Vermilion & District Housing Foundation

All Eligible Employees Working between 15 to 20 hours/week

Arranged by:

Canoe Benefits LP

Administered by:

Underwritten by:

SSQ, Life Insurance Company Inc.

SSQ Insurance Company Inc.

Industrial Alliance

Policy effective: ***January 1, 2020***
Policy amended: ***January 1, 2020***

Privacy Matters

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

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

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

This information is used to:

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

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

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

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

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

Puzzled about your benefits?

...let us put the pieces together.

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

Schedule of Benefits

Life Benefits

Group Life
Accidental Death, Disease & Dismemberment
Critical Illness

Health Benefits

Prescription Drugs
Pay Direct Drug Card
Extended Health Care
Survivor Benefits
Emergency Travel Assistance
Employee and Family Assistance Program
Medical Second Opinion

Dental Benefits

Basic Services
Major Restorative
Orthodontics
Survivor Benefits

Optional Benefits

Optional Critical Illness

Employee Classification

Class 002:	All Eligible Employees Working between 15 to 20 hours/week

Group Life
(underwritten by The Empire Life Insurance Company Group Policy # 780665)

All eligible Class 002	1 times annual earnings
Maximum Benefit:	$500,000
No Evidence Limit:	Evidence of Insurability is required for amounts in excess of $500,000.
Coverage reduces:	to 10% at age 70
Coverage terminates:	at the age of retirement
Waiver of Premium:	to age 65 or prior retirement.
Own Occupation Period:	2 years from the start of any benefit period for the purposes of the "Total Disability" definition for the Waiver of Premium Benefit.
Elimination Period:	For the purposes of the Waiver of Premium Benefit. Injury 119 days Sickness 119 days

Accidental Death, Disease & Dismemberment
(underwritten by The Empire Life Insurance Company Group Policy # 780665)

All eligible Class 002	an amount equal to your Life Insurance
Coverage reduces:	to 10% at age 70
Coverage terminates:	at the age of retirement

Life Benefits

Critical Illness

(underwritten by SSQ, Life Insurance Company Inc. Group Policy 1BL20)

All eligible Class 002	$25,000
Guaranteed issue:	$25,000
Overall maximum:	$25,000
Coverage terminates:	at the earlier of retirement or age 70

Extended Health Care

(underwritten by The Empire Life Insurance Company Group Policy # 780665)

All eligible Class 002 and their eligible dependents

Prescription drugs (mandatory generic substitution):	100%
Pay direct drug card	
Hospital (semi-private):	100%
Professional and medical care coverages:	100%
Paramedical practitioner services:	100%
Acupuncture:	50%
Eligible medical equipment and supplies:	100%
Survivor benefits:	24 months
Coverage terminates:	at the age of retirement

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

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

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

Coverage terminates:	at the earlier of retirement or age 75

Employee and Family Assistance Program
(provided by TELUS Health)

All eligible Class 002 and their eligible dependents

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

TELUS Health Full-Service EFAP includes:

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

TELUS Health Work-Life Services include:

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

Coverage terminates: at retirement

Medical Second Opinion Service
(provided by WorldCare International Inc. Policy # 780665)

All eligible Class 002 and their eligible dependents

The WorldCare ACCESS medical second opinion service confirms your diagnosis, provides treatment recommendations and answers your questions.

Coverage terminates: On the first policy anniversary after the Member reaches age 75

Dental Care

(underwritten by The Empire Life Insurance Company Group Policy # 780665)

All eligible Class 002 and their eligible dependents

Basic, endodontic and periodontal:	100%
Major restorative services:	50%
Combined calendar year maximum:	$1,500 for basic, endodontic, periodontal and major restorative services combined
Orthodontics:	50%*

**For qualified dependent children younger than age 21*

Lifetime maximum:	$1,500 for orthodontic treatment only
Survivor benefits:	24 months

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

Coverage terminates:	at the age of retirement

Dental Benefits

Optional Critical Illness
(underwritten by Industrial Alliance Policy # 780665)

All eligible Class 002 and/or spouse	units of $5,000 to a minimum benefit of $10,000 And a maximum of $100,000
Eligible dependent children	$10,000 Your Dependent children are eligible from birth to age 22; or 25 (26 in the province of Quebec) if in full-time attendance at an accredited school as students.
Guaranteed Issue Limit	Up to $50,000 is available on a guaranteed issue basis – i.e. medical evidence is not required

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

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

Waiting Period For All Benefits

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

General Provisions

Eligibility

You are eligible for coverage under this plan if you:

- have satisfied the Waiting Period;
- have not reached the coverage termination age of each respective benefit as specified in the Schedule of Benefits; and
- are Actively at Work for your employer at least 15 hours a week.

All persons to be insured under the Policy must:

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

Eligible Dependents

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

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

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

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

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

Evidence of Insurability

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

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

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

Coordination of benefits

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

Limitation of actions

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

Termination of coverage

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

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

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

Payment of Claims

Claim filing

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

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

Claim submission period

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

Payment

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

Access to personal information

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

Definitions

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

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

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

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

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

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

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

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

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

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

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

Life Benefits

Amount of insurance

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

Death Benefit

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

Appointment of beneficiary

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

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

Waiver of premium

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

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

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

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

Living benefit

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

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

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

Conversion privilege

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

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

Accidental Death, Disease & Dismemberment Coverage

General description of this coverage

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

Covered loss

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

Critical disease benefit

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

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

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

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

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

Accidental death benefit

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

Accidental disease/dismemberment benefit

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

Table of losses

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

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

Definitions

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

Loss of hand means severance at or above the wrist.

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

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

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

Loss of foot means severance at or above the ankle.

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

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

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

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

Exposure

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

Disappearance

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

Aggregate limit

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

Waiver of premiums

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

Day care benefit

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

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

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

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

Education benefit (dependent)

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

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

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

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

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

Spousal occupational training benefit

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

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

Family transportation benefit

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

Home alteration & vehicle modification benefit

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

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

Rehabilitation benefit

In the event you sustain a Covered Loss and within 2 years from that date you participate in a rehabilitation program in order to be qualified to engage in an occupation in which you would not have engaged except for such Covered Loss, the Insurer will pay the reasonable and necessary expenses actually incurred for the services of a licensed rehabilitation provider.

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

Repatriation benefit

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

Seat belt benefit

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

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

Exclusions

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

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

When and how to make a claim

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

Group Critical Illness

(Insured by SSQ Insurance Company Inc. – Policy #1BL20)

What is Critical Illness Insurance?

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

It is designed to provide a lump sum payment in the event that the individual is diagnosed for the first time with a given covered Critical Illness while the insurance is in force and survives at least 14 days following the diagnosis. Among the many advantages of this coverage, payment of benefits is not limited by your ability to work or even by a full recovery.

Should you receive a critical illness diagnosis, the benefit is paid directly to you and you are **free to choose how to use the amount you receive.**

Why is Critical Illness Insurance important?

Research has shown that a significant number of Canadians will face the challenge of a critical illness. Consider the following:

- 40% of Canadian women and 45% of men will develop cancer during their lifetimes.
- On average, 3,300 Canadians will be diagnosed with cancer every week.
- There are an estimated 70,000 heart attacks each year in Canada.
  One heart attack every 7 minutes.
- More than 50,000 strokes occur in Canada each year. That's one stroke every 10 minutes.
- 75% of stroke victims survive the initial event.
- Approximately 1,000 new cases of multiple sclerosis are diagnosed in Canada each year.

Source: Heart and Stroke Foundation, Canadian Cancer Society and Multiple Sclerosis Society of Canada

Critical illnesses are diagnosed everyday. Although healthy lifestyle choices can help protect against some health risks, a critical illness or condition can strike anyone at any time. Thanks to advances in modern medicine however, Canadians are enjoying longer and healthier lives. As survival rates improve, the need for Critical Illness Insurance, to help provide financial support throughout the recovery process is becoming more and more important.

A Critical Illness Insurance benefit can help you:

- obtain the appropriate care where and when you decide
- cover medical expenses not covered under your provincial health care plan
- focus on your recovery process by funding a leave of absence or time off to take care of a family member
- compensate for reduced family earnings and face increased costs, by using the benefit to pay for:
    - medical bills or private nursing care
    - mortgage payments or rent
    - debt or other financial liabilities
    - child care
    - hired domestic help
    - home or vehicle modifications

What are the advantages of your coverage?

