National Farmers Union
Union Nationale des Fermiers

All Eligible NFU Members – Premium Plan

Arranged by:

Regency Advisory Corporation

Administered by:

Underwritten by:

SSQ Insurance Company Inc.

Policy effective: ***May 1, 2016***
Booklet produced: ***March 23, 2016***

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, #400, 1550 - 5th Street SW, Calgary, Alberta T2R 1K3.

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

Puzzled about your benefits?

...let us put the pieces together.

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

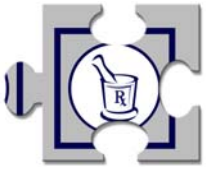
Schedule of Benefits

Life Benefits

Group Life
Accidental Death, Disease & Dismemberment
Dependent Life

Health Benefits

Prescription Drugs
Pay Direct Drug Card
Extended Health Care
Vision Care
Survivor Benefits
Emergency Travel Assistance



Dental Benefits

Basic Services
Major Restorative
Survivor Benefits

Optional Benefits

Voluntary Critical Illness

Employee Classification

Class 002:	All Eligible NFU Members – Premium Plan

Group Life
(underwritten by Co-operators Life Insurance Company Group Policy G.79 / Policy # 779909)

All eligible members	$10,000
Non-evidence maximum:	$10,000
Overall maximum:	$10,000
Coverage terminates:	at the earlier of retirement or age 70

Accidental Death, Disease & Dismemberment
(underwritten by Co-operators Life Insurance Company Group Policy G.1064)

All eligible members	an amount equal to your Life Insurance
Coverage terminates:	at the earlier of retirement or age 70

Dependent Life
(underwritten by Co-operators Life Insurance Company Group Policy G.79 / Policy # 779909)

All eligible members		
Spouse and each dependent child:	Spouse: Child:	$5,000 $2,500
Coverage terminates:	at the earlier of retirement or age 70	

Life Benefits

Extended Health Care

(underwritten by Co-operators Life Insurance Company Group Policy G.077 / Policy # 779909)

All eligible members and their eligible dependents

Prescription drugs (mandatory generic substitution):	100%
Pay direct drug card	
Calendar year maximum:	$5,000 per person
Hospital (private):	100%
Professional and medical care coverages:	100%
Eligible medical equipment and supplies:	100%
Vision care (eye wear):	100%
Adult:	$250/24 consecutive months
Qualified dependent children younger than 18 years of age:	$250/12 consecutive months
Survivor benefits:	24 months

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

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

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

Coverage terminates:	at the earlier of retirement or age 70

Dental Care

(underwritten by Co-operators Life Insurance Company Group Policy G.077 / Policy # 779909)

All eligible members and their eligible dependents

Basic, endodontic and periodontal:	100%
Major restorative services:	50%
Combined calendar year maximum:	$2,500 for basic, endodontic, periodontal and major restorative services combined
Survivor benefits:	24 months

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

Coverage terminates:	at the earlier of retirement or age 70

Dental Benefits

Voluntary Critical Illness
(underwritten by SSQ Insurance Company Inc. Group Policy 1PV00)

All eligible members	units of $10,000 to a maximum of $250,000 with a guaranteed issue amount of $50,000
Eligible spouse	units of $10,000 to a maximum of $250,000 with a guaranteed issue amount of $25,000
Eligible dependent children	units of $5,000 to a maximum of $25,000 with a guaranteed issue amount of $25,000
Coverage terminates:	at the earlier of retirement or age 70

Waiting Period For All Benefits

Benefits for eligible members will commence on the first of the month next following the application date.

General Provisions

Eligibility

For the purpose of this employee booklet, **you** refers to the employee of the Employer or policyholder.

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

- you are a permanent employee.
- you have completed the waiting period stated in the Schedule of Benefits.

You are considered to be Actively Working if you are performing all the usual and customary duties of your job with your employer for the scheduled number of hours. This includes scheduled non-working days and vacation days if you are Actively Working on the last scheduled working day. You are not considered to be actively at work if you are receiving disability benefits or are participating in a partial disability or rehabilitation program.

Your dependents become eligible for coverage on the date you become eligible or the date they first become dependent, whichever is later. You must apply for coverage for yourself in order for your dependents to be eligible.

Who qualifies as your dependent

Your dependent must be your spouse or your children who are residents of Canada.

To be eligible your spouse must be legally married to you, or your common-law partner who is publicly represented as your spouse and has resided with you for a minimum of 12 consecutive months. You can only cover one spouse at a time. You must insure the same person for all Spousal Benefits provided under this policy.

