

Knappett Projects Inc.

All Eligible Knappett Employees' Association Members to age 75

Arranged by:

Chris Redcliffe

Administered by:



Underwritten by:

beneva



SSQ Insurance Company Inc.

Industrial Alliance

Policy effective: January 1, 2019
Policy amended: March 1, 2026

Privacy Matters

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

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

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

This information is used to:

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

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

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

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

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

Life Benefits

Participant's Life
Accidental Death, Disease & Dismemberment
Dependent Life

Disability Benefits

Long Term Disability

Health Benefits

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

Dental Benefits

Basic Dental
Major Restorative
Orthodontics
Survivor Benefits

Optional Benefits

Optional Life
Optional Accidental Death & Dismemberment
Optional Critical Illness

Schedule of Benefits

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

Employee Classification

Class 007:

All Eligible Knappett Employees' Association Members
to age 75

Waiting Period For All Benefits

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

Participant's Life

(underwritten by La Capitale Civil Service Insurer Inc. Policy # 880366)

All eligible Class 007

Benefit Amount: \$100,000

Non-evidence maximum: \$100,000

Overall maximum: \$100,000

Coverage reduces: 50% at age 65

Waiver of premium: The Elimination Period for waiver of premium matches the Elimination Period for Long Term Disability Insurance if the Participant is eligible to receive LTD benefits. Otherwise the Elimination Period for waiver is 6 months of continuous Total Disability.

Accelerated benefit payment in the event of terminal illness: Participant who suffers a terminal illness may be eligible to receive 25% of his Life Insurance amount of benefits. The maximum benefit payable under this section is \$50,000.

End of Insurance: At the earlier of retirement or the Participant's age 70

Conversion privilege: Included to age 65

Accidental Death, Disease & Dismemberment

(underwritten by The Empire Life Insurance Company Policy # 880366)

All eligible Class 007 an amount equal to your Life Insurance

Coverage reduces: 50% at age 65

Coverage terminates: at the earlier of retirement or age 70

Schedule of Benefits

Dependent's Life

(underwritten by La Capitale Civil Service Insurer Inc. Policy # 880366)

All eligible Class 007

Benefit Amount:	Spouse:	\$10,000
	Child:	\$5,000

Stillbirth benefit	In the event of a stillbirth the plan will pay the child benefit amount
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Waiver of premium	Premiums are waived during the period that premiums are waived for Participant's Life Insurance
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Extension of coverage for Dependents of a Deceased Participant:	Included
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End of Insurance:	At the earlier of retirement or the Participant's age 70
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Conversion privilege	Included
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Long Term Disability

(underwritten by Wawanesa Life. Policy # GSS2004 / Policy # 880366)

All eligible Class 007

Benefit Formula	66.67% of the first \$3,700 of your monthly Earnings plus 55% of the next \$3,000, plus 50% of the balance of your monthly Earnings
Benefit Amount	The maximum amount available is \$6,000 per month
Definition of Disability	Own occupation during the Qualifying Period plus the next 24 months and, any occupation thereafter
Qualifying Period	119 days
Taxable Status	Non-Taxable
Maximum Benefit Period	Up to age 65
Survivor Income Benefit	not included
Coverage Termination Age	Earlier of attainment of age 65 of the Plan Member minus the Qualifying Period, or retirement

Schedule of Benefits

Extended Health Care

(Company Sponsored Benefit Policy # 880366)

All eligible Class 007 and their eligible dependents

Prescription drugs (mandatory generic substitution): 90%
Pay direct drug card

Hospital (semi-private): 100%

Professional and medical care coverages: 100%

Eligible medical equipment and supplies: 100%

Vision care (eye wear): 80%

Adult: \$500/24 consecutive months

Qualified dependent children
younger than 18 years of age: \$500/12 consecutive months

Survivor benefits: 24 months

Emergency travel assistance

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

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

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

Coverage terminates: at the earlier of retirement or age 75

sparrow
(powered by Greenshield)

All eligible Class 007 and their eligible dependents



sparrow is GroupSource’s unified health and wellness concierge – a single app that provides You, Your Spouse and Dependent Children with integrated mental and physical health support, as well as additional wellness services tailored to support them through all life’s challenges.

By transforming the landscape of healthcare integration and accessibility, sparrow gives You seamless access to comprehensive care so they can prioritize their whole health through their own team of medical experts ready to provide prompt, continuous care based on their individual needs.

Use sparrow for:

- Mental Health Support
- EFAP
- Virtual Healthcare
- Integrated Digital Pharmacy

Learn more about sparrow:

- At mysparrow.ca
- Download the app in Your app store
- By phone at 1-866-644-6881

Included in your sparrow app:

Mental Health Support

- Mental health counselling connects employees with a qualified therapist for Your needs within 24-72 hours – whether that’s individual or couples counselling, or virtual or person services. Five hours each of individual and couples counselling is available per calendar year.
- Dependent Children’s mental health support to support anxiety, ADHD, anger, autism, outburst, ODD, and more.
- A robust network of over 5,000 therapists offering services in over 30 languages, including Indigenous virtual counselling through Noojimo for those who are seeking culturally safe mental wellness support.
- Self-guided digital therapy (iCBT) to help develop positive coping strategies and reduce anxiety and depression symptoms.

Schedule of Benefits

Employee & Family Assistance Program (EFAP)

- Gateway to a modernized EFAP program that provides work, health, and life resources including legal and financial counselling, career counselling, health coaching, life transition services (support for navigating childcare, eldercare, pregnancy, and more).
- Critical incident assistance, 24/7 crisis support, and tools for substance use management.
- Evidence-based, personalized nutrition services to support Your eating and health goals.

Virtual Healthcare

- You, Your Spouse and Dependent Children can connect with a Canadian-licensed physician 24/7/365 in minutes – providing care for the whole family, even outside Canada.
- Physicians provide on-demand healthcare that includes acute care issues such as cold and flus, mental health support for collaborative care or referrals to other specialists, and chronic care issues for frequent touchpoints with a medical provider
- Access medical care without the need to use valuable sick days or personal time for doctors visits.

Integrated Digital Pharmacy

- Integrated pharmacy solutions allow You to manage all pharmacy needs from the unified sparrow app – including virtual pharmacist consultations, daily dose packaging, auto-refills and reminders, and more.
- Get fast and free medication delivery anywhere in Canada within 1-3 business days combined with a competitive dispensing fee.
- Virtual pharmacist consultations to assess medications and recommend therapy changes to support better health.

Please note, You may incur additional charges if You, Your Spouse and Dependent Children use sparrow's fee-for-service offerings. Depending on Your coverage, some of these charges may be submitted for claim reimbursement to GroupSource.

Coverage terminates:

at the earlier of retirement or age 75

Dental Care

(Company Sponsored Benefit Policy # 880366)

All eligible Class 007 and their eligible dependents	
Basic, endodontic and periodontal:	100%
Major restorative services:	60%
Combined calendar year maximum:	\$3,000 for basic, endodontic, periodontal and major restorative services combined
Orthodontics:	50%*
<i>*For qualified dependent children younger than age 19</i>	
Lifetime maximum:	\$3,000 for orthodontic treatment only
Survivor benefits:	24 months
<i>Benefits are paid in accordance with the current published Provincial Fee Schedule.</i>	
Coverage terminates:	at the earlier of retirement or age 75

Optional Critical Illness

(underwritten by Industrial Alliance Policy # 880366)

All eligible Class 007 and/or spouse	units of \$5,000 to a minimum benefit of \$10,000 And a maximum of \$100,000
Eligible dependent children	\$10,000 Your Dependent children are eligible from birth to age 22; or 25 (26 in the province of Quebec) if in full-time attendance at an accredited school as students.
Guaranteed Issue Limit	Up to \$50,000 is available on a guaranteed issue basis – i.e. medical evidence is not required

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

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

General Provisions

Eligibility

Employee

To be eligible for group benefits, the Employee must meet the following conditions:

- he is a permanent Employee.
- he is Actively at Work for the employer for at least 15 hours week unless otherwise specified in the Schedule of Benefits.
- he has completed the waiting period stated in the Schedule of Benefits.

The Employee is considered to be Actively at Work if he is performing all the usual and customary duties of his job with his Employer for the scheduled number of hours. This includes scheduled non-working days and vacation days if the Employee is Actively at Work on the last scheduled working day. He is not considered to be Actively at Work if he is receiving disability benefits or is participating in a partial disability or rehabilitation program.

Dependents become eligible for coverage on the date the Employee becomes eligible or the date they first become Dependent, whichever is later. The Employee must apply for coverage for himself in order for his Dependents to be eligible.

Dependent

A Dependent must be the Participant's spouse or children who are residents of Canada.

To be eligible the spouse must be legally married to the Participant, or be the common-law partner who is publicly represented as the spouse and has resided with the Participant for a minimum of 12 consecutive months. The Participant can only cover one spouse at a time. The Participant must enrol for coverage the same person for all Dependent Benefits provided under this contract.

The Participant's children and the spouse's children, who are unmarried, unemployed and under age 22 are eligible Dependents. Dependent children include natural, adopted or stepchildren. Children of a common-law spouse may be covered if the common law spouse is living with the Participant, is covered as a Dependent under this contract and has custody of the child/children.

An unmarried child who is attending college, trade school or university as a full-time student is also considered an eligible Dependent until the age of 25 as long as the child is dependent on the Participant for financial support.

If a Dependent becomes permanently incapacitated before the age of 22 or while a full time student at an accredited educational institution, before age 25, the Insurer will continue coverage as long as the Dependent is permanently incapable of financial independence, as confirmed in the Income Tax Act, due to a medically diagnosed physical illness or psychiatric disorder.

General Provisions

Application for Group Insurance

An Employee who is eligible to participate in the contract must complete and submit a personal application and an application for each of the Dependents, on their respective eligibility dates, on forms supplied by, or satisfactory to, the Insurer.

Late applicant

If the Employee or his Dependents apply for coverage later than 31 days after the Employee's date of eligibility, evidence of insurability, satisfactory to the Insurer, must be submitted and approved before benefits commence. The cost of providing evidence of good health is the Employee's responsibility. Some coverage restrictions may apply.

Effective date of insurance

Subject to these provisions, the effective date of insurance is determined in the following manner:

For Life Insurance, Short Term Disability Insurance and Long Term Disability Insurance benefits:

An Employee becomes insured under this coverage on the latest of the following dates:

- the effective date of this contract;
- the date he becomes eligible;
- the date the Insurer approves any required evidence of insurability

In the case of a group insured by a previous contract:

Nonetheless, for an Employee disabled on the effective date of the contract who is exempt from paying premiums under the previous contract, the insurance begins on the date of his return to work. In the case of a disabled Employee who has not yet satisfied the Elimination Period for being exempt from paying premiums under the previous contract, the insurance begins on the effective date of the contract. Upon the expiration of the Elimination Period, the insurance is suspended until his return to work.

In the case of a group without previous contract:

Nonetheless, for an Employee disabled on the effective date of the contract, the insurance begins after 30 days of continuous work if he has then met the eligibility conditions. Otherwise, the insurance begins on the date on which he meets the eligibility conditions.

For **Extended Health Care** benefits

An Employee becomes insured under this coverage on the latest of the following dates:

- the effective date of this contract;
- the date he becomes eligible;
- the date the Insurer approves any required evidence of insurability (applicable for residents of all Canadian provinces except Quebec).

For **Dental Care** benefits

An Employee becomes insured under this coverage on the latest of the following dates:

- the effective date of this contract;
- the date he becomes eligible.

Insurance for dependents becomes effective on the latest of the following dates:

- The effective date of this contract;
- The date on which the Dependents become eligible;
- The date on which the Employee completes the application for insurance for the Dependents;
- The date on which the Insurer approves any required evidence of insurability.

At no time can insurance for Dependents become effective before the Employee's insurance.

Effective date of modification to insurance

Increase in insurance coverage following a change in employment or family status

If the Participant is Actively at Work or temporarily absent from work and has maintained coverage during his interruption of work, any increase in insurance coverage following a change in employment or family status becomes effective on the date of the change, provided the Insurer receives a written application to such effect within 31 days following the change and subject to the provisions on Total Disability. Otherwise, the change in coverage will become effective on the date the Participant is once again Actively at Work, subject to any other eligibility provisions in force.

If the Insurer receives the application more than 31 days after the date of the event justifying an increase in insurance or if the modification applied for requires that the Participant provide evidence of insurability, the Participant will be required to provide such evidence and, if approved, the increase in insurance will become effective on the date the Insurer approves such evidence.

Insurance that cannot be modified

During any period where the Participant is retired or Totally Disabled, amounts of insurance cannot be increased and the provisions used to establish these amounts cannot be modified. Such modifications shall only become effective when the Participant is once again Actively at Work and provided he is not Totally Disabled at this time.

No waiver of premiums shall apply to the premiums payable for Participants who were not already entitled to coverage prior to a change in coverage status if such change must occur after the Date of Retirement or the start of a period of Total Disability.

