Benefits Booklet

Group Benefits Program

VICTOR

Prepared for the employees of

JIM DENT CONSTRUCTION

Your Group Benefits Program has been arranged for you by:

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As a leading managing general agent in Canada, Victor Insurance Managers Inc. develops and administers insurance programs and distributes them through a nationwide network of independent plan advisors and brokers to individuals, professionals, organizations and employers.

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Getting Started

Understanding Your Group Benefits Program

If you haven't already, please register for our plan member portal, Group Benefits Connect. Inside the portal, you can make claims, check out your Coverage Summary and find plenty more support.

This information booklet has been prepared to confirm the details of your group benefits program. Please read this booklet carefully. You can access a current version at any time through your Group Benefits Connect account.

You can also access your personalized Coverage Summary on Group Benefits Connect. This will confirm the effective date of your coverage, your identification number, your specific benefit coverage and levels and, if applicable, your covered dependents.

As you may not be covered for all of the benefits referenced in the booklet, please consult your Coverage Summary.

How to Register for Group Benefits Connect

If you haven't registered yet, go to www.victorinsurance.ca/gbconnect, click on the "Register here" button at the bottom of the screen, and follow the instructions to register.

Victor Central Mobile App

The Victor Central mobile app is our free app designed to make your life easier. With the same great features as the Victor Central desktop application, it is accessible anytime, anywhere for your convenience. Not only can you download your benefits card into your digital wallet, but it is your on-the-go hub for submitting claims, checking coverage, searching for providers and many other handy features. The app also gives you access to key health services including mental health (EAP), telemedicine and digital pharmacy services, if they are included in your plan.

Download the app from an App Store on your Apple or Android devices.

Your Plan Administrator

Your Plan Administrator is the person within your organization who manages your company's group benefits program. This is the person you should contact if you need assistance with a benefit issue.

You will need to inform your Plan Administrator, if the following changes occur:

- Dependent or coverage changes. These changes must be communicated within 31 days of the occurrence and include marriage, divorce, birth or adoption of a child, death of a family member and the loss of a spouse's coverage.

- A change in your home address. This address should be kept up-to-date for claims payment purposes.
- A change in your email address. Important plan updates will be communicated via email.

You can also update your own contact information through your Group Benefits Connect account.

Schedule of Benefits

Benefits Providers

Your group benefits program, provided to you by your employer and administered by Victor Insurance Managers Inc., is underwritten by the following companies:

Manulife

- Basic Life Insurance
- Dependent Life Insurance
- Optional Life and Spousal Optional Life Insurance
- Long Term Disability

Industrial Alliance Insurance and Financial Services Inc. ("iA Financial Group")

- Basic Accidental Death & Dismemberment
- Optional Accidental Death & Dismemberment
- Basic Critical Illness Insurance

Green Shield Canada ("GreenShield")

- Extended Health Care
- Emergency Travel Assistance
- Dental Care
- Wellness Spending Account

Plan Effective Date

Coverage for your employer's company first becomes effective on a specific day, known as the plan effective date. This is the earliest date you may join the plan. This plan was effective on January 1, 2023.

Eligibility

You become eligible to join the plan on the later of the plan effective date or the first day of your employment following 3 month(s) of continuous service with your employer. You must also be a permanent, full-time employee working a minimum of 20 hours per week and a resident of Canada.

Retired employees are not eligible for coverage.

Please refer to the General Provisions section in the back of this booklet for further information, including:

- When your benefits start.
- When your benefits terminate.

Basic Life Insurance

You are eligible for $25,000 of Basic Life Insurance.

Your benefit reduces by 50% at age 65 .

Note: If you have been declined for benefit coverage in the past, coverage can only be increased by providing evidence of insurability, satisfactory to the insurer.

Coverage terminates on the date you attain age 85 or retirement, whichever is earlier, and as outlined in the General Provisions section.

Basic Accidental Death & Dismemberment

In the event of accidental death, you are covered for the same amount as determined under the Basic Life Insurance Schedule of Benefits. Evidence of insurability is not required. Coverage terminates on the date you attain age 85 or retirement, whichever is earlier.

Dependent Life Insurance

Spouse	$10,000
Each Child	$5,000

A child is eligible for coverage from live birth.

Coverage terminates on the date you attain age 85 or retirement, whichever is earlier, and as outlined in the General Provisions section.

Optional Life Insurance

If you are under age 65, you may apply for this coverage:

- for yourself;
- for your spouse, provided he/she is under age 65; or
- for both you and your spouse.

Coverage is available in units of $10,000, subject to a maximum benefit of $250,000.

Evidence of insurability, satisfactory to the insurer, shall be required for all amounts of Optional Life. This coverage is available in addition to, not in lieu of, Basic Life and/or Dependent Life Insurance.

Coverage terminates: on the date you attain age 65 or retirement, whichever is earlier; coverage for your spouse terminates on the date your spouse attains age 65; or as outlined in the General Provisions section.

Optional Accidental Death & Dismemberment

Optional Accidental Death & Dismemberment benefits are available in units of $25,000 up to a maximum of $250,000.

This coverage is available in addition to Basic Accidental Death & Dismemberment.

Coverage terminates on the date you attain age 70 or retirement, whichever is earlier.

Long Term Disability

This benefit is equal to 66.67% of the first $2,250 of monthly earnings plus 50.00% of the next $3,500 of monthly earnings and 44.00% of monthly earnings over $5,750. Your benefit amount is subject to the 85% All Source Maximum described under the All Source Maximum section in the Long Term Disability section later in this booklet.

The maximum benefit payable is $10,000 per month.

The Elimination Period starts when you first become totally disabled and ends:

a) after 16 week(s) of continuous disability;

provided you are under age 65. If the disability is not continuous, the days you are disabled will be accumulated to satisfy the Elimination Period provided:

a) no interruption is longer than two weeks;

b) the disabilities arise from the same or related disease or injury.

Evidence of insurability, satisfactory to the insurer, will be required for the amount of your monthly benefit over $2,400.

Note: If you have been declined for benefit coverage in the past, coverage can only be increased by providing evidence of insurability, satisfactory to the insurer.

Taxable Benefits Status:
As you pay the full premium cost of this benefit, any benefits you receive are not taxable.

Coverage terminates on the date you attain age 65, less the Elimination Period, or retirement, whichever is earlier, and as outlined under the General Provisions section.

Critical Illness Insurance

You are eligible for $5,000 of Critical Illness Insurance.

Your benefit reduces by 50% at age 80.

Your coverage terminates on the earlier of the date you attain age 85 or you retire, and as outlined in the General Provisions section.

Extended Health Care

The following shows which expenses, if they are received in Canada, are considered eligible and the applicable coinsurance:

Hospital	100%	Semi-private
Drugs	90%	Mandatory Generic - Pay Direct Drug Plan included
Vision Care	100%	
Supplementary Medical	100%	

The coinsurance percentage is the amount you will be reimbursed for eligible expenses in excess of the deductible. The deductible, which is shown below, is the portion of eligible expenses that you must pay before you receive benefits.

Extended Health Care Deductible:

- Nil

The paramedical practitioner maximums are listed in the Extended Health Care section of this booklet.

The vision care maximum is $300 per person per 24 consecutive months.

The lifetime maximum for your Extended Health Care benefit is unlimited.

You must be insured under the provincial health plan to be eligible for Extended Health Care benefits.
You must be covered for Extended Health Care in order to be eligible for the following benefits:

- Emergency Travel Assistance
- Inkblot EAP
- LifeSpeak
- Maple Telemedicine
- Medical Second Opinion

Coverage terminates on the date you attain age 85 or retirement, whichever is earlier, and as outlined under the General Provisions section.

Emergency Travel Assistance

The GreenShield Emergency Travel Assistance has been made available to provide you with timely, efficient medical or travel assistance when you are out of province. If your provincial health insurance plan includes out-of-Canada benefits, the medical services are eligible only if that plan provides payment toward the cost of the incurred services.

Coinsurance	100%
Deductible	Nil
Lifetime Maximum	Unlimited

Coverage is limited to the first 60 days of travel. However, for students who are studying out of province or out of country, coverage is limited to 12 months of travel, beginning in September and ending in August of the following year.

The maximum benefit per individual is as follows:

Emergency Services:	$5,000,000 per person per calendar year.
Out-of-province Referral Services:	$75,000 per person per calendar year.

In the event of an emergency, you must contact GreenShield Travel Assistance within 48 hours of the commencement of treatment.

Coverage terminates on the date you attain age 85 or retirement, whichever is earlier, and as outlined in the General Provisions section.

Dental Care

The following shows which expenses, if they are received in Canada, are considered eligible and the applicable coinsurance:

Basic Services	100%
Major Restorative Services	50%
Orthodontics	50%

The coinsurance percentage is the amount you will be reimbursed for eligible expenses in excess of the deductible. The deductible, which is shown below, is the portion of eligible expenses that you must pay before you receive benefits.

Dental Care Deductible:

Nil

Fee Guide:
Benefits are paid in accordance with the current Fee Guide for General Practitioners in effect in the province where the service is rendered on the date the charge is incurred.

The standard oral examination frequency limit is six months.

The maximum benefit per individual is as follows:

Basic and Major Restorative Services combined $2,000 per person per calendar year.
Orthodontics $3,000 lifetime maximum for dependent children 18 years of age and under only.

Coverage terminates on the date you attain age 85 or retirement, whichever is earlier, and as outlined in the General Provisions section.

Wellness Spending Account

The following shows the annual credit amount that will be allocated to your Wellness Spending Account(WSA).

Single	$500
Family	$500

This amount will be allocated to your Wellness Spending Account on January 1 of each year. The WSA benefit year runs from January 1 to December 31.

Your account does not include any carry forward provision. Any balance remaining at the end of the benefit year will be forfeited.

Coverage terminates on the date you attain age 85 or retirement, whichever is earlier, and as outlined in the General Provisions section.

Important Information About Your Benefits

The information provided here is an overview of the coverage and services your plan sponsor has chosen to offer as part of your group benefits program and every effort has been made to describe the program accurately.

Where required by law, you or any claimant under the policy have the right to request a copy of any or all of the following items:

- Your application for group benefits; and
- Any evidence of insurability you submitted as part of your application for benefits.

In the case of a claimant, access to these documents is limited to that which is relevant to the filing of a claim, or the denial of a claim under the policy.

The benefits providers reserve the right to charge you for such documentation after your first request.

Basic Life Insurance

Basic Life Insurance coverage provides for a benefit to be paid at the time of your death if you are insured under this plan at the time. The amount of benefit is according to your classification as described in the Schedule of Benefits.

Beneficiary

The benefit is paid to the beneficiary designated on your enrollment form. Your beneficiary may have the benefits paid as a lump sum or in a series of monthly instalments with the approval of the insurance company.

You may designate a new beneficiary at any time, subject to the laws governing such changes, by completing a form available from your employer. If you do not name a beneficiary, benefits will be paid to your estate.

Compassionate Assistance Benefit

If you have been diagnosed with a terminal illness, you may request advance payment of a portion of your life insurance that would be payable upon your death. Your request must be approved. To be eligible, you must provide proof that your life expectancy is 24 months or less and your Waiver of Premium benefits must be approved.

The prepayment amount is equal to 50% of the amount of your life insurance to a maximum of $50,000. The prepaid amount is subject to any reduction in coverage scheduled to come into effect during the 24-month period following the date of your request. Upon your death, the amount payable to your designated beneficiary will be reduced by the amount of the Compassionate Assistance Loan.

Conversion Privilege

During the 31-day period following the termination of your employment, the reduction of your benefit amount, or your classification changing to one in which you are not insured, you may convert the amount of your Basic Life Insurance to an individual permanent life or convertible one-year term or term to age 65 plan without submitting evidence of health. To exercise your conversion privilege, you must apply in writing to the insurer no later than 31 days after your insurance under this benefit ends.

The amount of the individual policy shall not exceed the total amount of Basic plus Optional Insurance for which you were insured when coverage was discontinued, subject to a maximum of $200,000 ($400,000 for residents of Quebec) less any amount you become eligible for under a replacing contract of group life insurance.

The premium rate will be determined from your age, gender and smoking status at the time of conversion.

Waiver of Premium

If you are under age 65 and become totally disabled while insured, in accordance with the definition of total disability included in the LTD section, and are so disabled for at least six consecutive months, your insurance will continue in force without premium payment. Initial proof must be filed within 12 months of total disability and annually thereafter. The benefit terminates on the earliest of the date you:

- are no longer totally disabled;
- fail to provide satisfactory proof of your continuing disability;
- fail to be examined by a qualified physician as required by the insurance company; or
- attain age 65.

Optional Life Insurance

You may apply for additional term life insurance for yourself and/or for your spouse. Monthly premium rates are calculated according to the applicant's age, gender and smoking status. The Waiver of Premium and Conversion Privilege provisions described under Basic Life Insurance are also included under Optional Life Insurance.

Evidence of insurability satisfactory to the insurer is required for the full amount of chosen coverage.

No benefit will be paid for death resulting from self-destruction, whether sane or insane, within two years of your insurance becoming effective. Misstatement of non-smoker status shall mean the insurer will not pay any part of your Optional Life Insurance or your spouse's Optional Life Insurance, regardless of the cause of death.

To qualify as a non-smoker, you must submit evidence of insurability satisfactory to the insurer which supports total abstinence from smoking any tobacco product and cannabis for a one year period preceding the date of application for non-smoker status.

Dependent Life Insurance

Your spouse and dependent children are insured for the amounts shown in the Schedule of Benefits.

If a dependent, other than a newborn child, is confined to hospital or home on the date on which his or her Life Insurance would ordinarily commence, insurance on that dependent will not become effective until the dependent is no longer confined. Confinement at home shall mean that the dependent is unable to carry on any substantial part of the regular and customary duties or activities of a person in good health and of the same age and gender.

Beneficiary

You will be the beneficiary for the insurance provided for your dependents, unless otherwise directed. The benefit will be paid to your estate if you do not survive your dependent.

Conversion Privilege

During the 31-day period following your death, your classification changing to one in which you are not insured or your termination of employment, your spouse's and child's amount of Dependent Life Insurance may be converted to an individual permanent life or convertible one-year term or term to age 65 plan without submitting evidence of health. To exercise the conversion privilege, application to the insurer must be made in writing no later than 31 days after your insurance under this benefit ends.

The amount of the individual policy shall not exceed the amount of Optional plus Dependent Life Insurance for which your spouse was insured when coverage was discontinued or the amount of Dependent Life Insurance for which your child was insured when coverage was discontinued, subject to a maximum of $200,000 ($400,000 for residents of Quebec) less any amount your spouse or child becomes eligible for under a replacing contract of group life insurance.

The premium rate will be determined from your spouse's or child's age, gender and smoking status at the time of conversion.

Waiver of Premium

Waiver of Premium coverage shall be the same as for Basic Life Insurance except that waiver of premium benefit ceases on the earlier of: a) the date the Waiver of Premium for Basic Life Insurance ceases, or b) the date the policy or coverage terminates.

Basic Accidental Death & Dismemberment

You, your eligible spouse and dependent children are covered for any accident resulting in death or dismemberment anywhere in the world - 24 hours per day - on or off the job. Benefits are payable in addition to any other insurance you may have.

Your Principal Sum will be equal to the approved Basic Life Insurance benefit coverage. If you are not approved for the full amount of Basic Life Insurance, your coverage will be limited to an amount equal to the non-evidence Life Insurance maximum. Your spouse and dependent children will automatically become insured for an amount of insurance as follows:

Spouse: 50% of the employee's Principal Sum if there are dependent children, 60% if there are no dependent children.

Children: 15% of the employee's Principal Sum (subject to a maximum of $50,000) if there is a spouse, 20% of the employee's Principal Sum (subject to a maximum of $75,000) if there is no spouse.

Specific Loss Accident Indemnity

When injury results in any of the following losses within three hundred and sixty-five (365) days after the date of the accident, the insurer will pay for:

Brain Death	100%

Loss of:

Life	100%
Entire Sight of Both Eyes	100%
Speech and Hearing in Both Ears	100%
Entire Sight of One Eye	75%
Speech	75%
Hearing in Both Ears	75%
Hearing in One Ear	33-1/3%
All Toes of One Foot	25%

Loss or Loss of Use of:

Both Arms or Both Legs	200%
Both Hands or Both Feet	200%
One Hand and One Foot	100%
One Hand and the Entire Sight of One Eye	100%
One Foot and the Entire Sight of One Eye	100%
One Arm or One Leg	75%
One Hand or One Foot	75%
Thumb and Index Finger or at Least Four Fingers of One Hand	33-1/3%

Paralysis:

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

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

"Loss of Use" means a loss which is permanent, total, irrecoverable and continuous for a period of 12 months from the date of the accident.

Indemnity provided under this section for all losses sustained by any one insured person as the result of any one accident will not exceed the following:

- with the exception of quadriplegia, paraplegia and hemiplegia, the Principal Sum.
- with respect to quadriplegia, paraplegia and hemiplegia, Two Times the Principal Sum, or the Principal Sum if loss of life occurs within 90 days after the date of the accident.

In no event will indemnity payable for all losses under this section exceed, in the aggregate, Two Times the Principal Sum as the result of the same accident.

In addition to the Specific Loss Schedule, AD&D includes the following benefits:

Cosmetic Disfigurement Benefit

If an insured suffers a third degree burn, a percentage of the Principal Sum, depending on the area of the body which was burned according to the following table, will be paid:

Body Part	Area Classification (A)	Maximum Allowable Percentage for Area Burned (B)	Maximum Percentage of Principal Sum Payable (C)
		%	%
Face, Neck, Head	**10**	**10**	**100**
Hand and Forearm	**5**	**5**	**25**
Either Upper Arm	**3**	**5**	**15**
Torso (front or back)	**2**	**18**	**36**
Either Thigh	**1**	**10**	**10**
Either Lower Leg (below knee)	**3**	**9**	**27**

The maximum percentage of Principal Sum Payable (C) is determined by multiplying the Area Classification (A) by the maximum allowable percentage for Area Burned (B). In the event of a 50% surface burn, the maximum allowable percentage for Area Burned (B) is reduced by 50%. This table only represents the maximum percentage of the Principal Sum Payable for any one accident. If the insured suffers burns in more than one area, as a result of any one accident, benefits will not exceed a maximum of $25,000.

Seat Belt Benefit

If an insured is driving or riding in a vehicle and wearing a properly fastened seat belt at the time of the accident, and such insured sustains a specific loss for which an amount of Principal Sum becomes payable under the program, the amount payable for such specific loss is increased by 10%.

The driver of the vehicle must hold a current and valid driver's license of a rating authorizing him to operate such vehicle and neither be intoxicated nor under the influence of drugs, unless such drugs are taken as prescribed by a physician at the time of the accident.

Hospital Indemnity

If any specific loss covered under the program confines you, your insured spouse or your insured dependent child to a hospital and such person is under the regular care and attendance of a physician, you will receive a daily benefit of 1/30th of 1% of your Principal Sum from the 1st day of hospitalization to a maximum of $2,500 per month and for a maximum duration of 365 days per accident. Hospitalization must begin while the insurance is in force for you or your dependents.

Hospitalization for treatment of any injury other than for a specific loss will also be covered in accordance with the above, if hospitalized for at least 4 days.

Family Transportation Benefit

If any specific loss covered under the program confines an insured to a hospital under the regular care and attendance of a physician, and such hospital is located at least 150 kilometres from the insured's residence, this benefit will pay the reasonable expenses actually incurred by a member of the insured's immediate family for accommodation and transportation via the most direct route to the insured's bedside, to a maximum of $15,000. Private transportation expenses are limited to $0.35 per kilometre travelled.

Room, board or other ordinary living, travelling or clothing expenses are not covered.

Parental Care Benefit

If you sustain accidental loss of life for which an amount of Principal Sum becomes payable under the program, 5% of your Principal Sum to a maximum of $5,000 will be paid to an eligible dependent parent who, at the time of the accident, is a resident in a licensed nursing care facility, or enrolled in a home health care program, or living in your residence, or receiving support and care provided by you.

Psychological Therapy Benefit

If injury results in a loss payable to an insured under the "Specific Loss Accident Indemnity" section and results in the insured requiring psychological therapy, as prescribed by a physician, reasonable and necessary expenses actually incurred will be paid, to a maximum of $5,000.