Your children and your spouse's children, who are unmarried, unemployed and under age 22, are eligible dependents. Dependent children include natural, adopted or stepchildren. Children of a common-law spouse may be covered if the common law spouse is living with you, is insured under this policy and has custody of the child/children.

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

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

When coverage begins

You may elect coverage by completing an application within 31 days following the waiting period as indicated in the Schedule of Benefits. Your coverage begins on the date you become eligible for coverage.

If you are not Actively Working on the date coverage would normally begin, your coverage will not begin until you return to active work.

Dependent coverage begins on the date your coverage begins or the date the person qualifies as an eligible dependent, whichever is later, provided that dependent benefits were applied for within 31 days of their becoming eligible.

However, for a dependent, other than a newborn child, who is hospitalized, coverage will begin when the dependent is discharged from hospital and is actively pursuing normal activities. Newborns are covered from live birth.

Once you have dependent coverage, any subsequent dependents will be covered automatically.

Late applicant

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

Changes affecting your coverage

From time to time, there may be circumstances that change your coverage.

For example, your employment status may change, or your employer may change the group contract. Any resulting change in the coverage will take effect on the date of the change in circumstances.

The following exceptions apply if the result of the change is an increase in coverage:

- if evidence of insurability is required, the change cannot take effect before the Insurer approves the evidence of insurability.
- if you are not Actively Working when the change occurs or when the Insurer approves the evidence of insurability, the change cannot take effect before you return to active work.
- if a dependent, other than a newborn child, is hospitalized on the date when the change occurs, the change in the dependent's coverage cannot take effect before the dependent is discharged and is actively pursuing normal activities.

Updating your records

To ensure that coverage is kept up-to-date, it is important that you report any:

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

When coverage ends

As an employee, your coverage will end on the earlier of the following dates:

- the date you cease to be Actively Working.
- the date you cease to be a member of any eligible class.
- the date that premiums paid to the Insurer for your coverage ceases.
- the date the group contract ends.
- the date you submit any claim or collect any benefits founded on misrepresentations irrespective of the compulsory nature of any coverage or any other action the Insurer may take.
- the date you reach the benefit termination age as indicated in the Schedule of Benefits.
- the date you die.

A dependent's coverage terminates on the earlier of the following dates:

- the date your coverage ends.
- the date the dependent is no longer an eligible dependent.
- the date that premiums paid to the Insurer for the dependent coverage cease.

Continuation of coverage during absence from work

For Life and Disability benefits, if you cease to be Actively Working due to leave of absence, strike, lock-out or temporary lay-off, the Policyholder may elect, on a basis that precludes individual selection, to continue insurance coverage for up to the maximum period indicated below:

- Short Term Disability and Long Term Disability benefits can be continued for one month from the end of the month in which employment was interrupted.
- All Life Benefits can be continued up to six months from the end of the month in which employment was interrupted.

If you cease to be Actively Working due to an approved maternity leave and/or parental leave, you will be considered to be still working and eligible for continued insurance coverage for the duration of the period allowed by the Employment Insurance Act, whether or not benefits are paid or payable under the Employment Insurance Act.

No increase in insurance will be permitted for an Employee who is not Actively Working. All continuation of coverage is contingent upon the payment of the premiums to the Insurer in the normal manner.

For Health and Dental benefits, if you are absent from work on account of Injury or Sickness, coverage may be continued for the duration of such absence as if you are still at work, provided this Policy is in force and the premiums for you are remitted.

If you are absent from work on account of temporary lay-off, or an approved leave-of-absence, coverage may be continued, in a manner that precludes individual selection, for up to 6 months from the end of the month in which employment was interrupted provided this Policy is in force and the premiums for you are remitted.

If you cease to be Actively Working due to an approved maternity leave and/or parental leave, you will be considered to be still employed and eligible for continued insurance coverage for the duration of the period allowed by the Employment Insurance Act, whether or not benefits are paid or payable under the Employment Insurance Act.

If your employment is terminated by the Employer, coverage will be extended for the period permitted for involuntary termination of employment, as required by any provincial law or legislation in effect in your province of residence, provided this Policy is still in force and the premiums for you are remitted.

Reinstatement

If your insurance has been terminated due to termination of employment, leave of absence or lay-off and you return to Active Work with the employer within 6 months of termination, you will have the insurance under this Policy reinstated, without evidence of insurability, effective the date of return to Active Work, provided a written application for reinstatement is received by the Insurer within 31 days of your return to work date.