General Provisions

Reduction in insurance coverage following a change in employment or family status

Any decrease in insurance coverage following a change in employment or family status becomes effective on the date of the change, provided the Insurer receives a written application to such effect within 31 days following the change. If the Insurer receives the application more than 31 days after the date of the event justifying a decrease in insurance, the decrease becomes effective on the date the Insurer receives the application.

Continuation of insurance in the event of work interruption

Maternity, paternity, parental or adoption leave

Participants who cease to be Actively at Work full time due to maternity, paternity, parental or adoption leave must maintain participation in the Extended Health Care Insurance if participation in such benefit is required by an applicable legislation in the Participant's Province of Residence. Participants can also maintain all other benefits in force by sending a written request to the Insurer for all benefit they want to maintain within 31 days following the start date of the leave and continue to pay the required premiums, excluding the Employer's share, which remains payable by the Employer.

However, insurance may not be maintained in force for a period exceeding the period specified in the Schedule of Benefits. In certain situations, governing legislation may take precedence over this clause, requiring the Employer to pay its share of the premium and providing for an extension of the above-mentioned period.

If Disability Insurance coverage is maintained in force, the Elimination Period, for a disability that begins during a period in which the Participant is not receiving pregnancy-related Employment Insurance benefits, shall begin on the planned date of return to work, and payment of disability benefits, if applicable, shall only begin upon expiry of the Elimination Period. In the event that Disability Insurance coverage is not maintained in force by the Participant, such coverage is reinstated once the Participant is once again Actively at Work

Unpaid authorized leave of absence

Participants who cease to be Actively at Work full time due to an unpaid authorized leave of absence must maintain participation in the Extended Health Care Insurance if participation in such benefit is required by an applicable legislation in the Participant's Province of Residence. Participants can also maintain all other benefits in force by sending a written request to the Insurer for all benefit they want to maintain within 31 days following the start date of the leave and continue to pay the required premiums, excluding the Employer's share, which remains payable by the Employer.

However, insurance may not be maintained in force for a period exceeding the period specified in the Schedule of Benefits. In certain situations, governing legislation may take precedence over this clause, requiring the Employer to pay its share of the premium and providing for an extension of the above-mentioned period.

If Disability Insurance coverage is maintained in force, the Elimination Period for a disability that begins during the above-mentioned period shall begin as of the planned date of return to work, and payment of disability benefits, if applicable, shall begin only upon expiry of the Elimination

Period. If the Disability Insurance coverage is not maintained in force, they shall be automatically reactivated when the Participant returns to active, full-time work.

Temporary layoff

Participants who cease to be Actively at Work full time due to a temporary layoff must maintain participation in the Extended Health Care Insurance if participation in such benefit is required by an applicable legislation in the Participant's Province of Residence. Participants can also maintain all other benefits in force, except for Disability Insurance, by sending a written request to the Insurer for all benefits they want to maintain within 31 days following the start date of the leave and continue to pay the required premiums, excluding the Employer's share, which remains payable by the Employer.

However, insurance may not be maintained in force for a period exceeding the period specified in the Schedule of Benefits.

Disability Insurance coverage is reinstated once the Participant returns to active full-time work.

Temporary layoff is defined as an absence of a fixed length, during which the Participant is still considered an Employee by the Employer.

Dismissal or suspension

When a Participant is dismissed or suspended and contests the dismissal or suspension by means of a grievance or arbitration under governing legislation, the Participant is considered to have remained insured without interruption during the period in question if the decision rendered in arbitration or by the competent court reinstates the Participant's rights and obligations as an Employee. Any unpaid premiums are then payable within 31 days following the date of the final decision of the arbitrator or court.

Strike or lockout

In the case of a strike or a lockout, Extended Health Care Insurance is kept in force, with premium payments, for a period of 30 days. Thereafter, the Extended Health Care Insurance may be kept in force by means of paying the required premiums. Furthermore, all other coverages are kept in force by means of paying the required premiums insofar as the Health Insurance coverage is kept in force.

If Disability Insurance coverage is maintained in force by the Policyholder, the Elimination Period for any Total Disability that begins during the strike or lockout is considered to have begun on the date on which the Participant returns to work following the end of the strike or lockout and no disability benefits are payable during this period.

In the event that Disability Insurance coverage is not maintained in force by the Policyholder, such coverage is automatically reinstated when the Participant is once again Actively at Work.

General Provisions

Miscellaneous provisions

Coordination of benefits

If the Participant is covered for Extended Health Care or Dental Care under this plan and another plan, benefits will be co-ordinated with the other plan following insurance industry standards. These standards determine where the Participant should send a claim first. Here are some guidelines:

- if the Participant is claiming expenses for the spouse and the spouse is covered for those expenses under another plan, the Participant must send the claim to the spouse's plan first.
- if the Participant is claiming expenses for dependent children, and both the Participant and the spouse have coverage under different plans, the Participant must claim under the plan of the parent with the earlier birthday (month and day) in the calendar year. For example, if the Participant's birthday is May 1 and the spouse's birthday is June 5, the Participant must claim under his plan first. If both parents have the same birthday, claim under the plan of the parent whose first name begins with the earlier letter of the alphabet.
- the maximum amount that the Participant can receive from all plans for eligible expenses is 100% of actual expenses.
- when submitting a claim to a second payer, be sure to include payment details provided by the first payer.

Coverage elsewhere

A Participant who is eligible for Extended Health Care and/or Dental Care Insurance and whose spouse is covered for comparable insurance may decline coverage under the contract for such insurance.

The refusal of insurance under the contract may be in respect of the Participant and Dependents or in respect of the Dependents only.

If the insurance under the spouse's contract ceases because of termination of such contract or because eligibility for the insurance ceases, then application may be made under this contract to cover those persons whose insurance has terminated.

The application must be made within 31 days after cessation of the insurance under the spouse's contract and the insurance under the contract shall be effective on the day following the date of termination of the insurance under the spouse's contract.

Notice and proof of claim

To allow for prompt assessment, initial notice of a disability claim should be submitted to the Insurer within 30 days of the beginning of the Total Disability.

Evidence in support of the Participant's disability claim must be produced within 90 days of the initial notice of the disability claim.

In the event that the Insurer accepts that it was impossible for the Participant to provide proof of claim within 90 days and no more than 12 months have elapsed since the expiration of the deadline to provide proof of claim, the Participant will not lose his right to disability benefits.

Thereafter, an application for Extension of Disability Insurance form must be submitted each time the Insurer so requests. The Insurer may require the Participant to undergo a medical examination.

If the Participant does not provide the form or does not attend the medical examination within 31 days of the Insurer's written request, the Participant forfeits any right or benefit available to him under the contract until the Insurer receives the information or the Participant attends the medical examination.

Transfer provisions

For Participants insured alone or with Dependents under a previous contract, the Insurer guarantees continuity between this contract and the previous contract in compliance with any act or regulation respecting insurance, to avoid Participants and their Dependents, where applicable, sustaining any harm due to a change in contract, regardless of whether they are at work.

Therefore, no Participant or Dependent insured under the previous contract may be excluded from the new contract or be denied benefits solely because of a pre-existing condition exclusion that was not applicable or that did not exist in the previous contract, or because the Participant is not Actively at Work on the effective date of the new contract.

Also, every Participant or Dependent insured under the previous contract is insured by the new contract on the termination of the previous contract if the cessation of insurance is exclusively attributable to this termination and the Participant belongs to a class of Participants covered by this contract.

In the case of a Participant who, prior to application for participation, was insured under a previous contract, the Insurer is not liable for the payment of benefits which may be due by the preceding insurer under an extension, exemption, conversion or other clause.

Conformity to legislation

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

Updating the participant's records

To ensure that coverage is kept up-to-date, it is important that the Participant reports any:

- change of name.
- change of home address.
- change of Dependents.
- change of beneficiary.

General Provisions

Definitions

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

Accident

Any bodily injury confirmed by a Physician and directly resulting from a sudden and unforeseeable action of an exterior cause, and independent of any other cause. Any bodily injury resulting from an attempted suicide is not an Accident.

Actively at Work

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

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

Age

The Age of the Participant on his last birthday when it is calculated or the day that an event provided in the contract occurs.

Approved Hospital

A duly licensed general active treatment facility, which has one or more Physicians and registered nurses on duty or on call 24 hours per day. Unless otherwise stated, this term does not include a federal hospital, private hospital, rest home, nursing home, convalescent home, chronic care facility, health spa or hotel, home for the aged or an institution used primarily for the confinement or treatment of alcoholism or drug addiction.

Calendar Year Maximum

January 1 to December 31.

Close Relative

An individual who is related to another individual in one of the following ways: spouse, children, father, mother, brother, sister, stepfather, father-in-law, stepmother, mother-in-law, brother-in-law, sister-in-law, stepdaughter, daughter-in-law, son-in-law, grandparents and grandchildren of the Covered Person.

Consecutive Months

The applicable period of 12, 24, 36, 48, or 60 months, commencing on the date the first eligible expense is incurred.

Covered Person

An Employee or Dependent of an Employee who has satisfied the eligibility and application requirements for benefits provided under this contract and for whom the current premiums are

being paid. The Covered Person must be insured under a provincial Government Health Insurance Plan.

Date of Retirement

The date on which an Employee's retirement begins in accordance with the Participant's retirement plan, in accordance with the labour convention in force with the Employer, or in accordance with the Employer's current practice. Participants who become disabled before age 65 will be considered to be retired as soon as they reach age 65. Participants who become disabled at age 65 or over will be considered to be retired following expiry of the Long Term Disability Insurance Elimination Period, if Long Term Disability Insurance coverage is included in the Schedule of Benefits, or following expiry of a period of 6 months from the disability start date, if Long Term Disability Insurance coverage is not included in the Schedule of Benefits.

Elimination Period

A period which starts at the beginning of a period of Total Disability and during which no disability benefit is payable.

If the one-day surgery option is retained in the Schedule of Benefits, the waiting period in the event of Hospitalization also applies in the case of a patient admitted to a one-day surgical or treatment unit for whatever the duration of admission. Nonetheless, it does not apply in the case of a patient registered at the outpatient clinic or emergency ward.

Employee

A person who resides in Canada and works for the Employer on an active full-time basis as set out in the Schedule of Benefits.

Employer

The Policyholder of this contract or any Employer whose Employees or one category of Employees are represented by the Policyholder.

Hospitalization

The act of occupying a room in a Hospital Centre as an admitted inpatient, excluding any period where the Covered Person only receives services that could be dispensed by a residential and Long Term Care Centre or a Convalescent Hospital, whether or not there be a place available in such a centre.

Illness

An organic or functional alteration considered in its evolution and as a state which must be defined by a physician, including any complication resulting from pregnancy.

Residential and Long Term Care Centre

A facility recognized as such by the competent governmental authorities in the Province where it is located, or by the Insurer in the absence of such authorities. On-site nursing and Medical Care must be available 24 hours a day, 7 days per week. The reason for admitting a Covered Person to such a centre is that the Covered Person is no longer able to live in the usual living environment. Rehabilitation and convalescent centres are not considered to be residential and long-term care centres.

Medical Care

Necessary services, assessment, tests, supplies or surgery, including hospitalization, provided or ordered by a Physician in the treatment of a Covered Person's Sickness or Injury.

General Provisions

Medically Diagnosed Condition

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

Monthly Salary

The Participant's annual salary divided by 12.

Net Salary

Salary after deduction of applicable provincial and federal government income taxes, in accordance with the declarations of exemption made to the Employer.

Non-evidence Maximum

The amount of insurance for which an Employee may become eligible without having to submit satisfactory evidence of insurability. The Non-evidence Maximums are shown in the Schedule of Benefits.

Participant

An eligible Employee who is insured under this contract.

Physician

A Physician duly licensed to practise medicine in the place where the services are provided

Plan Administrator

An individual, appointed by the Policyholder, responsible for the administration of this group insurance plan. The Plan Administrator of this contract is GroupSource.

Province

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

Reasonable and Customary Charges

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

Reasonable and Customary Treatment

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

Residence

The primary dwelling where the Participant is an occupant and the premises on which the primary dwelling is situated.

Salary

Gross regular pay excluding sums received from the Employer which are not part of the Participant's regular pay, such as bonuses, overtime pay, fees, allowances for meals and lodging, isolation pay, any lump-sum payments or other sums payable from time to time.

For a Participant whose Salary comes in whole or in part from commissions or bonuses, Salary means the usual average pay of the Employee paid by the Employer, including commissions and bonuses reported on the Employee's tax slips for the previous two calendar years. If the Participant has not completed two continuous years of service with the same Employer, but has completed at least one year, the average income shall be determined based on the length of service. If however the Employee has less than one year of service, then Salary shall mean the Employee's usual pay, as declared by the Employer.

For a Participant whose remuneration is based in whole or in part on dividends, the term "Salary" means:

- a) the Participant's usual average remuneration paid by the Employer, as reported on T4 income tax slips for the 2 calendar years ending on the previous December 31 ; plus
- b) the average dividend income from the Employer that appears on the "relevé 3" slips as the actual amount of dividends received, or on any other slip issued by the provincial income for the 2 calendar years ending on the previous December 31.

