of the strike, or later if approved by the Policyholder;

4. with respect to any maternity/parental leave approved by the Policyholder, on the date the Insured Employee returns to work in any capacity for the Policyholder or any other employer, including self-employment; and

5. with respect to any disability leave approved by the Policyholder, on the date the Insured Employee reaches seventy (70) years of age, qualifies for a waiver of premium or returns to work in any capacity, whichever is earlier.

The coverage which is provided as a result of continuation under this section will be subject to the terms and provisions of the Policy that were in effect as of the date of commencement of the leave, including any provision providing for reductions in amounts of insurance.

Notwithstanding anything contained to the contrary in the Policy, in no event will indemnities payable for any event insured against which occurs while individual coverage is being continued under this section exceed the amount that would have been payable at the date of commencement of the leave of the Insured Employee.

EXTENSION OF COVERAGE

Individual coverage will be continued for a period of up to twelve (12) months for an Insured Employee whose employment has been terminated by the Policyholder, provided such continuation of coverage is required by any applicable provincial or federal employment law or by a severance package agreement received by the Insured Employee from the Policyholder and payment of premium in accordance with the Master Application is continued. Under such conditions, individual coverage for the Insured with respect to the Insured Spouse and/or Insured Dependent Children will also continue, provided payment of the appropriate premium is continued.

This extension of coverage will terminate at 12:01 a.m., Standard Time, on the first (1st) day of the month following either the completion of the twelve (12) month period or the date the Insured Employee returns to work in any capacity, whichever is earlier.

Extensions of coverage for periods in excess of twelve (12) months may be granted, provided written request is submitted by the Policyholder to the Insurer.

The coverage which is provided as a result of extension under this section will be subject to the terms and provisions of the Policy which were in effect as of the date of termination of employment, including any provision providing for reductions in amounts of insurance.

Notwithstanding anything contained to the contrary in the Policy, in no event will indemnities payable for any event insured against which occurs while coverage is being continued under this clause exceed the amount that would have been payable at the date of termination of employment.

EXCLUSIONS

No indemnity will be paid if a Critical Illness results directly or indirectly from any one or more of the following causes or situations:

1. Within ninety (90) days following the effective date of the Insured's coverage:
   a. Diagnosis of Cancer is made; or
   b. The Insured has any signs, symptoms or investigations, that lead to a Diagnosis of cancer (covered or excluded under the Policy), regardless of when the Diagnosis is made.
2. Within ninety (90) days following the effective date of the Insured's coverage:
   a. Diagnosis of Benign Brain Tumour is made; or
   b. The Insured has any signs, symptoms or investigations that lead to a Diagnosis of Benign Brain Tumour, regardless of when the Diagnosis is made.
3. The Insured does not satisfy the Survival Period limitations.
4. The Insured suffers a self-inflicted injury, Sickness or Disease, whether the Insured was sane or insane at the time of such infliction.
5. The Insured Person has used illicit drugs, or any drug other than as prescribed, recommended or administered by or in accordance with the instruction of a Physician, whether or not such drugs are available only by prescription.

6. The Insured has any cancer that manifests itself prior to the Insured's effective date of individual coverage when the same cancer either recurs or metastasizes after such effective date unless all the requirements in the "Cancer Recurrence Benefit" section have been met.

7. The Insured operated a motor vehicle while concentration of alcohol in his blood exceeded the applicable legal limit where the events causing the Critical Illness occurred.

8. The Insured committed or attempted to commit a criminal offense or provoked an assault.

9. The Critical Illness results from an abuse of alcohol.

10. The Insured participated in any riot, war or any civil strife.

11. A Pre-existing Condition, except if the Critical Illness being claimed for is Diagnosed at least twenty-four (24) months after the Insured's effective date of coverage and subject to all other provisions of the "Pre-existing Condition Exclusion" section.

PRE-EXISTING CONDITION EXCLUSION

This Pre-existing Condition Exclusion applies to all portions of the Principal Sum that are obtained without evidence of insurability, as well as all Critical Illnesses newly covered without evidence of insurability.

If the Critical Illness Insurance directly replaces one with the insurer or another insurer providing similar benefits and that the previous policy was cancelled within thirty-one (31) days from the effective date of the new policy, an Insured who has satisfied the time period of the Pre-existing Condition Exclusion in a previous policy will be deemed to have satisfied the time period under the new policy, but only to the extent of the benefit amount and Critical Illnesses covered in the previous policy. Any additional benefit amount or new illness provided in the new policy and which is obtained without evidence of insurability will be subject to the terms of this exclusion.