If the application is not made within the 31-day period, you must submit evidence of insurability and the insurance will not take effect until the Insurer has approved the application.

If you return to Active Work with the Employer after the expiration of the 6-month period you will be considered a new Employee and will be required to satisfy the eligibility requirements.

Making claims

You must submit a claim for benefits under this policy. You should contact your employer to get the proper forms to make a claim. Completed claim forms must include the following:

- your company name and policy number.
- your name, date of birth and complete address.
- your identification number.
- dependent's name, date of birth and relationship to you.
- **original** receipts.

There are time limits for making claims. These limits are discussed in the appropriate sections of this employee benefits booklet.

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

GroupSource
#400, 1550 – 5th Street S.W.
Calgary, Alberta T2R 1K3

Telephone # (403) 228-1644
Toll-free # 1-800-661-6195

Co-ordination of benefits

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

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

For **Emergency Travel Assistance,** in the event you and your spouse both work for the same employer and you both have opted for family coverage, an individual's Emergency Travel claims will be eligible under one plan only.

Medical examination

If you make a claim for benefits, the Insurer can require you to have an independent medical examination and will pay for the cost of the examination. If you fail or refuse to have this examination, benefits will not be issued.

Recovering overpayments

Whenever payments have been made for allowable expenses in a total amount that exceeds the maximum payment necessary, the Insurer has the right to recover by any available legal means, such benefit overpayments from any person to whom or for whom payments were made or from any Insurance company or other organization.

If you recover damages from another person

The Insurer has the right to part of any money you recover through legal action or settlement from another person, organization or company who caused your disability, to the extent of the payments or benefits provided.

If you decide to take legal action, you must comply with the applicable terms of the group contract concerning legal action.

The Insurer has the right to withhold or discontinue disability income payments if you refuse or fail to comply with any of these terms.

Definitions

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

Accident means a bodily injury that occurs solely as a direct result of a violent, sudden and unexpected action from an external source.

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

Calendar Year Maximum means January 1 to December 31.

Close Relative means an individual who is related to another individual in one of the following ways: spouse, son, daughter, father, mother, brother, sister.

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

Covered Person means an Employee or Dependent of an Employee who has satisfied the eligibility and application requirements for benefits provided under this Policy and for whom the current premiums are being paid. The Covered Person must be insured under a provincial Government Health Insurance Plan.

Earnings mean your regular Earnings from your Employer, not including bonuses or overtime.

If you are a commissioned employee or an employee who earns all or part of your remuneration on a similar basis, Earnings shall mean your actual earnings in the preceding 2 calendar years based on T4 slips. If employed less than 2 years, the Earnings will be averaged over the available length of service with the Employer;

If you are a self-employed individual, Earnings shall mean the average of the income received from employment less deductible expenses, as reported for federal income tax purposes in the last two calendar years;

If you are the owner of an incorporated company, Earnings shall mean the average of the earnings received from the incorporated company, and the share of the profit (net of expenses and after income tax) of the same company, as reported for federal tax purposes in the last two fiscal years.

If you are an hourly-rated employee, your earnings will be based on the number of regular hours worked per week.

For all categories: “Monthly Earnings” shall mean 1/12 of the annual earnings and “Weekly Earnings” shall mean 1/52 of the annual earnings.

Illness means a disease or a sickness. As it relates to Short Term Disability and Long Term Disability coverage, all disabilities that are not related to an Accident as defined herein, will be deemed to be a result of illness.

Medical Care means necessary services, supplies or surgery, including hospitalization, provided or ordered by a Physician in the treatment of a Covered Person's Sickness or Injury.

Medically Diagnosed Condition means 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.

Non-evidence Maximum means the amount of insurance for which an Employee may become insured without having to submit satisfactory Evidence of Insurability. The Non-evidence Maximums are shown in the Schedule of Benefits.

Physician means a person who is legally licensed to practice medicine in the Province or Territory where the service is rendered and is registered by the College of Physicians and Surgeons in the Province or Territory in which the person is practising. The Physician cannot be related to you.

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

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

Residence means the primary dwelling where you are an occupant and the premises on which the primary dwelling is situated.

Life Benefits

General description of the coverage

Your Life coverage provides a benefit for your beneficiary if you die while covered. The amount of your Life coverage (shown in the Schedule of Benefits) in effect on the date of your death will be paid when the Insurer receives due written proof of death.