With your Critical Illness Insurance, you benefit from:

- coverage up to $50,000 for you, tax-free, without having to answer any medical questions or provide any evidence of insurability;
- affordable coverage thanks to our competitive group rates;
- premium payments by way of payroll deductions;
- continued protection even if your health has diminished while covered under the Plan – even after having received a critical illness benefit, you may still be covered under the Insurer's Critical Illness coverage!

General Definitions

Critical Illness means a deterioration of health or bodily disorder which, while the individual's insurance is in force, leads to an initial Diagnosis of one of the illnesses or medical conditions covered under the insurance or to a covered surgery, according to the following list of Critical Illnesses. In addition, for the Diagnosed illness to be recognized as a Critical Illness for the purposes of the plan, the Diagnosis must be made by a Specialist and confirm that it meets the criteria indicated in the "Definitions of Covered Illnesses" section. For any covered surgery, a Specialist must confirm that it is medically necessary.

- Aortic surgery
- Aplastic anemia
- Bacterial meningitis
- Benign brain tumour
- Blindness
- Cancer (life-threatening)
- Coma
- Coronary angioplasty
- Coronary artery bypass surgery
- Crohn's disease requiring surgery

- Deafness
- Dementia, including Alzheimer's disease
- Dilated cardiomyopathy
- Ductal carcinoma in situ of the breast
- Fulminant viral hepatitis
- Heart attack
- Heart valve replacement or repair
- Hip replacement surgery
- Kidney failure
- Knee replacement surgery
- Liver failure of advanced stage
- Loss of independent existence
- Loss of limbs
- Loss of speech
- Major organ failure on waiting list
- Major organ transplant
- Motor neuron disease
- Multiple sclerosis
- Muscular dystrophy
- Occupational HIV infection
- Paralysis
- Parkinson’s disease and specified atypical Parkinsonian disorders
- Primary pulmonary hypertension
- Progressive systemic sclerosis
- Severe burns
- Severe rheumatoid arthritis
- Stage 1A malignant melanoma
- Stage A (T1a or T1b) prostate cancer
- Stroke
- Systemic lupus erythematosus

Any Critical Illness or health problem which is not defined in the present document is not covered according to this benefit and therefore, no benefit is payable in respect of such illness.

Diagnosis or **Diagnosed** refers to the determination by a Specialist, using tests or other diagnostic methods, that the Insured Person has a specific illness covered under the Policy. The Diagnosis of any covered illness must be made in Canada or the United States by a Specialist licensed to practice in Canada or the United States. Furthermore, his area of practice must include the area of medicine directly related to the illness in question.

Employee means a salaried employee of the participating Member Client of the Policyholder who is under the age of seventy (70) and resides in Canada, and whose usual place of work is in Canada.

Member Client means an organization who has purchased a group insurance plan from the Policyholder.

Insured means an individual whose coverage under the Policy is in force.

Insured Employee means an Employee whose coverage under the plan is in force.

Irreversible means a condition of the Insured where the prognosis cannot be improved by medical or surgical treatment at the time of Diagnosis. However, when the prognosis could be improved by medical or surgical treatment but would impose, in the opinion of the Insured's Physician, a risk to the Insured's health that would outweigh the expected benefit(s) of such treatment, the condition is then also considered as Irreversible for the purpose of this definition.

Life Support means the Insured is under the regular care of a licensed Physician for nutritional, respiratory and/or cardiovascular support when Irreversible cessation of all functions of the brain has occurred.

Physician means an individual who is legally licensed to practice medicine in Canada or the United States and provides treatment within the scope of his licence. The Physician must not ordinarily reside with the Insured. The Physician must not be the Insured, a relative of or business associate of the Insured.

Principal Sum means the amount of insurance applicable to the Insured and stated on the Insured Employee's most recently signed individual enrollment card on file with the Policyholder, if any.

Specialist means a licensed Physician who has been trained in the specific area of medicine relevant to the covered Critical Illness for which benefit is being claimed, and who has been certified by a specialty examining board. In the absence or unavailability of a Specialist, and as approved by the Insurer, a condition may be Diagnosed by a qualified Physician practising in Canada or the United States. The Specialist must not ordinarily reside with the Insured. The Specialist must not be the Insured, a relative of or business associate of the Insured.

Surgery means that the Insured undergoes medically necessary surgery performed on the written advice of a Specialist. The Surgery must be performed by a Physician in Canada or the United States.

Survival Period means the fourteen (14) days following the date of Diagnosis or fourteen (14) days following the date of Surgery if applicable, except where otherwise specified under the present document. The Survival Period does not include days on Life Support as defined in this section.

The Insured must be alive at the end of the Survival Period and must not have experienced Irreversible cessation of all functions of the brain.

For those conditions which have a qualifying period, for example ninety (90) days for Bacterial meningitis and Paralysis, the Survival Period runs concurrently with that condition's qualifying period.

Eligibility

All active Employees of the Participating Member Client of the Policyholder.

If an Employee is absent from active work for any reason other than maternity or parental leave or vacation or other paid leave, such Employee will only become eligible upon return to active work.

Effective Date Of Insurance

For coverage obtained without evidence of insurability

Coverage as to each eligible Employee becomes effective on the latest of the following dates:

- the Effective Date of the Policy with respect to an Employee who is insured under the Member Client's Basic Group Life program on or prior to the Effective Date of the Policy;
- the date the Employee returns to active full-time work if such Employee is absent from full-time work on the Effective Date of the Policy for any reason other than: vacation or other paid leaves; maternity leaves; parental leaves;
- on the date insurance under the Member Client's Basic Group Life Insurance Plan becomes effective with respect to an Employee who becomes eligible after the Effective Date of the Policy.

Definitions Of Covered Illnesses

Other illnesses are also covered under this plan. They are defined under section "Complementary Benefit in Case of Certain Illnesses".

Aortic Surgery means the undergoing of Surgery for disease of the aorta requiring excision and surgical replacement of any part of the diseased aorta with a graft. Aorta refers to the thoracic and abdominal aorta but not its branches.

Exclusion: No benefit will be payable under this condition for any of the following: angioplasty; intra-arterial procedures; percutaneous trans-catheter procedures; non-surgical procedures.

Aplastic anemia means a definite Diagnosis of a chronic persistent bone marrow failure, confirmed by biopsy, which results in anemia, neutropenia and thrombocytopenia requiring blood product transfusion, and treatment with at least one (1) of the following:

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

Bacterial meningitis means a definite Diagnosis of meningitis, confirmed by cerebrospinal fluid showing growth of pathogenic bacteria in culture, resulting in neurological deficit documented for at least ninety (90) days from the date of Diagnosis.

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

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

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

In addition, no benefit will be payable under this condition if one of the following occurred to the Insured Person within the first ninety (90) days following the last time the Insured Person's coverage under this benefit became effective:

- signs, symptoms or investigations that lead to a Diagnosis of benign brain tumour (covered or not), regardless of when the Diagnosis was made; or
- a Diagnosis of benign brain tumour (covered or not).

Restriction: This medical information as described above must be reported to the Insurer within six (6) months of the date of the Diagnosis. If this information is not provided within this period, the Insurer has the right to deny any claim for Benign brain tumour or any Critical Illness caused by any benign brain tumour or by its treatment.

Blindness means a definite Diagnosis of the total and Irreversible loss of vision in both eyes, evidenced by the corrected visual acuity being 20/200 or less in both eyes; or the field of vision being less than 20 degrees in both eyes.

Cancer (life-threatening) means a definite Diagnosis of a tumour characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. The following types of cancer are included: carcinoma, melanoma, leukemia, lymphoma and sarcoma.

Exclusion: No benefit will be payable under this condition for any of the following:

- lesions described as benign, pre-malignant, uncertain, borderline or non-invasive, carcinoma in situ (Tis) or tumors classified as Ta;
- malignant melanoma skin cancer that is less than or equal to 1.0 mm in thickness, unless it is ulcerated or is accompanied by lymph node or distant metastasis;
- any non-melanoma skin cancer, without lymph node or distant metastasis;
- prostate cancer classified as T1a or T1b, without lymph node or distant metastasis;
- papillary thyroid cancer or follicular thyroid cancer, or both, that is less than or equal to
- 2.0 cm in greatest diameter and classified as T1, without lymph node or distant metastasis;
- chronic lymphocytic leukemia classified less than Rai stage 1;
- malignant gastrointestinal stromal tumours (GIST) and malignant carcinoid tumours, classified less than the American Joint Committee on Cancer (AJCC) stage 2.
- In addition, no benefit will be payable under this condition if one of the following occurred to the Insured Person within the first ninety (90) days following the last time the Insured Person's coverage under this benefit became effective:
- signs, symptoms or investigations that lead to a Diagnosis of Cancer (covered or not), regardless of when the Diagnosis was made; or
- a Diagnosis of cancer (covered or not).
- Restriction: This medical information as described above must be reported to the Insurer within six
- (6) months of the date of the Diagnosis. If this information is not provided within this period, the Insurer has the right to deny any claim for Cancer or any Critical Illness caused by any Cancer or by its treatment.