An Insured who has not satisfied the time period of the Pre-existing Condition Exclusion in a previous policy will be allowed to apply any amount of time satisfied under the Pre-existing Condition Exclusion of the previous policy toward the satisfaction of the time period requirement of the Pre-existing Condition Exclusion of the new policy, but only to the extent of the benefit amount and Critical Illnesses covered in the previous policy and provided that the previous policy was cancelled within thirty-one (31) days from the effective date of the new policy. Any additional benefit amount or new illness provided in the new policy and which is obtained without evidence of insurability will be subject to the terms of this exclusion.

COVERAGE PAYMENT

Monthly premium

Monthly rates for each $ 1,000 of Principal Sum (provincial taxes not included):

	Premium Rates ($)			
	Male		Female	
AGE	Non-Smoker	Smoker	Non-Smoker	Smoker
15-19	$ 0.080	$ 0.091	$ 0.069	$ 0.080
20-24	$ 0.085	$ 0.096	$ 0.065	$ 0.076
25-29	$ 0.114	$ 0.138	$ 0.108	$ 0.134
30-34	$ 0.122	$ 0.156	$ 0.141	$ 0.190
35-39	$ 0.140	$ 0.201	$ 0.168	$ 0.261
40-44	$ 0.197	$ 0.336	$ 0.215	$ 0.398
45-49	$ 0.329	$ 0.665	$ 0.314	$ 0.653
50-54	$ 0.516	$ 1.187	$ 0.427	$ 0.938
55-59	$ 0.884	$ 2.176	$ 0.579	$ 1.245
60-64	$ 1.506	$ 3.643	$ 0.857	$ 1.699
65	$ 2.003	$ 4.848	$ 1.140	$ 2.260
66	$ 2.203	$ 5.333	$ 1.254	$ 2.486
67	$ 2.423	$ 5.866	$ 1.379	$ 2.734
68	$ 2.665	$ 6.453	$ 1.517	$ 3.007
69	$ 2.931	$ 7.098	$ 1.668	$ 3.307

Monthly rate for each $ 1,000 of Principal Sum for Dependent Children (provincial taxes not included): $ 0.410

To calculate your monthly premium or your Spouse's monthly premium, use the table above to find the unit rate that applies (based on age, gender and smoker status). Multiply the unit rate found by the number of $ 1,000 units of principal sum selected.

To calculate your Dependent Child's monthly premium, multiply the unit rate of $ 0.404 by the number of $ 1,000 units of Principal Sum selected for your Dependent Child.

Premium Payment

Premiums for your coverage, your Spouse's coverage and your Dependent Child's coverage, if applicable, are paid by you, using the means of payroll deductions.

LIMITATION OF CONTRACTUAL LIABILITY

If any amendment made to fiscal legislation, to a government plan, to an insurance plan provided for in employee working conditions or to an employer retirement plan has the effect of increasing liability under this benefit, then the provisions of the contract shall continue to apply as though such amendment had not been made, unless the parties expressly agree otherwise. If an increase in liability is required by law, however, then an additional premium shall be payable to the Insurer by the Policyholder. This additional premium shall be equal to the value of the increase in contractual liability.

AREA OF DIAGNOSIS

Should an Insured claim for a Critical Illness which occurred or was diagnosed outside of Canada or the United States, such Insured may be eligible to receive indemnity under this section upon that person's return to Canada. Prior to determining eligibility, however, the Insurer will have the right to require that the Insured obtain, on his return to Canada, a Diagnosis by a Physician in Canada.

CLAIMS PROVISIONS

Notice of Claim Written notice of Critical Illness on which claim is based must be given to the Insurer within thirty (30) days after the date of the Diagnosis resulting in such Critical Illness. Such notice must be given in writing by or on behalf of the Insured Person, his beneficiary or the person who is entitled the indemnity under the Policy, as the case may be, to the Insurer at 1200, Papineau Avenue, Suite 460, Montreal (Quebec), H2K 4R5, or to any Regional Office of the Insurer or to any authorized agent of the Insurer, with particulars sufficient to identify the Insured Person whose Critical Illness is the basis of such notice. Failure to give such notice within the time provided in the Policy will not invalidate any claim if it is shown not to have been reasonably possible to give such notice during such time and that such notice was given as soon as was reasonably possible, but in no event later than one (1) year after the date of the Diagnosis.