However, the annual salary for such Participants is limited to \$200,000.

Successive Periods of Disability

If the Participant who had been disabled returns to full-time active work and again becomes disabled while this benefit is in force, such disability will be considered a continuation of the previous disability, provided:

- It is due to the same cause or causes as the previous disability;
- During the Long-Term Disability Insurance Elimination Period (if the Participant is eligible for Long Term Disability Insurance) or during the first 6-month period of Total Disability (if the Participant is not eligible for Long Term Disability Insurance), he has been back at full-time active work for less than 15 consecutive days; and
- After the Elimination Period has been completed, he has been back at work for less than 180 days.

If the Successive Period of Disability is due to a cause or causes unrelated to the cause or causes of the previous disability, it will be considered a new disability and a new Elimination Period will apply.

Total Disability or Totally Disabled

During the period specified in the Schedule of Benefits: A state of incapacity resulting from an Illness or an Accident which prevents the Participant from carrying out the essential duties of his regular employment and requires continuous Medical Care.

Thereafter: A state of incapacity resulting from an Illness or an Accident which prevents the Participant from carrying out any gainful employment for which he is reasonably qualified by education, training or experience.

General Provisions

Total Disability is determined regardless of the existence or availability of such employment.

Participants who are required to hold a government permit or licence to perform the tasks of their regular employment are not considered Totally Disabled solely because such permit or licence has been revoked or has not been renewed.

Total Disability beginning more than 31 days following an Accident is deemed to be resulting from Illness.

Participant's Life

Benefit amount

Upon the death of a Participant while this coverage is in force, the Insurer pays the beneficiary an indemnity equal to the amount provided in the Schedule of Benefits, subject nonetheless to any reduction and maximums provided within the schedule.

Waiver of premiums in the event of total disability

If prior to age 65, a Participant is impaired by Total Disability while this coverage is in force, the Insurer waives the payment of any premium owing which falls due after the expiration of the waiting period set forth in the Schedule of Benefits, for as long as the Total Disability lasts.

The Participant's waiver of premiums ends on the earliest of the following dates:

- a) the date on which the Total Disability ends;
- b) the date of the Participant's 65th birthday;
- c) the Participant's effective Date of Retirement.

Accelerated benefit payment in the event of terminal illness

If this option is retained in the Schedule of Benefits, a disabled Participant under age 63, whose life expectancy is no more than 12 months and who is benefiting from the Waiver of premiums in the event of Total Disability clause may obtain an accelerated benefit payment by submitting an application in writing to the Insurer, accompanied by appropriate medical evidence and the beneficiary's written consent, if designated irrevocable.

The amount paid in accordance with this section is limited to the percentage indicated in the Schedule of Benefits of the Participant's Life Insurance amount, without exceeding the maximum amount indicated in the Schedule of Benefits.

The amount of life insurance used to calculate the accelerated benefit excludes any amount or fraction of an amount expiring in accordance with the provisions of the contract during the 24 months following the date of the application and which is not replaceable with another benefit.

At the Participant's death, the insured amount payable by the Insurer is reduced by the amount paid as an accelerated benefit plus interest. The interest rate used to compute the final payment for a given year corresponds to the yield of Government of Canada 5- to 10-year bonds as posted in the monthly review of the Bank of Canada (V121757 series) as at the preceding December 31 rounded up by $\frac{1}{4}$ of 1%.

The Insurer assumes no responsibility with regard to the tax treatment of any accelerated benefit paid.

Furthermore, the accelerated benefit payment provided under this section ceases upon termination of the contract, even for Participants who have been granted a waiver of premiums.

Beneficiary

Subject to the provisions of applicable legislation, any Participant may designate a beneficiary or change a beneficiary already designated by means of a written statement filed at the head office of the Insurer. The Insurer is not liable for the validity of any change of beneficiary. The rights of a beneficiary who dies before the Participant revert to the said Participant. If, at the time of the Participant's death, said Participant has not designated a beneficiary in writing, the amount of insurance becomes a part of the Participant's estate. In the case of a change in insurer, the beneficiary designation made under the terminated contract is automatically transferred under the new contract, unless the Participant changes this designation at the time of application to the new contract.

End of insurance

The Life Insurance coverage of any Participant terminates on the earliest of the following dates:

- the date of the end of the contract, subject to provisions of the “Waiver of Premiums in the Event of Total Disability” clause;
- the date on which the Participant's employment terminates, subject to the provisions of the “Conversion Privilege” clause;
- the due date of any unpaid premium, subject to the provisions of the “Waiver of Premiums in the Event of Total Disability” and “Conversion Privilege” clauses, and subject to any legislated grace period in the applicable provincial jurisdiction;
- when the Participant attains the termination Age indicated in the Schedule of Benefits for the concerned coverage;
- the Participant's effective Date of Retirement;
- for a Participant who becomes disabled before age 65: The date of the Participant's 65th birthday;
- for a Participant who becomes disabled at age 65 or over and has not returned to active full-time work: The date corresponding to the expiry of the Long Term Disability Insurance Elimination Period, if Long Term Disability Insurance is included in the Schedule of Benefits;
- for a participant who becomes disabled at age 65 or over and has not returned to active full-time or part-time work: The date corresponding to the end of a 6-month period from the onset of disability, if Long Term Disability Insurance is not included in the Schedule of Benefits.

Conversion privilege

Termination of membership in the group

Participants whose entitlement to coverage terminates before age 65 are entitled to convert their life insurance in whole or in part or, if applicable, the life insurance for their Dependents, to an individual life insurance policy without having to provide evidence of insurability for themselves or their Dependents.

Participant's Life Benefits

The minimal amount of insurance on the Participant's life that may be converted is \$10,000. Furthermore, the amount that may be converted must not exceed the lesser of the following amounts:

- all amounts of life insurance protection held by the Participant under the contract on the conversion date, or
- \$400,000 for Participants residing in Quebec; \$200,000 for Participants residing outside Quebec.

In addition, Dependents having at least \$5,000 of life insurance protection under this contract may convert their life insurance. Furthermore, the amount that may be converted must not exceed the lesser of the following amounts:

- all amounts of life insurance protections on each Dependent's life under the contract on the conversion date, or
- \$400,000 for Covered Persons residing in Quebec; \$200,000 for Covered Persons residing outside Quebec.

To exercise this conversion option, Participants must apply in writing to the Insurer within 31 days following the date on which their membership in the group of Covered Persons terminates. Coverage under this contract remains in force until the date on which it is converted to an individual life insurance policy, without however exceeding the aforementioned 31-day period. Any reduction in the amount of insurance due to Age or a change in category of Covered Person does not give entitlement to the Conversion Privilege.

Expiry of the contract

Participants who have been insured for a minimum of 5 years and who have at least \$10,000 of life insurance coverage are entitled to convert their life insurance coverage, in whole or in part, to an individual life insurance policy within 31 days following the expiry of this contract if it is not replaced or the replacement contract provides for a lesser amount of insurance.

The amount of insurance that may be converted must be at least \$10,000 or 25% of the amount of the Participant's life insurance on the expiry of the contract, whichever amount is greater.

To exercise this conversion option, Participants are not required to provide evidence of insurability but must apply in writing to the Insurer within 31 days following the expiry date of this contract. Any reduction in the amount of insurance due to Age or a change in category of Covered Persons does not give entitlement to the Conversion Privilege.

Coverage available upon conversion

Participants who exercise their Conversion Privilege according to the aforementioned provisions may obtain an individual whole life or term life insurance policy, without accessory coverage, of the type issued at that time by the Insurer in such circumstances and in accordance with the applicable provincial regulation under the act respecting insurance.

The premiums applicable to the individual life insurance products when exercising the Conversion Privilege are determined in compliance with the applicable provincial regulation under the act respecting insurance.

How to claim

Benefits are based on the amount of insurance in force at the time of the death of the Participant.

To claim the Life Insurance benefit, the beneficiary or his representative must provide to the Insurer:

- The death certificate bearing the Participant's cause of death; and
- Confirmation of the date of birth of the Participant; and
- The full name and date of birth of the beneficiary.

The Insurer must receive notice of any claim for a Life Insurance benefit as soon as possible after the date of the event which gives entitlement to the benefit, but in any event within one year of the event.

Accidental Death, Disease & Dismemberment Coverage

General description of this coverage

Accidental Death, Disease & Dismemberment coverage provides benefits if you suffer any of the losses indicated as a result of an accident or critical disease that occurs while you are insured.

Covered loss

Covered Loss means a Critical Disease Benefit, Accidental Death Benefit or an Accidental/Disease Dismemberment Benefit. The Covered Loss must occur while you are insured under this benefit. In the case of an accident, the Covered Loss must occur within 365 days after the date of the accident.

Critical disease benefit

The Insurer will pay you an amount equal to 10% of the principal sum to a maximum of fifty thousand dollars (\$50,000) provided:

- the loss occurs prior to your 65th birthday
- you have been medically diagnosed with one of the covered Critical Diseases while insured under this benefit.
- you have been Totally Disabled from that Critical Disease for at least 9 months. Benefits are limited to the first covered Critical Disease in your lifetime.

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

Total Disability or **Totally Disabled** for the **Critical Disease Benefit** shall mean disability as a result of Injury or sickness to the extent that:

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

Accidental death benefit

If the Insurer is furnished with proof that your death occurred as a direct result of accidental bodily injuries occasioned solely through external, violent and accidental means without negligence on your part, the Insurer will pay an amount equal to 100% of the principal sum to your beneficiary.

Accidental Death, Disease & Dismemberment

Accidental disease/dismemberment benefit

If the Insurer is furnished with proof that you sustained one of the following losses, as a direct result of a Critical Disease or resulting directly and independently of all other causes from bodily injuries occasioned solely through external, violent and accidental means, without negligence on your part, the Insurer will pay:

Table of losses

Quadriplegia (total paralysis of all four limbs)	200% of Principal Sum
Paraplegia (total paralysis of both lower limbs)	200% of Principal Sum
Hemiplegia (total paralysis of one side of the body)	200% of Principal Sum
Loss of life	100% of Principal Sum
Loss of both arms or both legs	100% of Principal Sum
Loss of both hands or both feet	100% of Principal Sum
Loss of sight of both eyes	100% of Principal Sum
Loss of one hand and one foot	100% of Principal Sum
Loss of use of both hands or both feet	100% of Principal Sum
Loss of use of one hand or arm and one leg	100% of Principal Sum
Loss of sight of one eye and one hand or one foot	100% of Principal Sum
Loss of speech & hearing in both ears	100% of Principal Sum
Loss of one arm or one leg	75% of Principal Sum
Loss of use of one arm or one leg	75% of Principal Sum
Loss of one hand or one foot	66 2/3% of Principal Sum
Loss of use of one hand or one foot	66 2/3% of Principal Sum
Loss of speech or hearing in both ears	66 2/3% of Principal Sum
Loss of sight of one eye	66 2/3% of Principal Sum
Loss of thumb and index finger of same hand	33 1/3% of Principal Sum
Loss at least four fingers of one hand	33 1/3% of Principal Sum
Loss of hearing in one ear	33 1/3% of Principal Sum
Loss of all toes of one foot	25% of Principal Sum

For injuries to the same limb resulting from any one accident, only one of the amounts shown above (the largest applicable) will be paid. Notwithstanding the amounts specified above, the maximum you will be paid under this plan for all losses sustained as a result of the same accident will not exceed the Principal Sum, with the exception of paraplegia, quadriplegia and hemiplegia.

Definitions

Loss of arm means severance at or above the elbow joint.

Loss of hand means severance at or above the wrist.

Loss of leg means complete severance at or above the knee joint.

Loss of thumb means the complete loss of one entire phalanx of the thumb.

Loss of the index finger means the complete loss of two entire phalanges of the index finger.

Loss of foot means severance at or above the ankle.

Loss of a toe means complete severance of two entire phalanges of the toe.

Loss of hearing, sight, or speech means the complete and irrecoverable loss of that faculty. If that faculty can be recovered or partially recovered by the use of some device or rehabilitative program, it shall be deemed there was no loss for the purpose of this provision.

Loss of use means loss of use caused by accidental tendon, nerve or bone damage. The loss must be total and irrecoverable and must be continuous for 12 consecutive months and must be determined to be permanent.

Paralysis means complete and irreversible paralysis caused by brain, spine, muscle or nerve damage as a result of an accidental injury or covered Critical Disease which has continued for a period of 12 months from the date of the injury or medical diagnosis of the Critical Disease.

Exposure

If you are exposed to the elements following the disappearance, forced landing, stranding, sinking or wrecking of a conveyance in which you were an occupant, such exposure will be deemed an injury by accidental means.

Disappearance

If your body has not been found within one year of the disappearance, forced landing, stranding, sinking or wrecking of a conveyance in which you were an occupant, then it will be deemed that you have suffered loss of life within the meaning of this coverage.