References: For the purposes of the policy, the terms Tis, Ta, T1a, T1b, T1 and AJCC Stage 2 are to be applied as defined in the American Joint Committee on Cancer (AJCC) cancer staging manual, 7th Edition, 2010. Also for the purposes of the policy, the term Rai staging is to be applied as set out in KR Rai, A Sawitsky, EP Cronkite, AD Chanana, RN Levy and BS Pasternack: Clinical staging of chronic lymphocytic leukemia. Blood 46:219, 1975

Coma means a definite Diagnosis of a state of unconsciousness with no reaction to external stimuli or response to internal needs for a continuous period of at least ninety-six (96) hours, and for which period the Glasgow coma score must be four (4) or less.

Exclusion: No benefit will be payable under this condition for any of the following:

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

Coronary artery bypass surgery means the undergoing of heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass graft(s).

Exclusions: No benefit will be payable under this condition for any of the following: angioplasty; intra-arterial procedures; percutaneous trans-catheter procedures or non-surgical procedures.

Deafness means a definite Diagnosis of the total and Irreversible loss of hearing in both ears, with an auditory threshold of 90 decibels or greater within the speech threshold of 500 to 3,000 hertz.

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

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

The following is also required:

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

Exclusion: No benefit will be payable under this condition for affective or schizophrenic disorders, or delirium.

Dilated cardiomyopathy means a condition of impaired ventricular function resulting in significant physical impairment of at least Class III of the New York Heart Association Classification of Cardiac Impairment. The Diagnosis of dilated cardiomyopathy must be confirmed by echocardiographic abnormalities demonstrating new abnormal cardiac function with a persistent low ejection fraction (less than 40%) for at least 3 months.

New York Heart Association Class III cardiomyopathy impairment means that the patient is comfortable at rest and is symptomatic during less than ordinary daily activities despite the use of medication and dietary adjustment, with evidence of abnormal ventricular function on physical examination and laboratory studies.

Exclusion: No benefit will be payable under this condition for ischemic and toxic causes (including alcohol, prescription and non-prescription drug use) of dilated cardiomyopathy.

Fulminant viral hepatitis means a definite Diagnosis of a sub-massive to massive necrosis of the liver caused by any virus leading precipitously to liver failure. Payment under this condition requires satisfaction of all of the following:

- a rapidly decreasing liver size as confirmed by abdominal ultrasound;
- necrosis involving entire lobules, leaving only a collapsed reticular framework to include histology, if available;
- rapidly deteriorating liver function tests;
- deepening jaundice.

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

- chronic hepatitis; or
- liver failure caused by alcohol, toxins and/or drugs.

Heart attack means a definite Diagnosis of the death of heart muscle due to obstruction of blood flow, that results in:

Rise and fall of biochemical cardiac markers to levels considered diagnostic of myocardial infarction, with at least one (1) of the following:

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

Exclusions: No benefit will be payable under this condition for any of the following:

- elevated biochemical cardiac markers as a result of an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty, in the absence of new Q waves; or
- ECG changes suggesting a prior myocardial infarction, which do not meet the heart attack definition as described above.

Heart valve replacement or repair means the undergoing of Surgery to replace any heart valve with either a natural or mechanical valve or to repair heart valve defects or abnormalities.

Exclusion: No benefit will be payable under this condition for any of the following: angioplasty; intra-arterial procedures; percutaneous trans-catheter procedures; non-surgical procedures.

Kidney failure means a definite Diagnosis of chronic Irreversible failure of both kidneys to function, as a result of which regular haemodialysis or peritoneal dialysis is required, or renal transplantation initiated.

Liver failure of advanced stage means a definite Diagnosis of Liver failure due to cirrhosis and resulting in all of the following:

- Permanent jaundice;
- Ascites;
- Encephalopathy.

Exclusion: No benefit will be payable under this condition for any liver failure secondary to alcohol or drug use (except those taken as prescribed by a Physician).

Loss of independent existence means a definite Diagnosis of the total inability to perform, by oneself, at least two (2) of the following six (6) Activities of Daily Living for a continuous period of at least ninety (90) days with no reasonable chance of recovery.

Activities of Daily Living are:

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

Loss of speech means a definite Diagnosis of the total and Irreversible loss of the ability to speak as the result of physical injury or disease, for a period of at least 180 days.

Exclusion: No benefit will be payable under this condition for all psychiatric related causes.

Major organ failure on waiting list means a definite Diagnosis of the Irreversible failure of the heart, both lungs, liver or bone marrow, and for which transplant must be medically necessary. To qualify under major organ failure on waiting list, the Insured Person must become enrolled as the recipient in a recognized transplant centre in Canada or the United States that performs the required form of transplant Surgery. For the purposes of the Survival Period, the date of Diagnosis is the date of the Insured Person's enrollment in the transplant centre.

Major organ transplant means a definite Diagnosis of the Irreversible failure of the heart, both lungs, liver or bone marrow, and transplantation must be medically necessary. To qualify under Major organ transplant, the Insured Person must undergo a transplantation procedure as the recipient of a heart, lung, liver or bone marrow, and limited to these entities.

Exclusion: No benefit will be payable under this condition for any organ transplant other than those described above.

Motor neuron disease means a definitive Diagnosis of one (1) of the following:

- Amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease);
- Primary lateral sclerosis;
- Progressive spinal muscular atrophy;
- Progressive bulbar palsy; or
- Pseudo bulbar palsy.

Multiple sclerosis means a definite Diagnosis of at least one (1) of the following:

- two (2) or more separate clinical attacks, confirmed by magnetic resonance imaging (MRI) of the nervous system, showing multiple lesions or demyelination; or
- well-defined neurological abnormalities lasting more than six (6) months, confirmed by MRI imaging of the nervous system, showing multiple lesions of demyelination; or
- a single attack, confirmed by repeated MRI imaging of the nervous system, which shows multiple lesions of demyelination which have developed at intervals at least one (1) month apart.

Muscular dystrophy means a definite Diagnosis of all of the following:

- Clinical presentation including skeletal muscle weakness, muscle pain and myotonia;
- Characteristic electromyography changes;
- Muscle biopsy confirming Diagnosis of muscular dystrophy.

Occupational HIV infection means a definite Diagnosis of infection with Human Immunodeficiency Virus (HIV) resulting from accidental injury during the course of the Insured Person's normal occupation, which exposed the person to HIV contaminated body fluids. The accidental injury leading to the infection must occur while this coverage is in force.

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

- The accidental injury must be reported to the Insurer within fourteen (14) days of the accidental injury;
- A serum HIV test must be taken within fourteen (14) days after the accidental injury and the result must be negative;
- A serum HIV test must be taken between ninety (90) days and one hundred and eighty (180) days after the accidental injury and the result must be positive; the Insured Person must survive at least fourteen (14) days following the date of this second serum HIV test;
- All HIV tests must be performed by a duly licensed laboratory in Canada or the United States;
- The accidental injury must have been reported, investigated and documented in accordance with current Canadian or United States workplace guidelines.

Exclusion: No benefit will be payable under this condition if:

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

Paralysis means a definite Diagnosis of the total loss of muscle function of two (2) or more limbs as a result of injury or disease to the nerve supply of those limbs, for a period of at least ninety (90) days following the precipitating event.

Parkinson's disease and specified atypical Parkinsonian disorders Parkinson's disease means a definite Diagnosis of primary Parkinson's disease, a permanent neurologic condition which is characterized by bradykinesia (slowness of movement) and at least one of: muscular rigidity or rest tremor.

Specified atypical Parkinsonian disorders (SAPD) means a definite Diagnosis of progressive supranuclear palsy, corticobasal degeneration, or multiple system atrophy.

The Diagnosis of Parkinson's disease or specified atypical Parkinsonian disorder must be made by a neurologist. In all cases, the Insured Person condition must exhibit objective signs of a progressive deterioration in function for at least one year, for which the treating neurologist has recommended dopaminergic medication or other generally medically accepted equivalent treatment for Parkinson's disease.

Exclusion: No benefit will be payable under this condition for any other type of Parkinsonism.