Claim Forms The Insurer, upon receipt of such notice, agrees to furnish to the claimant such forms as are usually furnished by it for filing proof of Critical Illness. If such forms are not so furnished within fifteen (15) days after the Insurer's receipt of such notice, the claimant will be deemed to have complied with the requirements of the Policy as to proof of such Critical Illness upon submitting, within the time fixed in the Policy for filing proofs of Critical Illness, written proof covering the occurrence, character and extent of the Critical Illness for which claim is made.

Proof of Critical Illness Written proof of Critical Illness must be furnished to the Insurer within ninety (90) days after the date of Diagnosis resulting in such Critical Illness. Failure to furnish such proof within such time will not invalidate any claim if it is shown not to have been reasonably possible to furnish such proof during such time and that such proof was furnished as soon as was reasonably possible, but in no event later than one (1) year after the date of the Diagnosis.

Physical Examination and Autopsy The Insurer will have the right and opportunity to confirm the Diagnosis at its own expense by appointing a medical practitioner to examine the Insured whose Critical Illness is the basis of claim under the Policy, where and so often as it may reasonably require while it determines the validity of a claim hereunder, and in the case of death, the right and opportunity to require an autopsy where it is not forbidden by law.

Payment of Claims All indemnities provided in the Policy for Critical Illness will be paid after customary proof of Critical Illness satisfactory to the Insurer has been given in accordance with the requirements of the Policy. All moneys payable under the Policy are payable in the lawful money of Canada.

RE-ENTRY EXCLUSIONS APPENDIX

This appendix provides for all Critical Illnesses that may be included in all of the Insurer's Critical Illness insurance packages so that the policyholder and the participants are informed that these exclusions shall continue to apply even when the policyholder or participant has chosen any new Critical Illness insurance package offered by the Insurer. Please refer to the provisions of the Critical Illness benefit to know what Critical Illnesses and Surgeries are actually covered under your policy.

After benefit has been claimed and adjudicated as payable for an individual other than a child with respect to a first event mentioned in the columns at the right of this schedule, no benefits can be paid for the same individual with respect to subsequent events mentioned on the lines of the left column hereunder, if the cell they have in common is marked with an X. Also, for an event to give rise to benefits, it must be included in the list of Covered Illnesses of the Insured's coverage or under the "Complementary Benefit in Case of Certain Illnesses" section, if any.

After benefit has been claimed and adjudicated as payable for a child with respect to a covered event, no benefits can be paid for the same child with respect to any subsequent event.

RE-ENTRY EXCLUSIONS APPENDIX (Cont'd)

	If a claim has been paid for this event						
	Aortic surgery	Aplastic anemia	Bacterial meningitis	Benign brain tumour	Blindness	Cancer (life threatening)	Coma
No claim can be paid for this subsequent event							
Aortic surgery	X						
Aplastic anemia		X				X	
Bacterial meningitis			X	X			
Benign brain tumour				X			
Blindness			X	X	X		X
Cancer (life threatening)		X				X *	
Coma	X		X	X			X
Coronary angioplasty	X						
Coronary artery bypass surgery	X						
Crohn's disease requiring surgery							
Deafness			X	X			X
Dementia, including Alzheimer's disease	X						
Dilated cardiomyopathy							
Ductal carcinoma in situ of the breast		X				X	
Fulminant viral hepatitis							
Heart attack	X						
Heart valve replacement or repair	X						
Hip replacement surgery							
Kidney failure	X						
Knee replacement surgery							
Liver failure of advanced stage	X					X	
Loss of independent existence	X	X	X	X	X	X	X
Loss of limbs							
Loss of speech			X	X			X
Major organ failure on waiting list	X						
Major organ transplant	X						
Motor neuron disease							
Multiple sclerosis							
Muscular dystrophy							
Occupational HIV infection							
Paralysis			X	X			X
Parkinson's disease and SAPD							
Primary pulmonary hypertension							
Progressive systemic sclerosis							
Severe burns							
Severe rheumatoid arthritis							
Stage 1A malignant melanoma		X				X	
Stage A (T1a or T1B) prostate cancer		X				X	
Stroke	X		X	X			X
Systemic lupus erythematosus							

RE-ENTRY EXCLUSIONS APPENDIX (Cont'd)