Aggregate limit

The aggregate limit for all covered persons involved in any one air travel accident is two million, five hundred thousand dollars (\$2,500,000).

Accidental Death, Disease & Dismemberment

Waiver of premiums

If you become totally and permanently disabled and your claim for Waiver of Premium Benefit has been approved and accepted by the Group Life Plan underwriter, premiums due under this Accidental Death, Disease & Dismemberment plan will also be waived but only so long as the policy remains in force.

Day care benefit

If a Covered Loss sustained by you results in your death within 365 days of the Covered Loss, the Insurer will pay a Day Care benefit for each eligible child.

For the purpose of the benefit, Dependant Child as defined is eligible for this benefit until he or she reaches 12 years and is enrolled in a licensed day care facility within 90 continuous days from the date of the accident.

Payment will be equal to the lesser of 3% of your principal Sum amount per year or \$3,000 per year and will be paid each year for 4 consecutive years to a maximum benefit of \$12,000 per year.

If no dependents are eligible for the Day Care benefit, the Insurer will pay one thousand five hundred dollars (\$1,500) additional benefit to your beneficiary.

Education benefit (dependent)

In the event your death occurs as a direct result of a Covered Loss, the Insurer will pay your beneficiary the Education Benefit stated below for each of your dependent children who are, at the time of your death, enrolled as full-time students:

- in an institution for higher learning above the secondary school level as defined in the province or territory of residence, or
- at the secondary school level but who will enroll as a full-time student in an institution for higher learning within 365 days after your death.

The education benefit is equal to the reasonable and necessary expenses actually incurred for tuition and books subject to the lesser of a maximum of 5% of your principal sum or five thousand dollars (\$5,000), for each year the dependent child continues the education, but not to exceed 4 years, which must run consecutively, with respect to any one dependent child.

This benefit will be paid each year immediately upon receipt of satisfactory proof that the dependent child is enrolled as a full-time student in an institution for higher learning, however, payment will not be made for expenses incurred prior to your death or for incidental expenses, including without limitation room, board or other ordinary living, traveling or clothing expenses.

If none of your dependent children satisfy the above requirements, the Insurer will pay an amount of two thousand five hundred dollars (\$2,500) to your beneficiary.

Spousal occupational training benefit

In the event your death occurs as a direct result of a Covered Loss, the Insurer will pay the reasonable and necessary expenses actually incurred for books and tuition, within 2 years from the date of your death, to the spouse who engages in a formal occupational training program in order to become qualified for active employment in an occupation for which he/she would not otherwise have sufficient qualifications.

Expenses must be incurred within 2 years from the date of your death and are subject to a maximum lifetime payment of ten thousand dollars (\$10,000). Payment will not be made for expenses incurred prior to your death or for incidental expenses, including without limitation room, board or other ordinary living, travelling or clothing expenses.

Family transportation benefit

When, following an injury which results in a loss payable under this policy, you are confined as an inpatient in a hospital located from a point of at least 150 kilometers from your normal place of residence, the Insurer will pay the reasonable expenses actually incurred by all members of your immediate family for hotel accommodation and return transportation. The total will not exceed the aggregate amount of ten thousand dollars (\$10,000) for all such expenses. Payment will not be made for board or other ordinary living, traveling or clothing expenses. If transportation occurs in a vehicle or device other than one operated under a license for the conveyance of passengers for hire, then reimbursement of transportation expenses will be limited to a maximum of twenty cents (\$0.20) per kilometer traveled.

Home alteration & vehicle modification benefit

In the event you sustain an eligible loss and subsequently require the use of a wheelchair to be ambulatory, the Insurer will pay a benefit not to exceed ten thousand dollars (\$10,000) in your lifetime for the reasonable and necessary expenses actually incurred within 2 years of the date of the loss for:

- the cost of alterations to your principal residence and/or
- the cost of modifications to one motor vehicle utilized by you, when such modifications are approved by licensing authorities where required, for the purpose of making them wheelchair accessible.

Rehabilitation benefit

In the event you sustain a Covered Loss and within 2 years from that date 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 Covered Loss, the Insurer will pay the reasonable and necessary expenses actually incurred for the services of a licensed rehabilitation provider.

Payment by the Insurer for the total of all expenses incurred under this provision will not exceed ten thousand dollars (\$10,000) as the result of any one Covered Loss. Payment does not include incidental expenses, including without limitation, charges for room and board, ordinary living, traveling or clothing expenses.

Accidental Death, Disease & Dismemberment

Repatriation benefit

If a covered person dies from any cause at least 150 kilometers from their usual place of residence, or outside of Canada regardless of distance, the Insurer will pay the reasonable and customary expenses, up to a maximum of ten thousand dollars (\$10,000), of the preparation of the body and its transportation to the funeral home or the place of interment in proximity to the normal place of residence of the deceased.

Seat belt benefit

When you sustain an eligible loss as the result of an accident, while driving or riding in a vehicle and wearing a properly fastened seat belt, the benefit payable will increase by 10%.

The driver of the vehicle must hold a current and valid drivers license and must not be intoxicated or under the influence of drugs (unless such drugs are taken as prescribed by a physician), at the time of the accident. Proof of seatbelt use must be provided.

Exclusions

No Accidental Death, Disease & Dismemberment Benefits will be paid if the Covered Loss is caused by or results directly or indirectly from one or more of the following:

- suicide, or self-inflicted injury while sane or insane.
- injuries caused by an act of declared or undeclared war, or participation in any riot.
- active service in the Armed Forces of any country.
- travel or flight in any aircraft, or descent from such aircraft, if you are a pilot or a member of the crew of the aircraft, or if such flight is made for the purposes of instruction, training or testing.
- medical care or treatment of any kind including surgery.
- committing, attempting or provoking an assault or criminal offense including without limitation driving a vehicle with alcohol in the blood in excess of 80 milligrams of alcohol per 100 millilitres of blood.
- any drug, poison, gas or intoxicant, taken, administered, absorbed or inhaled, voluntarily or otherwise (occupation-related accidents excepted).

When and how to make a claim

Claims for Accidental Death, Disease & Dismemberment Benefits must be made within 180 days from the date the Insurer is liable. Failure to furnish such proof within the time required will not invalidate nor reduce any claim if it is shown to not have been reasonably possible to furnish the proof and that proof is furnished as soon as reasonably possible.

Dependent Life

Benefit amount

The amount payable upon the death of an insured Dependent is equal to the amount specified in the Schedule of Benefits.

Stillbirth benefit

La Capitale will pay the child benefit provided under the Dependent Life Insurance benefit, provided:

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

Waiver of premium in the event of total disability

When a waiver of premiums has been granted for Participant's Life Insurance coverage in the event of Total Disability, the waiver shall also apply to this coverage under the same conditions.

Extension of coverage for dependent of a deceased participant

Following the death of a Participant, Life Insurance coverage for the Participant's Dependents will be extended without payment of premiums until the earliest of the following dates:

- a) the last day of the period immediately following the Participant's death that is specified in the Schedule of Benefits;
- b) the date on which the Dependents' insurance would have ended if the Participant had been alive;
- c) the date on which this benefit or contract terminates.

End of insurance

Dependents' insurance terminates on the earliest of the following dates:

- a) the date on which the Participant's insurance terminates, subject to the provisions of the "Extension of Dependents' Coverage of a Deceased Participant" and "Conversion Privilege" clauses, if applicable;
- b) the date on which he ceases to be a Dependent;
- c) the date indicated in the Schedule of Benefits

Conversion privilege

For Conversion Privilege available to Dependents, please refer to the corresponding section in the Participant's Life Insurance.

How to claim

Benefits are based on the amount of insurance in force at the time of the death of the Dependent. In the event of the death of a Participant's spouse or one of his dependent children, the benefits are payable to the Participant.

To claim the Life Insurance benefit, the beneficiary or his representative must provide to the Insurer:

- The death certificate bearing the Dependent's cause of death; and
- Confirmation of the date of birth of the Dependent; and
- The full name and date of birth of the beneficiary.

The Insurer must receive notice of any claim for a Life Insurance benefit as soon as possible after the date of the event which gives entitlement to the benefit, but in any event within one year of the event.

Long Term Disability

Your Plan Member Long-Term Disability coverage is designed to provide you with income protection if you become Disabled while covered under the Plan.

You may become eligible for Plan Member Long-Term Disability Benefits after satisfying the Qualifying Period specified in the Plan Summary. The Qualifying Period is the amount of time that you are absent from work due to an Injury or Illness before you can be considered eligible for benefits.

“**Disability**” or “**Disabled**” means that solely because of an Illness or Injury, you are unable to work at your own occupation during the qualifying period and the next 24 months. Thereafter, Disability means that you are unable to work at any occupation that you may qualify for because of your training, education, or experience.

The availability of work will not be considered by Wawanesa Life in assessing your Disability.

If you must hold a government permit or license to perform your duties, you will not be considered Disabled solely because such permit or license has been withdrawn, cancelled, suspended, or not renewed.

A particular condition will only qualify as an Injury under this definition of Disability or Disabled if it arises within 30 days after the Accident which causes the condition. If the condition does not arise within that time frame, it will be considered an Illness.

In order to receive benefits:

- a) you must be covered for this Benefit on the date of Disability;
- b) you must be Disabled as defined under this Benefit and remain so throughout the Qualifying Period and the Maximum Benefit Period (as specified in the Plan Summary);
- c) you must suffer a total loss of Earnings from your Employer; and
- d) Wawanesa Life must receive Plan Member Long-Term Disability premium for you throughout the Qualifying Period (as specified in the Plan Summary).

Your Plan Member Long-Term Disability Benefit payment will be reduced by any income you receive or are entitled to receive from:

- a) Workers Compensation or similar coverage, excluding automatic cost-of-living increases that occur after the benefit becomes payable under the Plan;
- b) Canada Pension Plan, Quebec Pension Plan, or similar government plans, excluding dependent benefits and automatic cost-of-living increases that occur after the benefits begin;
- c) any vacation pay you accrue during any period of Disability; and
- d) any motor vehicle insurance plan or policy, unless prohibited by law.

Your Plan Member Long-Term Disability Benefit payment will be further reduced so that your total income from All Sources (as defined below) does not exceed 85% of your pre-disability earnings if this Benefit is taxable, or 85% of your pre-disability earnings after income tax and statutory deductions if this Benefit is non-taxable.

Long Term Disability

“**All Sources**” include those stated above and any benefit you are entitled to receive from:

- a) any group, association, or franchise plan;
- b) any retirement or pension plan;
- c) earnings or payments from any Employer such as salary, severance payments, or vacation pay;
- d) self-employment; and
- e) any other government plan.

Residual Benefit

From the date of Disability, Wawanesa Life will assess each subsequent monthly period to determine if there was a loss of the Plan Member’s indexed monthly earnings of 20% or more. If there was a loss of 20% or more, the entire monthly period applies toward satisfying the Qualifying Period. A reset of the Qualifying Period will occur:

- a) when the Plan Member is no longer Disabled for more than 30 consecutive days; or
- b) when the Plan Member loses less than 20% of their indexed monthly earnings.

Partial Disability Plan

Once Wawanesa Life determines you are Disabled, where appropriate and at Wawanesa Life’s discretion, you may be required to participate in a partial disability return-to-work plan to assist you in returning to pre-disability occupation for a reduced number of hours per week (a “**Partial Disability Plan**”). Wawanesa Life is under no obligation to approve or continue the Partial Disability Plan for you. The decision to approve or discontinue the Partial Disability Plan will be made solely by Wawanesa Life.

During the Partial Disability Plan, you may receive regular salary from your Employer for any hours worked plus Plan Member Long-Term Disability Benefits. Plan Member Long-Term Disability Benefits will be reduced by the percentage of your normal work week represented by the Partial Disability Plan.

If you are not available, do not cooperate, or do not participate in the prescribed Partial Disability Plan, you will not receive Plan Member Long-Term Disability Benefits.

If you no longer participate in the Partial Disability Plan, evidence satisfactory to Wawanesa Life documenting why you cannot participate in the Partial Disability Plan will be required.

Your participation in the Partial Disability Plan will be limited to your own occupation period, as specified in the definition of Disability.

Rehabilitative Return-to-Work Plan

Once Wawanesa Life determines you are Disabled, where appropriate and at Wawanesa Life’s discretion, you may be required to participate in a plan, designed by Wawanesa Life acting reasonably (for the purposes of this Plan Member Long-Term Disability Benefit, the “**Rehabilitative Return-to-Work Plan**”) to assist you in returning to gainful employment. In considering whether a Rehabilitative Return-to-Work Plan is appropriate for you, Wawanesa Life will consider:

- a) the nature, extent, and expected duration of your Disability;
- b) your education, training, or experience; and
- c) the nature, scope, and objectives of the Rehabilitative Return-to-Work Plan.

If you are not available or do not cooperate or participate in Wawanesa Life’s recommended rehabilitation activities, you will no longer be entitled to Plan Member Long-Term Disability Benefits.