In addition, no benefit will be payable under Parkinson's disease or specified atypical Parkinsonian disorders if one of the following occurred to the Insured Person within the year following the last time the Insured Person's coverage under this benefit became effective:

- signs, symptoms or investigations that lead to a Diagnosis of Parkinson's disease or atypical Parkinsonian disorders or any other type of Parkinsonism, regardless of when the Diagnosis was made; or
- a Diagnosis of Parkinson's disease, atypical Parkinsonian disorders or any other type of Parkinsonism.

Restriction: This medical information as described above must be reported to the Insurer within six (6) months of the date of the Diagnosis. If this information is not provided during this period, the Insurer has the right to deny any claim for Parkinson's disease or specified atypical Parkinsonian disorder or any Critical Illness caused by Parkinson's disease or Parkinsonian disorders or by their treatments.

Primary pulmonary hypertension *(idiopathic pulmonary arterial hypertension and familial pulmonary arterial hypertension)* means a definite Diagnosis of primary pulmonary hypertension with a substantial right ventricular enlargement confirmed by investigations including cardiac catheterization, resulting in permanent Irreversible physical impairment to the degree of at least Class IV of the New York Heart Association Classification of Cardiac Impairment.

The New York Heart Association Classification of Cardiac Impairment (source: *Current Medical Diagnosis and Treatment-39th Edition*) states the following about Class IV:
"Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest."

Exclusion: No benefit will be payable under this condition for any other type of pulmonary arterial hypertension.

Progressive systemic sclerosis means a definite Diagnosis of Progressive systemic scleroderma with systemic involvement of the heart, lungs or kidneys. The Diagnosis must be unequivocally supported by clinical and serological evidence and with biopsy results when available.

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

- Localized scleroderma (linear scleroderma or morphea); or
- Eosinophilic fasciitis; or
- CREST syndrome.

Severe burns means a definite Diagnosis of third degree burns over at least 20% of the body surface.

Stroke means a definite Diagnosis of an acute cerebrovascular event caused by intra-cranial thrombosis or haemorrhage, or embolism from an extra-cranial source, with:

- acute onset of new neurological symptoms; and
- new objective neurological deficits on clinical examination; persisting for more than thirty (30) days following the date of Diagnosis.

These new symptoms and deficits must be corroborated by diagnostic imaging testing. Exclusion: No benefit will be payable under this condition for any of the following:

- transient ischaemic attacks; or
- intracerebral vascular events due to trauma; or
- lacunar infarcts which do not meet the definition of stroke as described above.

Complementary Benefit In Case Of Certain Illnesses

In addition to the Critical Illnesses described under section "Definitions of Covered Illnesses", the following illnesses, as defined hereunder, are covered under the Complementary Benefit in Case of Certain Illnesses.

- Coronary angioplasty
- Crohn’s disease requiring surgery
- Ductal carcinoma in situ of the breast
- Hip or knee replacement surgery
- Severe rheumatoid arthritis
- Stage A (T1a or T1b) prostate cancer
- Stage 1A malignant melanoma
- Systemic lupus erythematosus

Coronary angioplasty means the undergoing of an interventional procedure to unblock or widen a coronary artery that supplies blood to the heart to allow an uninterrupted flow of blood.

Crohn's disease requiring surgery means the unequivocal Diagnosis of Crohn's disease confirmed by results of typical endoscopy and histopathology findings. Also, the Insured must exhibit intra-abdominal or anal abscesses or fistulas, or intestinal obstruction or perforation, or intractable disease not responding to non- surgical management. In addition, symptoms must have persisted despite optimal non-surgical therapy and a surgical intervention including at least one bowel segment resection must be medically necessary.

Ductal carcinoma in situ of the breast means the Diagnosis of this illness, as confirmed by biopsy.

Hip or knee replacement surgery means an open Surgery resulting in the total prosthetic replacement of either the hip or the entire knee (known as total knee replacement), subject to the following:

- For hip replacement to qualify under this insurance, the femoral stem must be replaced. Also, this procedure should be performed in both total arthroplasty and hemiarthroplasty (both monopolar and bipolar).
- For knee replacement to qualify under this insurance, all three compartments of the knee (medial, lateral and patellofemoral) must be replaced.

Exclusions: No benefit will be payable under this condition for arthroscopic treatment of joint surfaces or revision of previous total hip or knee replacements.

Severe rheumatoid arthritis means the definite Diagnosis of severe seropositive rheumatoid arthritis, that must involve widespread joint destruction affecting at least 3 large joints (these are shoulders, elbows, hips, knees, and ankles), as well as 3 small joints (these are metacarpophalangeal joints, proximal interphalangeal joints, thumb interphalangeal joints, joints of the wrists and second through fifth metatarsophalangeal joints). The Diagnosis must be confirmed by clinical and radiological evidence of joints destruction and deformity.

Stage A (T1a or T1b) prostate cancer means the definite Diagnosis of this illness, as confirmed by pathological examination of prostate tissue.

Stage 1A malignant melanoma means the Diagnosis of a melanoma less than or equal to 1.0 mm in thickness, not ulcerated and without Clark level IV or V invasion. The Diagnosis of this illness must be confirmed by biopsy.

Systemic lupus erythematosus means the definite Diagnosis of systemic lupus erythematosus, that must involve renal system which requires corticosteroid treatment for a continuous period of six (6) months and permanent impairment of kidney function tests that show Glomerular Filtration Rate (GFR) below 30mL/min/1.73m^2. In addition, a positive ANA test must be present.

Exclusions: No benefit will be payable under this condition for any other forms of lupus, such as discoid lupus and those forms with only hematological and joint involvement.

If the Insured Employee is Diagnosed with one of the illnesses indicated previously in this section while his coverage is in force and subject to the conditions of the "Survival Period" section and the limitations specified in the "Re-Entry Conditions" section, the Insurer will pay the Insured Employee:

- 10% of the Principal Sum, subject to a maximum of $25,000, for the following conditions:

    - Coronary angioplasty
    - Ductal carcinoma in situ of the breast
    - Stage A (T1a or T1b) prostate cancer
    - Stage A malignant melanoma

The payment of the Complementary Benefit in Case of Certain Illnesses in group (1) above comes in addition to the Principal Sum and can only be paid once in a lifetime, in accordance with the limitations specified in the "Re-Entry Conditions" section.

- 10% of the Principal Sum, subject to a maximum of $10,000, for the following conditions:

    - Crohn's disease requiring surgery
    - Severe rheumatoid arthritis
    - Systemic lupus erythematosus

The payment of the Complementary Benefit in Case of Certain Illnesses in group (2) above comes in addition to the Principal Sum and can only be paid once in a lifetime, in accordance with the limitations specified in the "Re-Entry Conditions" section.

- 10% of the Principal Sum, subject to a maximum of $10,000, for the following conditions:

    - Hip replacement surgery
    - Knee replacement surgery

The payment of the Complementary Benefit in Case of Certain Illnesses in group (3) above comes in addition to the Principal Sum and can only be paid once in a lifetime, in accordance with the limitations specified in the "Re-Entry Conditions" section.

Cancer Recurrence Benefit

The Insurer will pay a Principal Sum amount if the Insured Employee is Diagnosed a subsequent time with Cancer and that more than sixty (60) months have passed since the previous Cancer Diagnosis and no treatment relating directly or indirectly to Cancer has been received within that sixty (60) month period (treatment does not include preventive medications and follow up visits to the doctor).

The subsequent Diagnosis must be made while coverage is in force.

Multiple Event Coverage

If an Insured Employee is Diagnosed with a covered Critical Illness for which the Principal Sum (or 10% of the Principal Sum under the Complementary Benefit in Case of Certain Illnesses) has been paid and is then Diagnosed with another covered Critical Illness, the Insurer will pay a Principal Sum amount (or 10% of the Principal Sum thereof under the Complementary Benefit in Case of Certain Illnesses) subject to the limitations specified in the "Re-Entry Conditions" section.

To give rise to a benefit payment under Multiple Event Coverage, the subsequent Diagnosis must be made ninety (90) days or more after the date another covered condition was Diagnosed.

Second Medical Opinion Service

Any Insured who is Diagnosed with a covered Critical Illness while enrolled in the insurance program is offered access to **AXA Assistance's Second Medical Opinion** program.

This program allows the Insured to obtain a second medical opinion from a highly qualified practitioner. It provides a thorough medical review that rigorously analyzes the Insured's file to confirm the initial Diagnosis and make recommendations on appropriate treatment.