Child Enhancement Benefit

With the exception of loss of life, the percentages indicated under the "Specific Loss Accident Indemnity" section are quadrupled with respect to your insured dependent children but in no event will exceed the maximum amount stated.

This provision does not apply if loss of life occurs within 90 days after the date of the accident.

Education Benefit

If you sustain accidental loss of life for which an amount of Principal Sum becomes payable under the program, up to 5% of your Principal Sum, to a maximum of $10,000, will be paid for reasonable and necessary expenses actually incurred for each of your dependent children who are already enrolled in an institution of higher learning above the secondary school level or who will do so within 365 days after your death.

The benefit is payable annually, for each year up to four consecutive years that the child continues school on a full-time basis beyond the secondary school level.

Room, board or other ordinary living, travelling or clothing expenses are not covered.

If none of your insured dependent children satisfy the above requirements, an amount of $2,500 will be paid to your beneficiary.

Daycare Benefit

If you sustain accidental loss of life for which an amount of Principal Sum becomes payable under the program, up to 5% of your Principal Sum, to a maximum of $5,000, will be paid for reasonable and necessary expenses actually incurred for each of your dependent children under 13 years of age who are enrolled in a legally licensed daycare centre or who will do so within 365 days after your death. This includes a child who is born within nine months of your date of loss, provided the child was conceived prior to the date of loss.

The benefit is payable annually, for each year up to four consecutive years that the child remains enrolled in a legally licensed daycare centre.

Room, board or other ordinary living, travelling or clothing expenses are not covered.

If none of your insured dependent children satisfy the above requirements, an amount of $2,500 will be paid to your beneficiary.

Spousal Retraining Benefit

If you sustain accidental loss of life for which an amount of Principal Sum becomes payable under the program, and your spouse engages in a formal occupational training program in order to become qualified for active employment in an occupation otherwise not qualified, this benefit will refund expenses incurred within 3 years following the date of your death, to a maximum of $15,000.

Room, board or other ordinary living, travelling or clothing expenses are not covered.

Rehabilitation Benefit

If you sustain a specific loss for which an amount of Principal Sum becomes payable under the program and such injury requires your participation in a rehabilitation program in order to be qualified in a different occupation, this benefit will refund expenses actually incurred during the 3 year period following the loss, to a maximum of $15,000.

Room, board or other ordinary living, travelling or clothing expenses are not covered.

Workplace Modification and Accommodation Benefit

If injury requires special adaptive equipment and/or workplace modification for you to return to active full-time employment, the cost of these modifications will be paid, to a maximum of $5,000, provided the employer agrees in writing to provide such modification and accommodation to the workplace for the purpose of making it accessible and adaptable to your needs and acknowledges in writing that the performance of the essential duties of your occupation may be altered.

Home Alteration and Vehicle Modification Benefit

If injury requires the use of a wheelchair to be ambulatory, the cost of alterations to the insured's principal residence and/or the cost of modification to one motor vehicle utilized by the insured will be paid, subject to a maximum amount of the greater of $15,000 or 10% of the insured's Principal Sum amount to a maximum of $50,000, as the result of any one accident, provided such injury results in a loss payable under the "Specific Loss Accident Indemnity" section.

Air Bag Benefit

If, due to a vehicular accident, injury results in a loss payable under the "Specific Loss Accident Indemnity" section, the insured's amount of Principal Sum will be increased by 5%, provided that:

a) such loss occurs while the insured is a passenger or driver of a private passenger type vehicle equipped with either a single air bag, air bags for both the driver and the front passenger seats, or air bags for the driver, front passenger and rear passenger seats; and

b) the seat belt is in actual use and properly fastened at the time of the accident, and due proof of seat belt use must be provided as part of the written proof of loss.

Assault Benefit

If injury results in a loss payable under the "Specific Loss Accident Indemnity" section, an additional indemnity equal to 10% of the applicable indemnity payable under that section will be paid, subject to a maximum of $25,000, if the injury is caused by an assault on premises owned or rented by the employer, or if the assault occurred while the insured was travelling on company business.

No benefit will be payable under this section if the assault was the act of another employee or a member of the immediate family of the insured or a member of the insured's household.

Carjacking Benefit ($10,000)

If injury sustained by the insured results in a loss payable under the "Specific Loss Accident Indemnity" section, the insured's amount of Principal Sum will be increased by 10%, if the injury occurs during a carjacking of an automobile that the insured was operating, getting into or out of, or riding as a passenger.

Comatose Benefit

If an injury does not cause loss of life, but results in a coma or comatose state, 1% of the Principal Sum (less any sum paid under the "Specific Loss Accident Indemnity" section) for each month the coma or comatose state continues will be paid, subject to an overall maximum of $50,000. Payments commence at the end of the waiting period and are subject to a maximum of 100 consecutive months.

Permanent Total Disability

If an injury totally and permanently disables an insured, under age 65, within 12 months of the date of the accident, preventing the insured from engaging in any and every occupation, the Principal Sum less any amounts paid or payable under the "Specific Loss Accident Indemnity" section as the result of the same accident will be paid, provided such disability has continued for a period of 12 consecutive months and is total, continuous and permanent at the end of this period.

Public Transportation Benefit

If an injury results in loss of life and indemnity becomes payable under the "Specific Loss Accident Indemnity" section, an additional amount equal to 100% of the Principal Sum will be paid if, at the time of the accident, the insured was riding as a passenger in a regularly scheduled public land, air or water conveyance licensed to carry fare-paying passengers, including a train, bus, taxi, subway, tramway, boat or commercial airplane.

Identification Benefit

If injury results in loss of life, and requires body identification, the expenses actually incurred by a member of the immediate family for lodging, board and transportation by the most direct route will be paid, provided the body is located at least 150 kilometres from the member of the immediate family's residence and the identification of the body is required by the police or a similar law enforcement agency having authority over such matters, to a maximum of $15,000.

If transportation occurs in a vehicle or device other than one operated under the license for the conveyance of passengers for hire, then reimbursement of transportation expenses will be limited to a maximum of $0.35 per kilometre travelled.

Repatriation Benefit

If an insured sustains accidental loss of life for which an amount of Principal Sum becomes payable under the program, repatriation benefits up to $15,000 will be paid for the reasonable and necessary expenses actually incurred for the transportation of the body to the city of residence, including the preparation of the body for transportation.

Funeral Expense Benefit

If an injury sustained by an insured results in loss of life, an additional amount is payable for funeral expenses actually incurred, to a maximum of $5,000.

Bereavement Benefit

If you sustain an injury that results in loss of life, reasonable and necessary expenses actually incurred by your spouse and dependent children for up to six (6) sessions of grief counselling, by a professional counsellor will be paid, to a maximum of $1,000.

Common Disaster Benefit

If you and your insured spouse both sustain accidental loss of life as a result of a common accident or two separate accidents occurring within the same 24-hour period, and such losses become payable under the program, your spouse's amount of coverage will be increased to the same level as yours, subject to an overall total for you and your spouse of $1,000,000.

Limited Air Travel Coverage

An insured is covered only while flying as a passenger in any aircraft holding a current and valid certificate of airworthiness (other than an aircraft owned, operated or leased by or on behalf of your employer) and operated by a person holding a current and valid pilot's license with a rating authorizing him to pilot such aircraft. Coverage also applies while flying as a passenger in a military aircraft.

Exposure and Disappearance

Unavoidable exposure to the elements will be covered under the program as any other loss, provided such exposure is sustained as the result of a covered accident and the loss for which indemnity would be payable occurs within 1 year of the accident.

An insured will be presumed to have suffered accidental loss of life if the insured's body is not found within 1 year after the disappearance, sinking or wrecking of the conveyance in which the insured was riding at the time of the accident.

Waiver of Premium

If, as the result of total disability, you are approved for Waiver of Premium and remain eligible for such under the terms of your employer's Basic Life Insurance contract, you need not pay any further premiums under this program for yourself, your insured spouse and your insured dependent children.

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

- the date the program terminates;
- the date you reach age 65; or
- the date you cease to be totally disabled.

The insurer reserves the right to request proof of disability from time to time as may be reasonably required. Failure to provide proof satisfactory to the insurer may result in termination of the waiver of premium benefit.

All terms and provisions of the program will apply during the period your premiums are waived, including provisions relating to reductions in amounts of insurance.

Extended Family Coverage

In the event of your death due to an injury for which benefits are payable, the coverage will be continued for your spouse and your insured dependent children for a period of six months, provided payment of premium is continued.

Continuation of Coverage

Coverage will be continued for you, your insured spouse and your insured dependent children during your approved leave of absence, temporary layoff, maternity or parental leave, provided payment of premium is continued. Coverage will be continued for any approved disability leave until you reach 65 years of age, qualify for Waiver of Premium benefits or return to work in any capacity, whichever is earlier.

All terms and provisions of the program will apply during the period coverage is continued including provisions relating to reductions in amounts of insurance.

Conversion Privilege

Upon termination of your insurance and provided the program is still in effect, you may convert your own insurance (but not your insured spouse's or your insured dependent children), without evidence of insurability to an individual accident insurance policy. You may elect an amount equal to or lower than the amount of the Principal Sum in force at the time of termination.

You must apply within 31 days of the termination of your coverage.

Co-ordination of Benefits

The total maximum payable in combination with the similar benefit maximum provided under any other policy issued to you will not exceed the actual expenses incurred or the maximum amount of benefit provided, whichever is less: Repatriation Benefit, Daycare Benefit, Family Transportation Benefit, Spousal Retraining Benefit, Rehabilitation Benefit, Education Benefit, Identification Benefit, Workplace Modification and Accommodation Benefit, and Home Alteration and Vehicle Modification Benefit.

Aggregate Limit

$2,500,000 is the maximum payable to all insureds involved in any one accident.

Exclusions

- Suicide or any attempt thereat or intentionally self-inflicted injury while sane or insane.
- Declared or undeclared war or any act thereof.
- Active full-time service in the armed forces of any country.
- Flying as a pilot or crew member of any aircraft.
- Flying as a passenger or otherwise in any aircraft owned, operated or leased by your employer.
- Flying in any vehicle or device for aerial navigation except as provided in the Limited Air Travel Coverage section.

Beneficiary

Benefits payable in the event of loss of life are payable to the beneficiary or beneficiaries designated in writing by you and on file with your Plan Administrator. If there is no such beneficiary designation, such indemnity shall be payable to your estate. All other benefits payable, including those payable to your spouse or dependent children, are payable to you with the exception of indemnities payable under the Family Transportation, Parental Care, Education, Daycare, Spousal Retraining, Workplace Modification and Accommodation, Identification, Repatriation, Funeral Expense and Bereavement benefits.

In the situation where the policy replaces an existing policy issued to the employer, the beneficiary designation recorded under the replaced policy will be deemed to be valid and of full force and effect until changed in writing by the insured.

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

Optional Accidental Death & Dismemberment

Optional AD&D allows you to purchase additional accident coverage for yourself as well as for your spouse and dependent children. You will be covered for any accident resulting in death or dismemberment anywhere in the world - 24 hours per day - on or off the job. Benefits are payable in addition to any other insurance you may have.

Amount of Insurance

You may select any amount of coverage for yourself from a minimum of $25,000 to a maximum of $250,000 in units of $25,000.

You may also elect to insure your family. Your spouse will be insured for 60% of the benefit you have selected for yourself if there are no eligible children, and 50% if there are eligible children. Each dependent child will be insured for 15% of the benefit you have selected for yourself, subject to a maximum of $25,000. If there is no eligible spouse, each eligible child is insured for 20% up to a maximum of $37,500.

In the event that you and your spouse are both employed at the same company, you both may enroll in the benefit. However, one would select Single Coverage Only and the other may elect the Family Coverage. If only one of you elects to enroll in the plan, the other will be insured under the Family Plan as the spouse.

Specific Loss Accident Indemnity

When injury results in any of the following losses within three hundred and sixty-five (365) days after the date of the accident, the insurer will pay for:

Brain Death	100%

Loss of:

Life	100%
Entire Sight of Both Eyes	100%
Speech and Hearing in Both Ears	100%
Entire Sight of One Eye	75%
Speech	75%
Hearing in Both Ears	75%
Hearing in One Ear	33-1/3%
All Toes of One Foot	25%

Loss or Loss of Use of:

Both Arms or Both Legs	200%
Both Hands or Both Feet	200%
One Hand and One Foot	100%
One Hand and the Entire Sight of One Eye	100%
One Foot and the Entire Sight of One Eye	100%
One Arm or One Leg	75%
One Hand or One Foot	75%
Thumb and Index Finger or at Least Four Fingers of One Hand	33-1/3%

Paralysis:

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

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

"Loss of Use" means a loss which is permanent, total, irrecoverable and continuous for a period of 12 months from the date of the accident.

Indemnity provided under this section for all losses sustained by any one insured person as the result of any one accident will not exceed the following:

- with the exception of quadriplegia, paraplegia and hemiplegia, the Principal Sum.
- with respect to quadriplegia, paraplegia and hemiplegia, Two Times the Principal Sum, or the Principal Sum if loss of life occurs within 90 days after the date of the accident.

In no event will indemnity payable for all losses under this section exceed, in the aggregate, Two Times the Principal Sum as the result of the same accident.

In addition to the Specific Loss Schedule, the following benefits are included:

Cosmetic Disfigurement Benefit

If an insured suffers a third degree burn, a percentage of the Principal Sum, depending on the area of the body which was burned according to the following table, will be paid:

Body Part	Area Classification (A)	Maximum Allowable Percentage for Area Burned (B) %	Maximum Percentage of Principal Sum Payable (C) %
Face, Neck, Head	**10**	**10**	**100**
Hand and Forearm	**5**	**5**	**25**
Either Upper Arm	**3**	**5**	**15**
Torso (front or back)	**2**	**18**	**36**
Either Thigh	**1**	**10**	**10**
Either Lower Leg (below knee)	**3**	**9**	**27**

The maximum percentage of Principal Sum Payable (C) is determined by multiplying the Area Classification (A) by the maximum allowable percentage for Area Burned (B). In the event of a 50% surface burn, the maximum allowable percentage for Area Burned (B) is reduced by 50%. This table only represents the maximum percentage of the Principal Sum Payable for any one accident. If the insured suffers burns in more than one area, as a result of any one accident, benefits will not exceed a maximum of $25,000.

Seat Belt Benefit

If an insured is driving or riding in a vehicle and wearing a properly fastened seat belt at the time of the accident, and such insured sustains a specific loss for which an amount of Principal Sum becomes payable under the program, the amount payable for such specific loss is increased by 10%.

The driver of the vehicle must hold a current and valid driver's license of a rating authorizing him to operate such vehicle and neither be intoxicated nor under the influence of drugs, unless such drugs are taken as prescribed by a physician at the time of the accident.

Hospital Indemnity

If any specific loss covered under the program confines you, your insured spouse or your insured dependent child to a hospital and such person is under the regular care and attendance of a physician, you will receive a daily benefit of 1/30th of 1% of your Principal Sum from the first day of hospitalization to a maximum of $2,500 per month and for a maximum duration of 365 days per accident. Hospitalization must begin while the insurance is in force for you or your dependents.

Hospitalization for treatment of any injury other than for a specific loss will also be covered in accordance with the above, if hospitalized for at least four days.

Family Transportation Benefit

If any specific loss covered under the program confines an insured to a hospital under the regular care and attendance of a physician, and such hospital is located at least 150 kilometres from the insured's residence, this benefit will pay the reasonable expenses actually incurred by a member of the insured's immediate family for accommodation and transportation via the most direct route to the insured's bedside, to a maximum of $15,000. Private transportation expenses are limited to $0.35 per kilometre travelled.

Room, board or other ordinary living, travelling or clothing expenses are not covered.

Parental Care Benefit

If you sustain accidental loss of life for which an amount of Principal Sum becomes payable under the program, 5% of your Principal Sum to a maximum of $5,000 will be paid to an eligible dependent parent who, at the time of the accident, is a resident in a licensed nursing care facility, or enrolled in a home health care program, or living in your residence, or receiving support and care provided by you.

Psychological Therapy Benefit

If injury results in a loss payable to an insured under the "Specific Loss Accident Indemnity" section and results in the insured requiring psychological therapy, as prescribed by a physician, reasonable and necessary expenses actually incurred will be paid, to a maximum of $5,000.

Child Enhancement Benefit

With the exception of loss of life, the percentages indicated under the "Specific Loss Accident Indemnity" section are quadrupled with respect to your insured dependent children but in no event will exceed the maximum amount stated.

This provision does not apply if loss of life occurs within 90 days after the date of the accident.

Education Benefit

If you sustain accidental loss of life for which an amount of Principal Sum becomes payable under the program, up to 5% of your Principal Sum, to a maximum of $10,000, will be paid for reasonable and necessary expenses actually incurred for each of your dependent children who are already enrolled in an institution of higher learning above the secondary school level or who will do so within 365 days after your death.

The benefit is payable annually, for each year up to 4 consecutive years that the child continues school on a full-time basis beyond the secondary school level.

Room, board or other ordinary living, travelling or clothing expenses are not covered.

If none of your insured dependent children satisfy the above requirements, an amount of $2,500 will be paid to your beneficiary.

Daycare Benefit

If you sustain accidental loss of life for which an amount of Principal Sum becomes payable under the program, up to 5% of your Principal Sum, to a maximum of $5,000, will be paid for reasonable and necessary expenses actually incurred for each of your dependent children under 13 years of age who are enrolled in a legally licensed daycare centre or who will do so within 365 days after your death. This includes a child who is born within nine months of your date of loss, provided the child was conceived prior to the date of loss.

The benefit is payable annually, for each year up to four consecutive years that the child remains enrolled in a legally licensed daycare centre.

Room, board or other ordinary living, travelling or clothing expenses are not covered.

If none of your insured dependent children satisfy the above requirements, an amount of $2,500 will be paid to your beneficiary.

Spousal Retraining Benefit

If you sustain accidental loss of life for which an amount of Principal Sum becomes payable under the program, and your spouse engages in a formal occupational training program in order to become qualified for active employment in an occupation otherwise not qualified, this benefit will refund expenses incurred within 3 years following the date of your death, to a maximum of $15,000.

Room, board or other ordinary living, travelling or clothing expenses are not covered.

Rehabilitation Benefit

If you sustain a specific loss for which an amount of Principal Sum becomes payable under the program and such injury requires your participation in a rehabilitation program in order to be qualified in a different occupation, this benefit will refund expenses actually incurred during the 3 year period following the loss, to a maximum of $15,000.

Room, board or other ordinary living, travelling or clothing expenses are not covered.

Workplace Modification and Accommodation Benefit

If injury requires special adaptive equipment and/or workplace modification for you to return to active full-time employment, the cost of these modifications will be paid, to a maximum of $5,000, provided the employer agrees in writing to provide such modification and accommodation to the workplace for the purpose of making it accessible and adaptable to your needs and acknowledges in writing that the performance of the essential duties your occupation may be altered.

Home Alteration and Vehicle Modification Benefit

If injury requires the use of a wheelchair to be ambulatory, the cost of alterations to the insured's principal residence and/or the cost of modification to one motor vehicle utilized by the insured will be paid, subject to a maximum amount of the greater of $15,000 or 10% of the insured's Principal Sum amount to a maximum of $50,000, as the result of any one accident, provided such injury results in a loss payable under the "Specific Loss Accident Indemnity" section.

Air Bag Benefit

If, due to a vehicular accident, injury results in a loss payable under the "Specific Loss Accident Indemnity" section, the insured's amount of Principal Sum will be increased by 5%, provided that:

a) such loss occurs while the insured is a passenger or driver of a private passenger type vehicle equipped with either a single air bag, air bags for both the driver and the front passenger seats, or air bags for the driver, front passenger and rear passenger seats; and

b) the seat belt is in actual use and properly fastened at the time of the accident, and due proof of seat belt use must be provided as part of the written proof of loss.

Assault Benefit

If injury results in a loss payable under the "Specific Loss Accident Indemnity" section, an additional indemnity equal to 10% of the applicable indemnity payable under that section will be paid, subject to a maximum of $25,000, if the injury is caused by an assault on premises owned or rented by the employer or if the assault occurred while the insured was travelling on company business.

No benefit will be payable under this section if the assault was the act of another employee or a member of the immediate family of the insured or a member of the insured's household.