You may continue to receive benefits for the Maximum Benefit Period as long as you are Disabled and under the care of a Physician. If your Plan Member Long-Term Disability Benefit would otherwise terminate because your Employer terminates the group benefits plan with Wawanesa Life and you are still Disabled, your benefit payment may continue to the end of the Maximum Benefit Period specified in the Plan Summary but will not continue past the Coverage Termination Age specified in the Plan Summary. You must continue to be Disabled to the end of the Maximum Benefit Period.

When Benefit Payments Stop

Your benefit payments will stop for any period that you:

- a) are not receiving from a Physician Reasonable and Customary and ongoing care and treatment appropriate for the disabling condition, as determined by Wawanesa Life;
- b) are on Lay-off and the date of Disability is within 2 months of the notice period;
- c) are on leave of absence during which you become Disabled, unless your Employer is required to pay benefits during this period as a result of legislation;
- d) are Disabled and then take an approved leave of absence, unless your Employer is required to pay benefits during this period as a result of legislation; or
- e) are incarcerated in a prison, correctional facility, or psychiatric hospital by order of authority of a criminal court.

Termination of Plan Member Long-Term Disability Benefit Payments

Your benefit payments will terminate on the earliest of:

- a) the date you cease to meet the Benefit definition of Disabled;
- b) the date you work in any occupation for earnings or profit, except as provided under the Partial Disability Plan or the Rehabilitative Return-to-Work Plan;
- c) the date you fail or refuse to participate or cooperate in a prescribed Partial Disability Plan or a prescribed Rehabilitative Return-to-Work Plan;
- d) the date you do not supply Wawanesa Life with appropriate Medical Evidence documenting how your Illness or Injury causes restrictions or lack of ability, such that you remain Disabled as defined in the Benefit;
- e) the date you do not attend an Independent Assessment by an examiner selected by Wawanesa Life;
- f) the date on which benefits have been paid up to the Maximum Benefit Period specified in the Plan Summary;
- g) the date you reach the Coverage Termination Age specified in the Plan Summary; or
- h) the date you die.

Recurrent Disability

If you return to work for less than 6 months and become Disabled again due to the same or related Illness or Injury, Wawanesa Life will waive the Qualifying Period. This recurrence will be considered a continuation of the same Disability and benefits will be based on your earnings when you first became Disabled. Benefits for all recurrences will not be paid for a combined period that is longer than the Maximum Benefit Period specified in the Plan Summary.

A Disability due to causes unrelated to the previous Disability is considered separate if:

- c) benefit approval has ceased or benefit payments have stopped for the previous Disability; and
- d) you have returned to work for at least 1 full day.

Long Term Disability

Pre-existing Plan Member Long-Term Disability Exclusion

In addition to the Claim Exclusions listed in the “Making a Claim” section in this booklet, no amount will be payable under this Plan Member Long-Term Disability Benefit for any Disability directly or indirectly related to a Pre-existing Condition which causes Disability within the first 12 months of coverage under the Benefit. A Pre-existing Condition for the purposes of this Pre-existing Plan Member Long-Term Disability Exclusion provision is any Injury or Illness (whether diagnosed or not) for which you were treated or attended to by a Physician, or for which drugs were prescribed, within 90 days prior to the date your coverage under the Benefit became effective.

Claim Submission Deadlines

Claims received outside the time frames specified under this Claim Submission Deadlines section will be denied.

Claim forms and proof that benefits are payable must be submitted by you or on your behalf and received by Wawanesa Life at its Executive Office as follows:

- a) for a Plan Member Life claim, within 180 days from the date of loss;
- b) for a Plan Member Long-Term Disability claim, within 180 days from the end of the Qualifying Period;
- c) for a Waiver of Premium claim, within 180 days from the date of Disability.

If your coverage terminates due to termination of a benefit provision or termination of the Plan and is replaced by another insurer within 31 days of the termination date, a claim for a loss that occurred prior to the Plan’s termination date may be submitted up to 6 months from the date of termination for Plan Member Life and loss of income due to Disability.

Survivor Income Benefit

If you die while Plan Member Long-Term Disability Benefits are payable, Wawanesa Life will pay the Survivor Income Benefit Amount specified in the Plan Summary, less the amount of any Plan Member Long-Term Disability Benefit overpayments which have not been recovered:

- a) to your Spouse, if they survive you;
- b) to your surviving Dependent Children; or
- c) to your estate.

Benefit Tax Status

If you pay the premium for your Plan Member Long-Term Disability coverage, any benefit you receive will be provided on a tax-free basis.

If your Employer pays any part of your premium for your Plan Member Long-Term Disability coverage, any benefit you receive will be taxable income to you.

Extended Health Care

General description

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

If you incur medically necessary services or supplies due to an Accident or Illness, the Plan will pay the reasonable and customary charges for the listed eligible services except where specific maximums or limitations are indicated.

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

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

The calendar year is from January 1 to December 31.

Deductible

The deductible as indicated in the Schedule of Benefits is the portion of claims that you are responsible for paying each calendar year. After the deductible has been paid, claims will be paid up to the percentage of coverage (co-insurance) indicated in the Schedule of Benefits, subject to any maximums identified for the covered services or supplies.

Prescription drugs

Coverage includes the cost of drugs that are, by law, only available with a prescription excluding speciality drugs that may have a potential annual cost of \$10,000 or more, as long as they are prescribed by a physician or dentist and are obtained from a licensed pharmacist.

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

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

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

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

Extended Health Care

Speciality drugs

Speciality drugs are drugs that target specific, complex and chronic conditions such as, but not limited to, hepatitis C, rheumatoid arthritis, cancer and multiple sclerosis. They are typically very expensive and require special handling, administration and monitoring. Your plan does not cover speciality drugs that may have a potential annual cost of \$10,000 or more.

However, if you are a resident of British Columbia, Saskatchewan or Manitoba, the plan will cover any of the cost of the speciality drug not covered by your provincial drug plan, provided:

- the speciality drug you are prescribed is listed on the provincial formulary of your province of residence;
- you are enrolled in the applicable provincial drug plan program dealing with speciality drugs; and
- you have received special authorization from the applicable provincial drug plan.

“Exceptions” or “Prior Authorization drugs”

Certain prescription drugs are only covered under specific clinical criteria and directions for use determined by the appropriate government authorities. Special Authorization forms are available from GroupSource Health & Dental Department. You are responsible for any charges for completion of forms.

Coverage navigation services

For participants who are prescribed a speciality drug, Coverage Navigation Services are available to help participants access their provincial drug program, apply for manufacturer sponsored program or to seek alternative coverage options. If you are prescribed a speciality drug, please contact GroupSource Health & Dental Department for more information.

The Plan will only pay for quantities that can reasonably be used within a three month period.

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

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

- any drug that does not have a drug identification number as defined by the Food and Drugs Act, Canada;
- any drug prescribed for treatment of a medical condition that is not an approved indication by the manufacturer
- drugs or medicines dispensed by a Physician, Dentist, clinic or non-approved Hospital;
- fees for the administration of any injectable drugs, including but not limited to serums, vaccines, vitamins, insulin, and allergy extracts;
- drugs that are considered cosmetic, including hair growth stimulants and sunscreens;
- treatments for weight loss, health foods, and vitamins (unless injected);
- erectile dysfunction medication;
- experimental drugs, proprietary or patent medicines registered under the Food and Drugs Act, governed by Health Canada

Medical services & supplies

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

Ambulance

Ambulance services, including air ambulance services, are covered if a licensed ambulance company provides them. Transportation must be to the nearest Approved Hospital where Reasonable and Customary Treatment is available, or from an Approved Hospital to a Convalescent Hospital. There is no coverage if you are not transported to a hospital. Where medically necessary, the fee for one person to attend you when being transported will be covered.

Dental accident

Coverage includes expenses for the repair or replacement of whole, functioning, sound, natural teeth, where damage has resulted from a direct accidental injury which occurs while you are covered under your Employer's group benefit plan. There is no coverage for eating accidents or using teeth for purposes for which they are not intended.

Treatment must start within 100 days after the accident and be completed within 12 months of the accident and must be the least expensive that will provide professionally adequate treatment. Coverage is limited to the fee stated in the current Provincial Dental Fee Schedule for a general practitioner in the province where you live at the time that treatment is received. Expenses for the treatment of temporomandibular joint dysfunction (TMJ) or orthodontic services are not covered under this provision.

Diabetic supplies

The following diabetic supplies are covered:

- insulin syringes;
- Novolin-Pens or similar insulin injection devices using a needle;
- test strips;
- blood letting devices, including platforms and lancets;
- insulin infusion sets, not including infusion pumps; and
- glucometres prescribed by a Physician, up to a lifetime maximum of seven hundred dollars (\$700) per person

Diagnostic services

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

Extended Health Care

Eye exams

Charges for eye exams performed by a licensed ophthalmologist or optometrist are covered, up to a maximum of two hundred dollars (\$200) per person over 24 consecutive months, provided no portion of the cost is covered under your provincial health care plan. Dependent children under age 18 are covered to a maximum of two hundred dollars (\$200) per child over 12 consecutive months.

Hearing aids

Coverage includes charges for hearing aids, including repair (excluding batteries or routine maintenance). Hearing aid batteries, tubing and ear molds provided at the time the hearing aid is purchased are covered. The maximum amount payable is one thousand dollars (\$1,000) per person every 5 years.

Home nursing care

Costs related to home nursing care are covered, if care starts while you are insured under this benefit, and you receive acute, convalescent or palliative care. Nursing care is care that requires the skills and training of a professional nurse; and is provided by a professional nurse who is not a member of your family.

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

Pre-determination of benefits

To establish the amount of coverage available under this provision before home nursing begins, you must apply for a pre-determination of benefits. A pre-determination of benefits is an assessment by the Plan that identifies:

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

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

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

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

Hospital accommodation

Costs related to Hospital accommodation are covered, if care starts while you are insured under this benefit, and you receive acute, convalescent or palliative care. No benefits will be paid for hospital or home nursing care for Medically Diagnosed Conditions where significant improvement or deterioration is unlikely within the next 12 months. This is considered Chronic Care.

Hospital accommodation

The difference in cost between an Approved Hospital's standard ward rate and the hospital accommodation shown in the Schedule of Benefits will be covered, provided that you specifically elect that accommodation in writing. The Plan will also cover any out-of-province out-patient charges in an Approved Hospital outside your province of residence.

Convalescent Hospital accommodation

Costs of accommodation in a Convalescent Hospital for a Medically Diagnosed Condition that requires convalescent care are covered, provided care immediately follows at least 3 or more days of confinement for acute care in an Approved Hospital.

Convalescent Hospital accommodation is limited to a maximum of 180 days. The maximum will be reinstated for a subsequent period of Convalescent Hospital accommodation, when:

- it follows a period of at least 30 days during which no Approved Hospital or Convalescent Hospital confinement was required; or
- it is required for a Medically Diagnosed Condition unrelated to the conditions for which benefits have already been paid.

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

Medical equipment

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

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

Extended Health Care

Orthopedic shoes & foot orthotics

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

- custom-made foot orthotic inserts for shoes that are specially designed and molded for you. The maximum amount payable is two hundred dollars (\$200) per calendar year.
- custom-made and custom-fitted orthopedic shoes that are specially designed and fitted for you. Coverage is also provided for modifications to orthopedic shoes. The maximum amount payable is four hundred dollars (\$400) per calendar year.

Ostomy supplies

The following colostomy and ileostomy supplies are covered:

- irrigation sets, bags, deodorants, adhesives and skin creams
- charges for catheters, catheterization supplies and urinary kits

Oxygen & equipment

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

Paramedical practitioners services

Charges for out-of-hospital services of the following practitioners, when treating a Medically Diagnosed Condition, are covered when provided in Canada. Only one treatment by any one practitioner is covered per day, per Covered Person. The Insurer will cover up to a combined maximum of one thousand two hundred dollars (\$1,200) per person in a calendar year for all categories of paramedical specialists listed below:

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

Prosthetic equipment

Charges for the following standard prosthetic equipment are covered:

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

Coverage for myoelectric prosthesis will be reimbursed only to the amount allowed for the cost of standard prosthesis, only when a standard prosthetic is deemed not medically adequate. Prior approval by the Plan is required.

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

Sclerotherapy

Sclerosing injections are covered when prescribed by a Physician for medical reasons.

Smoking cessation

Smoking cessation aids that legally require a prescription are covered to a lifetime maximum of five hundred dollars (\$500) for each covered person.

Speech aids

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

Therapeutic equipment

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

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

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

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

Extended Health Care

Wheelchairs and hospital beds

Coverage is provided for manual wheelchairs, including Reasonable and Customary Charges for repairs. Special wheelchairs necessary to permit independent participation in daily living are included. Special wheelchair features required primarily for participation in sports are not covered.

Coverage is provided for standard Hospital Beds. Electric and air-fluidized hospital beds are not covered.