If you have been Diagnosed with a covered Critical Illness, simply call: **1-877-266-6550** in order to benefit from AXA Assistance's Second Medical Opinion program.

Re-Entry Conditions

If a benefit amount has already been received for a covered Critical Illness of an Insured Employee, coverage continues for that person, provided payment of premium is continued. Subsequent benefit payments are subject to the "Re-entry Exclusions Appendix" of this insurance.

Conditions For Payment

When an Insured is Diagnosed with a covered Critical Illness and the required Survival Period is completed, the Insurer shall pay the Principal Sum, unless otherwise provided under the contract and subject to all of the conditions and limitations of this Policy.

Beneficiary

Amounts payable under this Critical Illness benefit will be payable to the Insured Employee.

However, accrued benefits, if any, unpaid at the time of the beneficiary becoming unable to legally receive payment of benefits will be paid to the beneficiary's estate.

Termination Of Coverage

Coverage of an Insured will immediately terminate on the earliest of the following dates:

- the date the Policy is terminated;
- the premium due date if the Policyholder fails to pay the required premium, except as the result of an inadvertent error;
- the premium due date coincident with or following the date the Insured Employee reaches seventy (70) years of age;
- the premium due date coincident with or following the date the Insured Employee ceases to be an active Employee of the Participating Member Client of the Policyholder on account of leave of absence, lay-off, maternity or parental leave, disability, resignation, dismissal, pension or retirement, except as provided under the following sections:
  - Continuation of Coverage during Approved Leaves
  - Extension of Coverage
- the date the Insured Employee dies;
- the premium due date coincident with or following the date the Insured Employee gives notice of cancellation to the Participating Member Client of the Policyholder.

Conversion Of Group Coverage To An Individual Insurance Contract

In the event an Insured Employee’s coverage is terminated because:

- the Insured Employee ceases to be an active Employee of the Participating Member Client of the Policyholder on account of resignation, dismissal, retirement or failure to return to work for the Participating Member Client of the Policyholder following a period of total disability; or
- the Insured Employee ceases to be an eligible person under the plan; or
- the period of extension of coverage ends,

the Insured Employee who has not yet reached the age of sixty-five (65) may make a written application to the Insurer within thirty-one (31) days of said termination to obtain an individual Critical Illness policy. On reception of such application, the Insurer will, without evidence of insurability, issue an individual Critical Illness policy to the applicant that will consist of 4 illnesses [Cancer (life- threatening), Coronary artery bypass surgery, Heart attack and Stroke].

However, conversion will not be possible if the Policy is terminated at the time of the application. An Insured Employee may only convert if he has never received a benefit payment and has never received a payment under the "Complementary Benefit in Case of Certain Illnesses" section in the past.

The amount of insurance that may be converted will not exceed the lesser of:

- the amount of insurance then in effect on the date of termination; or
- a total aggregate amount of one hundred thousand dollars ($100,000) for all such conversions by any Insured.

Premiums for such individual Critical Illness policy being issued in compliance with the aforementioned condition will be calculated at the Insurer's rates in force for the attained age of such Insured at the date of conversion. Premiums will be payable annually in advance and the Critical Illness policy will be issued on an annually renewable basis.

Exclusions

No indemnity will be paid if a Critical Illness results directly or indirectly from any one or more of the following causes or situations:

- Within ninety (90) days following the effective date of the Insured's coverage:
  - Diagnosis of Cancer is made; or
  - The Insured has any signs, symptoms or investigations, that lead to a Diagnosis of cancer (covered or excluded under the Policy), regardless of when the Diagnosis is made.
- Within ninety (90) days following the effective date of the Insured's coverage:
  - Diagnosis of Benign Brain Tumour is made; or
  - The Insured has any signs, symptoms or investigations that lead to a Diagnosis of Benign Brain Tumour, regardless of when the Diagnosis is made.
- The Insured does not satisfy the Survival Period limitations.
- The Insured suffers a self-inflicted injury, Sickness or Disease, whether the Insured was sane or insane at the time of such infliction.
- The Insured Person has used illicit drugs, or any drug other than as prescribed, recommended or administered by or in accordance with the instruction of a Physician, whether or not such drugs are available only by prescription.
- The Insured has any cancer that manifests itself prior to the Insured's effective date of individual coverage when the same cancer either recurs or metastasizes after such effective date unless all the requirements in the "Cancer Recurrence Benefit" section have been met.
- The Insured operated a motor vehicle while concentration of alcohol in his blood exceeded the applicable legal limit where the events causing the Critical Illness occurred.
- The Insured committed or attempted to commit a criminal offense or provoked an assault.
- The Critical Illness results from an abuse of alcohol.
- The Insured participated in any riot, war or any civil strife.

Premium Payment

Premiums for your coverage are paid by you, using the means of payroll deductions.

Limitation Of Contractual Liability

If any amendment made to fiscal legislation, to a government plan, to an insurance plan provided for in employee working conditions or to an employer retirement plan has the effect of increasing liability under this benefit, then the provisions of the contract shall continue to apply as though such amendment had not been made, unless the parties expressly agree otherwise. If an increase in liability is required by law, however, then an additional premium shall be payable to the Insurer by the Policyholder. This additional premium shall be equal to the value of the increase in contractual liability.

Area Of Diagnosis

Should an Insured claim for a Critical Illness which occurred or was diagnosed outside of Canada or the United States, such Insured may be eligible to receive indemnity under this section upon that person's return to Canada. Prior to determining eligibility, however, the Insurer will have the right to require that the Insured obtain, on his return to Canada, a Diagnosis by a Physician in Canada.

Claims Provisions

Notice of Claim Written notice of Critical Illness on which claim is based must be given to the Insurer within thirty (30) days after the date of the Diagnosis resulting in such Critical Illness. Such notice must be given in writing by or on behalf of the Insured Person, his beneficiary or the person who is entitled the indemnity under the Policy, as the case may be, to the Insurer at 1200, Papineau Avenue, Suite 460, Montreal (Quebec), H2K 4R5, or to any Regional Office of the Insurer or to any authorized agent of the Insurer, with particulars sufficient to identify the Insured Person whose Critical Illness is the basis of such notice. Failure to give such notice within the time provided in the Policy will not invalidate any claim if it is shown not to have been reasonably possible to give such notice during such time and that such notice was given as soon as was reasonably possible, but in no event later than one (1) year after the date of the Diagnosis.

Claim Forms The Insurer, upon receipt of such notice, agrees to furnish to the claimant such forms as are usually furnished by it for filing proof of Critical Illness. If such forms are not so furnished within fifteen (15) days after the Insurer's receipt of such notice, the claimant will be deemed to have complied with the requirements of the Policy as to proof of such Critical Illness upon submitting, within the time fixed in the Policy for filing proofs of Critical Illness, written proof covering the occurrence, character and extent of the Critical Illness for which claim is made.

Proof of Critical Illness Written proof of Critical Illness must be furnished to the Insurer within ninety (90) days after the date of Diagnosis resulting in such Critical Illness. Failure to furnish such proof within such time will not invalidate any claim if it is shown not to have been reasonably possible to furnish such proof during such time and that such proof was furnished as soon as was reasonably possible, but in no event later than one (1) year after the date of the Diagnosis.

Physical Examination and Autopsy The Insurer will have the right and opportunity to confirm the Diagnosis at its own expense by appointing a medical practitioner to examine the Insured whose Critical Illness is the basis of claim under the Policy, where and so often as it may reasonably require while it determines the validity of a claim hereunder, and in the case of death, the right and opportunity to require an autopsy where it is not forbidden by law.

Payment of Claims All indemnities provided in the Policy for Critical Illness will be paid after customary proof of Critical Illness satisfactory to the Insurer has been given in accordance with the requirements of the Policy. All moneys payable under the Policy are payable in the lawful money of Canada.

Re-Entry Exclusions Appendix

This appendix provides for all Critical Illnesses that may be included in all of the Insurer's Critical Illness insurance packages so that the Policyholder and the participants are informed that these exclusions shall continue to apply even when the policyholder or participant has chosen any new Critical Illness insurance package offered by the Insurer. Please refer to the provisions of the Critical Illness benefit to know what Critical Illnesses and Surgeries are actually covered under your policy.

After benefit has been claimed and adjudicated as payable for an individual other than a child with respect to a first event mentioned in the columns at the right of this schedule, no benefits can be paid for the same individual with respect to subsequent events mentioned on the lines of the left column hereunder, if the cell they have in common is marked with an X. Also, for an event to give rise to benefits, it must be included in the list of Covered Illnesses of the Insured's coverage or under the "Complementary Benefit in Case of Certain Illnesses" section, if any.