Carjacking Benefit ($10,000)

If, injury sustained by the insured results in a loss payable under the "Specific Loss Accident Indemnity" section, the insured's amount of Principal Sum will be increased by 10%, if the injury occurs during a carjacking of an automobile that the insured was operating, getting into or out of, or riding as a passenger.

Comatose Benefit

If an injury does not cause loss of life, but results in a coma or comatose state, 1% of the Principal Sum (less any sum paid under the "Specific Loss Accident Indemnity" section) for each month the coma or comatose state continues will be paid, subject to an overall maximum of $50,000. Payments commence at the end of the waiting period and are subject to a maximum of 100 consecutive months.

Permanent Total Disability

If an injury totally and permanently disables an insured, under age 65, within 12 months of the date of the accident, preventing the insured from engaging in any and every occupation, the Principal Sum less any amounts paid or payable under the "Specific Loss Accident Indemnity" section as the result of the same accident will be paid, provided such disability has continued for a period of 12 consecutive months and is total, continuous and permanent at the end of this period.

Public Transportation Benefit

If an injury results in loss of life and indemnity becomes payable under the "Specific Loss Accident Indemnity" section, an additional amount equal to 100% of the Principal Sum will be paid if, at the time of the accident, the insured was riding as a passenger in a regularly scheduled public land, air or water conveyance licensed to carry fare-paying passengers, including a train, bus, taxi, subway, tramway, boat or commercial airplane.

Identification Benefit

If injury results in loss of life, and requires body identification, the expenses actually incurred by a member of the immediate family for lodging, board and transportation by the most direct route will be paid, provided the body is located at least 150 kilometres from the member of the immediate family's residence and the identification of the body is required by the police or a similar law enforcement agency having authority over such matters, to a maximum of $15,000.

If transportation occurs in a vehicle or device other than one operated under the license for the conveyance of passengers for hire, then reimbursement of transportation expenses will be limited to a maximum of $0.35 per kilometre travelled.

Repatriation Benefit

If an insured sustains accidental loss of life for which an amount of Principal Sum becomes payable under the program, repatriation benefits up to $15,000 will be paid for the reasonable and necessary expenses actually incurred for the transportation of the body to the city of residence, including the preparation of the body for transportation.

Funeral Expense Benefit

If an injury sustained by an insured results in loss of life, an additional amount is payable for funeral expenses actually incurred, to a maximum of $5,000.

Bereavement Benefit

If you sustain an injury that results in loss of life, reasonable and necessary expenses actually incurred by your spouse and dependent children for up to six (6) sessions of grief counselling, by a professional counsellor will be paid, to a maximum of $1,000.

Common Disaster Benefit

If you and your insured spouse both sustain accidental loss of life as a result of a common accident or two separate accidents occurring within the same 24-hour period, and such losses become payable under the program, your spouse's amount of coverage will be increased to the same level as yours, subject to an overall total for you and your spouse of $500,000.

Limited Air Travel Coverage

An insured is covered only while flying as a passenger in any aircraft holding a current and valid certificate of airworthiness (other than an aircraft owned, operated or leased by or on behalf of your employer) and operated by a person holding a current and valid pilot's license with a rating authorizing him to pilot such aircraft. Coverage also applies while flying as a passenger in a military aircraft.

Exposure and Disappearance

Unavoidable exposure to the elements will be covered under the program as any other loss, provided such exposure is sustained as the result of a covered accident and the loss for which indemnity would be payable occurs within 1 year of the accident.

An insured will be presumed to have suffered accidental loss of life if the insured's body is not found within 1 year after the disappearance, sinking or wrecking of the conveyance in which the insured was riding at the time of the accident.

Waiver of Premium

If, as the result of total disability, you are approved for Waiver of Premium and remain eligible for such under the terms of your employer's Basic Life Insurance contract, you need not pay any further premiums under this program for yourself, your insured spouse and your insured dependent children.

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

- the date the program terminates;
- the date you reach age 65; or
- the date you cease to be totally disabled.

The insurer reserves the right to request proof of disability from time to time as may be reasonably required. Failure to provide proof satisfactory to the insurer may result in termination of the waiver of premium benefit.

All terms and provisions of the program will apply during the period your premiums are waived, including provisions relating to reductions in amounts of insurance.

Extended Family Coverage

In the event of your death due to an injury for which benefits are payable, the coverage will be continued for your spouse and your insured dependent children for a period of six months, provided payment of premium is continued.

Continuation of Coverage

Coverage will be continued for you, your insured spouse and your insured dependent children during your approved leave of absence, temporary layoff, maternity or parental leave, provided payment of premium is continued. Coverage will be continued for any approved disability leave until you reach 65 years of age, qualify for Waiver of Premium benefits or return to work in any capacity, whichever is earlier.

All terms and provisions of the program will apply during the period coverage is continued including provisions relating to reductions in amounts of insurance.

Conversion Privilege

Upon termination of your insurance and provided the program is still in effect, you may convert your own insurance (but not your insured spouse's or your insured dependent children), without evidence of insurability to an individual accident insurance policy. You may elect an amount equal to or lower than the amount of the Principal Sum in force at the time of termination.

You must apply within 31 days of the termination of your coverage.

Co-ordination of Benefits

The total maximum payable in combination with the similar benefit maximum provided under any other policy issued to you will not exceed the actual expenses incurred or the maximum amount of benefit provided, whichever is less: Repatriation Benefit, Daycare Benefit, Family Transportation Benefit, Spousal Retraining Benefit, Rehabilitation Benefit, Education Benefit, Identification Benefit, Workplace Modification and Accommodation Benefit, and Home Alteration and Vehicle Modification Benefit.

Aggregate Limit

$2,500,000 is the maximum payable to all insureds involved in any one accident.

Exclusions

- Suicide or any attempt thereat or intentionally self-inflicted injury while sane or insane.
- Declared or undeclared war or any act thereof.
- Active full-time service in the armed forces of any country.
- Flying as a pilot or crew member of any aircraft.
- Flying as a passenger or otherwise in any aircraft owned, operated or leased by your employer.
- Flying in any vehicle or device for aerial navigation except as provided in the Limited Air Travel Coverage section.

Beneficiary

Benefits payable in the event of loss of life are payable to the beneficiary or beneficiaries designated in writing by you and on file with your Plan Administrator. If there is no such beneficiary designation, such indemnity shall be payable to your estate. All other benefits payable, including those payable to your spouse or dependent children, are payable to you with the exception of indemnities payable under the Family Transportation, Parental Care, Education, Daycare, Spousal Retraining, Workplace Modification and Accommodation, Identification, Repatriation, Funeral Expense and Bereavement benefits.

In the situation where the policy replaces an existing policy issued to the employer, the beneficiary designation recorded under the replaced policy will be deemed to be valid and of full force and effect until changed in writing by the insured.

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

Long Term Disability

In the event you become totally disabled for the required period of time known as the Elimination Period and you are receiving regular, ongoing care and treatment from a legally qualified physician during the Elimination Period, you will receive a monthly income benefit.

The Elimination Period, monthly benefit and maximum disability period are shown in the Schedule of Benefits.

Benefits will not be payable beyond age 65, unless you satisfy the Elimination Period while age 64, in which case benefits will be payable for a maximum of 12 months.

Eligibility Criteria

To be entitled to disability benefits, you must meet the criteria outlined below.

For the purposes of this coverage, you will be considered totally disabled if, solely as a result of a disease or injury:

- during the Elimination Period and for the next 24 months, you have a restriction or lack of ability due to an illness or injury which prevents you from performing the essential duties of your own occupation;
- you have a restriction or lack of ability due to an illness or injury which prevents you from performing the essential duties of any occupation for which you are qualified, or may reasonably become qualified, by training, education or experience; and

a) you are continuously totally disabled throughout the Elimination Period. If you cease to be totally disabled during this period and then become disabled again within 2 weeks due to the same or related illness or injury, your Elimination Period will be extended by the number of days during which you ceased to be totally disabled;

b) you provide medical evidence documenting how your illness or injury causes you to be totally disabled. You will be considered totally disabled if a restriction or lack of ability due to an illness or injury prevents you from performing the essential duties of your own occupation;

c) you are receiving from a physician, regular, ongoing care and treatment appropriate for your disabling condition, as determined by the insurer.

At any time, the insurer may require you to submit to a medical, psychiatric, psychological, functional, educational and/or vocational examination or evaluation by an examiner selected by the insurer.

For purposes of this coverage, your own occupation refers to the nature of your work rather than your specific job with your employer at the time disability commenced.

The availability of employment will not be considered in the assessment of your claim under this coverage. Your failure to obtain or retain any license or certification required to practice your own occupation will not be considered in the assessment of a claim under this coverage.

Recurrent Disability

If you become totally disabled again from the same or related causes as those for which Long Term Disability benefits have been paid under this policy and this disability recurs within 6 months from the end of the period for which benefits were paid, the Elimination Period will be waived.

All such recurrences will be considered a continuation of the same disability. The benefit payable will be based on your earnings as at the original date of disability. Benefits for all recurrences will not be paid for a combined period longer than the maximum benefit period shown in the Schedule of Benefits.

If the same disability recurs within 6 months after the end of the period for which benefits were paid, and the maximum benefit period shown in the Schedule of Benefits has already been reached, no further disability benefits are payable for that same disability.

If the same disability recurs more than 6 months after the end of the period for which benefits were paid, such disability will be considered a separate disability.

Two disabilities which are due to unrelated causes are considered separate disabilities if they are separated by a return to work of at least one day.

Benefit Offsets

The amount payable under this benefit for total disability is calculated by deducting from your benefit other sources of income you receive or are entitled to receive for the same or related disability. These include the following:

- Workers' Compensation or similar coverage;
- Canada or Quebec Pension Plans, including Canada or Quebec Pension Plan Retirement benefits, excluding dependent benefits;
- any government motor vehicle automobile insurance plan or policy, unless prohibited by law;
- any group, association or franchise plan;
- earnings or payments from any employer, including severance payments and vacation pay; and
- disability benefits payable by government for victims of crime.

All Source Maximum

Your total monthly income while disabled cannot exceed:

a) 85% of your gross monthly earnings if your benefit payments are taxable; or

b) 85% of your net monthly earnings if your benefit payments are not taxable;

as of the date your disability commenced.

If your total income exceeds 85%, your Long Term Disability benefit will be reduced accordingly. All sources include those stated above and any benefit you are entitled to receive from:

- any retirement or pension income;
- self-employment;
- any government plan, excluding Employment Insurance Benefits; and

- Canada or Quebec Pension Plans' dependent benefits.

The Schedule of Benefits confirms whether or not your benefit payments are taxable.

Disability Case Management Program

The insurer has developed a disability case management program. The purpose of this program is to assist you, in the event you become totally disabled and qualify for benefits, to return to productive employment. A disability case management team will work with you, your employer and your physician to assist you to recover and return to the workplace.

Rehabilitative Employment

In the event you become totally disabled, you must agree to participate in good faith in any rehabilitation program approved and supervised by the insurer.

Your benefits will be reduced by any remuneration you receive during the rehabilitation period that, when combined with other income from the sources specified under the Benefit Offsets section with regard to reduction of benefits, exceeds 100% of your monthly salary prior to the start of your total disability.

Termination of Benefit Payments

Your disability benefit payments will cease on the earliest of

a) The date you cease to be totally disabled, as defined in the Eligibility Criteria section;

b) The date you do not supply the insurer with appropriate medical evidence documenting how your illness or injury causes you to be totally disabled as defined under the explanation of common insurance terms;

c) The date you do not attend an examination by an examiner selected by the insurer;

d) The date you refuse to perform work offered by your employer, as approved by the insurer, that accommodates your medical restrictions and limitations and provides an income comparable to your pre-disability earnings;

e) The date on which benefits have been paid up to the maximum benefit period for this benefit, or

f) The date of your death.

Exclusions and Limitations

No benefits are payable for any disability directly or indirectly related to:

- self-inflicted injuries, unless medical evidence establishes that the injuries are related to a mental health illness;
- war, insurrection, the hostile actions of any armed forces or participation in a riot or civil commotion;
- medical or surgical care which is not medically necessary;
- the committing of or the attempt to commit an assault or criminal offence;
- injuries sustained while operating a motor vehicle, either while under the influence of any intoxicant or if your blood contained more than 80 milligrams of alcohol per 100 millilitres of blood at the time of injury;

- abuse of addictive substances, including drugs and alcohol, unless you are actively participating and co-operating in an in-patient medical treatment program for substance abuse which has been approved; and
- a Pre-Existing Condition which causes disability within the first 12 months of insurance under this benefit. A Pre-Existing Condition is any injury or illness (whether diagnosed or not) for which you were treated or attended by a Physician, or for which drugs were prescribed, within 90 days prior to the date your insurance under this benefit became effective.

Waiver of Premium

Premiums will be waived for any period during which you are receiving benefits.

Survivor Benefit

In the event of your death before the end of a period during which you are entitled to benefits under this benefit, a lump sum payment equivalent to three full months of benefits will be made to your estate, or to your designated beneficiary, as applicable. The lump sum is calculated based on the amount of the last payment made.

How to Make a Claim

Claim forms may be obtained from your employer. The claim form should be fully completed and submitted one month prior to the expiration of the Elimination Period but no later than six months after the commencement of disability.

Subrogation

If you are entitled to recover compensation for loss of income from a third party as a result of the incident which caused or contributed to the disability, for which benefits are paid or payable, the insurer will be subrogated to all your rights of recovery for loss of income, to the extent of the sum of benefits paid or payable by the insurer. You shall execute such documents as required by the insurer.

In the event you provide proof to the Insurer that you have not recovered full compensation for loss of income, the insurer shall determine the proportion of damages actually recovered and share pro rata in that amount.

Should you choose to settle the matter prior to judicial determination, it is understood that the sum reached in settlement will be deemed to be full compensation for loss of income, and the insurer's right of subrogation will apply.

The term compensation shall include any lump sum or periodic payments which you receive or are entitled to receive on account of past, present or future loss of income.

Critical Illness Insurance

Critical Illness Insurance provides for a benefit to be paid in the event you are diagnosed with a Covered Condition or an AdvanceCare Benefit Condition while coverage is in force.

Covered Condition Benefit

If you are diagnosed by a Specialist with a Covered Condition while coverage is in force and survives for 30 days following the Date of Diagnosis or such longer period as described in the "Definitions of Covered Conditions" section below, the insurer will pay the amount of Critical Illness Insurance in force (the "Covered Condition Benefit") subject to the limitations, exclusions and other terms and conditions described in this booklet. The Date of Diagnosis must be later than the effective date or latest reinstatement date of coverage.

In the event you receive a simultaneous Diagnosis of multiple Covered Conditions, the insurer will pay the Covered Condition Benefit for one Covered Condition only. The Covered Condition for which the Covered Condition Benefit is paid will be the Covered Condition which first appears in the lowest Multiple Event Coverage Benefit grouping (MEC Grouping) shown in the "Multiple Event Coverage Benefit" section, starting with MEC Grouping Group 1.

Multiple Event Coverage Benefit

This coverage allows you to claim more than once under Critical Illness Insurance, provided subsequent claims are for unrelated Covered Conditions, as illustrated in the Multiple Event Coverage (MEC) Grouping chart below.

If you receive a Covered Condition Benefit under this policy, and then are subsequently diagnosed with a different Covered Condition in a different MEC Grouping, the insured person will be eligible for a benefit payment (the "Multiple Event Coverage Benefit"). The insured person cannot claim more than once within each grouping. Please note that Stroke is included in both Group 2 and Group 3.

You must survive for 30 days following the Date of Diagnosis or such longer period as described in the "Definitions of Covered Conditions" section below to qualify for this Multiple Event Coverage Benefit. If the insured person dies before the approved Multiple Event Coverage Benefit is paid, the Multiple Event Coverage Benefit will be paid to your such insured person's estate.

MEC Grouping	Covered Condition
Group 1	Cancer
Group 2	Aortic Surgery, Coronary Artery Bypass Surgery, Heart Attack, Heart Valve Replacement or Repair, Stroke
Group 3	Bacterial Meningitis, Benign Brain Tumour, Coma, Dementia including Alzheimer's Disease, Loss of Independent Existence, Loss of Speech, Motor Neuron Disease, Multiple Sclerosis, Paralysis, Parkinson's Disease and Specified Atypical Parkinsonian Disorders, Stroke
Group 4	Aplastic Anemia, Kidney Failure, Major Organ Failure on Waiting List, Major Organ Transplant
Group 5	Blindness
Group 6	Deafness

Group 7	Severe Burns
Group 8	Loss of Limbs
Group 9	Occupational HIV Infection

AdvanceCare Benefit

If you are diagnosed by a Specialist with an AdvanceCare Benefit Condition, the insurer will pay a benefit equivalent to 10% of the Critical Illness Insurance coverage amount.

The benefit is payable for only one AdvanceCare Benefit Condition, and payment of an AdvanceCare Benefit will not affect the payment of a subsequent Diagnosis of a Covered Condition under a Covered Condition Benefit or a Multiple Event Coverage Benefit.

Cancer Recurrence Benefit

If you receive a Diagnosis of Cancer as described in this booklet, and thereafter the insured person is diagnosed with Cancer again only as described below, the insurer will pay the insured person the Benefit Amount in force (the "Cancer Recurrence Benefit") as summarized in this booklet. Cancer Recurrence means the insured person will receive a subsequent Diagnosis of Cancer, provided that:

a) more than 60 months have passed between the previous Cancer Date of Diagnosis and the date of the subsequent Diagnosis;
b) the insured person has not received any treatment relating directly or indirectly to the previous Cancer within a continuous 60-month period prior to the subsequent Diagnosis;
c) the insured person does not have any new signs, symptoms or deliberate or incidental findings, during a continuous 60-month period prior to the subsequent Diagnosis, for which the insured person sought medical investigation, consultation to investigate and/or diagnose, Diagnosis, treatment, care, medication or medical advice, or for which there were symptoms that would have caused an individual to seek the same relating to a Diagnosis of any cancer covered or excluded; and
d) both the first and subsequent diagnoses are made subsequent to the effective date of your coverage and prior to the termination date of your coverage.

Limitations

a) Cancer

You will not be entitled to a Covered Condition Benefit for Cancer if, within the first 90 days following the effective date of coverage, the insured person has a Diagnosis of Cancer, or has any signs, symptoms or investigations leading to the Diagnosis of Cancer, regardless of when the Diagnosis is actually made.

In the event of such Diagnosis:

- the Covered Condition Benefit will not be paid.
- If the insured person continues to satisfy the eligibility provisions for coverage, Critical Illness Insurance will remain in force but Cancer in MEC Grouping 1 will no longer be considered a Covered Condition for such insured person.

b) Benign Brain Tumour

You will not be entitled to a Covered Condition Benefit for Benign Brain Tumour if, within 90 days following the effective date of coverage, Benign Brain Tumour is diagnosed, or the insured person has any signs, symptoms or investigations leading to the Diagnosis of Benign Brain Tumour, regardless of when the Diagnosis is made.

In the event of such Diagnosis:

- the Covered Condition Benefit will not be paid.
- If the insured person continues to satisfy the eligibility provisions for coverage, Critical Illness Insurance will remain in force but Benign Brain Tumour and all other MEC Group 3 Covered Conditions will no longer be considered a Covered Condition for such insured person.

c) Multiple Sclerosis

You will not be entitled to a Covered Condition Benefit for Multiple Sclerosis if, within the first year following the effective date of coverage, Multiple Sclerosis is diagnosed, or the insured person has any signs, symptoms or investigations leading to the Diagnosis of Multiple Sclerosis, regardless of when the Diagnosis is actually made.

In the event of such Diagnosis:

- the Covered Condition Benefit will not be paid.
- If the insured person continues to satisfy the eligibility provisions for coverage, Critical Illness Insurance will remain in force but Multiple Sclerosis and all Covered Conditions in MEC Grouping 3 will no longer be considered Covered Conditions for such insured person.

d) Parkinson's Disease and Specified Atypical Parkinsonian Disorders

You will not be entitled to a Covered Condition Benefit for Parkinson's Disease and Specified Atypical Parkinsonian Disorders if, within the first year following the effective date of coverage, Parkinson's Disease and Specified Atypical Parkinsonian Disorders is diagnosed, or the insured person has any signs, symptoms or investigations leading to the Diagnosis of Parkinson's Disease and Specified Atypical Parkinsonian Disorders, regardless of when the Diagnosis is actually made.