Wigs and hair pieces

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

What is not covered

The Plan will not pay for the costs of:

- expenses that private insurers are not permitted to cover by law;
- services or supplies not specifically listed as covered;
- services or supplies payable in whole or in part under any legislation, except for user fees and extra billing if the legislation allows the user fees and extra billing;
- services or supplies that do not represent Reasonable and Customary Treatment of your Medically Diagnosed Condition;
- care, services or supplies utilized as treatment of lifestyle choices, as determined by the Plan;
- services or supplies which are primarily for cosmetic purposes;
- services or supplies associated with recreation or sports rather than with other regular daily living activities;
- anti-obesity treatment, including drugs, protein and dietary or food supplements whether or not prescribed for a medical reason;
- diagnosis or treatment of infertility except for prescription fertility drugs as indicated in Schedule of Benefits;
- contraception, other than oral contraceptives and intrauterine devices;
- equipment that the Plan considers ineligible (such as orthopedic mattresses, exercise equipment, air-conditioning or air-purifying equipment, vaporizers, whirlpools, humidifiers, and equipment used to treat seasonal affective disorders);
- additional, duplicate or replacement appliances or devices, except where the replacement is required because the existing appliance can no longer be made serviceable due to normal wear and tear, or as the result of a pathological change, unless prior approval in writing is obtained from the Plan; or
- expenses incurred for the completion of claim forms, obtaining further medical information regarding claims for covered expenses, medical screening or examinations for the use of a Third Party, or broken appointments, travel expenses or communication costs by a Medical Practitioner.
- services provided by an individual who resides with the Covered Person.
- services provided by an individual who is a Close Relative of the Covered Person.

The Plan will not cover expenses arising from:

- war, insurrection, civil commotion, acts of terrorism; voluntary participation in a riot; or
- active duty as a member of any branch of the armed forces of any government; or
- committing, attempting or provoking an assault or criminal offence.

Any benefits payable under this policy will be reduced by any amount you receive or are eligible to receive from:

- any Government Health Insurance Plan;
- Worker's Compensation Act; or
- any government hospital, medical, dental or health care plan, whether payable or not.

Extended Health Care

When & how to make a claim

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

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

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

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

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

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

Vision Care

The charges for the purchase of lenses, frames or contact lenses are covered as long as they are required to correct vision and are prescribed and dispensed by a licensed Ophthalmologist, Optometrist or Optician.

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

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

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

Survivor Health Benefit

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

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

Emergency Travel Assistance

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

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

Definitions

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

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

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

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

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

Emergency means unexpected and not pre-planned.

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

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

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

Emergency Travel Assistance

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

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

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

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

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

When and how to make a claim

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

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

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

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

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

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

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

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

Payments

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

Evacuation benefit

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

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

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

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

The total maximum amount payable under this section will not exceed two hundred and fifty thousand dollars (\$250,000) as a result of any one (1) Accident, Sickness or Disease.

Emergency Travel Assistance

Emergency dental treatment benefit

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

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

Family transportation and accommodation benefit

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

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

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

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

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

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

Fare means the regular fare charged for:

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

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

Medical reimbursement expense benefit

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

- Hospital charges including those for room and board, up to and including the semi-private accommodation level, subject to a maximum duration of 12 months.
- Hospital charges for out-patient services when medically required.
- expenses for the services of a Nurse ordered or prescribed by a Physician, provided the Nurse does not ordinarily reside with you. The maximum payable per Accident, Sickness or Disease is five thousand dollars (\$5,000).
- charges for prescription drugs, sera and vaccines, obtainable only upon a written prescription by a Physician or legally qualified dentist and dispensed by a registered pharmacist or Physician, but excluding any charges made for the administration of injectable drugs, sera and vaccines, subject to a dispensing maximum of a 30 day supply.
- expenses charged for the services of a licensed professional physiotherapist for physiotherapy treatment ordered or prescribed by a Physician, provided such physiotherapist does not ordinarily reside with you and is not a Member of your Immediate Family. The maximum amount payable per Accident, Sickness or Disease is one thousand dollars (\$1,000).
- expenses for a licensed ground ambulance service or, when recommended by a Physician, by any other conveyance licensed to carry passengers for hire, to or from the nearest Hospital which is equipped to provide the required treatment, subject to a maximum of five thousand dollars (\$5,000) per Accident, Sickness or Disease.
- expenses incurred for the following:
 - blood plasma, whole blood or oxygen, including the administration thereof.
 - x-rays and laboratory examinations which are required for diagnostic purposes.
 - artificial limbs, eyes or other prosthetic appliances, subject to a maximum of two thousand dollars (\$2,000) per calendar year.

Emergency Travel Assistance

- rental or purchase of casts, cervical collars, crutches, trusses, splints and braces (except dental braces and splints).
- rental of a wheelchair, an iron lung and other durable medical equipment for temporary therapeutic treatment, subject to a maximum of five thousand dollars (\$5,000) per Accident, Sickness or Disease.
- expenses for medical care and treatment rendered or surgical procedures performed by a Physician.
- expenses for the services of a licensed anaesthetist when recommended by a Physician.
- expenses for the services of any of the following licensed practitioners, provided such practitioner does not ordinarily reside with you and is not a member of your Immediate Family. The maximum payable is three hundred dollars (\$300) per specialty per Accident, Sickness or Disease (such services do not require the recommendation of a Physician except as indicated below):
 - Chiropractor
 - Osteopath
 - Chiropodist or podiatrist
 - Massage Therapist on the recommendation of a Physician
 - Speech therapist
 - Licensed psychologist

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

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

Return of vehicle benefit

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

Repatriation benefit

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

Up to ten thousand dollars (\$10,000) will be reimbursed towards the reasonable and necessary expenses actually incurred for the transportation of a deceased person to the first resting place (including but not limited to a funeral home or the place of interment) in the vicinity of the normal place of Residence of the deceased. This includes charges for the preparation of the body for such transportation. The benefit will be payable to the person who actually incurred the expenses.

Exclusions and limitations

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

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

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

- expenses covered under any government hospital, medical, dental or health care insurance plan, whether payable or not, or expenses for which insurance is prohibited by law.
- medical examinations for the use of a third party, cosmetic surgery and dental services other than those required as a result of an accident.
- oral contraceptives and patent medicines.
- charges for experimental drugs not approved by Drugs Directorate, Health Protection Branch of Health and Welfare Canada.
- charges for any experimental medical treatments.
- services for which no charge would ordinarily be made if there was no insurance coverage.
- expenses incurred for treatment or surgery which medically could be delayed until the Insured Person has returned to his province of Residence.
- medical expenses for treatment or surgery which the Insured Person elects to have rendered or performed outside his province of Residence, following Emergency treatment for or diagnosis of a medical condition which (on medical evidence) would not prevent the Insured Person from returning to his province of Residence prior to such treatment or surgery.
- Expenses incurred in a location for which the Government of Canada issued an advisory to avoid all travel as well as expenses incurred during cruise ship travel while the Government of Canada issued an advisory to avoid all cruise ship travel. If the Insured Person is already present at the location in question or on a cruise ship at the time the advisory is issued, they must comply with the advisory within 14 days following its issuance. If the Insured Person does not comply with the advisory within 14 days following its issuance, no expenses incurred by the Insured Person will be eligible after this deadline.

Emergency Travel Assistance

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

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

Non duplication

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

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

The AXA Assistance Program

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

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

- 24 hour worldwide medical information and assistance including pre-trip information such as local English-speaking doctors and phone numbers for local hospitals.
- medical monitoring during treatment and ongoing updates to family and/or employer.
- arrangements for emergency medical evacuation to the nearest facility capable of providing the required medical care.
- special assistance on medically supervised emergency transportation.
- hospital deposit guarantee after verification of insurance coverage.
- dispatch of a doctor or specialist if condition cannot be adequately assessed to evaluate the need for evacuation.
- access to legal referrals.
- assistance in obtaining bail bond services.

- access or referral to interpreter services.
- assistance in making travel arrangements for family member to join disabled Member, for the return of minor children to their normal place of Residence.
- emergency message transmission between the family and/or employer.
- assistance in obtaining replacements of lost or stolen travel documents such as passport, credit cards, etc.
- assistance in making arrangements for the return of vehicle to the rental agency or the current principal Residence.

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

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

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

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

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

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

sparrow

Charting a Better Path for Health

sparrow is GroupSource's unified health and wellness concierge – a single app that provides You, Your Spouse and Dependent Children with integrated mental and physical health support, as well as additional wellness services tailored to offer support through all life's challenges.

By transforming the landscape of healthcare integration and accessibility, sparrow gives Participants seamless access to comprehensive care so they can prioritize their whole health through their own team of medical experts ready to provide prompt, continuous care based on their individual needs.

Value through integration

With one app, Participants have a single unified patient record, meaning sparrow's network of medical professionals – therapists, doctors, pharmacists, and more – can provide the best continuity of care for everyone.

Comprehensive Wellness and Support Services

Mental Health Support

Mental health challenges affect us all at some point in our lives. sparrow provides enhanced mental health support for short and long-term care needs, including Dependent Children's mental health, digital iCBT, and a network of over 5,000 therapists nationally ready to provide effective, high-quality care, in over 30 languages. sparrow's concierge services makes it easy for Participants to find the right healthcare professional suited to their individual needs. They can find support faster with convenient, holistic well-being support such as virtual and in-person individual and couples counselling.

If You identify as Indigenous, sparrow offers virtual counselling through Noojimo, Canada's only Indigenous-owned and staffed mental wellness clinic, for those seeking culturally safe mental health support.

Although counselling is a hugely beneficial tool for mental health needs, sparrow doesn't stop there. Through the app, Participants can access self-guided digital therapy (iCBT) to help them develop positive coping strategies and reduce anxiety and depression symptoms.

Employee and Family Assistance Program (EFAP) for Work, Health & Life Challenges

sparrow is a gateway to a transformed Employee and Family Assistance Program (EFAP) that includes critical incident support, 24/7 crisis support, substance-use management, and other resources that go beyond expectation from traditional EFAP.

To help You achieve Your goals and find balance, plan member can access:

- Legal and financial phone consultations, and legal referrals at a discounted rate
- Career counselling to help with development, workplace issues, or retirement planning
- Support to navigate life transitions, such as childcare, eldercare, pregnancy, and more
- Personalized nutrition advice from certified dietitians and AI
- Webinars and training to cover your organization's engagement needs

Virtual Healthcare

Accessing proper medical care in Canada can be challenging. With sparrow's virtual healthcare services, You, Your Spouse, and Dependent Children can connect with a Canada-licensed physician 24/7/365 in minutes – providing care for the whole family, even outside Canada. Physicians provide on-demand healthcare that includes acute care issues such as cold and flus, mental health support for collaborative care or referrals to other specialists, and chronic care issues for frequent touchpoints with a medical provider. Participants value the access to medical care without the need to use valuable sick days or personal time for doctors' visits.

Integrated Digital Pharmacy Services, powered by Greenshield Pharmacy

The trust and expertise of a traditional pharmacy with the convenience of a digital experience. sparrow's pharmacy, powered by Greenshield Pharmacy lets Participants manage all their pharmacy needs through the unified sparrow app – including virtual pharmacist consultations, daily dose packaging, auto-refills and reminders, and more.

With sparrow, You get affordable dispensing fees with fast and free delivery to anywhere in Canada within 1-3 business days.

Learn more about sparrow:

Online: mysparrow.ca

Download the app in Your app store

By phone at 1-866-644-6881

Dental Care

General description of this coverage

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

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

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

The calendar year is from January 1 to December 31. Reference to months means consecutive months.

Alternate benefit

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

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

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

Deductible

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

Pre-authorization

You should submit an estimate, before the work is done, for any major treatment or any procedure that will likely cost more than \$500. To submit an estimate, you need to send a completed dental claim form that shows the detailed treatment that the dentist is planning and the cost. Both you and the dentist will have to complete parts of the claim form. Your dentist may be requested to submit any relevant x-rays. GroupSource will advise you how much of the planned treatment is covered. This way you will know how much of the cost you will be responsible for before the work is done.

Basic Dental Services

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

Oral examinations

You are covered for the following oral examinations:

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

X-rays

You are covered for all the following x-rays:

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

Laboratory

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

Cleaning

You are covered for teeth cleaning (up to and including 2 time units of polishing) once every 6 months.

Topical fluoride treatment

You are covered for fluoride treatments once every 6 months.

Oral hygiene instruction

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

Space maintainers and maintenance

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

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

Caries, trauma and pain control

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

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

Fillings

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

Pre-fabricated metal or plastic restorations

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

Pit and fissure sealant

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

Endodontics

Endodontics is root canal therapy and root canal fillings and treatment of disease of the pulp tissue. Root canal therapy for permanent and primary teeth is limited to one course of treatment per tooth.

Periodontics

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

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

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

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

Periodontal appliance includes impression, insertion and adjustments within 6 months of insertion. Periodontal appliance coverage must be pre-approved by the Dental Consultant.

Temporomandibular joint (TMJ) disorders

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

Related surgical services

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

Repairing, relining or rebasing dentures

Repairing dentures means fixing broken or damaged dentures.

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

Rebasing dentures means fitting dentures with a new base.