Who will be paid

If you die while coverage is in place, the Insurer will pay the full amount of your benefit to your last named beneficiary on file with the Insurer.

If you have not named a beneficiary, the benefit amount will be paid to your estate. Anyone can be your beneficiary. Subject to any legal restrictions, you can change your beneficiary at any time. The change will be effective on the date the designation form is signed, but it will not apply to any payment made by the Insurer prior to the date the form is received by the Insurer.

Living benefit

A special advance payment of the Life Benefit may be provided if you are suffering from a medically certified terminal condition. An application for the Total Disability premium waiver benefit must be received and approved by the Insurer (prior to age 63 if your Life Benefit terminates at age 65, or age 65 if your Life Benefit terminates at age 70).

Your employer must approve your application for this benefit and the Insurer will confirm that your medically diagnosed condition meets the program's requirements before approving payment. The amount of money available as a living benefit payment is 50% of your Life Benefit to a maximum of $50,000.

Coverage during total disability

If you become Totally Disabled, the amount of insurance in force on the disability date under this Policy for you and your Dependents (if applicable) shall continue without payment of premium. This benefit will cease on the earlier of your 65th birthday, recovery, retirement, death or termination of this policy.

Totally disabled means that as a result of accident or sickness you are unable to engage in any gainful occupation for which you are reasonably qualified based on education, training, or experience and are not performing any work for remuneration or profit. However, if you are in receipt of Long Term Disability benefits, you will be deemed to be Totally Disabled with respect to this benefit. Termination of employment or this policy will not affect the continuation of insurance under this provision.

If you are insured for Long Term Disability, premiums will be waived once you become entitled to receive Long Term Disability benefits. If you are not insured for Long Term Disability benefits premiums will be waived after 6 months of Total Disability.

Converting Life coverage

When your Life coverage ends, you may apply to convert the group Life insurance benefits to an individual Life policy with the Insurer without providing proof of good health. The maximum amount available for you to convert is the lesser of the amount of group life insurance you are covered for or two hundred thousand dollars ($200,000). If you are over age 65, the maximum amount available to convert is $25,000.

The request **must** be made and the required premium submitted within 31 days after ceasing to be protected under this coverage. The premium for the individual policy will be based on the Insurer's individual policy rates in effect on the date of the application.

Limitations

When eligibility for insurance ceases because the group policy is terminated and if the policy is not replaced, the conversion privilege is available only to participants who had life insurance coverage under a group insurance contract for a continuous period of five years and who submit a request during the 31-day period following termination of the policy. If the policy is terminated and replaced with another policy within a period of 180 days, any individual policies issued under this conversion are terminated when the participant becomes eligible under a new policy.

A participant who ceases to be eligible for this benefit because he enlists for active duty in the armed forces of any country cannot exercise his conversion privilege.

Extension of benefit

Your Life coverage provides a benefit if you die within 31 days after ceasing to be insured under this plan. The amount of benefit is equal to the amount you are entitled to convert.

Assignment

No assignment of insurance or benefits provided by this policy is permitted.

When and how to make a claim

Claims for Life benefits must be made as soon as reasonably possible and in any event no later than 180 days from the date of death. Failure to furnish such proof within the time required will not invalidate nor reduce any claim, if it is not reasonably possible to furnish the proof within such time, provided the proof is given as soon as is reasonably possible.

Claim forms are available from your employer.

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.

Dependent Life

General description of the coverage

If one of your dependents dies while insured, the benefit amount, shown in the Schedule of Benefits, is paid to you. In the case of a child born while this coverage is in force, the Dependent coverage will take effect at birth.

Pre-natal benefit

In the event that you or your spouse has a stillbirth, while this coverage is in force, the Insurer will indemnify you for funeral expenses to a maximum not exceeding the Dependent Life insurance amount for which a Child is covered under this Policy.

Converting Life coverage

If you terminate your employment, your spouse may apply to convert the Dependent Life coverage to an individual Life Policy with the Insurer without providing proof of good health.

The premium for the individual policy will be based on the Insurer's rate as of the effective date of the individual policy, the amount converted and your spouse’s attained age.

Your spouse must apply for the individual policy within 31 days after ceasing to be covered.

This conversion option does not extend to any insurance on your dependent children.

When and how to make a claim

Claims for Dependent Life benefits must be made as soon as reasonably possible and in any event no later than 180 days from the date of death.

Waiver of premium

If you are totally disabled and the premium for your Life coverage is being waived, premium for the Dependent Life coverage will also be waived. The Dependent Life waiver will terminate if the policy terminates.