In the event of such Diagnosis:

- the Covered Condition Benefit will not be paid.
- If the insured person continues to satisfy the eligibility provisions for coverage, Critical Illness Insurance will remain in force but Parkinson's Disease and Specified Atypical Parkinsonian Disorders, and all Covered Conditions in MEC Grouping 3 will no longer be considered Covered Conditions for such insured person.

e) AdvanceCare Benefit

You will not be entitled to an AdvanceCare Benefit for Early Stage Cancer if within 90 days following the effective date of coverage, Early Stage Cancer is diagnosed, or such insured person has any signs, symptoms or investigations leading to the Diagnosis of Early Stage Cancer, regardless of when the Diagnosis is made.

In the event of such Diagnosis:

- the Covered Condition Benefit will not be paid.
- Critical Illness Insurance remains in force but Early Stage Cancer will be removed as an AdvanceCare Benefit Condition for such insured.

Exclusions

In addition to the exclusions included within the definitions of certain Covered Conditions, no benefit will be paid if a Covered Condition or AdvanceCare Benefit Condition results directly or indirectly from any one or more of the following:

a) A Pre-existing Condition. A Pre-existing Condition means any symptom, condition, disorder, illness, pre-disease or disease, or any mental, nervous or psychiatric condition or disorder for which any one of medical advice, treatment, service, prescribed medication, Diagnosis or consultation, including consultation to investigate and/or diagnose (where Diagnosis has not yet been made), was received by the insured person or would have been received by a prudent individual within the 24 months immediately preceding the effective date of your coverage. This exclusion applies for the 24 months following the effective date of the insured person's coverage;

b) Attempted suicide;

c) Taking poison or inhaling gas, whether voluntarily or involuntarily, not connected with the insured's employment;

d) Taking any drug other than as prescribed by a licensed physician;

e) Participation in a criminal act or any attempt to commit a criminal offense, including but not limited to, operating a motor vehicle while the concentration of alcohol in 100 millilitres of the insured's blood exceeds 80 milligrams;

f) Intentionally self-inflicted injury, regardless of any impairment, illness or state of mind; and/or

g) If the insured suffers Paralysis, Blindness, Deafness, Severe Burns, Stroke, Coma or Loss of Limbs, as a result, directly or indirectly, from amateur or professional boxing, bungee jumping, B.A.S.E. jumping, cliff diving, mountain climbing, motor vehicle racing or speed competition on land and/or water, parachuting or underwater activities, including scuba diving and snuba diving.

Note 1: If an insured person's amount of coverage under critical illness is increased by two times or more, the 24/24 pre-existing condition exclusion in a) above will apply to all Covered Conditions on the increased portion only from the effective date of the increase.

Note 2: Exclusion a) above will not apply to an insured who is required to submit satisfactory evidence of insurability and is subsequently approved for critical illness coverage. For such an insured person, the Covered Condition Benefit and the AdvanceCare Benefit will not be paid if a Covered Condition or AdvanceCare Benefit Condition results from any Covered Condition or AdvanceCare Benefit Condition diagnosed prior to the effective date of the insured person's critical illness coverage.

Waiver of Premium Disability Benefit

If you are under age 80 and become Totally Disabled while insured and are so disabled for at least six consecutive months, your Critical Illness Insurance will continue in force and premiums will be waived retroactively subject to the terms and conditions described in this booklet. Initial proof must be filed within 12 months of Total Disability and as required thereafter. You will continue to satisfy the Pre-Existing Condition Timeframe if applicable, while premiums are waived and coverage is in force.

The Waiver of Premium Disability benefit terminates on the earlier of the following dates:

- the date you are no longer Totally Disabled;
- the date you fail to provide satisfactory proof of your continued disability;
- the date you fail to be examined by a qualified physician as required by the insurance company;
- if you are Totally Disabled prior to age 63, your Waiver of Premium Disability benefit will terminate at the end of the month coincident with or next following your 65th birthday; or

- if you are Totally Disabled at age 63 or older but under age 80, your Waiver of Premium Disability benefit will apply for a maximum of 24 consecutive months.

Continuation of Critical Illness Insurance During a Leave of Absence

If you are not actively at work as a result of an employer-approved disability leave of absence, a leave of absence in accordance with applicable Provincial or Federal legislation (i.e., maternity/parental leave, jury duty, compassionate care leave, etc.) or temporary layoff:

- Your Critical Illness Insurance will continue in force subject to the continued payment of premium.
- You will continue to satisfy the Pre-Existing Condition Timeframe, if applicable.

In the event you are subsequently approved for the Waiver of Premium Disability Benefit, premiums will be waived in accordance with the terms and conditions described in this booklet.

Termination of Critical Illness Insurance When on Disability

If you are not actively at work as a result of a disability and were under age 63 when your disability commenced, your Critical Illness Insurance will terminate at the end of the month coincident with or next following the date you reach age 65, unless you return to full time active employment before the age of 65.

If you are not actively at work as a result of a disability and were age 63 or older but less than age 80 when your disability commenced, your Critical Illness Insurance will terminate at the earlier of your termination age or the end of the month coincident with or next following 24 consecutive months of disability-related absence from work.

If you are not actively at work as a result of a disability and were age 80 or older when your disability commenced, your Critical Illness Insurance will terminate at the earlier of your termination age or the end of the month coincident with or next following 12 consecutive months of disability-related absence from work.

Conversion Privilege

If your employment terminates or changes so that you cease to be eligible under the plan, the insured person may convert their Critical Illness Insurance, without evidence of insurability to a separate critical illness policy subject to the following:

- The insured person is under age 65 and reside in Canada at the time you cease to be eligible;
- The insured person has not received a Covered Condition Benefit or AdvanceCare Benefit under this plan or any other Critical Illness Insurance benefit under any group policy issued by iA Financial Group;
- The maximum amount to be converted will be limited to the lesser of $100,000 and the amount of coverage in force at the date of your termination;
- The insurer must be notified of the conversion request within 31 days of the insured person ceasing to be eligible;
- Premiums will be charged based on your individual gender, smoker status and age at the time of conversion;
- The converted policy will be of a type then issued by the insurer providing term insurance to age 75 and will be issued without waiver of premium benefit, return of premium benefit, paid-up benefit or guaranteed increase benefit; and

- If the insured person has not been insured under the Critical Illness Insurance plan for at least 24 months when you cease to be eligible, any time remaining under the pre-existing condition exclusion will carry over to the separate policy.

Claims at TuGo

Critical Illness Insurance also provides access to Claims at TuGo. If an insured chooses to obtain private treatment for a diagnosed condition, Claims at TuGo can help. The service provides assistance in obtaining specialized, private medical treatment at claim time. Claims at TuGo coordinates medical appointments and procedures with specialists and surgeons at special pricing discounts.

For assistance in accessing this service, please visit www.tugo.com/tms. Note that utilization fees may apply.

Plan Definitions

"Covered Conditions" for which a benefit is paid with respect to an insured employee are Aortic Surgery, Aplastic Anemia, Bacterial Meningitis, Benign Brain Tumour, Blindness, Cancer, 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 and Specified Atypical Parkinsonian Disorders, Severe Burns and Stroke. Each Covered Condition is defined below.

"Date of Diagnosis" means the date on which a Specialist diagnoses the insured with one of the Covered Conditions, with Cancer Recurrence or one of the AdvanceCare Benefit Conditions.

"Diagnosis" means the certified diagnosis of the insured with a Covered Condition, with Cancer Recurrence or one of the AdvanceCare Benefit Conditions by a Specialist.

"Pre-Existing Condition Timeframe" means a period of 24 months during which the Critical Illness Insurance is in force, commencing with the effective date of coverage.

"Specialist" means a licensed medical practitioner who:

- has been trained in the specific area of medicine relevant to the Covered Condition or AdvanceCare Benefit Condition for which a benefit is being claimed;
- has been certified by a specialty examining board; and
- is currently practicing in their area of specialty in Canada or the United States of America.

Specialist includes but is not limited to: cardiologist, neurologist, nephrologist, oncologist, ophthalmologist, burn specialist and internist. The Specialist and any medical professional performing any tests or examinations required to satisfy the Covered Condition requirements must not be the Insured Person, or a relative or business associate of the Insured Person.

In the absence or unavailability of a Specialist, and as approved by the insurer, a Covered Condition or AdvanceCare Benefit Condition may be diagnosed by a qualified medical practitioner practicing in Canada or the United States of Amercia.

"Total Disability" or **"Totally Disabled"** means disability resulting from injury or sickness which requires the regular care and personal attendance of a registered physician and which totally and continuously disables and prevents an insured Employee from performing every duty pertaining to his regular occupation during the first 24 months of injury or sickness; and thereafter, totally and continuously disables and prevents an insured Employee from performing any gainful occupation for which he is or may become reasonably fitted by reason of his training, education or experience.

Definitions of Covered Conditions

Aortic Surgery

Aortic Surgery means the undergoing of surgery for disease of the aorta requiring excision and surgical replacement of the diseased aorta with a graft. Aorta refers to the thoracic and abdominal aorta but not its branches. The surgery must be determined to be medically necessary by a Specialist.

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

Aplastic Anemia

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

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

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

Bacterial Meningitis

Bacterial Meningitis means a definite Diagnosis of meningitis, confirmed by cerebrospinal fluid showing growth of pathogenic bacteria. The presence of pathogenic bacteria must be confirmed by culture or other generally medically accepted microbiological testing. The Bacterial Meningitis must result in objective neurological deficits persisting for at least 90 days from the Date of Diagnosis. The Diagnosis of Bacterial Meningitis must be made by a Specialist.

For purposes of the group policy, neurological deficits must be detectable by the Specialist and may include, but are not restricted to, measurable loss of hearing, measurable loss of vision, measurable changes in neuro-cognitive function, objective loss of sensation, paralysis, localized weakness, dysarthria (difficulty with pronunciation), dysphasia (difficulty with speech), dysphagia (difficulty swallowing), impaired gait (difficulty walking), difficulty with balance, lack of coordination, or new-onset seizures undergoing treatment. Headache or fatigue will not be considered a neurological deficit.

Exclusions: No benefit will be payable under this Covered Condition for viral meningitis.

Benign Brain Tumour

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

These deficits must be corroborated by diagnostic imaging showing changes that are consistent in character, location and timing with the neurological deficits.

The Diagnosis of Benign Brain Tumour must be made by a Specialist.

For purposes of the group policy, neurological deficits must be detectable by the Specialist and may include, but are not restricted to, measurable loss of hearing, measurable loss of vision, measurable changes in neuro-cognitive function, objective loss of sensation, paralysis, localized weakness, dysarthria (difficulty with pronunciation), dysphasia (difficulty with speech), dysphagia (difficulty swallowing), impaired gait (difficulty walking), difficulty with balance, lack of coordination, or new-onset seizures undergoing treatment. Headache or fatigue will not be considered a neurological deficit.

Exclusions: No benefit will be payable under this Covered Condition for pituitary adenomas less than 10 mm; vascular malformations, cholesteatomas or infectious or inflammatory tumours.

90-day Exclusion: No benefit will be payable under this Covered Condition if, within the first 90 days following the later of the Issue Date of an Insured Person's coverage, or the last reinstatement date of an Insured Person's coverage, such Insured Person has any of the following:

- Signs, symptoms, or investigations that lead to a Diagnosis of Benign Brain Tumour (covered or excluded under the Group Policy), regardless of when the Diagnosis is made; or
- A Diagnosis of Benign Brain Tumour (covered or not covered under the Group Policy).

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

Blindness

Blindness means a definite Diagnosis of the total and irreversible loss of vision in both eyes, evidenced by:

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

The Diagnosis of Blindness must be made by a Specialist.

Cancer

Cancer means the definite Diagnosis of a malignant tumour. This tumour 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 and must be confirmed by a pathology report.

For purposes of the Group Policy:

- T1a or T1b prostate cancer means a clinically inapparent tumour that was not palpable on digital rectal examination and was incidentally found in resected prostatic tissue.
- The term gastrointestinal stromal tumours (GIST) classified as AJCC Stage 1 means:
    - Gastric and omental GISTs that are less than or equal to 10 cm in greatest dimension with five or fewer mitoses per 5 mm2, or 50 per HPF; or
    - Small intestinal, esophageal, colorectal, mesenteric and peritoneal GISTs that are less than or equal to 5 cm in greatest dimension with 5 or fewer mitoses per 5 mm2, or 50 per HPF;
- The terms Tis, Ta, T1a, T1b, T1 and AJCC Stage 1 are as defined in the American Joint Committee on Cancer (AJCC) cancer staging manual, 8th Edition, 2018.

- The term Rai stage 0 is as defined in KR Rai, A Sawitsky, EP Cronkite, AD Chanana, RN Levy and BS Pasternack: Clinical staging of chronic lymphocytic leukemia. Blood 46:219,1975.

Exclusions: No benefit will be payable under this Covered Condition for the following:

- Lesions described as benign, non-invasive, pre-malignant, of low and/or uncertain malignant potential, borderline, carcinoma in situ, or tumors classified as Tis or Ta;
- Malignant melanoma of skin that is less than or equal to 1.0mm 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. This includes but is not limited to, cutaneous T cell lymphoma, basal cell carcinoma, squamous cell carcinoma or Merkel cell carcinoma;
- 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 2.0cm in greatest dimension and classified as T1, without lymph node or distant metastasis;
- Chronic lymphocytic leukemia classified as Rai stage 0 without enlargement of lymph nodes, spleen or liver and with normal red blood cell and platelet counts;
- Gastro-intestinal stromal tumours classified as AJCC Stage 1;
- Grade 1 neuroendocrine tumours (carcinoid) confined to the affected organ, treated with surgery alone and requiring no additional treatment, other than perioperative medication to oppose effects from hormonal oversecretion by the tumour; or
- Thymomas (stage 1) confined to the thymus, without evidence of invasion into the capsule or spread beyond the thymus.

90-day Exclusion: No benefit will be payable under this Covered Condition if, within the first 90 days following the later of the Issue Date of an Insured Person's coverage, or the last reinstatement date of an Insured Person's coverage, the Insured Person has any of the following:

- Signs, symptoms or investigations leading directly or indirectly to a diagnosis of any cancer (covered or not covered under the Group Policy), regardless of when the diagnosis is made; or
- A diagnosis of any cancer (covered or not covered under the Group Policy).

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

Coma

Coma means a definite Diagnosis of a state of unconsciousness with no reaction to external stimuli or response to internal needs for a continuous period of at least 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.

Exclusions: 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.

Coronary Artery Bypass Surgery

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

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

Deafness

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

Dementia, Including Alzheimer's Disease

Dementia, including Alzheimer's Disease means 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);
- aphraxia (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 behavior), 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, including Alzheimer's Disease must be made by a Specialist.

Exclusions: No benefit will be payable under this Covered Condition for affective or schizophrenic disorders, or delirium.

For purposes of the Policy, reference to the Mini Mental State Exam is to Folstein MF, Folstein SE, McHugh PR, J Psychiatr Res. 1975;12(3):189.

Heart Attack

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

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

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

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

- ECG changes suggestive of a prior myocardial infarction;
- Other acute coronary syndromes, including angina pectoris and unstable angina; or
- Elevated cardiac biomarkers and/or symptoms that are due to medical procedures or diagnoses other than heart attack.

Heart Valve Replacement or Repair

Heart Valve Replacement or Repair means the undergoing of surgery to replace any heart valve with either a natural or mechanical valve or to repair heart valve defects or abnormalities. The surgery must be determined to be medically necessary by a Specialist.

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

Kidney Failure

Kidney Failure means the definite Diagnosis of chronic irreversible failure of both kidneys to function, as a result of which regular haemodialysis, peritoneal dialysis or renal transplantation is initiated. The Diagnosis of Kidney Failure must be made by a Specialist.

Loss of Independent Existence

Loss of Independent Existence means a definite Diagnosis of the total inability, due to disease or injury, to perform independently, with or without the aid of assistive devices, at least 3 of 6 Activities of Daily Living listed below for a continuous period of at least 90 days with no reasonable chance of recovery. The Diagnosis must be made by a physician and supported by an independent home care assessment made by an occupational therapist or equivalent.

Activities of Daily Living are as follows:

- Bathing - washing oneself in a bathtub, shower or by sponge bath;
- Dressing - putting on and removing necessary clothing, braces, artificial limbs or other surgical appliances;
- Toileting - the ability to get on and off the toilet and maintain personal hygiene with or without the aid of assistive devices;
- Bladder and Bowel Continence - the ability to manage bowel and bladder function with or without protective undergarments or surgical appliances so that a reasonable level of hygiene is maintained;
- Transferring - the ability to move in and out of a bed, chair or wheelchair, with or without the aid of assistive devices;
- Feeding - the ability to consume food or drink that already has been prepared and made available, with or without the use of adaptive utensils.

No additional survival period is required once the conditions described above are satisfied.

Loss of Limbs

Loss of Limbs means 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

Loss of Speech means a definite Diagnosis of the total and irreversible loss of the ability to speak as a result of physical injury or disease, for a period of at least 180 days. The Diagnosis of Loss of Speech must be made by a Specialist.

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

Major Organ Failure on Waiting List

Major Organ Failure on Waiting List means 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 center in Canada or the United States of America that performs the required form of transplant surgery. For the purpose of the survival period, the Date of Diagnosis is the date of the insured person's enrollment in the transplant centre. The Diagnosis of the major organ failure must be made by a Specialist.

Major Organ Transplant

Major Organ Transplant means a definite Diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow and transplantation must be medically necessary. To qualify under Major Organ Transplant, the insured person must undergo a transplantation procedure as the recipient of a heart, lung, liver, kidney or bone marrow, and limited to these entities. The Diagnosis of the major organ failure must be made by a Specialist.

Motor Neuron Disease

Motor Neuron Disease means 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 limited to these conditions. The Diagnosis of Motor Neuron Disease must be made by a Specialist.

Multiple Sclerosis

Multiple Sclerosis means a definite Diagnosis of at least one of the following:

- Two or more separate clinical attacks, confirmed by a magnetic resonance imaging (MRI) of the nervous system, showing multiple lesions of demyelination;
- A single attack, with objective neurological deficits lasting more than 6 months, confirmed by MRI of the nervous system, showing multiple lesions of demyelination; or,
- A single attack, confirmed by repeated MRI 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.

For purposes of the Group Policy, neurological deficits must be detectable by a Specialist and may include, but are not restricted to, measurable loss of hearing, measurable loss of vision, measurable changes in neuro-cognitive function, objective loss of sensation, paralysis, localized weakness, dysarthria (difficulty with pronunciation), dysphasia (difficulty with speech), dysphagia (difficulty swallowing), impaired gait (difficulty walking), difficulty with balance, lack of coordination, or new-onset seizures undergoing treatment. Headache or fatigue will not be considered a neurological deficit.

Exclusions: No benefit will be payable for the following:

- Solitary sclerosis;
- Clinically isolated syndrome;

- Radiologically isolated syndrome;
- Neuromyelitis optica spectrum disorders; or
- Suspected multiple sclerosis or probable multiple sclerosis.

1-year Exclusion: No benefit will be payable under this Covered Condition if, within the first year following the later of the Issue Date of an Insured Person's coverage or the last reinstatement date of an Insured Person's coverage, the Insured Person has any of the following:

- Signs, symptoms or investigations leading directly or indirectly to a diagnosis of multiple sclerosis (covered or not covered under the Group Policy) regardless of when the diagnosis is made; or
- A diagnosis of multiple sclerosis (covered or not covered under the Group Policy).

Medical information about the Diagnosis and any signs, symptoms or investigations leading to the Diagnosis must be reported to the insurer within 6 months of the Date of Diagnosis.

Occupational HIV Infection

Occupational HIV Infection means a definite Diagnosis of infection with Human Immunodeficiency Virus (HIV) resulting from accidental injury during the course of the insured person's normal occupation, which exposed the person to HIV contaminated body fluids. The accidental injury leading to the infection must have occurred after the later of the effective date of the insured's coverage or the latest reinstatement date of such insured person's insurance coverage.