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

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

Major Dental Procedures

Your dental benefits include procedures used to treat major dental problems. All expenses under this provision require a pre-authorization.

Crowns

Crowns are dental restorations, sometimes referred to as “caps” which are coverings that fit over teeth to strengthen and protect remaining tooth structure. Crowns are covered when a tooth has extensive structural loss due to traumatic injury, fracture of the tooth or cusps, or where there have been very large areas of filling combined with decay that prevent the use of more traditional filling materials such as silver amalgam and plastics to adequately restore the tooth.

Temporary stainless steel crowns for an adult must fulfil the same criteria as a regular crown to be a covered benefit. The cost of a temporary stainless steel crown will be deducted from the cost of a permanent crown. If the permanent crown is not placed within 12 months of the temporary one, the temporary stainless steel crown is considered permanent.

Replacement of existing crowns are covered when the existing restoration is at least 4 years old and cannot be made serviceable.

No benefits will be paid for:

- crowns needed due to wear (attrition) and cosmetic reasons.
- covering of a tooth with a crown in order to prevent possible future damage to the tooth.
- extra lab charges for a crown made to fit an existing partial denture clasp.

Inlays and onlays

Inlays and onlays are metal or porcelain fillings placed on the surface of the tooth. Inlays and onlays are only covered for teeth that cannot be restored with a regular filling because of extensive structural loss due to traumatic injury, fracture of the tooth or cusps, or where there have been very large areas of filling combined with decay that prevent the use of more traditional filling materials such as silver amalgam and plastics to adequately restore the tooth.

Replacement of existing inlays and onlays are covered when the existing restoration is at least 4 years old and cannot be made serviceable.

Veneers

Veneers are white facings put on the front of the tooth's surface. Veneers are only covered for teeth that cannot be restored with a regular filling as long as they are not used primarily to improve appearance. Veneers, composite or porcelain, whether lab processed or not, must be referred to the Dental Consultant for pre-authorization.

Replacements must be separated by at least 4 years.

Dentures and bridgework

The following appliances are covered when required to replace one or more teeth extracted while you are insured for major coverage under this Policy.

- initial installation of standard complete dentures or overdentures, or
- standard cast or acrylic partial removable dentures or fixed bridgework.

Coverage for tooth-coloured retainers and pontics on molars are limited to the cost of metal retainers and pontics.

Replacement appliances are also covered when:

- the existing appliance is temporary. The amount reimbursed for the temporary appliance will be deducted from the cost of the permanent appliance.
- the existing appliance is at least 4 years old and cannot be made serviceable. If the existing appliance is less than 4 years old, a replacement will still be covered if the existing appliance becomes unserviceable while the Covered Person is insured for Major coverage under this Policy as a result of:
 - the placement of an initial opposing appliance; or
 - the extraction of additional teeth. If additional teeth are extracted but the existing appliance can be made serviceable, coverage is limited to the replacement of the additional teeth.

Appliances will be replaced with similar appliances.

No benefits will be payable for:

- services or supplies for equilibration of dentures, or denture cleaning or polishing.
- replacement of dentures which are mislaid, lost or stolen. Denture Repairs are covered under Basic Dental Services.
- services or supplies for implantology, including tooth implantation and surgical insertion of fabricated implants.
- services for precision attachments, oral rehabilitation, personalization or characterization or any charge for both a permanent and temporary crown or prosthesis in excess of the eligible charge for the permanent crown or prosthesis alone.

Orthodontic Procedures

Your dental benefits include procedures used to treat misaligned or crooked teeth.

Only your dependent children under age 19 are covered for these procedures. The benefit will terminate on your dependent child's 19th birthday whether or not the child is a student.

Orthodontic treatment

Coverage includes charges incurred for fixed and removable appliances used in the correction of malocclusion caused by dental irregularities. This includes related charges for observations, adjustments, repairs, alterations, removal and retention. Simple space maintainers are covered under Basic Services.

Orthodontic treatment plan

For each course of orthodontic treatment, a treatment plan is required. The Orthodontist must submit a treatment plan to the Plan Administrator before treatment begins. If the orthodontic treatment is terminated before it is completed, the Plan's obligation to pay benefits will cease at such termination. Should the treatment be resumed, benefit payments for these services shall be resumed to the extent specified in the original treatment plan.

Expenses incurred for any procedure which commenced before the date you became insured under this benefit are not covered. However, if this Policy replaces coverage for orthodontic services with a Previous Carrier, the Plan may, at its discretion and subject to the submission of a treatment plan, assume responsibility for charges incurred in respect of the completion of the course of orthodontic treatment which began prior to the effective date of coverage under this Policy.

Payment of orthodontic services

Orthodontic services are not prepaid. If you choose to pay the Orthodontist in advance, the Plan will reimburse incurred expenses as follows:

- the initial payment will be one third of the total paid to the Orthodontist, and
- the remaining balance of the covered expense will be reimbursed monthly, based on the estimated length of treatment as indicated by the orthodontist. It is the responsibility of the Employee to submit the monthly amount paid with a completed dental claim form and a copy of the original paid in full receipt.

Lost, mislaid or stolen orthodontic appliances will not be replaced.

Limitations & exclusions

No dental benefits will be paid for:

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

Benefits after termination

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

When and how to make a claim

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

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

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

Upon completion, please mail the original claim form to:

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

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

Survivor Dental Benefit

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

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

Optional Life Coverage

General description of the coverage

In addition to the Basic Life Insurance and Dependent insurance provisions, You and/or Your insured spouse may apply for an additional amount of life coverage. You and/or Your spouse may select, in increments of \$10,000 or \$25,000, any amount of coverage from a minimum of \$10,000 to a maximum of \$500,000. If You or Your Spouse die while insured for an amount of Optional Life coverage, the optional amount in force will be paid when the Insurer receives due written proof of death.

Portability Coverage

If Your coverage under this Policy terminates, You will be eligible to transfer Your Optional Life Insurance coverage under this Policy to a Group Life Policy offered by the Insurer for this purpose and administered by GroupSource providing the same coverage as your Optional Life coverage under this Policy. Portability will also be triggered upon Your death for Your insured Spouse's and Dependent Children's Optional Dependent Life coverages provided they meet the eligibility requirements of the Policy and continue to pay premiums.

If You are eligible to transfer Your coverage under this Policy, you should contact GroupSource at 1-800-661-6195 within 60 days of the loss of this coverage to initiate Your transfer to a Group Life Policy offered for that purpose by the Insurer. This portability benefit is available to both You and Your Dependents insured under this Policy, provided that the necessary forms provided by GroupSource for this purpose are properly completed and deliver along with the initial premium to GroupSource within 60 days of the termination of Your coverage under this Policy.

The Portability Privilege is not available to You or Your Dependents if Your coverage under this Policy terminates:

1. when You enter the armed forces of any country on a full-time basis;
2. when You reach the age of 70 years; or
3. when You have received the maximum amount payable under Your Benefit Plan.

Extension of benefit

The Optional Life coverage provides a benefit if You or Your spouse die within 31 days after ceasing to be insured for an amount of Optional Life Insurance. The amount of the benefit is equal to the amount of Optional Life Insurance You or Your spouse are entitled to convert.

Waiver of premium

If You are totally disabled and the premiums for the Basic Life coverage are being waived, premiums for this Optional Life coverage will also be waived.

To whom payable

Any benefit payable on account of Your death will be paid to the designated beneficiary. For Your spouse's Optional Life, any benefit payable is payable to You. If no beneficiary has been designated, the insurance shall be paid to the estate.

Optional Life

Exclusions

No benefit shall be payable under this provision where the cause of death is suicide occurring within 2 years from the date that this coverage became effective.

Proof of claim

Written proof of a claim must be given to the Insurer no later than six months after the date of death.

Optional Accidental Death & Dismemberment

General description of this coverage

In addition to the Basic Accidental Death, Disease and Dismemberment Insurance, an employee may apply for an additional amount of Accidental Death & Dismemberment coverage. This Optional Accidental Death and Dismemberment coverage provides benefits if a covered person suffers any of the following losses or accidental death as a direct result of accidental bodily injuries occasioned solely through external, violent and accidental means.

Eligibility

If you are an active, full-time employee and satisfy the eligibility requirements of the current Life insurance carrier, you are eligible to apply for insurance under this policy.

Coverage

You may elect either of the following schedules of insurance:

Plan I - Employee only

You may select any amount of coverage from a minimum of \$10,000 to a maximum of \$500,000, in increments of \$10,000 or \$25,000. When combined with the Basic Accidental Death, Disease and Dismemberment Coverage, the combined total under both plans may not exceed \$1,200,000.

Plan II - Family coverage

You may select any amount of coverage from a minimum of \$10,000 to a maximum of \$500,000 in increments of \$10,000 or \$25,000. When combined with the Basic Accidental Death, Disease and Dismemberment Coverage, the combined total under both plans may not exceed \$1,200,000.

If you have a spouse but no dependent children, the spouse will be insured for 50% of the principal sum.

If you have a spouse and dependent children, the spouse will be insured for 40% of the principal sum. Each dependent child will be insured for 10% of the principal sum, to a maximum of \$25,000.

If you have dependent children, but no spouse, each dependent child will be insured for 20% of the principal sum to a maximum of \$50,000.

Optional AD&D

Loss schedule

When injuries result in any of the following specified losses within 365 days from the date of the accident, the Insurer will pay for:

Loss of life	Principal Sum
Loss of both hands or both feet or sight of both eyes	Principal Sum
Loss of one hand and one foot	Principal Sum
Loss of speech & hearing in both ears	Principal Sum
Loss of use of both arms, both hands or both legs	Principal Sum
Loss of one arm or one leg	3/4 of Principal Sum
Loss of use of one arm or one leg	3/4 of Principal Sum
Loss of sight of one eye	2/3 of Principal Sum
Loss of one hand or one foot	2/3 of Principal Sum
Loss of use of one hand	2/3 of Principal Sum
Loss of speech or hearing in both ears	1/2 of Principal Sum
Loss of thumb and index finger of same hand	1/3 of Principal Sum
Loss of four fingers of one hand	1/3 of Principal Sum
Loss of hearing in one ear	1/6 of Principal Sum
Loss of all toes of one foot	1/8 of Principal Sum
Quadriplegia (total paralysis of both upper and lower limbs)	200% of Principal Sum
Paraplegia (total paralysis of both lower limbs)	200% of Principal Sum
Hemiplegia (total paralysis of upper and lower limbs of one side of the body)	200% of Principal Sum

Notwithstanding the amounts specified above, the maximum amount payable under this plan for all losses sustained as a result of the same accident will not exceed the principal sum, with the exception of paraplegia, quadriplegia and hemiplegia.

Definitions

Loss of a hand will mean complete severance at or above the wrist.

Loss of thumb will mean the complete loss of one entire phalanx of the thumb.

Loss of the index finger will mean the complete loss of two entire phalanges of the index finger.

Loss of foot will mean complete severance at or above the ankle.

Loss of use must be caused by accidental tendon, nerve or bone damage. The Loss must be total and irrecoverable and must be continuous for 12 consecutive months after which the benefit is payable provided the loss is determined to be permanent.

Paralysis will mean complete and irreversible paralysis caused by accidental brain or spine damage

Loss of sight, loss of hearing or loss of speech will mean total and irrecoverable loss of that faculty. If that faculty can be recovered or partially recovered by the use of some device or rehabilitative program, it will be deemed that there was no loss for the purposes of this benefit.

Institution for higher learning for the Education benefit includes any university, college or trade school.

Disappearance

If the body of a covered person has not been found within one year of the disappearance, forced landing, stranding, sinking or wrecking of a conveyance in which the person was an occupant, then it will be deemed that the person will have suffered loss of life within the meaning of this coverage.

Exposure

If a covered person is exposed to the elements following the disappearance, forced landing, stranding, sinking or wrecking of a conveyance in which the person was an occupant, such exposure will be deemed an injury by accidental means.

Aggregate limit

The aggregate limit for all protected persons involved in any one air travel accident is two million, five hundred thousand dollars (\$2,500,000).

Waiver of premiums

If you become totally and permanently disabled and your claim for Waiver of Premium Benefit has been approved and accepted by the Group Life Plan underwriter, then premiums due under Optional Accidental Death & Dismemberment will also be waived but only so long as this policy is in force.

Optional AD&D

Common disaster

If the Family Plan is elected and injuries sustained in the same accident result in the death of you and your spouse (within 90 days of the date of the accident), the Optional Accidental Death and Dismemberment benefit payable for death of your spouse will be increased to an amount equal to the Optional Accidental Death and Dismemberment benefit selected by yourself.

Education benefit (Dependent)

In the event a covered person's death occurs as a direct result of a Covered Loss, the Insurer will pay the Education Benefit stated below for each dependent child who is enrolled as a full-time student:

- in an institution for higher learning above the secondary school level as defined in the province or territory of residence, or
- at the secondary school level but who will enroll as a full-time student in an institution for higher learning within 365 days after the covered person's death.