Extended Health Care

General description

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

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

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

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

The calendar year is from January 1 to December 31.

Deductible

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

Prescription drugs

Coverage includes the cost of drugs that are, by law, only available with a prescription, as long as they are prescribed by a Physician or Dentist and are obtained from a licensed pharmacist.

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

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

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

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

The Insurer will only pay for quantities that can reasonably be used within 90 days.

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

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

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

Medical services & supplies

The 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 Approved Hospital where Reasonable and Customary Treatment is available, or from an Approved Hospital to a Convalescent Hospital. There is no coverage if you are not transported to a hospital. Where medically necessary, the fee for one person to attend you when being transported will be covered.

Dental accident

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

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

Diabetic supplies

The following diabetic supplies are covered:

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

Diagnostic services

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

Eye exams

Charges for eye exams performed by a licensed ophthalmologist or optometrist are covered, up to a maximum of sixty dollars ($60) per person over 24 consecutive months, provided no portion of the cost is covered under your provincial health care plan. Dependent children under age 18 are covered to a maximum of sixty dollars ($60) per child over 12 consecutive months.

Hearing aids

Coverage includes charges for hearing aids, including repair (excluding batteries or routine maintenance). Hearing aid batteries, tubing and ear molds provided at the time the hearing aid is purchased are covered. The maximum amount payable is five hundred dollars ($500) per person over a 60 consecutive month period.

Home nursing care

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

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

Pre-determination of benefits

To establish the amount of coverage available under this provision before home nursing begins, you must apply for a pre-determination of benefits. A pre-determination of benefits is an assessment by the 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, etc.), child-care or house-keeping duties, or for home nursing care for Medically Diagnosed Conditions where significant improvement or deterioration is unlikely within the next 12 months. This is considered Chronic Care.

Hospital accommodation

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

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

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

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

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

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

Medical equipment

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

- crutches, casts, trusses, walkers and canes.
- orthopedic braces. Braces are wearable, orthopedic appliances that rely on a rigid material such as metal or hard plastic to hold parts of the body in the correct position. Elastic supports and foot orthotics are not considered braces. Dental braces are not considered a covered Extended Health Care expense.
- splints, including shoes attached to a splint. Intra-oral splints are not covered.
- surgical elastic stockings / pressure gradient hose to a maximum of 6 pairs per calendar year.
- Intrauterine device (IUD) when inserted by a Physician.

Orthopedic shoes & foot orthotics

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

- custom-made foot orthotic inserts for shoes that are specially designed and molded for you. The maximum amount payable is four hundred dollars ($400) per 24 consecutive months.
- custom-made and custom-fitted orthopedic shoes that are specially designed and fitted for you. Coverage is also provided for modifications to orthopedic shoes. The maximum amount payable is four hundred dollars ($400) per calendar year.

Ostomy supplies

The following colostomy and ileostomy supplies are covered:

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

Oxygen & equipment

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

Paramedical practitioners services

Charges for out-of-hospital services of the following practitioners, when treating a Medically Diagnosed Condition, are covered when provided in Canada. Only one treatment by any one practitioner is covered per day, per Covered Person. The maximum benefit available is three hundred dollars ($300) per Covered Person per calendar year, for each category of paramedical specialist listed below:

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

Prosthetic equipment

Charges for the following standard prosthetic equipment are covered:

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

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

Reimbursement for covered prosthetic equipment is subject to the lifetime maximum aggregate amount of twenty five thousand dollars ($25,000).

Sclerotherapy

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

Smoking cessation

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

Speech aids

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

Therapeutic equipment

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

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

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

To establish the amount of coverage available under this provision you must apply for a pre-determination of benefits. If the pre-determination is not obtained, the 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 and hospital beds

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

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

Wigs and hair pieces

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

What is not covered

The Insurer will not pay for the costs of:

- expenses that private insurers are not permitted to cover by law;
- services or supplies not specifically listed as covered;
- services or supplies payable in whole or in part under any legislation, except for user fees and extra billing if the legislation allows the user fees and extra billing;
- services or supplies that do not represent Reasonable and Customary Treatment of your Medically Diagnosed Condition;
- care, services or supplies utilized as treatment of lifestyle choices, as determined by the Insurer;