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

- the accidental injury must be reported to the insurer within 14 days of the accidental injury;
- a serum HIV test must be taken within 14 days of the accidental injury and the result must be negative;
- a serum HIV test must be taken between 90 days and 180 days after the accidental injury 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 accidental injury must have been reported, investigated and documented in accordance with current Canadian or United States of America workplace guidelines.

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

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

- the insured person 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 accidental injury; or
- HIV infection has occurred as a result of non-accidental injury including, but not limited to, sexual transmission and intravenous (IV) drug use.

Paralysis

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

Parkinson's Disease and Specified Atypical Parkinsonian Disorders

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

Specified Atypical Parkinson's 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.

1-year Exclusion: No benefit will be payable for Parkinson's Disease or Specified Atypical Parkinsonian Disorders if, within the first year following the later of the issue date or the latest reinstatement date of an Insured Person's coverage, such Insured Person 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 the insurer within 6 months of the Date of Diagnosis. If this information is not provided within this period, the insurer has the right to deny any claim for Parkinson's Disease or Specified Atypical Parkinsonian Disorders or its treatment.

No benefit will be payable under Parkinson's Disease and Specified Atypical Parkinsonian Disorders for any other type of Parkinsonism.

Severe Burns

Severe Burns means 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)

Stroke (cerebrovascular accident) resulting in persistent neurological deficits means a definite Diagnosis of an acute cerebrovascular event caused by intra-cranial thrombosis, haemorrhage, or embolism 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 showing changes that are consistent in character, location and timing with the new neurological deficits. The Diagnosis of Stroke must be made by a Specialist.

For purposes of the Group Policy, neurological deficits must be detectable by a Specialist and may include, but are not restricted to, measurable loss of hearing, measurable loss of vision, measurable changes in neuro-cognitive function, objective loss of sensation, paralysis, localized weakness, dysarthria (difficulty with pronunciation), dysphasia (difficulty with speech), dysphagia (difficulty swallowing), impaired gait (difficulty walking), difficulty with balance, lack of coordination, or new-onset seizures undergoing treatment. Headache or fatigue will not be considered a neurological deficit.

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

- Transient Ischemic Attacks;
- Intracerebral vascular events due to trauma;
- Ischaemic disorders of the vestibular system;
- Death of tissue of the optic nerve or retina without total loss of vision of that eye; or
- Lacunar infarcts which do not meet the definition of stroke as described above.

Note: Any illness or disorder not specifically defined as a Covered Condition will not be payable.

Definitions of AdvanceCare Benefit Conditions

Coronary Angioplasty

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

Early Stage Cancer

Early Stage Cancer refers to the following conditions:

- 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;
- 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 0 without enlargement of lymph nodes, spleen or liver and with normal red blood cell and platelet counts;
- gastrointestinal stromal tumours classified as AJCC Stage 1; or
- Grade 1 neuroendocrine tumours (carcinoid) confined to the affected organ, treated with surgery alone and requiring no additional treatment, other than perioperative medication to oppose effects from hormone oversecretion by the tumour;
- Thymomas (Stage 1), confined to the thymus, without evidence of invasion into the capsule or spread beyond the thymus; or
- Ductal Carcinoma in situ of the Breast.

The Diagnosis of Early Stage Cancer must be made by a Specialist.

Extended Health Care

Employee and Dependent Coverage

Health benefits are designed to help meet the medical and hospital expenses incurred by you and your family and are intended to supplement your provincial health care plan. In the event you or a covered dependent incurs an eligible expense in Canada, as listed below and as shown in the Schedule of Benefits, you will be paid a percentage (coinsurance) of the expense, in excess of the deductible for that year.

Lifetime Maximum Benefit

The total lifetime benefit payable in respect to you or your dependents is unlimited.

Eligible Expenses - Hospital

Preferred Accommodation in Canadian Hospitals

The difference between the charges made for ward and semi-private room and board in a licensed Canadian hospital. Such charges shall not be subject to the deductible.

Eligible Expenses - Prescription Drugs

Reasonable and customary charges incurred for medically necessary mandatory generic drugs and medicines as specified in the Schedule of Benefits which:

- are dispensed by a licensed pharmacist or physician legally authorized to dispense such drugs and medicines, and
- are prescribed by a physician or other professional authorized by provincial legislation to prescribe medicines for the treatment of an illness or injury and are either:

  a) drugs requiring the prescription of a physician or other health practitioner as permitted by law; or

  b) other specified drugs and medicines which have been identified as covered expenses and are by convention usually not dispensed without a physician's prescription; or

  c) approved by GreenShield's drug review process; or

  d) injectable preparations identified as eligible and allergy serums; or

  e) insulin preparations, test strips, diabetic needles and syringes.

Where a generic equivalent drug exists, your plan allows for reimbursement based on the cost of the lowest priced equivalent drug. Should you decide to purchase a higher priced drug, you may pay the difference. However, if a medical practitioner indicated a brand name drug is medically required due to a serious medical reaction to at least two generic equivalent drugs, GreenShield must be provided with a copy of the "Health Canada Vigilance Adverse Reaction Reporting Form" (that can be obtained from the Health Canada website) completed by the medical practitioner, to determine eligibility for payment of the cost of the prescribed drug.

GreenShield reserves the right to manage its drug formularies through an evidence-based review process in which drugs are evaluated based on overall value taking into account clinical efficacy, safety, unmet need and plan affordability. Formulary management includes the right to:

- add a drug to GreenShield's formularies;
- exclude or remove a drug from GreenShield's formularies regardless of Health Canada approval and/or the existence of provincial coverage;
- place restrictions on a formulary drug as determined by GreenShield. Restrictions may include, but are not limited to, GreenShield's pre-approval of the drug before the claim can be reimbursed, requirement to obtain the drug through an approved provider and requirement to obtain a lower cost alternative of the same treatment such as a generic or a biosimilar drug.

Certain drugs require prior approval from GreenShield before your prescription claim can be reimbursed. Further, certain drugs defined by GreenShield as specialty, high cost drugs may be required to be purchased from an approved pharmacy that is a member of GreenShield's Specialty Drug Preferred Provider Network (PPN) before your claim can be reimbursed. You can determine if your drug requires prior approval or is included in the PPN either by using the online drug search tool available through Victor's Plan Member Online Services or by contacting GreenShield's Customer Service Centre.

Notes:

- Reference biologic drugs that have an approved biosimilar are not an eligible expense.
- Drugs prescribed in connection with fertility treatment and erectile dysfunction are not covered.

All provinces other than Quebec

Maintenance drugs required to treat lifelong chronic conditions may be required to be purchased in a 90-day supply of a prescription at any one time. Non-maintenance drugs may be purchased in a supply not exceeding 3-months (90-day) supply of a prescription at any one time. However, for all drugs, 6 months for a vacation supply may be purchased and not more than a 13-month supply in any 12 consecutive months.

Quebec only

In no event will the amount dispensed exceed a 3-month supply (6 months if a vacation supply is required) of a prescription at any one time and not more than a 13-month supply in any 12 consecutive months.

No benefit shall be payable for any single purchase of drugs which would not reasonably be used within 90 days from the date of purchase.

Drugs Covered Under the Quebec Universal Drug Plan Formulary

Drugs not covered under the group plan but listed in the Quebec Universal Drug Plan formulary, will be reimbursed in accordance with the Quebec Universal Drug Plan.

A child age 22 to 25 inclusive will be considered a dependent if in full-time attendance at an accredited school, college or university.

Coverage will be maintained if payments are made for a minimum period of 30 days in the event of strike, lock-out or any other organized work stoppage.

At age 65, you have the choice of being covered either by the Régie de l'assurance maladie du Québec (RAMQ) or this policy. If you choose to be covered under this policy, an annual fee will be charged. A decision to take coverage under the RAMQ plan is considered irrevocable and you cannot at a later date apply for drug coverage under the group plan.

Eligible Expenses - Vision Care

Reasonable and customary charges for vision care as follows:

a) lenses and frames for eyeglasses or contact lenses not covered in (b), or laser eye surgery, when prescribed by an ophthalmologist or optometrist, subject to the Vision Care Maximum shown in the Schedule of Benefits;

b) contact lenses prescribed for severe corneal astigmatism, severe corneal scarring, Keratoconus (conical cornea) or Aphakia, provided visual acuity can be improved to at least the 20/40 level by contact lenses but cannot be improved to that level by spectacle lenses, subject to the Vision Care Maximum shown in the Schedule of Benefits.

Eligible Expenses - Supplementary Health Care

Reasonable and customary charges for supplementary health care expenses as follows:

- licensed Convalescent Care Facility, subject to a daily maximum benefit equal to the charge made for semi-private accommodation for not more than 120 days of confinement per calendar year. Confinement must begin following a minimum of three consecutive days of hospital confinement and prior to your or your covered dependent's 65th birthday;
- medical services (excluding custodial care, psychological or personal counselling) provided by a Registered Nurse (R.N.) or Registered Practical Nurse/Licensed Practical Nurse (R.P.N. / L.P.N.) which are rendered while you or your covered dependents are not confined to a hospital subject to an overall maximum benefit of $10,000 in any calendar year provided such nurse is not a resident in your home or a relative of your family. These charges will be considered eligible expenses only if recommended by a physician and if medically necessary. For the purpose of this policy, custodial care is defined as assistance with daily living or tasks which a layperson could perform;
- professional ambulance service, other than airline, to and from the nearest hospital qualified to provide the necessary treatment.
- emergency transportation (except while travelling outside of your or your covered dependent's province of residence) by airline to and from the nearest hospital qualified to provide the necessary treatment. Such emergency transportation includes, if medically required, transportation costs for a medical attendant who is neither a resident in your home nor a relative of your family;
- diabetic equipment and supplies, such as:
    - blood glucose meters;
    - glucose monitoring system (GMS) such as continuous and flash type monitors subject to medical pre-authorization and reimbursed to the cost of a blood glucose meter. Disposable GMS supplies (used with the monitor), such as, but not limited to, sensors and transmitters, are included and subject to the overall annual maximum applicable to diabetic testing and monitoring equipment and supplies;
- rental (or, at GreenShield's option, purchase) of durable medical or surgical equipment required for therapeutic purposes and as approved by GreenShield;
- rental (or, at GreenShield's option, purchase) of crutches, custom-made braces and the purchase of prostheses;
- necessary dental treatment required as the result of an accidental injury to natural teeth when necessitated by a direct blow to the mouth and not by an object wittingly or unwittingly placed in the mouth, provided the accident occurred while covered under this coverage, subject to a maximum

benefit of $5,000 per accident. As determined by the benefit provider, only such charges directly related to such an accidental injury are considered a covered medical expense. The dental work must be completed within 12 months of the accident to be considered a covered medical expense;

- custom-made orthopedic shoes and orthotics which have been specially designed and molded for the covered individual and are required to correct a diagnosed physical impairment. The custom-made orthopedic shoes or orthotics must have been prescribed by a podiatrist, chiropodist, nurse practitioner or physician and dispensed by an orthotist, pedorthist, podiatrist, chiropodist or chiropractor. Such charges are limited to a maximum benefit of $200 per orthopedic shoe up to a maximum of $400 in any calendar year, or up to a maximum of $400 in any calendar year for orthotics;
- laboratory tests and x-rays not covered by your provincial health care plan;
- pharmacogenetic testing only through GenXys Health Care Systems, subject to prior approval and limited to once per lifetime;
- purchase of hearing aids (excluding batteries) provided by a certified clinical audiologist, subject to a maximum benefit of $500 per person in any three consecutive years;
- eye examinations performed by a qualified optometrist or ophthalmologist, once every 24 months, where provincial health care plan coverage of eye exams is not available.

Paramedical Practitioners

Reasonable and customary charges for the services of the following paramedical practitioners, when operating within their field of expertise and when certified, registered or licensed by the appropriate provincial or federal body, are eligible for reimbursement subject to the conditions and calendar year maximums shown below:

Practitioner	Covered	Physician Referral Required	Annual Maximum
Speech Therapist	Yes	No	$500
Psychologist/Social Worker/Psychotherapist	Yes	No	$500
Osteopath	Yes	No	$500
Chiropractor	Yes	No	$500
Physiotherapist	Yes	No	$500
Naturopath	Yes	No	$500
Acupuncturist	Yes	No	$500
Chiropodist/Podiatrist	Yes	No	$500
Massage Therapist	Yes	No	$500

Charges for x-rays are covered, subject to a maximum benefit of $20 per calendar year for all specialties combined.

Exclusions

The foregoing list of eligible expenses shall not include any of the following:

- charges which are considered an insured service of any provincial government plan;
- charges which were considered an insured service of any provincial government plan at the time this plan/benefit was issued and subsequently were modified, suspended or discontinued;
- charges for general health examinations, and examinations required for use of third party;

- charges for a surgical procedure or treatment performed primarily for beautification, or charges for hospital confinement for such surgical procedure or treatment;
- charges for medical treatment or surgical procedures by a physician;
- charges for transport or travel, other than as specifically provided under eligible expenses;
- charges not specified in the foregoing list of eligible medical expenses;
- any charges for treatment, drug, service, or supply received outside of Canada on a non-emergency basis;
- any specific treatment or drug which:
    - does not meet expected standards of medical, dental or ophthalmic practice, including charges for services or supplies which are experimental in nature;
    - is not considered to be effective (either medically or from a cost perspectives) as determined by GreenShield's drug review process regardless if Health Canada has approved the drug;
    - is an adjunctive drug prescribed in connection with any treatment or drug that is not an eligible service;
    - is administered in a hospital or is required to be administered in a hospital in accordance with Health Canada's approved indication for use;
    - is not dispensed by the pharmacist in accordance with the payment method shown under the Prescription Drugs benefit;
    - is not being used and/or administered in accordance with Health Canada's approved indication for use, even though such drug or procedure may customarily be used in the treatment of other illnesses or injuries (i.e., off label use);
- charges for services or supplies which are furnished without the recommendation and approval of a physician acting within the scope of his license;
- charges which are not medically necessary to the care and treatment of any existing or suspected injury, disease or pregnancy;
- charges which are from an occupational injury or disease covered by any Workplace Safety and Insurance Board or similar legislation;
- charges which would not normally have been incurred but for the presence of this coverage or for which you are not legally obligated to pay;
- charges which GreenShield is not permitted, by any law or regulation, to cover;
- charges for dental work where a third party is responsible for payment for such charges;
- charges for bodily injury resulting directly or indirectly from attempting to commit or committing a criminal act or an illegal act, war or act of war (whether declared or undeclared), insurrection or riot, or hostilities of any kind;
- charges for drugs, sera, injectable drugs or supplies which are not approved by Health Canada or are experimental or limited in use whether or not so approved;
- charges for any form of medical cannabis for the treatment of any medical condition, regardless of whether it is authorized by way of a medical document from a legally-authorized medical practitioner and obtained from a Health Canada-licensed producer pursuant to any federal or provincial legislation or regulation regarding access to and/or distribution of medical cannabis;
- charges for experimental medical procedures or treatment not approved by the Canadian Medical Association or the appropriate medical specialty society;
- charges made by a physician for travel, broken appointments, communication costs, completion or translation of forms, or physician's supplies.

Benefit Continuance for Surviving Dependents

Extended Health Care coverage for dependents shall continue at no charge following your death for up to a maximum of 24 months from the date of death or to the date the policy or benefit terminates, whichever is earlier.

The following benefits continue throughout the survivor benefit period.

- Emergency Travel Assistance
- Inkblot EAP
- LifeSpeak
- Maple Telemedicine
- Medical Second Opinion

Emergency Travel Assistance

Employee and Dependent Coverage

You are only eligible for the Emergency Travel Assistance (ETA) benefit if you are covered for the Extended Health Care benefit. Refer to your Benefits Booklet and Coverage Summary on GB Connect to determine if you are covered for these benefits.

Eligible travel benefits will be based on reasonable and customary charges in the area where they were received, less the amount payable by your provincial/territorial health care plan, if your province/territory provides such coverage.

Important Notes

This Travel benefit includes requirements, limitations and exclusions that can affect eligibility and/or reimbursement of incurred expenses. You must be accurate and complete in your dealings with GreenShield at all times. Please take the time to read through this benefit before you travel to ensure you are aware of the terms and conditions, making note of the following:

With the exception of the "Referral Services", this Travel benefit is an emergency medical benefit only and provides coverage while you are temporarily outside of your regular province/territory of residence for vacation, education or business reasons. It does not cover any non-emergency, elective, cosmetic or experimental treatment, surgery, procedure or any other service a covered person chooses to have performed outside of his or her home province/territory - whether pre-planned or not.

GreenShield reserves the right to review your medical information at the time of claim. Any invasive or investigative procedures must be pre-approved by GreenShield Travel Assistance. If the covered person is the patient and it is medically impossible for the covered person to call prior to obtaining emergency treatment, it is extremely important to have someone call GreenShield Travel Assistance on the covered person's behalf within 48 hours. If GreenShield Travel Assistance is not notified within the first 48 hours, reimbursement of incurred expenses may be limited to the lesser of the amount of only those expenses incurred within the first 48 hours of any and each treatment/incident or the plan maximum. This means the covered person will be responsible for all expenses thereafter.

Emergency means a sudden and unforeseen medical condition that requires treatment. An emergency no longer exists when the evidence reviewed by GreenShield Travel Assistance indicates that no further treatment is required at destination or you are able to return to your province/territory of residence for further treatment. If GreenShield Travel Assistance determines that you transfer to another facility or return to your home province/territory of residence, and you choose not to, the benefits will not be paid for further medical treatment and coverage will be limited for unrelated events.

Emergency excludes treatment of a pre-existing condition that was not completely stable for the 90-day period immediately preceding the covered person's departure.

Pre-existing condition means any medical condition that exists prior to the date of the covered person's departure.

Medical condition means any disease, illness or injury (including symptoms of undiagnosed conditions).

A medical condition is considered stable when all of the following statements are true during the 90-day period immediately preceding the date of the covered person's departure:

a) There has not been any new treatment prescribed or recommended, or change(s) to existing treatment (including stoppage in treatment);

b) The medical condition has not become worse;

c) There has not been any new, more frequent or more severe symptoms;

d) There has been no hospitalization or referral to a specialist;

e) There have not been any tests, investigation or treatment recommended, but not yet complete, nor any outstanding test results;

f) There is no planned or pending treatment; and

g) There has not been any change to an existing prescribed drug (including an increase, decrease, or stoppage to prescribed dosage), or any recommendation or starting of a new prescription drug. The following are not considered changes to existing prescribed drug treatment:

- Routine dosage adjustments of Coumadin, Warfarin or insulin, as long as these medications have not been newly prescribed or stopped;
- A change from a brand name to a generic equivalent product as long as the dosage is the same - including a transition from a biologic to a biosimilar product;
- A decrease in the dosage of a medication due to the improvement of a condition.

All of the above conditions must be met during the 90-day period prior to the covered person's departure in order for a medical condition to be considered stable.

Travelling companion means any person who has prepaid accommodation and/or transportation with the covered person for the same covered trip.

Treat, treated, treatment means a procedure prescribed, performed, or recommended by a physician for a medical condition. This includes but is not limited to prescribed medication, investigative testing and surgery.

Benefit Details

Eligible benefits are limited to the maximum days per trip shown in the Schedule of Benefits, commencing with the date of departure from your province/territory of residence. If you are hospitalized on the last day shown in the Schedule of Benefits, benefits will be extended until the date of discharge.

Hospital Services and Accommodation

- Up to a standard ward rate in a public general hospital.
- Up to $350 for out-of-pocket expenses such as telephone, television rental, and parking.

Medical/Surgical Services

When rendered by a legally qualified physician or surgeon to relieve the symptoms of, or to cure an unforeseen illness or injury.

Emergency Transportation

- By land ambulance to the nearest qualified medical facility.
- By air ambulance - the cost of air evacuation (including a medical attendant when necessary) between hospitals and for hospital admission into Canada when approved in advance by your provincial/territorial health care plan or to the nearest qualified medical facility.

Referral Services

Reasonable and customary hospital, medical, surgical and transportation expenses in excess of those expenses covered by your provincial/territorial health insurance plan for you and an approved escort.

Prior to the commencement of any referral treatment, written pre-authorization from your provincial/territorial health care plan and GreenShield must be obtained. Your provincial/territorial health insurance plan may cover this referral benefit entirely. You must provide GreenShield with a letter from your attending physician stating the reason for the referral, and a letter from your provincial/territorial health care plan outlining their liability. Failure to obtain pre-authorization will result in non-payment.