The Education Benefit is equal to the reasonable and customary expenses actually incurred, subject to the lesser of a maximum of 5% of your principal sum or five thousand dollars (\$5,000), for each year the dependent child continues the education, but not to exceed 4 years, which must run consecutively, with respect to any one dependent child.

This benefit will be paid each year immediately upon receipt of satisfactory proof that the dependent child is enrolled as a full-time student in an institution for higher learning, however, payment will not be made for expenses incurred prior to the death of the covered person nor for room, board or other ordinary living, travelling or clothing expenses.

If none of the dependent children satisfy the above requirements, the Insurer will pay an amount of two thousand five hundred dollars (\$2,500) to the covered person's beneficiary.

Family transportation benefit

When, following an injury which results in a loss payable under this policy, the covered person is confined as an inpatient in a hospital located from a point of not less than 150 kilometres from his normal place of Residence, and such person is under the regular care and attendance of a legally qualified physician or surgeon, the Insurer will pay the reasonable expenses actually incurred by all members of the covered person's Immediate Family for hotel accommodation in the vicinity of the hospital and for transportation by the most direct route to the covered person. The total payment will not exceed the aggregate amount of three thousand dollars (\$3,000) for all such expenses. Payment will not be made for board or other ordinary living, travelling or clothing expenses.

If transportation occurs in a vehicle or device other than one operated under a license for the conveyance of passengers for hire, then reimbursement of transportation expenses will be limited to a maximum of twenty cents (\$0.20) per kilometre travelled.

Immediate family means a person who is the spouse, son daughter, father, mother, brother, sister, of the covered person.

Regular care and attendance means observation and treatment to the extent necessary under existing standards of medical practice for the condition causing the confinement.

Home alteration & vehicle modification benefit

In the event a covered person sustains an eligible loss and he/she subsequently requires the use of a wheelchair to be ambulatory, the Insurer will pay a benefit not to exceed ten thousand dollars (\$10,000) for the reasonable and necessary expenses actually incurred within 2 years of the date of the loss for:

- the cost of alterations to the covered person's principal residence for the purpose of making it wheelchair accessible.
- the cost of modifications to one motor vehicle utilized by the covered person, when such modifications are for the purpose of making it wheelchair accessible and are approved by licensing authorities where required.

Occupational training benefit (Spouse)

In the event a covered person's death occurs as a direct result of a Covered Loss, the Insurer will pay the reasonable and necessary expenses actually incurred by the spouse of the covered person who engages in a formal occupational training program in order to become qualified for active employment in an occupation for which he/she would not otherwise have sufficient qualifications. Payment will not be made for room, board or other ordinary living, travelling or clothing expenses.

Expenses must be incurred within 2 years from the date of the covered person's death and are subject to a maximum aggregate amount of ten thousand dollars (\$10,000).

Rehabilitation benefit

In the event the employee sustains an injury which results in a loss payable under this provision and such injury requires that the employee undergo special training in order to be qualified to engage in a special occupation in which the employee would not have engaged except for such injury, the Insurer will pay the reasonable and necessary expenses actually incurred for such training. The special training expenses must be incurred within 2 years from the date of the accident.

Payment by the Insurer for the total of all expenses incurred under this provision will not exceed ten thousand dollars (\$10,000) as the result of any one accident. Payment does not include incidental expenses, including without limitation, charges for room and board, ordinary living, traveling or clothing expenses.

Repatriation benefit

If a covered person's accidental death occurs not less than 150 kilometres from their normal place of Residence and indemnity for such loss becomes payable in accordance with the terms of this policy, the Insurer will pay the reasonable and customary expenses incurred for the transportation of the body of the deceased covered person to the first 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, including charges for the preparation of the body for such transportation. Covered expenses are subject to a maximum aggregate amount of ten thousand dollars (\$10,000) for all such expenses.

Exclusions

No Optional Accidental Death, & Dismemberment Benefit will be paid for any loss if the Covered Loss is caused by or results directly or indirectly from one or more of the following:

- suicide, or self-inflicted injury while sane or insane;
- injuries caused by an act of declared or undeclared war, or participation in any riot;
- travel or flight in any aircraft, or descent from such aircraft, if the insured individual is a pilot or a member of the crew of the aircraft, or if such flight is made for the purposes of instruction, training or testing;
- committing, attempting or provoking an assault or criminal offence including without limitation driving a vehicle with alcohol in the blood in excess of 80 milligrams of alcohol per 100 milliliters of blood. A **vehicle** means a vehicle that is drawn, propelled or driven by any means other than muscular;
- any drug, poison, gas or intoxicant, taken, administered, absorbed or inhaled, voluntarily or otherwise (occupational related accidents excepted).

When and how to make a claim

Claims for Optional Accidental Death & Dismemberment Benefits must be made within 180 days from the date the Insurer is liable. Failure to furnish such proof within the time required will not invalidate nor reduce any claim if it is shown to not have been reasonably possible to furnish the proof and that proof is furnished as soon as reasonably possible.

Protector Series™

Optional Critical Illness

What is Critical Illness Insurance?

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

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

General Information

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

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

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

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

Some terms we use throughout this booklet are:

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

Optional Critical Illness

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

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

Benefit Features

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

Face Amount means the dollar amount of insurance coverage.

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

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

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

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

Face Amount of Insurance

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

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

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

Covered Conditions

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

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

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

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

Optional Critical Illness

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

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

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

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

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

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

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

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

Children are not covered for this benefit.

Reinstatement Benefit for Cancer

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

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

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

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

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

Optional Critical Illness

Who can be covered

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

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

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

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

Your spouse is eligible for coverage if he or she:

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

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

Your dependent child is eligible for coverage if they are:

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

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

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

When are you eligible

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

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

When is medical evidence required

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

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

When does coverage start

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

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

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

Optional Critical Illness

Life Event

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

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

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

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

When does coverage terminate

Coverage terminates on the earliest of the following dates:

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

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

✓

Portability Privilege

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

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

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

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

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

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

Pre-Existing Condition Limitation

What is a pre-existing condition

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

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

What is the pre-existing condition limitation

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

What if I had coverage before?

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

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

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

Premium Rates

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

- Age
- Gender
- Face Amount
- Smoking Status

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

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

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

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

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

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

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

Currency

All payments under the policy are made in Canadian dollars.

Grace Period

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

Claim information

To receive a claim payment under the policy:

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

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

Payment of a claim

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

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

Right to appeal

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

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

Covered Condition Definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

Optional Critical Illness

Blindness is defined as a definite Diagnosis of the total and Irreversible loss of vision in both eyes, evidenced by:

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

The Diagnosis of Blindness must be made by a Specialist.

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

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

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

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

Exclusion: No benefit will be payable for the following:

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

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

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

Cancer (Non-Life-Threatening) includes:

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

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

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

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

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

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

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

Optional Critical Illness

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

List A

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

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

List B

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

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

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

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

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

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

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

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

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

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

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

The Insured Person must exhibit:

- dementia of at least moderate severity, which must be evidenced by a Mini Mental State Exam of 20/30 or less, or equivalent score on another generally medically accepted test or tests of cognitive function; and
- evidence of progressive worsening in cognitive and daily functioning either by serial cognitive tests or by history over at least a 6-month period.

The Diagnosis of Dementia must be made by a Specialist.

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

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

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

- heart attack symptoms;
- new electrocardiogram (ECG) changes consistent with a heart attack; or
- development of new Q waves during or immediately following an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty.

The Diagnosis of Heart Attack must be made by a Specialist.

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

- elevated biochemical cardiac markers as a result of an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty, in the absence of new Q waves; or
- ECG changes suggesting a prior myocardial infarction, which do not meet the Heart Attack definition as described above; or
- diagnosis or working diagnosis of Heart Attack without the supporting cardiac-biochemical markers diagnostic of myocardial infarction and new ECG changes consistent with a heart attack as defined in this Policy.

Optional Critical Illness

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

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

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

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

Activities of Daily Living are:

- Bathing – the ability to wash oneself in a bathtub, shower or by sponge bath, with or without the aid of assistive devices;
 - Dressing – the ability to put on and remove necessary clothing, braces, artificial limbs or other surgical appliances with or without the aid of assistive devices;
 - Toileting – the ability to get on and off the toilet and maintain personal hygiene with or without the aid of assistive devices;
 - Bladder and bowel continence – the ability to manage bowel and bladder function with or without protective undergarments or surgical appliances so that a reasonable level of hygiene is maintained;
 - Transferring – the ability to move in and out of a bed, chair or wheelchair, with or without the aid of assistive devices; and
 - Feeding – the ability to consume food or drink that already has been prepared and made available, with or without the use of assistive devices.
- Loss of Limbs** is defined as a definite Diagnosis of the complete severance of two or more limbs at or above the wrist or ankle joint as the result of an Accident or medically required amputation. The Diagnosis of Loss of Limbs must be made by a Specialist.

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

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

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

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

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

Multiple Sclerosis is defined as a definite Diagnosis of at least one of the following:

- two or more separate clinical attacks, confirmed by magnetic resonance imaging (MRI), of the nervous system showing multiple lesions of demyelination;
- well-defined neurological abnormalities lasting more than 6 months, confirmed by MRI imaging of the nervous system showing multiple lesions of demyelination; or
- a single attack confirmed by repeated MRI imaging of the nervous system, which shows multiple lesions of demyelination which have developed at intervals at least one month apart.

The Diagnosis of Multiple Sclerosis must be made by a Specialist.

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

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

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

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

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

Optional Critical Illness

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

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

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

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

Parkinson's Disease and Specified Atypical Parkinsonian Disorders Parkinson's Disease is defined as a definite Diagnosis of primary Parkinson's disease, a permanent neurologic condition which must be characterized by bradykinesia (slowness of movement) and at least one of: muscular rigidity or rest tremor. The Claimant must exhibit objective signs of progressive deterioration in function for at least one year, for which the treating neurologist has recommended dopaminergic medication or other generally medically accepted equivalent treatment for Parkinson's Disease.

Specified Atypical Parkinsonian Disorders are defined as a definite Diagnosis of progressive supranuclear palsy, corticobasal degeneration, or multiple system atrophy.

The Diagnosis of Parkinson's Disease or a Specified Atypical Parkinsonian Disorder must be made by a Specialist who is a neurologist.

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

- signs, symptoms or investigations that lead to a Diagnosis of Parkinson's Disease, a Specified Atypical Parkinsonian Disorder or any other type of parkinsonism, regardless of when the Diagnosis is made; or
- a Diagnosis of Parkinson's Disease, a Specified Atypical Parkinsonian Disorder or any other type of parkinsonism.

Medical information about the Diagnosis and any signs, symptoms or investigations leading to the Diagnosis must be reported to us within 6 months of the date of the Diagnosis. If this information is not provided within this period, we have the right to deny any Claim for Parkinson's Disease, Specified Atypical Parkinsonian Disorders or any Covered Condition caused by Parkinson's Disease or Specified Atypical Parkinsonian Disorders or its treatment.

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

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

Stroke (Cerebrovascular Accident) is defined as a definite Diagnosis of an acute cerebrovascular event caused by intracranial thrombosis or haemorrhage, or embolism from an extra-cranial source, with:

- acute onset of new neurological symptoms, and
- new objective neurological deficits on clinical examination, persisting for more than 30 days following the Date of Diagnosis. These new symptoms and deficits must be corroborated by diagnostic imaging testing. The Diagnosis of Stroke must be made by a Specialist.

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

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

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

Dependent Child Critical Illness Exclusions

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

General Exclusions for Adult and Dependent Child Covered Conditions

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

Optional Critical Illness

- any Accident, Injury or Sickness caused by hazardous activities such as, but not limited to: professional sports, underwater activities including scuba and snuba diving; parachuting; hang gliding; B.A.S.E. jumping; cliff diving; bungee jumping; mountaineering; motor vehicle racing or speed competition on land and/or water;
 - injuries sustained while operating a motor vehicle, either while under the influence of any intoxicant or if the Insured's blood contained more than 80 milligrams of alcohol per 100 millilitres of blood at the time of the injury;
 - medical care which is not Medically Necessary or which is cosmetic in nature (the donation of an organ or tissue will be considered as Medically Necessary care); or
 - any specific exclusions relating to any given Condition as set out within the definition for that Covered Condition in this Article.
- No benefit will be payable if the Claimant fails to seek treatment in order to avoid the Pre-Existing Condition Period limitations or other conditions and restrictions of this policy.
 - No benefit will be payable if, within 90 days following the later of the Effective Date of Coverage or date of Reinstatement of Coverage, if:
 - a diagnosis of cancer is made or the Insured Person has any signs, symptoms or investigations that lead to a Diagnosis of cancer (covered or excluded under this benefit), regardless of when the Diagnosis is made; or
 - a diagnosis of benign brain tumour is made or the Insured Person has any signs, symptoms or investigations that lead to a Diagnosis of benign brain tumour (covered or excluded under this benefit), regardless of when the Diagnosis is made.

Privacy Policy

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

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

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

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

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

Privacy Officer
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Québec (Québec) G1K 7M3
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