After benefit has been claimed and adjudicated as payable for a child with respect to a covered event, no benefits can be paid for the same child with respect to any subsequent event.

Re-Entry Exclusions Appendix (Cont'd)

	If a claim has been paid for this event						
	Aortic Surgery	Aplastic Anemia	Bacterial meningitis	Benign brain tumour	Blindness	Cancer (life threatening)	Coma
No claim can be paid for this subsequent event							
Aortic Surgery	X						
Aplastic Anemia		X					
Bacterial meningitis			X	X		X	
Benign brain tumour				X			
Blindness			X	X	X		X
Cancer (life threatening)		X				X*	
Coma	X		X	X			X
Coronary angioplasty	X						
Coronary artery bypass surgery	X						
Crohn's disease requiring surgery							
Deafness			X	X			X
Dementia, including Alzheimer's disease	X						
Dilated cardiomyopathy							
Ductal carcinoma in situ of the breast		X				X	
Fulminant viral hepatitis							
Heart attack	X						
Heart valve replacement or repair	X						
Hip replacement surgery							
Kidney failure	X						
Knee replacement surgery							
Liver failure of advanced stage	X					X	
Loss of independent existence	X	X	X	X	X	X	X
Loss of limbs							
Loss of speech			X	X			X
Major organ failure on waiting list	X						
Major organ transplant	X						
Motor neuron disease							
Multiple sclerosis							
Muscular dystrophy							
Occupational HIV infection							
Paralysis			X	X			X
Parkinson's Disease and SAPD							
Primary pulmonary hypertension							
Progressive systemic sclerosis							
Severe burns							
Severe rheumatoid arthritis							
Stage 1A malignant melanoma		X					
Stage A (T1a or T1B) prostate cancer		X				X	
Stroke	X		X	X			X
Systemic lupus erythematosus							

Re-Entry Exclusions Appendix (Cont'd)

	If a claim has been paid for this event						
	Coronary angioplasty	Coronary artery bypass surgery	Crohn's disease requiring surgery	Deafness	Dementia, including Alzheimer's disease	Dilated cardiomyopathy	Ductal carcinoma in situ of the breast
No claim can be paid for this subsequent event							
Aortic Surgery		X				X	
Aplastic Anemia							
Bacterial meningitis							
Benign brain tumour							
Blindness							
Cancer (life threatening)							
Coma		X				X	
Coronary angioplasty		X				X	X
Coronary artery bypass surgery	X	X				X	
Crohn's disease requiring surgery			X				
Deafness				X			
Dementia, including Alzheimer's disease		X			X	X	
Dilated cardiomyopathy						X	
Ductal carcinoma in situ of the breast	X						X
Fulminant viral hepatitis							
Heart attack		X				X	
Heart valve replacement or repair		X				X	
Hip replacement surgery							
Kidney failure		X	X			X	
Knee replacement surgery							
Liver failure of advanced stage		X	X			X	
Loss of independent existence		X	X	X	X	X	
Loss of limbs							
Loss of speech							
Major organ failure on waiting list		X	X			X	
Major organ transplant		X	X			X	
Motor neuron disease							
Multiple sclerosis							
Muscular dystrophy							
Occupational HIV infection							
Paralysis							
Parkinson's Disease and SAPD							
Primary pulmonary hypertension							
Progressive systemic sclerosis							
Severe burns							
Severe rheumatoid arthritis			X				
Stage 1A malignant melanoma	X						X
Stage A (T1a or T1B) prostate cancer	X						X
Stroke		X				X	
Systemic lupus erythematosus			X				

Re-Entry Exclusions Appendix (Cont'd)

	If a claim has been paid for this event						
	Coronary angioplasty	Coronary artery bypass surgery	Crohn's disease requiring surgery	Deafness	Dementia, including Alzheimer's disease	Dilated cardiomyopathy	Ductal carcinoma in situ o the breast
No claim can be paid for this subsequent event							
Aortic Surgery		X				X	
Aplastic Anemia							
Bacterial meningitis							
Benign brain tumour							
Blindness							
Cancer (life threatening)							
Coma		X				X	
Coronary angioplasty		X				X	X
Coronary artery bypass surgery	X	X				X	
Crohn's disease requiring surgery			X				
Deafness				X			
Dementia, including Alzheimer's disease		X			X	X	
Dilated cardiomyopathy						X	
Ductal carcinoma in situ of the breast	X						X
Fulminant viral hepatitis							
Heart attack		X				X	
Heart valve replacement or repair		X				X	
Hip replacement surgery							
Kidney failure		X	X			X	
Knee replacement surgery							
Liver failure of advanced stage		X	X			X	
Loss of independent existence		X	X	X	X	X	
Loss of limbs							
Loss of speech							
Major organ failure on waiting list		X	X			X	
Major organ transplant		X	X			X	
Motor neuron disease							
Multiple sclerosis							
Muscular dystrophy							
Occupational HIV infection							
Paralysis							
Parkinson's Disease and SAPD							
Primary pulmonary hypertension							
Progressive systemic sclerosis							
Severe burns							
Severe rheumatoid arthritis			X				
Stage 1A malignant melanoma	X						X
Stage A (T1a or T1B) prostate cancer	X						X
Stroke		X				X	
Systemic lupus erythematosus			X				

Re-Entry Exclusions Appendix (Cont'd)

	If a claim has been paid for this event						
	Fulminant viral hepatitis	Heart attack	Heart valve replacement or repair	Hip replacement surgery	Kidney failure	Knee replacement surgery	Liver failure of advanced stage
No claim can be paid for this subsequent event							
Aortic Surgery		X	X				X
Aplastic Anemia							
Bacterial meningitis							
Benign brain tumour							
Blindness							X
Cancer (life threatening)	X						X
Coma		X	X		X		X
Coronary angioplasty		X	X				X
Coronary artery bypass surgery		X	X				X
Crohn's disease requiring surgery					X		
Deafness							
Dementia, including Alzheimer's disease		X	X				
Dilated cardiomyopathy							
Ductal carcinoma in situ of the breast	X						X
Fulminant viral hepatitis	X						
Heart attack		X	X		X		X
Heart valve replacement or repair		X	X				
Hip replacement surgery				X		X	
Kidney failure		X	X		X		X
Knee replacement surgery				X		X	
Liver failure of advanced stage	X	X	X		X		X
Loss of independent existence	X	X	X	X	X	X	X
Loss of limbs							
Loss of speech							
Major organ failure on waiting list	X	X	X		X		X
Major organ transplant	X	X	X		X		X
Motor neuron disease							
Multiple sclerosis							X
Muscular dystrophy							
Occupational HIV infection							
Paralysis							X
Parkinson's Disease and SAPD							
Primary pulmonary hypertension							
Progressive systemic sclerosis							X
Severe burns							
Severe rheumatoid arthritis				X	X	X	
Stage 1A malignant melanoma	X						X
Stage A (T1a or T1B) prostate cancer	X						X
Stroke		X	X		X		X
Systemic lupus erythematosus					X		

Re-Entry Exclusions Appendix (Cont'd)

	If a claim has been paid for this event						
	Loss of independent existence	Loss of limbs	Loss of speech	Major organ failure on waiting list	Major organ transplant	Motor neuron disease	Multiple sclerosis
No claim can be paid for this subsequent event							
Aortic Surgery	X						
Aplastic Anemia	X			X	X		
Bacterial meningitis	X						
Benign brain tumour	X						
Blindness	X					X	X
Cancer (life threatening)	X			X	X		
Coma	X			X	X	X	X
Coronary angioplasty							
Coronary artery bypass surgery	X						
Crohn's disease requiring surgery	X						
Deafness	X					X	X
Dementia, including Alzheimer's disease	X						
Dilated cardiomyopathy	X						
Ductal carcinoma in situ of the breast				X	X		
Fulminant viral hepatitis	X						
Heart attack	X			X	X	X	
Heart valve replacement or repair	X						
Hip replacement surgery	X						
Kidney failure	X			X	X		X
Knee replacement surgery	X						
Liver failure of advanced stage	X			X	X		
Loss of independent existence	X	X	X	X	X	X	X
Loss of limbs	X	X					
Loss of speech	X		X			X	X
Major organ failure on waiting list	X						
Major organ transplant	X						
Motor neuron disease	X					X	
Multiple sclerosis	X						X
Muscular dystrophy	X						
Occupational HIV infection	X						
Paralysis	X					X	X
Parkinson's Disease and SAPD	X						
Primary pulmonary hypertension	X						
Progressive systemic sclerosis	X						
Severe burns	X						
Severe rheumatoid arthritis	X						
Stage 1A malignant melanoma				X	X		
Stage A (T1a or T1B) prostate cancer				X	X		
Stroke	X			X	X	X	X
Systemic lupus erythematosus	X						