Services of a Registered Private Nurse

Up to a maximum of $10,000 per calendar year, at the reasonable and customary rate charged by a qualified nurse registered and licensed in the jurisdiction in which treatment is provided. You must contact GreenShield Travel Assistance for pre-approval.

Diagnostic Laboratory Tests and X-rays

When prescribed by the attending physician. Except in emergency situations, GreenShield Travel Assistance must pre-approve these services (i.e., cardiac catheterization or angiogram, angioplasty and bypass surgery).

Reimbursement of Prescriptions

Drugs, serums and injectables which require a prescription by law and are prescribed by a legally qualified medical practitioner (vitamins, patent and proprietary drugs are excluded).

Paramedical Practitioners

Up to a maximum of $500 per practitioner per emergency (including x-rays) for the services of a licensed chiropractor, physiotherapist, podiatrist/chiropodist, or osteopath in conjunction with the treatment for an emergency.

Medical Appliances

Including casts, crutches, canes, slings, splints and/or the temporary rental of a wheelchair when deemed medically necessary and required due to an accident which occurs, and when the devices are obtained outside your province/territory of residence.

Treatment by a Dentist

Only when required on an emergency basis for:

- Services and treatment of a direct accidental blow to the mouth up to a maximum of $2,500. Treatments (prior to and after return) must be provided within 90 days of the accident. Details of the accident must be provided to GreenShield Travel Assistance along with dental x-rays.
- Treatment to relieve dental pain up to a maximum of $500 per trip.

Child Care

When pre-approved by GreenShield Travel Assistance, up to $5,000 for one of the following benefits for dependent children under the age of 16 in the event of an emergency involving you or your spouse while travelling:

- Additional cost of one-way economy airfare for the return home of accompanying dependent children when you or your spouse are hospitalized, plus the cost of an escort if required.
- The cost of services of a caregiver (who is not a relative) in the location where you or your spouse is hospitalized.
- The cost of services of a caregiver (who is not a relative) in your home province when the children are left unattended due to the delayed return of you or your spouse.

Pet Return

- Up to a maximum of $500 for the return of your accompanying pet(s) in the event you are hospitalized or repatriated during an Emergency.

Coming Home
When your emergency illness or injury is such that

- GreenShield Travel Assistance specifies in writing that you immediately return to your province/territory of residence for immediate medical attention, reimbursement will be made for the extra cost incurred for the purchase of a one-way economy airfare, plus the additional economy airfare if required to accommodate a stretcher, to return you and a travelling companion by the most direct route to the major airport nearest the departure point in your province/territory of residence.
- This benefit assumes that you are not holding a valid open-return air ticket. Charges for upgrading, departure taxes, or cancellation penalties are not included.
- GreenShield Travel Assistance or commercial airline stipulates in writing that you must be accompanied by a qualified medical attendant, reimbursement will be made for the cost incurred for one round-trip economy airfare and the reasonable and customary fee charged by a medical attendant who is not your relative by birth, adoption or marriage and is registered in the jurisdiction in which treatment is provided, plus overnight hotel and meal expenses if required by the attendant.

Return Trip Delay - Transportation
Charges incurred for delay of the return trip of a covered person due to the hospitalization of that person or another covered person with whom the individual is travelling, limited to the cost of one-way economy class transportation.

Return of Dependent Children
Charges incurred for the return of dependent children to their residence in Canada in the event you or your spouse is hospitalized and the children are left unattended. The children must be under 16 years of age. Arrangements for an escort to accompany the children will be made if necessary.

Returning Your Personal Use Motor Vehicle
The cost involved to your residence or nearest appropriate vehicle rental agency when you are unable to because of sickness, physical injury or death, up to a maximum of $10,000 per trip. GreenShield Travel Assistance requires original receipts for costs incurred, i.e., gasoline, accommodation and airfares.

Meals and Accommodation
Up to a maximum of $250 per day to a maximum of $5,000 per trip will be reimbursed for the extra costs of commercial hotel accommodation and meals incurred by you or a covered dependent when the trip is delayed or interrupted due to an illness, accidental injury to or death of a covered person or travelling companion and the covered person remains until they or their travelling companion is fit to travel. This must be verified in writing by the attending legally qualified physician or surgeon and supported with original receipts from the commercial organization.

Transportation to the Bedside
Round-trip economy airfare by the most direct route from your province/territory of residence, for any one spouse, parent, child, brother or sister, and up to $150 per day for a maximum of five days for meals and accommodation at a commercial establishment will be paid for that family member to:

- be with you or your covered dependent when confined in hospital. This benefit requires that the covered person must eventually be an inpatient for at least seven days outside your province/territory of residence, plus the written verification of the attending physician that the situation was serious enough to have required the visit; and/or
- identify a deceased prior to release of the body.

Return Airfare

If the personal use motor vehicle of you or your covered dependent is stolen or rendered inoperable due to an accident, reimbursement will be made for the cost of a one-way economy airfare to return you and your covered dependents travelling with you, or a travelling companion, by the most direct route to the major airport nearest your departure point in your province/territory of residence.

Return of Deceased

Up to a maximum of $15,000 toward the cost of preparation and transportation in an appropriate container of yourself or your covered dependent when death is caused by illness or accident. The body will be returned to the major airport nearest the point of departure in your province/territory of residence. In the case of cremation and/or burial at the place of death, this benefit is limited to $5,000. The benefit excludes the cost of a burial coffin, urn or any funeral-related expenses, makeup, clothing, flowers, eulogy cards, church rental, etc.

Travel Assistance Services

The following services are available 24 hours per day, seven days per week through GreenShield's international medical service organization.

- Access to Pre-trip Assistance (prior to departure), including Canada Direct Calling Codes, information about vaccinations, government-issued travel advisories, and visa/document requirements for entry into country of destination;
- Multilingual assistance;
- Assistance in locating the nearest, most appropriate medical care;
- International preferred provider networks;
- Medical consultation and monitoring to review appropriateness and quality of medical care;
- Assistance in establishing contact with family, personal physician and employer as appropriate;
- Monitoring of progress during treatment and recovery and confirming when the patient is medically fit for transportation when a transfer or repatriation is necessary;
- Emergency message transmittal services;
- Translation services and referrals to local interpreters as necessary pertaining to the medical emergency;
- Verification of coverage facilitating entry and admissions into hospitals and other medical care providers;
- Special assistance regarding the co-ordination of direct claims payment;
- Co-ordination of embassy and consular services;
- Management, arrangement and co-ordination of emergency medical transportation and evacuation as necessary;
- Management, arrangement and co-ordination of repatriation of remains;
- Special assistance in making arrangements for interrupted and disrupted travel plans resulting from emergency situations to include:

  a) The return of unaccompanied travel companions

  b) Travel to the bedside of a stranded person

  c) Rearrangement of ticketing due to accident or illness and other travel-related emergencies

  d) The return of a stranded personal use motor vehicle and related personal items
- Knowledgeable legal referral assistance;
- Co-ordination of securing bail bonds and other legal instruments;

- Guidance in replacing lost or stolen travel documents including passports; and
- Courtesy assistance in securing incidental aid and other travel-related services.

How Travel Assistance Works

If you are traveling and need immediate assistance, please call GreenShield Travel Assistance. They are available 24/7:

- Toll free from within North America: **1-800-936-6226**
- Collect from outside of North America: **519-742-3556**

These numbers appear on your Victor Benefits Card.

Instructions on how to place a collect call:

1. Dial **00** for an **international** operator. If calling from a cell phone, you may want to dial 00 (519-742-3556) since the 00 alone may not work from a cell phone.
2. **Make sure to speak with a human operator. Do not use the robot-assisted option.**
3. Tell the operator you want to make a collect call.
4. Give the operator the phone number you are trying to reach. The operator will confirm that we accept the charges.

Quote the Emergency Travel Assistance Group Number and your Identification Number, found on your Victor Benefits Card, and explain your medical emergency. You must always be able to provide your Identification Number and your provincial/territorial health insurance plan number.

A multilingual Assistance Specialist will provide direction to the best available medical facility or legally qualified physician able to provide the appropriate care.

Upon admission to a hospital or when consulting a legally qualified physician or surgeon for major emergency treatment, GreenShield Travel Assistance will guarantee the provider (hospital, clinic or physician), that you have both the required provincial/territorial health insurance plan coverage and the GreenShield travel benefits as detailed above. The provider may then bill GreenShield directly for these approved services.

GreenShield Travel Assistance will follow your progress to ensure that you are receiving the best available medical treatment. GreenShield Travel Assistance also keeps in constant communication with your family physician and your family, depending on the severity of your condition.

When calling collect while travelling outside Canada and the United States, you may require a Canada Direct Calling Code. In the event that a collect call is not possible, keep your receipts for phone calls made to GreenShield Travel Assistance and submit them for reimbursement upon your return to Canada.

Travel Limitations

- Coverage becomes effective at the time you or your dependent crosses the provincial/territorial border departing from your province/territory of residence and terminates upon crossing the border returning to your province/territory of residence on the return home. If travelling by air, coverage becomes effective at the time the aircraft takes off in the province/territory of residence and terminates when the aircraft lands in the province/territory of residence on the return home.
- GreenShield Travel Assistance must be notified before obtaining emergency treatment in order for GreenShield Travel Assistance to:

  a) confirm coverage; and

  b) provide pre-approval of treatment.

  If it is medically impossible for the covered person to call prior to obtaining emergency treatment,

GreenShield Travel Assistance requires either the covered person or someone on behalf of the covered person to call GreenShield Travel assistance within 48 hours of commencement of treatment.

If GreenShield Travel Assistance is not notified before the emergency treatment was received, benefits will be limited to the lesser of the amount of only those expenses incurred within the first 48 hours of any and each treatment/incident or the plan maximum. This mean you will be responsible for all expenses thereafter.

- After your medical emergency treatment has started, GreenShield Travel Assistance must assess and pre-approve additional medical treatment. If you undergo tests as part of a medical investigation, treatment or surgery, obtain treatment or undergo surgery that is not pre-approved, your claim will not be paid. This includes invasive testing, surgery, cardiac catheterization, other cardiac procedures, transplants and MRI.
- Repatriation is mandatory when GreenShield Travel Assistance determines that the covered person should transfer to another facility or return to the home province/territory of residence for treatment, or at the end of the emergency. If you choose not to return:

  a) no benefits will be paid for any further medical treatment;

  b) no benefits will be paid for any recurrence or complications related directly or indirectly to the medical condition that caused the emergency; and

  c) for the remainder of the trip, coverage will be limited to medical conditions completely unrelated to the medical condition that caused the emergency.
- Air ambulance services will only be eligible if:

  a) they are pre-approved by GreenShield Travel Assistance;

  b) there is a medical need for you or your dependent to be confined to a stretcher or for a medical attendant to accompany you during the journey;

  c) you or your dependent are admitted directly to a hospital in your province/territory of residence;

  d) medical reports or certificates from the dispatching and receiving legally qualified physicians are submitted to GreenShield Travel Assistance; and

  e) proof of payment (including air ticket vouchers or air carrier invoices) is submitted to GreenShield Travel Assistance.
- If planning to travel in areas of political or civil unrest, or in areas where the Canadian government has issued a formal travel warning regarding non-essential travel, contact the GreenShield Travel Assistance for pre-travel advice, as they may be unable to guarantee assistance services.
- GreenShield Travel Assistance reserves the right, without notice, to suspend, curtail or limit its services in any area if any of the following occur:

  a) political or civil unrest, rebellion, riot, military uprising;

  b) labour disturbance or strike;

  c) act of God; or

  d) refusal of authorities in a foreign country to permit GreenShield Travel Assistance to provide service.

  This includes travel if, when you booked your trip (including delay of travel), or before your departure date, the Canadian government issued a formal travel warning advising Canadians to avoid either all travel or non-essential travel regarding the country, region or city or other key components of your travel arrangements (i.e., cruise ship) due to a likely or actual epidemic or pandemic.

  In this limitation, non-essential travel means anything other than a significant medical or family emergency, such as the death of a family member).

Travel Exclusions

In addition to the Extended Health Care exclusions, travel claims will not be paid for the following:

Any expenses incurred for the treatment related directly or indirectly to a pre-existing medical condition that, at the time of your departure from your province/territory of residence and the 90-day period immediately preceding your departure from your province/territory of residence:

- was not completely stable in the professional opinion of GreenShield Travel Assistance Team;
- where medical evidence suggested a reasonable expectation that treatment or hospitalization could be required while traveling; or
- a physician advised the covered person not to travel.

GreenShield Travel Assistance reserves the right to review the covered person's medical information at the time of claim. A physician's opinion that the covered person was fit to travel does not override or eliminate the requirement for the covered person to satisfy all the conditions of stable.

Any expenses submitted if the covered person or anyone acting on behalf of a covered person attempts to deceive GreenShield Travel Assistance, or makes a fraudulent, false or exaggerated statement or claim.

Any expenses incurred for any services received that:

a) were not required to treat an emergency;

b) were not recommended by a legally qualified physician or surgeon;

c) are not covered under your provincial/territorial health insurance plan; or

d) are normally covered under the out-of-Canada benefits of your provincial/territorial health insurance plan's out-of-Canada coverage (where applicable), when the provincial/territorial plan has declined payment.

Any expenses incurred for services received after GreenShield Travel Assistance determined:

- the covered person was to return to the province/territory of residence for treatment, but the covered person chose not to return to the province/territory of residence;
- the services could be reasonably delayed until the covered person returned to the province/territory of residence;
- the emergency had ended; or
- the services are for a recurrence or complication directly or indirectly related to the emergency that GreenShield Travel Assistance determined in a), b) or c) in the previous exclusion.

Any expenses incurred for services to treat a medical condition or complications of a medical condition directly or indirectly related to an epidemic or pandemic if, when the trip was booked, or before the departure date:

- An official travel advisory was issued by the Canadian government advising Canadians to avoid either all travel or all non-essential travel regarding any country, region, city, or other key components of your travel arrangements (e.g., cruise ship).
- To view the travel advisories, visit the Government of Canada Travel site.

Any expenses incurred for services to treat:

- any medical condition, including symptoms of withdrawal, arising from or in any way related to the chronic use of alcohol, drugs or other intoxicants whether prior or during the trip;
- any medical condition resulting from not following treatment as prescribed, including prescribed or over-the-counter medication.

Any expenses related to pregnancy, delivery, or complications of either, arising during the 8-week period before and after the expected date of delivery.

Any expenses incurred for a child born during the trip within the 8-week period before and after the expected date of delivery.

Any expenses incurred during any trip made for the purpose of obtaining a diagnosis, treatment, surgery, palliative care or any alternative therapy, as well as any directly or indirectly related complication.

GreenShield Travel Assistance does not assume responsibility for nor will it be liable for any medical advice given, but not limited to a physician, pharmacist or other health care provider or facility recommended by GreenShield Travel Assistance.

Inkblot EAP

Life happens. Let us help.

Your Inkblot Employee Assistance Program (EAP) can offer you help when you need it most - from everyday challenges to complex issues, and everything in-between. Your EAP provides professional, confidential support services including short and long-term counselling, programs and resources to help you and your immediate family members deal with work, health and life issues. The EAP is completely confidential within the limits of the law and no one at your workplace will know you have used the service.

Access Support Services

Anytime, anywhere, anyway! Your EAP is available 24/7, and can be accessed easily online by browser and by mobile app, or by telephone. You and your eligible dependents can receive support virtually, in person and by phone.

You and your eligible dependents will have a set of sponsored hours to use, following which you can continue seeing your practitioner by using your paramedical benefits to cover the cost of the sessions.

Included in your Inkblot EAP is:

- 6 hours of individual counselling
- 6 hours of couples counselling
- 5 hours of health coaching
- 5 hours of life coaching
- 5 hours of career coaching
- 24/7 crisis support

What can the EAP help you with?

Common issues that the EAP can help you and your family with include:

- Emotional and mental health
- Relationships and family
- Workplace concerns
- Work-life balance and stress
- Addictions
- Physical health and nutrition
- Career questions
- Child and eldercare
- Legal and financial concerns

Professional Counselling

Inkblot counselling supports the full range of personal and work-related issues brought to the EAP. Our counsellors specifically have deep experience in providing mental health counselling as well as relationship and family counselling, stress management, domestic violence, workplace issues, addictions, conflict and anger management, grief/bereavement and separation.

Virtual appointments are available within 24-72 hours and in-person appointments are available within 5-7 days. Sessions can be booked for 30, 60 or 90 minutes. Inkblot's EAP counsellor network is a diverse team of professionals, who all have minimum master's-level education and have minimum 5 years of clinical experience.

Inkblot's EAP is strongly focused on providing personalized care to you. You will be asked to complete a brief matching survey which will take into consideration your clinical needs, religion, culture, race, gender and sexual identities. From there, you will see a short-list of the most effective counsellors for you, and you will be able to read through their biographies and book directly into their calendars at a date and time that works well for you.

Once you match with the counsellor of your choice, you will have the option of a free 15-minute consultation to meet the counsellor and ask any questions. Should you decide you would like to match with another counsellor instead, you can easily unmatch and match with a new counsellor to see if they are the right fit.

Your first 6 hours of counselling are sponsored through the EAP, following which subsequent sessions may be eligible under your paramedical benefits or, be at your own expense.

Advisory Services

Advisory Services provide you with comprehensive additional supports for all aspects of your work and personal life.

Legal and Financial Consultations

Get professional financial and legal advice to empower you to make the right decisions on topics including:

- Budgeting, investing and retirement planning
- Credit management and mortgage planning and taxes
- Family conflict
- Wills and estate planning
- Criminal matters
- Consumer concerns and property law

Health Coaching

Work one on one with specialized and certified coaches including, but not limited to:

- Registered Nurses
- Registered Dieticians

- Sleep Coaches
- Lactation Consultants
- Doulas
- Ergonomists
- Fitness and Yoga Coaches
- Occupational Therapists
- Diabetes Educators
- Respiratory Therapists

Life Coaching

We all experience change in our personal lives, whether it is related to becoming a new parent, raising children or supporting elderly parents.

- Becoming a new parent and navigating childcare
- Family planning
- Eldercare support
- Relationships
- Moving homes
- Parenting kids and teens

Career Coaching

Whether you are looking to take your career to the next level, or planning for retirement, Inkblot's career coaches can support you along the way.

- Professional development
- Career transitions
- Workplace stress or conflict
- Adapting to a changing workforce

Connect with the EAP Service

Connect to people and resources that can make a difference in your life. Accessing Inkblot EAP is easy - get started by selecting Inkblot EAP in Victor Central, our Claims & Digital Wellness Centre - it's a direct link from GB Connect. Alternatively, you can call toll free 1-888-525-7587 and press 2 for Inkblot. You will be able to speak to the support team to ask any questions or assist in booking an appointment.

Your dependents can register for Inkblot EAP by following the steps below:

- Go to app.inkblottherapy.com/signup and enter the required information on screen to create an account.
- After an account is created and when logged in, go to the Preferences tab and enter the plan member's Victor identification number and dependent number.

After completing the steps above, your dependents will have access to sponsored counselling hours and services available through your Inkblot EAP.

LifeSpeak

What is LifeSpeak?

LifeSpeak is an entirely unique digital well-being education platform that gives you and your families around-the-clock access to the world's leading experts on topics ranging from Mental Health to Preventative Health to Financial Well-being to Family Issues & Relationships to Diversity, Equity and Inclusion (DEI) and Professional Skills Development.

You can access over 2,000 trainings, 24/7/365 from any computer or device, as well as through the LifeSpeak app. Access is completely confidential and includes videos, blogs, audio podcasts and expert-written tip sheets. You also have access to "Ask the Expert", a live monthly moderated web chat with subject matter experts, where you can have any of your pressing questions answered in real time.

LifeSpeak's platform is completely accessible and responsive, and it is available in English and French.

Making Experts Available to You

LifeSpeak's 300+ experts are doctors, psychologists, professors at renowned institutions, authors in short, they have impeccable credentials, extensive experience and are at the top of their fields. They are experts you can trust. Their passion and personalities shine through their videos, providing a human element to a digital experience. LifeSpeak's experts provide practical and easily implemented tips to help you make real changes in your life.