- services or supplies which are primarily for cosmetic purposes;
- services or supplies associated with recreation or sports rather than with other regular daily living activities;
- anti-obesity treatment, including drugs, protein and dietary or food supplements whether or not prescribed for a medical reason;
- diagnosis or treatment of infertility except for prescription fertility drugs as indicated in Schedule of Benefits;
- contraception, other than oral contraceptives and intrauterine devices;
- equipment that the Insurer considers ineligible (such as orthopedic mattresses, exercise equipment, air-conditioning or air-purifying equipment, vaporizers, whirlpools, humidifiers, and equipment used to treat seasonal affective disorders);
- additional, duplicate or replacement appliances or devices, except where the replacement is required because the existing appliance can no longer be made serviceable due to normal wear and tear, or as the result of a pathological change, unless prior approval in writing is obtained from the Insurer; or
- expenses incurred for the completion of claim forms, obtaining further medical information regarding claims for covered expenses, medical screening or examinations for the use of a Third Party, or broken appointments, travel expenses or communication costs by a Medical Practitioner.

The Insurer will not cover expenses arising from:

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

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

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

When & how to make a claim

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

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

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

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

GroupSource
#400, 1550 – 5th Street S.W.
Calgary, Alberta T2R 1K3

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

Vision Care

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

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

The available vision care benefit means the benefit amount as described in the Schedule of Benefits, less any vision care expenses reimbursed in the past 24 months.

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

Survivor Health Benefit

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

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

Emergency Travel Assistance

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

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

Definitions

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

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

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

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

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

Emergency means unexpected and not pre-planned.

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

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

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

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 #400, 1550-5th Street SW, Calgary, Alberta T2R 1K3.

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
#400, 1550 – 5th Street S.W.
Calgary, Alberta T2R 1K3

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, mountaineering, hang gliding, scuba diving, 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.

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".

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.

Pre-determination of benefits

In the event Allowable Expenses are likely to exceed $500, a detailed dental treatment plan must be submitted to the Insurer before any treatment, other than necessary emergency treatment, begins. The Insurer will then advise you how much of the planned treatment is covered. This pre-determination of benefits is valid for 1 year from the date it was provided. In order for benefits to be paid, you must be eligible for coverage under this Benefit plan on the date the expense is actually incurred.

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

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. 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 specialist 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 24 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, and tomography x-rays to a combined maximum of 10 x-rays per 12 month period.

Laboratory

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

Cleaning

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

Topical fluoride treatment

You are covered for fluoride treatments once every 6 months.

Oral hygiene instruction

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

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.

Extractions

You are covered for the extraction of teeth and their roots, including pre and post-operative care. No benefits are payable for any addition charge for the removal of sutures in connection with any dental treatment.

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. Preventative restorative resins are not covered.

Discing

Filing the surfaces of the teeth (interproximal discing) is covered.

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.

Endodontics

Endodontics is the treatment of the pulp tissue and pulp chamber. Standard root canal therapy for permanent and primary teeth, is covered, up to one course of treatment per tooth. Repeat treatment is covered only if the original therapy fails after the first 24 months and has not been reimbursed. If retreatment is payable, it will be considered as if it were initial treatment.

- Opening through a crown is not covered in conjunction with endodontic therapy.
- No benefits will be paid for enlargement of pulp chambers or endosseous intra-coronal implants.
- Extra charges for difficult access, exceptional anatomy and calcified canals are not covered.

Periodontics

Periodontics is the treatment of soft tissue (gums) 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.

Scaling and root planing are limited to 10 time units combined per calendar year.
Occlusal adjustment and equilibration are limited to 10 time units combined per calendar year.

Periodontal surgery is limited to 4 sites per calendar year with one surgical procedure per site.

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

Temporomandibular joint (TMJ) disorders

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

Related surgical services

Reasonable and Customary Expenses for general anaesthesia in conjunction with covered periodontal oral surgery are covered. Any charges for facility fees or other related expenses are not covered.

Repairing, relining or rebasing dentures

Repairing dentures means fixing broken or damaged dentures. **Relining dentures** means adding material so that the dentures fit properly. **Rebasing dentures** means fitting dentures with a new base.

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

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

Major Dental Procedures

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

Crowns

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

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

Related Items

The following items related to crowns, veneers and onlays are covered:

- Posts, cores, pins and copings related to covered crowns
- Repairs to covered tooth-covered materials
- Removal and recementation of crowns and onlays

Dentures and bridgework

The following appliances are covered when required to replace one or more teeth extracted while you are insured for major coverage with this Employer:

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

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

Replacement appliances are also covered when:

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

Appliances will be replaced with similar appliances.