Re-Entry Exclusions Appendix (Cont'd)

	If a claim has been paid for this event						
	Muscular dystrophy	Occupational HIV infection	Paralysis	Parkinson's Disease and SAPD	Primary pulmonary hypertension	Progressive systemic sclerosis	Severe burns
No claim can be paid for this subsequent event							
Aortic Surgery					X		
Aplastic Anemia							
Bacterial meningitis							
Benign brain tumour							
Blindness	X	X					
Cancer (life threatening)		X					
Coma	X	X	X	X	X	X	
Coronary angioplasty							
Coronary artery bypass surgery					X		
Crohn's disease requiring surgery							
Deafness	X	X					
Dementia, including Alzheimer's disease							
Dilated cardiomyopathy	X				X		
Ductal carcinoma in situ of the breast		X					
Fulminant viral hepatitis							
Heart attack	X				X	X	
Heart valve replacement or repair	X				X		
Hip replacement surgery							
Kidney failure	X	X			X	X	
Knee replacement surgery							
Liver failure of advanced stage	X	X				X	
Loss of independent existence	X	X	X	X	X	X	X
Loss of limbs							
Loss of speech	X	X	X	X			
Major organ failure on waiting list	X				X	X	
Major organ transplant	X				X	X	
Motor neuron disease							
Multiple sclerosis							
Muscular dystrophy	X						
Occupational HIV infection		X					
Paralysis	X	X	X	X			X
Parkinson's Disease and SAPD				X			
Primary pulmonary hypertension					X		
Progressive systemic sclerosis						X	
Severe burns							X
Severe rheumatoid arthritis							
Stage 1A malignant melanoma		X					
Stage A (T1a or T1B) prostate cancer		X					
Stroke	X	X			X	X	
Systemic lupus erythematosus							

Re-Entry Exclusions Appendix (Cont'd)

	If a claim has been paid for this event				
	Severe rheumatoid arthritis	Stage 1A malignant melanoma	Stage A (T1a or T1B) prostate cancer	Stroke	Systemic lupus erythematosus
No claim can be paid for this subsequent event					
Aortic Surgery				X	
Aplastic Anemia					
Bacterial meningitis					
Benign brain tumour					
Blindness					
Cancer (life threatening)					
Coma				X	
Coronary angioplasty		X	X	X	
Coronary artery bypass surgery				X	
Crohn's disease requiring surgery	X				X
Deafness					
Dementia, including Alzheimer's disease				X	
Dilated cardiomyopathy					
Ductal carcinoma in situ of the breast		X	X		
Fulminant viral hepatitis					
Heart attack				X	
Heart valve replacement or repair				X	
Hip replacement surgery	X				
Kidney failure	X			X	X
Knee replacement surgery	X				
Liver failure of advanced stage	X			X	X
Loss of independent existence	X			X	X
Loss of limbs					
Loss of speech					
Major organ failure on waiting list	X			X	X
Major organ transplant	X			X	X
Motor neuron disease					
Multiple sclerosis					
Muscular dystrophy					
Occupational HIV infection					
Paralysis					
Parkinson's Disease and SAPD					
Primary pulmonary hypertension					X
Progressive systemic sclerosis					
Severe burns					
Severe rheumatoid arthritis	X				X
Stage 1A malignant melanoma		X	X		
Stage A (T1a or T1B) prostate cancer		X	X		
Stroke				X	X
Systemic lupus erythematosus	X				X

* Following a life threatening Cancer claim, the Insured cannot claim again for Cancer, except for plans with a "Cancer Recurrence Benefit" section, when all of its requirements have been met.

Extended Health Care

General description of this coverage

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

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

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

Reasonable and Customary Expenses are the lowest of:

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

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

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

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

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

The calendar year is from January 1 to December 31.

Deductible

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

Pre-Determination of Allowable Expenses

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

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

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

Prescription drugs

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

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

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

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

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

Drugs for the treatment of infertility are covered up to a lifetime maximum of two thousand four hundred dollars ($2,400) for each covered person.

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

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

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

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

Medical services and supplies

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

Ambulance

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

Dental accident

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

Prior to beginning dental treatment, details of the accident, relevant x-rays, pre-accident condition of the teeth, plan treatment and cost must be submitted to the Insurer. Approval of a treatment plan (except for emergency treatment required to alleviate pain) must be obtained from the Insurer prior to starting a course of treatment. These services must start within 100 days after the accident and be completed within 12 months of the accident and must be the least expensive that will provide professionally adequate treatment. Coverage is limited to the fee stated in the current Provincial Dental Fee Schedule for a general practitioner in the province where you live at the time that treatment is received. Expenses for the treatment of temporomandibular joint dysfunction (TMJ) or orthodontic services are not covered under this provision. The Insurer will cover up to a maximum of one thousand dollars ($1000) per person per injury.

Diabetic supplies

The following diabetic supplies are covered:

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

Diagnostic services

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

Eye exams

Eye exams performed by a licensed ophthalmologist or optometrist are covered up to one eye exam per person over 24 consecutive months. Dependent children under age 18 are covered up to one eye exam per child over 12 consecutive months, provided no portion of the cost is covered under your provincial health care plan.

Hearing aids

Coverage includes charges for the cost of, installation and repair (excluding batteries or routine maintenance of) hearing aids. Hearing aid batteries, tubing and ear molds provided at the time the hearing aid is purchased are covered. The maximum amount payable is eight hundred dollars ($800) per person over a 60 consecutive month period.

Home nursing care

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

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

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

Pre-determination of home nursing care benefits

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

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

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

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

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

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

Hospital accommodation

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

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

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

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

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

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

Medical equipment

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

- crutches, casts, trusses and canes.
- glucometers prescribed by a medical physician, up to a lifetime maximum of seven hundred dollars ($700) per person.

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

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

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

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

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

Orthopaedic shoes and foot orthotics

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

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

Ostomy supplies

The following colostomy and ileostomy supplies are covered:

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

Oxygen and equipment

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

Paramedical practitioners services

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

- Acupuncturist - treatment by a Licensed Acupuncturist.
- Audiologist- treatment by a Licensed Audiologist.
- Chiropractor - treatment of muscle and bone disorders, including diagnostic x-rays.
- Dietician – treatment by a Registered Dietician.
- Massage Therapist - treatment by a Registered Massage Therapist for muscle, tissue and joint disorders.
- Naturopath - treatment by a Licensed Naturopath (naturopathic remedies and/or supplements are excluded).
- Occupational Therapist – treatment by a Registered Occupational Therapist.
- Osteopath - treatment of musculoskeletal disorders, including diagnostic x-rays.
- Podiatrist/Chiropodist - treatment of foot disorders, including diagnostic x-rays.
- Speech Therapist - treatment by a Licensed Speech Therapist for speech impairments.

The Insurer will cover up to a maximum of seven hundred and fifty dollars ($750) per person in a calendar year for each category of paramedical specialists listed below:

- Physiotherapist - treatment by a Registered Physiotherapist.
- Psychologist/Social Worker/Psychoanalyst – treatment by a Registered or Chartered Psychologist, Registered Social Worker or Psychoanalyst.

Smoking cessation aids

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

Speech aids

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

Prosthetic equipment

Charges for the following standard prosthetic equipment are covered:

- artificial limbs, including repairs; stump socks (maximum 5/calendar year).
- artificial eyes, including rebuilding and polishing.
- external breast prostheses /mastectomy forms (maximum of $400 every 24 consecutive months) and surgical bras (maximum of 6/calendar year).

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

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

Therapeutic equipment

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

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

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

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

Wheelchairs, walkers and hospital beds

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

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

Wigs and hair pieces

Coverage is provided for wigs or hairpieces following traumatic surgery, cancer treatments or for the diagnosis of alopecia universalis. The maximum amount payable is five hundred dollars ($500) per 36 consecutive months per covered person.

What is not covered

The Insurer will not pay for the costs of:

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

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

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

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

When and how to make a claim

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

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

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

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

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

Phone: 1-833-200-3430
Email: Canoe@groupsource.ca

Survivor Health Benefit

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

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

Emergency Travel Assistance

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

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

Definitions

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

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

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

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

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

Emergency means unexpected and not pre-planned.