How to Access the LifeSpeak Platform

Access is available from any computer or mobile device:
URL: https://victor.lifespeak.com
Access ID: victor

You can download the LifeSpeak app for free from the Apple Store or Google Play:
Client Identifier: victor
Access ID: victor

MapleTelemedicine

Feel Better Sooner

Maple is a technology platform that tackles some of the world's most meaningful issues in health care, starting with timely and convenient access to General Practitioners and other health care providers. It allows you to connect directly with doctors for medical care in minutes from your smartphone or computer 24/7. Maple guarantees a connection with a doctor on every visit, enabling an issue resolution rate of 91% across all of their patient visits.

Your Coverage Details

Thanks to your Victor coverage, you and your eligible dependents have access to **unlimited 24-hour weekday and weekend visits (including holidays) free of charge,** with a General Practitioner. General Practitioners provide round-the-clock support to patients, with an average wait time of less than 5 minutes, regardless of where a patient is located in Canada and what time of day the request comes in.

How to Access Services

Maple is accessible via any modern browser or through the Maple mobile application (iOS and Android). To access the service, please follow these steps:

- Navigate to Victor Central at victorinsurance.ca/gbconnect and click on telemedicine
- If you are brand new to Maple, you will need to create an account and establish login credentials that you can use to log in to Maple's mobile app. If you have used Maple in the past, you can link your existing account to the refreshed telemedicine experience
- After completing the above steps, you will be directed to the Maple platform
- To see a doctor, click "Get Care" and select General Practitioner

Highly Skilled General Practitioners

Maple has over 1,000 skilled physicians providing care on the Maple platform across Canada. Each doctor goes through a comprehensive screening and onboarding process to ensure top quality physicians and care interactions.

What Can Maple General Practitioners Help You With?

Maple can help prevent the need to go to a walk-in clinic or the hospital's emergency room. Maple doctors are safely and accurately able to diagnose and address the majority of common illnesses and medical issues including, but not limited to, the following:

- Abrasions
- Allergies
- Bacterial vaginosis
- Bites and stings
- Dehydration
- Body aches
- Bronchitis
- Bruises
- Cough
- Nasal congestion

- Diarrhea
- Earache
- Fever
- Flu
- Frostbite
- Headaches and migraines
- Hives
- Insomnia
- Itchy eyes
- Lice
- Mild lacerations
- Mental health
- Nausea
- Pinkeye
- Respiratory infections
- Sexually transmitted infections
- Sinus infections
- Skin infections
- Sore throats
- Sprains and strains
- Urinary tract infections
- Vomiting
- Yeast infections

Multiple Options for Consulting with Health Care Providers

You have the option to choose whichever communication medium is most convenient and comfortable for you. Options include secure instant messaging, video chat and phone.

Prescriptions, Renewals and Free Delivery

If you are issued a digital prescription during your consultation, you have the option to send it directly to a local pharmacy for pickup, or have it delivered anywhere in Canada through The Health Depot (Medzy in Quebec), free of charge. For pickup, the prescription is sent directly to your pharmacy via electronic fax. Each prescription has the physician's electronic signature along with the physician's practicing address and contact details.

Lab & Imaging Requisitions

If you are issued a lab or imaging requisition during your consultation, you can download and print the completed form and take it to any lab or imaging centre in the province. You will be notified via email when your results are ready, and they will be uploaded to your Maple virtual care record. You will also be notified if a follow-up with a doctor is required to review the results. For this follow-up, you can request another visit with a Maple doctor or make an appointment with a doctor in the community.

Fully Bilingual Service

Maple's in-app experience, communications, onboarding and physician consultations are all available in both English and French. You can easily switch your language preference in the account setting tab.

Robust Virtual Medical Record

On Maple, you will have a personal virtual health record. This is owned by you, is securely stored on the platform and is accessible at any time. The virtual health record captures data from each of your interactions with providers on Maple. At the click of a button, consultation summaries can be shared with an in-person care provider, such as your family doctor. You can also add to your virtual record by uploading previous medical data, outlining pre-existing conditions, surgeries, immunization records, medication lists, etc.

Privacy by Design

In order to maintain medical records, great care has been taken to ensure that how Maple collects, stores, shares and discloses personal health information is Canadian privacy legislation compliant. All your records are encrypted, and only visible to the treating physician and yourself. You are able to `hide' records from certain interactions on the platform if you do not want this visible to other doctors you visit on Maple. All sharing of your health records with other providers or programs is only performed at your direction and with your express consent.

Access to Maple While Travelling

While Maple does not replace travel insurance coverage, you can use Maple when travelling internationally, and speak with Canadian doctors anywhere in the world for medical advice, 24/7. This can help provide you with peace of mind while travelling to the United States and beyond.

Other Health Care Providers

During the virtual consultation, your General Practitioner may deem it necessary for you to speak with a specialist. In this case, the General Practitioner will provide a specialist referral to the public system. There is no additional cost for this referral. You may choose to speak with a specialty doctor and health care provider directly through Maple. These providers are available to you for an additional charge.

Connect With Customer Support

If you have any issues or questions, you can speak to a Maple representative by clicking the chat icon on the bottom corner of the Maple mobile app or website app or by sending an email to support@getmaple.ca. Maple has a dedicated team to provide full-service customer support from 7 a.m. to 10 p.m. each day (Eastern Standard Time).

Medical Second Opinion

Your WorldCare Medical Second Opinion service provides independent medical second opinions for critical illnesses from the top-ranked academic and research hospitals in the United States through The WorldCare Consortium. You and your physician have immediate access to highly experienced specialist teams with leading edge medical expertise from world-renowned research and academic hospitals. The medical second opinion will provide confirmation or modification of your original diagnosis and treatment recommendations, including alternative treatments and/or therapies.

This service is available to you and your family provided you are covered for Extended Health Care benefits. You are eligible to receive two medical second opinions per family per year, up to a lifetime maximum of six. Health care coverage must be in force at the time the medical second opinion is requested. No pre-existing condition limitation applies.

WorldCare International, Inc.

Founded in Boston, Massachusetts in 1992, WorldCare is a pioneer and leader in providing global e-health consultative services and solutions. Committed to medical excellence, WorldCare has partnered with some of the top academic medical centres in the United States which comprise The WorldCare Consortium. This enables unique access to over 20,000 specialists and sub-specialists for expert second medical opinions. Best of all, WorldCare manages the entire process remotely via phone or secure email. You do not need to travel or schedule additional appointments.

WorldCare strives to support local physician-patient relationships and medical institutions by bringing them access to these multi-disciplinary teams of acclaimed specialists and subspecialists at The WorldCare Consortium medical centres, which have access to over $4 billion in annual research funding on critical illnesses. Every WorldCare medical second opinion case is handled by the most appropriate team within one of the Consortium partners.

The WorldCare Consortium includes the following top-ranked medical institutions in the United States:

- Boston Children's Hospital
- Children's Mercy Kansas City
- Jefferson University Hospitals
- Mayo Clinic
- Northwestern Medicine
- Partners HealthCare, which includes:
    - Brigham and Women's Hospital
    - Dana-Farber Cancer Institute
    - Massachusetts General Hospital
    - McLean Hosptial
    - Spaulding Rehabilitation Hospital
- UCLA Health

Covered Conditions

You are entitled to receive medical second opinions for the following critical illnesses or conditions:

Neurological

- Neuro-degenerative disorders
  - Alzheimer's disease
  - Multiple Sclerosis
  - Parkinson's disease
  - Amyotrophic neuron disease
  - Motor neuron disease
- Vascular disorders
  - Intracranial aneurysm
  - Vascular malformation: brain/spinal cord
  - Brain/spinal cord embolism
  - Disabling cerebral vascular accident
- Cancer
  - Brain and spinal cord tumors
  - Brain and spinal cord metastases
- Trauma
  - Traumatic brain and spinal cord injuries
- Infection
  - Brain and spinal cord abscess
- Paralysis caused by any of the above

Cardiovascular conditions

- Cardiac infarction
- Aneurysm of great vessels
- Vasculitis, myocarditis
- Cardiac tumors
- Cardiac failure
- Cardiac myopathy
- Pericarditis, Cardiac tamponade
- Cardiac valve disease
- Cardiac arrhythmias

Gastrointestinal tract

- Cancer: primary or metastatic
  - Esophagus
  - Stomach, small and large intestine, rectum
  - Liver, spleen, pancreas, gall bladder
  - Peritoneum
- Infection
  - Pancreatitis
  - Peritoneal infections

Genitourinary tract

- Cancer
  - Kidney
  - Ureter and urinary bladder
  - Prostate
- Renal failure
- Complicated renal transplant

Respiratory tract

- Cancer
  - Lung, trachea
  - Thymoma
- Respiratory failure
- Pulmonary embolism
- Chronic obstructive airways disease/emphysema
- Traumatic injuries to the lung/pneumothorax
- Cystic fibrosis
- Heart/lung transplant

Musculoskeletal disorders

- Cancer
  - Bone tumors: primary/metastatic
  - Tumors of the muscles
- Infections
  - Bone and joint infections
  - Myositis
- Trauma
  - Complicated fractures: pelvis, hips, ribs
  - Amputation
- Muscular dystrophy

Hematology

- Complications of Sickle cell disease and Thalassemia
- Leukemia
- Multiple myeloma
- Lymphoma
- Severe anemia

Obstetrics and gynecology

- Cancer
  - Ovary
  - Uterus/fallopian tube

Otolaryngology

- Cancer
  - Tumor of the paranasal sinuses/salivary glands
  - Tumor of the pharynx/larynx
  - Tumor of the vocal cords
  - Tumor of the tongue and buccal cavity
- Sudden onset deafness
- Traumatic facial injuries

Breast

- Cancer
- Abscess

Skin/Dermatology

- Melanoma
- Complications from major burns

Endocrinology

- Cancer
  - Thyroid
  - Pancreas
  - Pituitary gland
- Hashimoto thyroiditis
- Disabling diabetic complications

HIV infection/AIDS

Ophthalmology

- Sudden onset blindness
- Retinal detachment

Congenital disabling disorders

Mental Health

- Bipolar disorder
- Generalized anxiety disorders
- Major depression
- PTSD - Post traumatic stress disorders

Exclusions

Conditions resulting from the following are excluded from coverage:

- attempted suicide, self-inflicted injuries or injuries caused by a third person with the patient's knowledge;
- alcohol or drug abuse;
- radioactive contamination;
- war or warlike operations (whether war is declared or not), riot, civil commotion, revolution, insurrections, conspiracy, or any events or causes which determine the proclamation or maintenance of martial law or state of siege;
- natural disasters such as fire, flood, earthquake, tornado, hurricane and other Acts of God; or
- poisoning or poisonous gas inhalation.

Access the WorldCare Medical Second Opinion Service

A simple three-step process is in place:

- You contact WorldCare online, by phone, email, fax or mail to request a medical second opinion.
- WorldCare works with you and your physician to gather your medical records and determines the medical institution(s) best suited to address your medical condition.
- The designated physician team reviews your records and provides an independent medical second opinion to you and your doctor. If necessary, WorldCare can co-ordinate a call between your physician and the lead physician on the team that supplied the medical second opinion to discuss outstanding questions on your case.

There is an average turnaround time of five working days once the complete medical information is received and pathology, if any, is reviewed, while emergency cases can be completed within hours.

The WorldCare MSO Report

When a medical second opinion is provided, you and your physician will receive a comprehensive, multi-disciplinary report, known as the WorldCare MSO Report. It is provided electronically and includes:

- The medical second opinion report, including confirmation of your diagnosis and treatment plan recommendations;
- Background information on the physician(s) and medical institution(s) rendering the medical second opinion;
- Educational material about your illness;
- Local and online support services;
- The original medical records upon which the medical second opinion was based.

WorldCare has rigorous procedures in place to ensure quality and to safeguard privacy. Electronic transfer of records is done using FDA-cleared compression and encryption technology and handling of all information is consistent with HIPAA guidelines and the Canadian Personal Information Protection and Electronic Documents Act (PIPEDA).

Medical records and opinions are permanently stored in WorldCare's secure database to facilitate follow-up or future second opinions.

Right of Refusal

The WorldCare Consortium physicians make every effort to provide a medical second opinion based upon the information provided. In certain cases, the medical information submitted may not be sufficient, or of adequate quality, to render a medical second opinion (e.g. if the quality of the submitted imaging is substandard for interpretation and you do not provide optimal imaging, the radiologist will maintain the right to refuse delivery of a diagnostic report). In such cases, WorldCare will inform you of the reasons for the inability to deliver a report within 24 hours. You will have the opportunity to deliver additional or alternative material to WorldCare.

How to Obtain a WorldCare Medical Second Opinion

If you would like to request a WorldCare Medical Second Opinion for one of the covered conditions, your first step is to contact WorldCare. Submit an online request, call toll free or send your request via email to:

WorldCare

Toll Free: 1-877-676-6439
Email: MemberCare@worldcare.com
Online form: www.worldcare.com/contact

Consult the WorldCare Second Medical Opinion Service Guide for complete details about the process. Log in at www.victorinsurance.ca/gbconnect to download the guide (located under My Benefits), or contact your plan administrator.

Dental Care

Employee and Dependent Coverage

As the wording of this dental coverage is technically oriented, you may wish to take this booklet with you when you visit your dentist.

In the event you incur in a calendar year any of the eligible expenses listed below, and also listed in the Schedule of Benefits, you will be paid a percentage (coinsurance) of such expenses in excess of the deductible for that year provided benefits are received in Canada. The percentage (coinsurance) and deductible are specified in the Schedule of Benefits.

Maximum Benefit

The total benefits payable are subject to the maximums specified in the Schedule of Benefits.

Extension of Benefits

No benefits for Eligible Expenses will be paid for claims incurred after the termination of the group benefits program or after your benefits under this coverage ceases.

Alternate Benefits and Submission of Treatment Plan

Where there exists more than one customarily employed and professionally adequate method of treating injury or disease to the teeth, GreenShield reserves the right to determine eligible expenses on the basis of an alternate benefit.

As a service to you, GreenShield will advise you in advance of the amount of its liability when a proposed course of treatment is expected to exceed $500. To use this service, simply have your dentist submit a treatment plan, including pre-treatment x-rays if the proposed treatment involves crowns, bridgework or implants.

Eligible Expenses

Charges for the following supplies and services are considered Eligible Expenses if they do not exceed the reasonable and customary charges in accordance with the Fee Guide and the maximum shown in the Schedule of Benefits.

Eligible Expenses - Basic Services

Basic Restorative Dentistry

The basic procedures used to restore the natural teeth to their normal functions by the use of silver amalgam, silicate, synthetic or inlay restorations (fillings), including white fillings on molar teeth. In addition, sedative dressings are covered.

Oral Surgery
Routine oral surgical procedures as follows: surgical removal of impacted teeth, residual roots and associated post-operative care.

Anaesthesia
General anaesthesia, deep sedation and intravenous sedation where reasonably and customarily required in conjunction with extractions or eligible oral surgery.

Diagnostics
Procedures required to assist the dentist in evaluating existing conditions and determining any further dental care which may be required subject to the following limitations:

- oral examinations: standard oral examinations as shown in the Schedule of Benefits;
- x-rays: single diagnostic x-rays; complete series or equivalent once every two years;
- study casts: once per year;
- consultations.

Preventive Therapy
Procedures intended to eliminate or reduce the need for future dental treatment subject to the following limitations:

- preventive visits for scaling (where one unit of time = 15 minutes): limited to one unit of time every six consecutive months;
- polishing: limited to one unit of time every six consecutive months;
- topical fluoride: once every six consecutive months.

Extractions
Removal of teeth.

Endodontics
Endodontic procedures including root canal therapy.

Periodontics
- Adjunctive Services as follows: Periodontal scaling, Root planing (up to 10 time units per calendar year), Acute infections, Occlusal Adjustment, Provisional splinting;
- Surgical Services as follows: gingival curettage, gingivoplasty, gingivectomy or osseous surgery;
- Special Periodontal Appliances.

Basic Restorative Dentistry
The basic procedures used to restore the natural teeth to their normal functions by the use of silver amalgam, silicate, synthetic or inlay restorations (fillings), including white fillings on molar teeth. In addition, sedative dressings are covered.

Oral Surgery
Routine oral surgical procedures as follows: surgical removal of impacted teeth, residual roots and associated post-operative care.

Anaesthesia
General anaesthesia, deep sedation and intravenous sedation where reasonably and customarily required in conjunction with extractions or eligible oral surgery.

Repairs, Relining and Rebasing of Dentures
Repair or relining and rebasing of dentures, including addition of new teeth, but not including the cost of dentures, their replacement or duplication.

Eligible Expenses - Major Restorative Services

Dentures
The initial installation of dentures and replacement of existing dentures is covered if:

- It is required because of extraction or loss of one or more teeth after the individual became covered under this plan; or
- The existing dentures are at least five years old and no longer serviceable.

Replacement of lost or stolen dentures, the duplication of dentures and personalization or characterization of dentures is not covered.

Extensive Restorative Dentistry
Those procedures, including onlays and crowns, used to restore the natural teeth to their normal functions where the tooth, as a result of extensive caries or fracture, cannot be restored with a filling. When a tooth can be restored with amalgam or composite restorations, benefits will be determined based on the usual costs of such a restoration. Existing onlays and crowns must be at least five years old and no longer serviceable.

Bridgework
Recementing and replacement of the facing or veneer of the bridge.

The initial installation of bridgework and replacement of existing bridgework is only covered if:

- It is required because of extraction or loss of one or more teeth after the individual became covered under this plan, or
- The existing bridge is at least five years old and no longer serviceable.

Implant Treatment
Implantology including tooth implantation and surgical insertion of fabricated implants, limited to one attempt per tooth (frequency once per lifetime).

Eligible Expenses - Orthodontics

The diagnosis or correction of teeth irregularities and malocclusion of jaws, by wire appliances, braces or other mechanical aids, commonly known as "straightening of the teeth", and monitored on an ongoing basis by an eligible provider. These include active space retainers or orthodontic appliances, for the purpose of repositioning or moving of the teeth.

When a lump sum fee has been paid toward orthodontic treatment, the total amount of the claim will be split into separate portions to allow for payment of an initial fee (approximately one-third of the total lump sum). The balance of the claim will be divided into monthly fees of equal amounts to be reimbursed over the duration of the treatment. Receipts for payment must be received by GreenShield no later than 180 days following the end of the calendar year in which the expense was incurred while treatment is in progress, not at the end of the treatment.

If orthodontic treatment is terminated for any reason before completion, the obligation to pay benefits will cease with payment to the date of termination. If such services are resumed, benefit for the remaining services, will be resumed. The benefit payment for orthodontic services will be only for the months that coverage is in force.

Exclusions and Limitations

For dentures, bridges and implants:

- payments will not be made for any dental procedure in respect of teeth extracted or missing before the employee or dependent became covered for that procedure except for appliance replacement as specifically stated under Eligible Expenses.
- no benefit will be payable for the initial installation (or addition) of prosthetic devices unless such installation (or addition) is required primarily due to teeth that were missing or extracted after becoming covered under this plan for prosthetic devices.

Payments for crowns on implants will be limited to once every 10 years. Payments will not be made for implants on the second molar or wisdom teeth.

No benefit is payable for the following:

- services or supplies that are primarily for cosmetic dentistry;
- charges which were considered an insured service of any provincial government plan at the time this plan/benefit was issued and subsequently were modified, suspended or discontinued;
- services or supplies which are not furnished by a legally qualified dentist or denturist acting within the scope of his license;
- any charge for an injury resulting directly or indirectly from attempting to commit or committing a criminal act or illegal act, war or act of war (whether declared or undeclared, insurrection or riot, or hostilities of any kind;
- any miscellaneous charges such as counselling or instruction, travel, broken appointments, communication costs or completion or translation of forms;
- any services covered in whole or in part by any government plan, services for which no charge is made, or services which GreenShield is not permitted by law to cover;
- any charge for services which would not normally have been incurred, but for the presence of this coverage, or for which you are not required to pay;
- any hospital charges for board and room and related services and supplies;
- any dental examinations required by a third party;

- services or supplies which are not medically necessary to the care and treatment of any existing or suspected injury, or disease;
- diagnostic procedures in connection with any benefit categories excluded as eligible expenses;
- any treatment, drug, service, or supply received outside of Canada on a non-emergency basis; or
- any specific treatment or drug which:
    - does not meet expected standards of medical, dental or ophthalmic practice, including charges for services or supplies which are experimental in nature;
    - is not considered to be effective (either medically or from a cost perspectives) as determined by GreenShield's drug review process regardless if Health Canada has approved the drug;
    - is an adjunctive drug prescribed in connection with any treatment or drug that is not an eligible service;
    - is administered in a hospital or is required to be administered in a hospital in accordance with Health Canada's approved indication for use;
    - is not dispensed by the pharmacist in accordance with the payment method shown under the Prescription Drugs benefit;
    - is not being used and/or administered in accordance with Health Canada's approved indication for use, even though such drug or procedure may customarily be used in the treatment of other illnesses or injuries (i.e., off label use).