No benefits will be payable for:

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

Limitations & exclusions

No dental benefits will be paid for:

- services or supplies not specifically listed as covered;
- expenses that private insurers are not permitted to cover by law;
- 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;
    - sporting activities (ex. mouth guards)
    - congenital defects or developmental malformations or replacement of congenitally missing teeth;
    - bacteriological tests or smears;
- miscellaneous services:
    - nutritional counselling or, 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;
- expenses arising from war, insurrection, civil commotion, acts of terrorism, voluntary participation in a riot, or active duty as a member of any branch of the armed forces.

Benefits after termination

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

When and how to make a claim

To make a claim, complete the claim form that is available from your employer. The dentist will have to complete a section of the form. The 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 claim form and original receipts to:

GroupSource
#400, 1550 – 5th Street S.W.
Calgary, Alberta T2R 1K3

Telephone # (403) 228-1644
Toll-free # 1-800-661-6195

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.

Voluntary Group Critical Illness

(Insured by SSQ Insurance Company Inc. – Policy #1PV00)

What is critical illness insurance?

Critical illness insurance can 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·Choice·Care is designed to provide you with a lump sum payment in the event that you are diagnosed with a covered Critical Illness and survive at least 30 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 Critical·Choice·Care benefit payment.**

Critical illnesses are diagnosed every day. 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.

What is Critical Illness insurance?

Critical Illness insurance can 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 when faced with a Critical Illness.

Critical Choice Care is designed to provide you with a lump sum payment in the event that you are diagnosed with a covered Critical Illness and survive at least 30 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 Critical Choice Care benefit payment**.

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.

Definitions

Employee means an active employee who works the minimum hours per week indicated in the General Provisions section, and is under the age of 70, and who resides in Canada.

Insured Person means you, or your Spouse, or insured Dependent Children, while meeting the Spouse and Dependent Child definition criteria presented in this section, and before the date of coverage termination.

Insurer, **We**, **Us** means SSQ Insurance Company Inc.

You and **Your** refer to the Insured Person to whom this booklet was intended.

Spouse means an individual under 70 years if age:

a) to whom you are legally married, or
b) with whom you have continuously cohabitated in a conjugal relationship for a minimum of one year immediately before a Critical Illness is Diagnosed

However, when the individual is the biological or adoptive mother or father of at least one of your children, the spouse shall be so recognized from the date of birth or adoption, if that date precedes the end of the period of one year of cohabitation.

Only one individual will qualify as your Spouse. If you are legally married but are also cohabitation with an individual a described under Item (b) above, you may elect in writing which one of the individuals will qualify as a Spouse under this Policy. This election must be filed with GroupSource LP. The Insurer will not be bound by an election not filed before the occurrence of the event insured against. If an election is not filed, the Spouse will be the individual to whom you are legally married.

Dependent Child means a natural child, adopted child, stepchild or child who is in a parent-child relationship with you. The child must be unmarried and dependent on you for maintenance and support and:

- under 21 years of age; or
- under 25 years of age (26 in the province of Quebec) and in attendance at an Institution for Higher Learning on a full-time basis; or
- no matter his age, has been struck with a functional disability while satisfying the conditions under either of the two paragraphs above. Proof of existence of this situation must be presented to the Insurer within 31 days after the child reaches the applicable limiting age indicated above (age at which he would no longer qualify as a Dependent Child under this provision). Thereafter, the Insurer may periodically require that other proof be submitted establishing to its satisfaction that the situation still exists.

Claimant means the person who has requested or is in the process of requesting a settlement after being Diagnosed with an illness covered under the Critical Choice Care program.

Critical Illness means, with respect to the insured Employee and to the insured Spouse, one of the illnesses, conditions or surgical operations listed under "*Covered Critical Illnesses – (for insured Employee and insured Spouse)"*. With respect to insured Dependent Children, "Critical Illness" means one of the illnesses, conditions or surgical operations listed under "*Critical Illnesses Covered for Dependent Children*".

Any Critical Illness or health problem which is not defined, in the section of this booklet pertinent to a benefit of the Critical Choice Care program applicable to the Insured Person, is not covered according to such benefit and therefore, no benefit is payable.

Diagnosis or **Diagnosed** means the time when a Specialist establishes, using tests or other diagnostic methods, that the Insured Person has a specific Critical Illness. The Diagnosis of any covered Critical Illness must be made by a licensed Specialist practising in Canada, whose practice is limited to the branch of medicine directly linked to the Critical Illness for which benefit is being claimed.