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

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

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

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

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

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

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

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

When and how to make a claim

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

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

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

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

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

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

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

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

Payments

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

Evacuation benefit

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

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

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

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

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

Emergency dental treatment benefit

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

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

Family transportation and accommodation benefit

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

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

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

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

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

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

Fare means the regular fare charged for:

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

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

Medical reimbursement expense benefit

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

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

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

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

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

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

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

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

Return of vehicle benefit

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

Repatriation benefit

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

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

Exclusions and limitations

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

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

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

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

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

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

Non duplication

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

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

The AXA Assistance Program

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

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

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

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

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

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

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

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

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

Employee & Family Assistance Program

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

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

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

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

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

Contact TELUS Health toll-free, 24/7: 1.833.300.9511

Service en Français :1 833.237.5117; TTY: 1.877.371.9978

Online: one.telushealth.com
(User ID: groupsource, Password: wellness)

WorldCare ACCESS

Medical Second Opinion Service

Medical decisions can be overwhelming. When you are faced with surgery or a complex medical condition, how can you be confident you're making the most informed decision?

WorldCare can help

The WorldCare ACCESS medical second opinion service confirms your diagnosis, provides treatment recommendations and answers your questions. The medical second opinions are completed by teams of specialists at WorldCare Consortium® hospitals and delivered directly to you and your doctor along with the information you need to make informed decisions with greater confidence

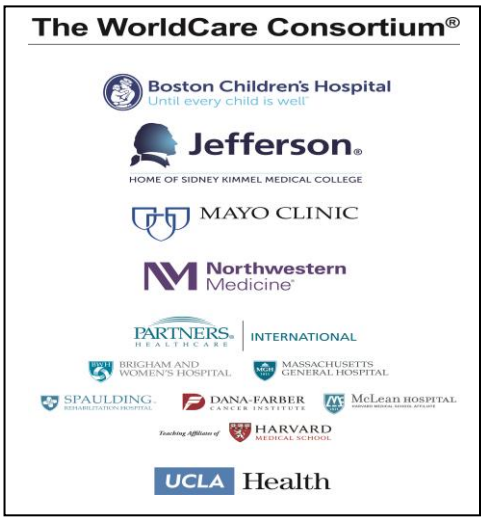
How the service works

Provided to you via your insurer or employer, the service is available to you free of charge. When you are facing a complex medical condition, use the following three-step process to initiate service:

Step 1: Call 877.676.6439 to initiate service.

Step 2: WorldCare will work with you and your doctor(s) to gather your medical records and send them to the medical institutions best suited to review your case.

Step 3: The specialists review your records and diagnostic material and provide a medical second opinion to you and your doctor



Sample covered conditions

1. AIDS
2. ALS
3. Alzheimer's disease
4. Amputation
5. Any life threatening illness
6. Benign brain tumor
7. Cancer
8. Cardiovascular conditions
9. Chronic pelvic pain
10. Coma
11. Deafness
12. Emphysema
13. Hip and knee replacement
14. Loss of speech
15. Major burns
16. Major organ transplants
17. Major trauma
18. Multiple Sclerosis
19. Neuro-degenerative diseases
20. Paralysis
21. Parkinson's disease
22. Renal insufficiency or kidney failure
23. Rheumatoid arthritis
24. Stroke
25. Sudden blindness due to sickness
26. Thrombophlebitis and embolism

To initiate service, please call 877.676.6439 or visit www.worldcare.com.

Dental Care

General description of this coverage

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

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

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

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

The calendar year is from January 1 to December 31.

Alternate benefit

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

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

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

Deductible

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

Preauthorization

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

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

Basic Dental Services

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

Oral examinations

You are covered for the following oral examinations:

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

X-rays

You are covered for all the following x-rays:

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

Laboratory

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

Cleaning

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

Topical fluoride treatment

You are covered for fluoride treatments once every 6 months.

Oral hygiene instruction

You are covered for instruction on how to brush and floss once per lifetime.

Space maintainers and maintenance

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

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

Caries, trauma and pain control

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

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

Fillings

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

Pre-fabricated metal or plastic restorations

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

Pit and fissure sealant

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

Endodontics

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

Periodontics

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

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

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

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

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

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

Temporomandibular joint (TMJ) disorders

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

Related surgical services

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

Repairing, relining or rebasing dentures

Repairing dentures means fixing broken or damaged dentures.

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

Rebasing dentures means fitting dentures with a new base.

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

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

Major Dental Procedures

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

Crowns

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

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

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

No benefits will be paid for:

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

Inlays and onlays

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

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

Veneers

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

Replacements must be separated by at least 4 years.

Dentures and bridgework

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

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

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

Coverage of services or supplies for implantology, including tooth implantation and surgical insertion of fabricated implants.

Replacement appliances are also covered when:

- the existing appliance is temporary and less than 12 months old. The amount reimbursed for the temporary appliance will be deducted from the cost of the permanent appliance. If the temporary appliance is over 12 months old, it will be considered the permanent appliance.
- the existing appliance is at least 4 years old and cannot be made serviceable. If the existing permanent appliance is less than 4 years old, a replacement will still be covered if the existing appliance becomes unserviceable, while you are insured for Major coverage under the Policy, as a result of:
    - the placement of an initial opposing appliance; or
    - the extraction of additional teeth. If additional teeth are extracted but the existing appliance can be made serviceable, coverage is limited to the replacement of the additional teeth.

Appliances will be replaced with similar appliances.

Implants

All procedures and care related to implants are eligible including, but not limited to:

- examination and diagnosis
- surgical installation of implants
- surgical reimplantation
- installation of attachments
- post-surgical care
- installation of a prosthetic pin and crown on the implant
- laboratory expenses

If laboratory expenses are applicable for one of the procedures covered under the complex restorative services, expenses are limited to 60% of the fees of the procedure.

No benefits will be payable for:

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

Orthodontic Procedures

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

Only your dependent children under age 21 are covered for these procedures. The benefit will terminate on your dependent child's 21st birthday whether or not the child is a student.

Orthodontic treatment

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

Orthodontic treatment plan

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

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

Payment of orthodontic services

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

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

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

Limitations & exclusions

No dental benefits will be paid for:

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

Benefits after termination

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

When and how to make a claim

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

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

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

Upon completion, please mail the original claim form to:

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

Phone: 1-833-200-3430
Email: Canoe@groupsource.ca

Survivor Dental Benefit

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

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

Protector Series™
Optional Critical Illness

What is Critical Illness Insurance?

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

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

General Information

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

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

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

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

Some terms we use throughout this booklet are:

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

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

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

Benefit Features

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

Face Amount means the dollar amount of insurance coverage.

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

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

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

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

Face Amount of Insurance

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

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

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

Covered Conditions

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

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

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

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

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

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

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

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

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

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

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

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

Children are not covered for this benefit.

Reinstatement Benefit for Cancer

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

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

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

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

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

Who can be covered

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

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

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

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

Your spouse is eligible for coverage if he or she:

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

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

Your dependent child is eligible for coverage if they are:

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

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

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

When are you eligible

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

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

When is medical evidence required

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

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

When does coverage start

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

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

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

Life Event

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

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

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

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

When does coverage terminate

Coverage terminates on the earliest of the following dates:

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

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

Portability Privilege

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

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

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

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

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

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

Pre-Existing Condition Limitation

What is a pre-existing condition

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

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

What is the pre-existing condition limitation

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

What if I had coverage before?

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

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

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

Premium Rates

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

- Age
- Gender
- Face Amount
- Smoking Status

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

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

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

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

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

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

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

Currency

All payments under the policy are made in Canadian dollars.

Grace Period

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

Claim information

To receive a claim payment under the policy:

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

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

Payment of a claim

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

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

Right to appeal

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

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

Covered Condition Definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Diagnosis of Blindness must be made by a Specialist.

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

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

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

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

Exclusion: No benefit will be payable for the following:

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

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

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

Cancer (Non-Life-Threatening) includes:

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

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

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

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

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

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

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

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

List A

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

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

List B

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

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

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

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

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

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

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

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

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

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

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

The Insured Person must exhibit:

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

The Diagnosis of Dementia must be made by a Specialist.

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

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

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

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

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

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

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

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

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

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

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

Activities of Daily Living are:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Dependent Child Critical Illness Exclusions

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

General Exclusions for Adult and Dependent Child Covered Conditions

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

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

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

Privacy Policy

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

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

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

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

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

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