Benefit Continuance for Surviving Dependents

Dental Care coverage for dependents shall continue at no charge following your death for up to a maximum of 24 months from the date of death or to the date the policy or benefit terminates, whichever is earlier.

Wellness Spending Account

Your Wellness Spending Account is a spending account funded by your employer that you can use to pay for a range of personal wellness related expenses not covered by your group benefit plan or provincial health plan. Expenses claimed are subject to income tax as outlined by the Canada Revenue Agency.

At the beginning of each calendar year, a predetermined lump sum amount as shown in the Schedule of Benefits will be allocated to your account to cover the reimbursement of your eligible expenses incurred during that year. When you submit a claim, you will be reimbursed for eligible benefits up to the balance in your account. Any balance remaining in your account on the last day of the benefit year will be forfeited at the expiration of the year in which it was allocated.

Eligible Expenses

The following items are covered through your Wellness Spending Account. These items are a taxable benefit so all expense submitted for payment will be shown on your T4A slip. Items not included on this list are not eligible. For clarification or additional details, you should contact the Green Shield Canada Customer Service Centre at 1-888-711-1119.

Eligible expenses include:
Co-ordination with Existing Benefits

- Drugs
- Accommodation (Hospital, Long-term Care, Respite) Fees
- Medical Services and Supplies
- Vison Care
- Paramedical Services
- Dental Care

Fitness/Sports Fees

- Recreational Programs, Classes, Team Registration Fees
- Personal Training, Consultation
- Club, Resort, Park Annual Memberships
- Recreational, Individual Event Pass, Registration or Fee
- Gym, Fitness Centre, Pool, Annual Memberships

Fitness Equipment

- Fitness Equipment
- Sports Equipment
- Bicycle (Manual)
- Heart Rate Monitor
- Athletic Sportswear and Accessories
- Wii Fit or Xbox Kinect, PlayStation Fitness (entertainment system not included)
- Fishing Equipment

Family Care

- Childcare
- Eldercare
- Home Care Assistance Services and Products (lifts, supportive aids)
- Caregiver Support Programs and Services

Educational and Personal Development

- Hobby and General Interest Classes
- Education Fees, Tuition, Books
- Training, Classes, Tutoring, Language, First Aid, CPR
- Professional Designation and Membership Fees and/or Dues
- Personal Computer and/or Accessories
- Music Equipment

Wellness Services

- Smoking Cessation Programs
- Safety Equipment
- Health Assessments
- Weight Loss Programs, Counselling (food not included)
- Nutritional Counselling
- Vitamins, Supplements, Natural Products
- Maternity Services (Pre-natal Classes, Mid-wife Services)
- Stress Management Services
- Medical Tests
- Alternative Health Practitioners (Reflexologist, Iridologist, Herbalist, Homeopath, Chinese Medicine, Shiatsu Therapist)
- Holistic Health Services

Non-Health Professional Services

- Legal Services
- Financial Services

Insurance Premiums

- Individual Health and Dental Plans
- Individual Life and Disability Plans
- Individual Travel Plans
- Individual Critical Illness Plans
- Individual Long Term Care Plans

General Provisions

When Your Benefits Start

Your benefits will begin on the latest of the following dates if you are actively at work on that date:

- the date you become eligible;
- the date you apply; or
- if Evidence of Insurability is required, the date it is approved.

If you contribute to the cost of the benefits, an enrollment form must be completed within 31 days of your eligibility date. Otherwise, evidence of health satisfactory to the benefits provider must be submitted and approved before you will be eligible for benefits.

If you are not actively at work on the date your benefits would normally be effective or change, then the date on which commencement or change will take place will be the first day on which you are again actively at work.

Commencement of Dependent Coverage

Coverage for your dependent(s) commences on the date you become eligible. Health evidence is not required provided application is made within 31 days after the date of eligibility.

If you are initially enrolled for single coverage and later acquire a dependent, you must apply for dependent coverage. Coverage will be effective from the date of application provided the request is made within 31 days of acquiring dependents. If application is made after 31 days, evidence of good health will be required for each dependent.

When dependent coverage is in effect, notification of a new dependent is still required or claims service will be affected.

Evidence of Insurability

Evidence of Insurability is required if:

- you apply for benefits coverage more than 31 days after becoming eligible to apply;
- the amount of insurance you are eligible for exceeds or increases beyond the Non-Evidence Maximum;
- you reapply after your benefits have terminated due to non-payment of monthly charges.

When Your Benefits Terminate

Your benefits terminate on the earliest of the following:

- non-payment of monthly charges;
- a change in your classification to one not covered;
- termination of your coverage;

- termination or amendment of the Policy;
- your commencing active duty in any armed forces;
- the date outlined in the Schedule of Benefits.

Coverage for your dependents terminate on the earliest of the following:

- termination of your coverage;
- the date your dependent is no longer an eligible dependent;
- the date your dependent attains the specified age limit;
- non-payment of monthly charges;
- termination or amendment of the Policy.

Note: In the event you are absent from work due to sickness, injury, layoff or leave of absence, your group benefits may continue if the required monthly charges are paid. Continued coverage may be subject to pre-approval.

Eligible Dependents

The following are considered eligible dependents:

- Your spouse as the result of a valid civil or religious ceremony, or a person with whom you have cohabited for a minimum of 6 consecutive months and who has been publicly represented as your spouse.

  Note: You may only cover one spouse for coverage at any given time and you must cover the same person for all spousal benefits provided under this plan. Divorced or separated spouses (with a court order or separation agreement) are eligible for coverage.
- Unmarried children who are under age 22, or under age 25 (age 26 for health and dental benefits for Quebec residents) if attending an accredited school, college, or university as a full-time student. Dependent children must be dependent on you for support and not employed at a regular full-time job.
- Functionally impaired children who are totally dependent upon you for support. For the purposes of this plan, functionally impaired shall mean an unmarried person who was registered as your dependent prior to becoming functionally impaired who is wholly dependent upon you for support and maintenance within the terms of the Income Tax Act.

  Note: Functionally impaired dependents are not eligible for Critical Illness benefits beyond 24 years of age.
- A child of your spouse provided:

  a) he/she is also your biological child; or

  b) your spouse is living with you and has custody of the child.

Change in Amounts of Coverage

Changes in your coverage levels shall become effective on the date of change, if you are actively at work for that full scheduled working day, otherwise on the first day thereafter on which you are actively at work.

Naming a Beneficiary

This Plan contains a provision removing or restricting the right of the group life insured to designate persons to whom or for whose benefit insurance money is to be payable.

The insurers do not accept beneficiary designations for any benefits other than Employee Life Insurance and Accidental Death & Dismemberment.

You have the right to designate and/or change a beneficiary, subject to governing law. The necessary forms are available online at victorinsurance.ca/gbconnect or from your plan administrator.

You should review your beneficiary designation to be sure that it reflects your current intent.

Change in Government-sponsored Programs

The medical, dental and hospital benefits under this group benefits plan are provided in conjunction with government-sponsored provincial programs. In the event coverage under any provincial program is modified, suspended or discontinued, the group benefits plan will not automatically assume responsibility for any services or products previously covered under the provincial programs.

MIB, Inc., formerly known as Medical Information Bureau

MIB, Inc. is a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members.

The insurers or their reinsurers may periodically report information to MIB, Inc. If you apply to receive life or health insurance coverage from another MIB member company or submit a claim for benefits to such a company, the MIB upon request will supply the other insurer with the information on file.

The insurers or their reinsurers may also release information in its file to other life and health insurance companies to whom you may apply for insurance or submit a claim for benefits. All information obtained will be treated as confidential.

Upon your request, the MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the MIB's file, you may contact the MIB and seek a correction. Their address is:

MIB, Inc.
330 University Avenue, Suite 501, Toronto, Ontario M5G 1R7
www.mib.com

Co-ordination of Benefits

Payment of Extended Health Care, Emergency Travel Assistance and Dental Care benefits shall be co-ordinated so that benefits from all plans do not exceed 100% of the eligible claim. For this purpose, GreenShield has a right to receive and release information on benefits and if necessary, collect any overpayments made by it.

Time Limitations

A claim for Life Insurance benefits must be submitted within six months of the date of death.

A claim for Long Term Disability benefits must be submitted within six months of the end of the Elimination Period.

A claim for Weekly Indemnity benefits must be submitted within six months from the date of disability.

A claim for Waiver of Premium benefits must be submitted within 12 months of the date of disability.

A claim for Accidental Death & Dismemberment must be submitted within 90 days of the accident as is reasonably possible, but in no event later than 12 months following the date of the accident.

A claim for Critical Illness, either a Covered Condition benefit or an AdvanceCare Benefit Condition, must be submitted within 90 days of the date of diagnosis.

Health and dental claims must be received within 180 days following the end of the calendar year in which the expense was incurred.

Wellness Spending Account claims must be received within 180 days following the end of the calendar year in which the expense was incurred.

However, in the event of termination of benefits, all claims must be received within 90 days following the date of termination of your benefits or the date following termination of a coverage or the policy.

Submitting Claims

How to Submit a Claim

If you have Extended Health, Emergency Travel Assistance and/or Dental benefits, you will receive a Victor Benefits Card. Please refer to your Coverage Summary on our plan member portal, Group Benefits Connect, to confirm your benefit coverage.

GreenShield reserves the right to request supplementary claims information. Failure to respond to such requests may result in the denial of the claim.

The intentional omission, misrepresentation or falsification of information relating to any claim constitutes fraud. Submission of a fraudulent claim is a criminal offence and will be reported by GreenShield to the applicable law enforcement and/or regulatory agencies and to Victor Insurance Managers Inc., who will report the fraudulent claim activity to your employer. This could result in the termination of your coverage under this benefit plan.

Prescription Drug Claims

Pay Direct Plan - Show your Benefits Card to your pharmacist, who will submit claims directly to GreenShield. You will only pay the amount not covered by your plan.

Reimbursement Plan - Show your Benefits Card to your pharmacist, who will submit claims electronically to GreenShield. You will pay the full amount at the time of sale and eligible expenses will be reimbursed.

Prescription drug claim questions should be directed to GreenShield at 1-888-711-1119.

Other Medical Claims

The Benefits Card can also be used for other types of claims, such as vision and paramedical claims. Service providers will require the name of the carrier and your Identification Number. Show your service provider your Benefits Card in case the claim may be submitted electronically.

Medical claim questions should be directed to GreenShield at 1-888-711-1119.

Emergency Travel Assistance Claims

The Emergency Travel Assistance policy and phone numbers are listed on your Benefits Card. If you require emergency medical assistance while travelling, you should contact GreenShield Travel Assistance immediately. This multilingual call centre, which operates 24 hours a day, 365 days a year, will ensure you get the care you need without incurring unnecessary expenses.

- Toll free from within North America: **1-800-936-6226**
- Collect from outside of North America: **519-742-3556**

Instructions on how to place a collect call:

1. Dial **00** for an **international** operator. If calling from a cell phone, you may want to dial 00 (519-742-3556) since the 00 alone may not work from a cell phone.
2. **Make sure to speak with a human operator. Do not use the robot-assisted option.**
3. Tell the operator you want to make a collect call.
4. Give the operator the phone number you are trying to reach. The operator will confirm that we accept the charges.

If you pay out-of-pocket for any medical expenses, keep the receipts and make sure you tell GreenShield Travel Assistance about all the travel coverage you have when submitting claims. Your provincial health plan and GreenShield will reimburse you for those approved eligible expenses from all sources (e.g., provincial plans that provide out-of-Canada coverage, a spousal plan, travel coverage provided through your credit card, etc.) upon your return.

You are encouraged to contact GreenShield Travel Assistance at the numbers listed above before you submit your claim. However, claim forms are available at www.canassistance.com/en/greenshield.

Wellness Spending Account (WSA) Claims

Claims can be submitted directly to GreenShield for adjudication.

Only expenses incurred prior to the date of termination of employment, retirement, death, or leave of absence greater than 30 days (other than Maternity, Adoption or Parental Leave) will be eligible for reimbursement.

WSA claim questions should be directed to GreenShield at 1-888-711-1119.

Dental Claims

Your dental services provider can submit both pre-determination requests and dental claims electronically. Show your card to your provider, who will submit the request or claim electronically. You will only pay the amount not covered by your plan.

Dental claim questions should be directed to GreenShield at 1-888-711-1119.

Other Claims

For Life, Long Term Disability, Weekly Indemnity, AD&D and/or Critical Illness insurance questions, please contact your Plan Administrator for details.

Overpayments

Your benefits providers reserve the right to recover all amounts resulting from overpaid or unsupported claims for benefits by deducting such amounts from future claims and/or by any other legal means.

Time Limit on Legal Action

If an appealed claim is subsequently denied, then you may not commence legal action against the benefits provider less than 60 days after the proof has been filed as outlined under Submitting Claims. Every action or proceeding against the benefits provider for the recovery of money payable under the plan is absolutely barred unless commenced within the time set out in the:

Insurance Act (AB, BC, MB, NS, NT, NU, PE and YT)
Limitations Act, 2002 (ON)
Limitations Act (NL and SK)
Limitations of Actions Act (NB)
Civil Code of Quebec (QC)

Definitions

Actively at Work
An employee shall be considered actively at work for the purposes of benefits coverage if on the date in question the employee reports for work at the usual place of employment with the employer, which is outside of the employee's home, and is able to perform all of the usual and customary duties of his/her occupation on a regular full-time basis. If an employee does not customarily so report, or if the usual place of employment with the employer is not outside the home, an employee shall be considered actively at work if at any time on the date in question the employee is neither (i) hospital confined, nor (ii) disabled to a degree that the employee could not have then reported to a place of employment outside the home and performed all the usual and customary duties of his/her occupation on a regular and full-time basis.

An employee who is not disabled is also deemed to be actively at work if his/her absence is due only to a period of leave or a non-working day.

Beneficiary
The beneficiary is a person designated by the insured to receive the benefit proceeds when the insured dies.

Biologic Drug
A drug that is produced using living cells or microorganisms (i.e., bacteria) and are often manufactured using a specific process known as DNA technology.

Biosimilar Drug
A biologic drug demonstrated to be similar to a reference biologic drug already authorized for sale by Health Canada.

Claim
A claim is a notification to the benefits provider that details a covered person's loss and request for payment of benefits under the policy.

Class
A class is a group of employees as defined in your Group Insurance Application (e.g., "salaried employees" or "Alberta staff").

Client Number
Your organization has been assigned an eight-digit Client Number, which is your Victor file number. The Client Number is not used by other companies or individuals, or in the claims process.

Coinsurance
Coinsurance percentage is the amount that an employee will be reimbursed for a claimed eligible expense, in excess of any applicable deductible.

Covered Person
Means a plan member and any eligible dependents.

Deductible
The portion of eligible expenses that you must pay before a benefits provider will pay any claim. The deductible may be a per claim or annual amount.

Earnings
Earnings are defined as follows:

For self-employed, partners, sole proprietors or contract workers, eligible earnings are based on the average of the person's net self-employment income or net partnership income as reported for federal tax purposes in the last two calendar years.

For an owner of an incorporated company, eligible earnings are based on the average of the owner's earnings including salary, bonuses, overtime, commissions and dividends received from their incorporated company as reported for federal tax purposes in the last two calendar years, less taxable benefits included in the earnings.

For salaried employees, eligible earnings are based on the employee's earnings including salary, regular bonuses, regular overtime, profit sharing plans and shift differentials. Earnings do not include sporadic bonus, sporadic overtime, incentive pay and automobile allowances.

For commission salespersons, eligible earnings are based on the average of the person's earnings including salary, commissions and bonuses as reported for federal tax purposes in the last two calendar years, less taxable benefits included in earnings. If employed less than two calendar years, earnings will be averaged over the length of service with the employer.

If there is a difference between the actual annual earnings and those reported by the employer for premium purposes, the lesser of the two amounts will be considered the annual earnings amount under this policy.

Elimination Period
With respect to disability insurance, the Elimination Period is the period of time that must elapse after the onset of illness or disability before the insured person is eligible for benefits.

Emergency
Means a sudden, unexpected occurrence (disease or injury) that requires immediate medical attention.

Essential Duties
The physical and cognitive functions or tasks, recognized by the benefit provider to be, fundamental to the occupation and are performed at a regular frequency and duration or are infrequent, seldom or rare, but if not performed, would not fulfill the requirements of the occupation.

These functions or tasks, if omitted, modified or changed, would leave the requirements of the occupation unfulfilled.

Evidence of Insurability
Evidence of insurability is any statement or proof of a person's physical condition, medical history, occupation, leisure activities or other factors which may affect his/her acceptance for benefits coverage. This evidence is usually requested to supplement information provided on an application form and is required so that the benefits provider can accurately assess the risk for coverage.

Late Applicant
An enrollment or a change in coverage request is considered to be late if it is submitted more than 31 days after the employee's eligibility date for coverage or more than 31 days after the occurrence that prompted the change in coverage. Late applicants are required to submit evidence of insurability in order to obtain group benefits coverage.

Leave of Absence
This means a period of time away from work mutually agreed to by you and your employer. In the case of maternity leave of absence, the leave shall begin and finish on dates agreed to by you and your employer or as required by Provincial or Federal Law.

Misrepresentation
A misstatement, falsehood or omission which may influence a benefits provider's approval or rejection of the risk (i.e., the person to be covered). Misrepresentation is grounds for employee coverage and/or policy termination.

Medical Underwriting
The process of assessing whether a person can be covered based on his/her medical history. The benefits provider will review the medical history of the applicant and, based on the health of the applicant, determine if coverage can be made available.

The process of being medically underwritten can take anywhere from four to eight weeks, depending on the amount of coverage requested, the type of additional medical information required and how quickly the medical information is provided.

Non-Evidence Maximum (NEM)
A non-evidence maximum is the maximum amount of coverage an employee can receive without providing evidence of insurability. Non-evidence maximums will usually apply to life and disability benefits. This is sometimes referred to as a non-evidence limit or NEL.

Non-Smoker
A person who has totally abstained from smoking all tobacco products and cannabis for a one year period immediately preceding the date of his/her application for Non-Smoker Status.

Non-Taxable Benefits
When an employee pays for full premium cost of Weekly Indemnity and/or Long Term Disability benefits, benefits that are received are not taxable.

Off-Label Use
The use of a drug for a purpose or to treat a condition other than what Health Canada has approved that drug to be used.

Overage Children
These are children of covered employees who are older than the usual maximum age for benefit coverage but may qualify for continued coverage because they are full-time students or because they are functionally impaired and dependent on the employee for support.

Plan Effective Date
Coverage for your employer's company first becomes effective on a specific day, known as the plan effective date. This is the earliest date you may join the plan.

Pre-existing Condition
A sickness or injury for which the covered person received medical treatment, consultation, care or services including diagnostic measures, or had taken prescribed drugs or medicines for a specific period prior to the coverage effective date.

Reasonable and Customary
The usual fee charged in a geographic area by a health or dental provider for a specific medical procedure or service.

These reasonable and customary amounts are established by a benefits provider using a combination of their own claims data, the published fee schedules from provincial/territorial associations, typical reasonable and customary fees for provincial/territorial associations without published fee schedules and surveyed responses from practitioners within specific provinces/territories when information from associations is not available.

Reference Biologic Drug
A biologic drug that is first authorized for sale by Health Canada.

Taxable Benefits
When an employer pays any portion of the premium for Weekly Indemnity and/or Long Term Disability benefits, the benefits an employee will receive are taxable.

Waiting Period
The waiting period is the period of time each new employee must work for your organization before becoming eligible to join your plan. The employee's "eligibility date" is the day following the end of the waiting period.

Log in to victorinsurance.ca/gbconnect for more information.