	If a claim has been paid for this event						
	Coronary angioplasty	Coronary artery bypass surgery	Crohn's disease requiring surgery	Deafness	Dementia, including Alzheimer's disease	Dilated cardiomyopathy	Ductal carcinoma in situ of the breast
No claim can be paid for this subsequent event							
Aortic surgery		X				X	
Aplastic anemia							
Bacterial meningitis							
Benign brain tumour							
Blindness							
Cancer (life threatening)							
Coma		X				X	
Coronary angioplasty	X	X				X	X
Coronary artery bypass surgery		X				X	
Crohn's disease requiring surgery			X				
Deafness				X			
Dementia, including Alzheimer's disease		X			X	X	
Dilated cardiomyopathy						X	
Ductal carcinoma in situ of the breast	X						X
Fulminant viral hepatitis							
Heart attack		X				X	
Heart valve replacement or repair		X				X	
Hip replacement surgery							
Kidney failure		X	X			X	
Knee replacement surgery							
Liver failure of advanced stage		X	X			X	
Loss of independent existence		X	X	X	X	X	
Loss of limbs							
Loss of speech							
Major organ failure on waiting list		X	X			X	
Major organ transplant		X	X			X	
Motor neuron disease							
Multiple sclerosis							
Muscular dystrophy							
Occupational HIV infection							
Paralysis							
Parkinson's disease and SAPD							
Primary pulmonary hypertension							
Progressive systemic sclerosis							
Severe burns							
Severe rheumatoid arthritis			X				
Stage 1A malignant melanoma	X						X
Stage A (T1a or T1B) prostate cancer	X						X
Stroke		X				X	
Systemic lupus erythematosus			X				

RE-ENTRY EXCLUSIONS APPENDIX (Cont'd)

	If a claim has been paid for this event						
	Fulminant viral hepatitis	Heart attack	Heart valve replacement or repair	Hip replacement surgery	Kidney failure	Knee replacement surgery	Liver failure of advanced stage
No claim can be paid for this subsequent event							
Aortic surgery		X	X				X
Aplastic anemia							
Bacterial meningitis							
Benign brain tumour							
Blindness							X
Cancer (life threatening)	X						X
Coma		X	X		X		X
Coronary angioplasty		X	X				X
Coronary artery bypass surgery		X	X				X
Crohn's disease requiring surgery					X		
Deafness							
Dementia, including Alzheimer's disease		X	X				
Dilated cardiomyopathy							
Ductal carcinoma in situ of the breast	X						X
Fulminant viral hepatitis	X						
Heart attack		X	X		X		X
Heart valve replacement or repair		X	X				
Hip replacement surgery				X		X	
Kidney failure		X	X		X		X
Knee replacement surgery				X		X	
Liver failure of advanced stage	X	X	X		X		X
Loss of independent existence	X	X	X	X	X	X	X
Loss of limbs							
Loss of speech							
Major organ failure on waiting list	X	X	X		X		X
Major organ transplant	X	X	X		X		X
Motor neuron disease							
Multiple sclerosis							X
Muscular dystrophy							
Occupational HIV infection							
Paralysis							X
Parkinson's disease and SAPD							
Primary pulmonary hypertension							
Progressive systemic sclerosis							X
Severe burns							
Severe rheumatoid arthritis				X	X	X	
Stage 1A malignant melanoma	X						X
Stage A (T1a or T1B) prostate cancer	X						X
Stroke		X	X		X		X
Systemic lupus erythematosus					X		

RE-ENTRY EXCLUSIONS APPENDIX (Cont'd)

	If a claim has been paid for this event						
	Loss of independent existence	Loss of limbs	Loss of speech	Major organ failure on waiting list	Major organ transplant	Motor neuron disease	Multiple sclerosis
No claim can be paid for this subsequent event							
Aortic surgery	X						
Aplastic anemia	X			X	X		
Bacterial meningitis	X						
Benign brain tumour	X						
Blindness	X					X	X
Cancer (life threatening)	X			X	X		
Coma	X			X	X	X	X
Coronary angioplasty							
Coronary artery bypass surgery	X						
Crohn's disease requiring surgery	X						
Deafness	X					X	X
Dementia, including Alzheimer's disease	X						
Dilated cardiomyopathy	X						
Ductal carcinoma in situ of the breast				X	X		
Fulminant viral hepatitis	X						
Heart attack	X			X	X	X	
Heart valve replacement or repair	X						
Hip replacement surgery	X						
Kidney failure	X			X	X		X
Knee replacement surgery	X						
Liver failure of advanced stage	X			X	X		
Loss of independent existence	X	X	X	X	X	X	X
Loss of limbs	X	X					
Loss of speech	X		X			X	X
Major organ failure on waiting list	X			X	X		
Major organ transplant	X			X	X		
Motor neuron disease	X					X	
Multiple sclerosis	X						X
Muscular dystrophy	X						
Occupational HIV infection	X						
Paralysis	X					X	X
Parkinson's disease and SAPD	X						
Primary pulmonary hypertension	X						
Progressive systemic sclerosis	X						
Severe burns	X						
Severe rheumatoid arthritis	X						
Stage 1A malignant melanoma				X	X		
Stage A (T1a or T1B) prostate cancer				X	X		
Stroke	X			X	X	X	X
Systemic lupus erythematosus	X						

RE-ENTRY EXCLUSIONS APPENDIX (Cont'd)

	If a claim has been paid for this event						
	Muscular dystrophy	Occupational HIV infection	Paralysis	Parkinson's disease and SAPD	Primary pulmonary hypertension	Progressive systemic sclerosis	Severe burns
No claim can be paid for this subsequent event							
Aortic surgery					X		
Aplastic anemia							
Bacterial meningitis							
Benign brain tumour							
Blindness	X	X					
Cancer (life threatening)		X					
Coma	X	X	X	X	X	X	
Coronary angioplasty							
Coronary artery bypass surgery					X		
Crohn's disease requiring surgery							
Deafness	X	X					
Dementia, including Alzheimer's disease							
Dilated cardiomyopathy	X				X		
Ductal carcinoma in situ of the breast		X					
Fulminant viral hepatitis							
Heart attack	X				X	X	
Heart valve replacement or repair	X				X		
Hip replacement surgery							
Kidney failure	X	X			X	X	
Knee replacement surgery							
Liver failure of advanced stage	X	X				X	
Loss of independent existence	X	X	X	X	X	X	X
Loss of limbs							
Loss of speech	X	X	X	X			
Major organ failure on waiting list	X				X	X	
Major organ transplant	X				X	X	
Motor neuron disease							
Multiple sclerosis							
Muscular dystrophy	X						
Occupational HIV infection		X					
Paralysis	X	X	X	X			X
Parkinson's disease and SAPD				X			
Primary pulmonary hypertension					X		
Progressive systemic sclerosis						X	
Severe burns							X
Severe rheumatoid arthritis							
Stage 1A malignant melanoma		X					
Stage A (T1a or T1B) prostate cancer		X					
Stroke	X	X			X	X	
Systemic lupus erythematosus							

RE-ENTRY EXCLUSIONS APPENDIX (Cont'd)

	If a claim has been paid for this event				
	Severe rheumatoid arthritis	Stage 1A malignant melanoma	Stage A (T1a or T1B) prostate cancer	Stroke	Systemic lupus erythematosus
No claim can be paid for this subsequent event					
Aortic surgery				X	
Aplastic anemia					
Bacterial meningitis					
Benign brain tumour					
Blindness					
Cancer (life threatening)					
Coma				X	
Coronary angioplasty		X	X	X	
Coronary artery bypass surgery				X	
Crohn's disease requiring surgery	X				X
Deafness					
Dementia, including Alzheimer's disease				X	
Dilated cardiomyopathy					
Ductal carcinoma in situ of the breast		X	X		
Fulminant viral hepatitis					
Heart attack				X	
Heart valve replacement or repair				X	
Hip replacement surgery	X				
Kidney failure	X			X	X
Knee replacement surgery	X				
Liver failure of advanced stage	X			X	X
Loss of independent existence	X			X	X
Loss of limbs					
Loss of speech					
Major organ failure on waiting list	X			X	X
Major organ transplant	X			X	X
Motor neuron disease					
Multiple sclerosis					
Muscular dystrophy					
Occupational HIV infection					
Paralysis					
Parkinson's disease and SAPD					
Primary pulmonary hypertension					X
Progressive systemic sclerosis					
Severe burns					
Severe rheumatoid arthritis	X				X
Stage 1A malignant melanoma		X	X		
Stage A (T1a or T1B) prostate cancer		X	X		
Stroke				X	X
Systemic lupus erythematosus	X				X

* Following a life threatening Cancer claim, the Insured cannot claim again for Cancer, except for plans with a "Cancer Recurrence Benefit" section, when all of its requirements have been met.