Institution for Higher Learning means and is limited to universities, colleges, CEGEP's and trade schools.

Irreversible means the condition cannot be improved by medical or surgical treatment at the time of Diagnosis. The medical or surgical treatment need not be undertaken if it would involve an undue risk to the Insured Person's health.

Life Support means the Insured Person 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 and provide treatment within the scope of his licence. The Physician must not be the Insured Person, a relative of or business associate of the Insured Person.

Policy means the Critical Choice Care 31 Illnesses #1PV00 insurance program's Master Policy, endorsements and attached papers, if any, and contains the entire contract of insurance.

Pre-Existing Condition means:

- the existence of symptom(s) which would cause an ordinarily prudent person to seek diagnosis, care or treatment within the 24 month period preceding the Insured Person's effective date of coverage; or
- an illness or condition for which the Insured Person, during 24 months prior to the effective date of his coverage incurred medical expenses, received medical treatment, took prescribed drugs or medicine or consulted a physician.

Principal Sum means the amount applicable to the Insured Person, as listed under the *"Coverage Amount"* section of this booklet.

Specialist means a licensed Physician who has been trained in the specific area of medicine relevant to the covered Critical Illness condition 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. Specialist includes, but is not limited to, cardiologist, neurologist, nephrologist, oncologist, ophthalmologist, burn specialist and internist. The Specialist must not be the Insured Person, a relative of or business associate of the Insured Person.

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

Survival Period means 30 days following the date of Diagnosis or 30 days following the date of Surgery, if applicable, except where otherwise specified under the Policy. The Survival Period does not include the number of days on Life Support as defined in this section. The Insured Person 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 90 days for Bacterial meningitis and Paralysis, the Survival Period runs concurrently with that condition's qualifying period.

When referring to a female person, male pronouns used in this document shall be construed as the feminine.

Eligibility

The **Critical Choice Care** insurance program is available to Employees of Participating Member Clients of GroupSource LP and their dependents (Spouse and Dependent Children).

As an active Employee of Participating Member Clients GroupSource LP, you are eligible under the Critical·Choice·Care program if you are residing in Canada. If you are absent from active work for any reason other than bona fide vacation or maternity or parental leave, you will only become eligible upon return to active work.

Your spouse is eligible for coverage if he or she resides in Canada and meets the Spouse definition as presented under the "Definitions for a better comprehension of this booklet" section.

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

Your Spouse under the Critical·Choice·Care program will be the person whom you designate as your spouse under the group benefit program of Policyholder.

Coverage amounts

Critical·Choice·Care insurance is a voluntary group coverage for you, your Spouse and your Dependent Children.

You have the option to buy an amount of principal sum in units of $10,000 up to a maximum of $250,000, subject to acceptance by the Insurer under the basis of proof of insurability and subject to the terms of premium payment indicated in the "Monthly Premium" section.

Your Spouse has option to buy an amount of principal sum in units of $10,000 up to a maximum of $250,000, subject to acceptance by the Insurer under the basis of proof of insurability and subject to the terms of premium payment indicated in the "Monthly Premium" section.

You can enroll your Dependent Children for coverage up to $25,000 of principal sum, each, without having to provide any evidence of insurability.

With regard to evidence of insurability, you may request an amount of coverage equal or less than the guaranteed issue amount of $50,000 and your Spouse may request an amount of coverage equal or less than the guaranteed issue amount of $25,000 without having to answer medical questions or having to present evidence of insurability. However, if you or your Spouse wishes to request an amount of coverage greater than the guaranteed issue amount, you and/or your Spousemust submit to the Insurer satisfactory evidence of insurability.

Note: Your Spouse may not request an amount of coverage greater than your amount of coverage.

Effective date

If you or your Spouse request an amount of coverage less than or equal to the guaranteed issue amount, your insurance is effective on the later of the following two dates:

1. the effective date of the Policy, if the request is received by GroupSource LP on or prior to the effective date of the Policy; or
2. the first of the month coincident with or following the date the request was received by GroupSource LP, if the request is received by GroupSource LP after the effective date of the Policy.

If you or your Spouse requests an amount of coverage greater than the guaranteed issue amount, your insurance is effective on the later of the following two dates:

1. the effective date of the Policy, if the approval from the Insurer has been received by GroupSource LP on or prior to effective date of the Policy; or
2. the first of the month coincident with or following the date the approval from the Insurer has been received by GroupSource LP, if the approval from the Insurer has been received by GroupSource LP after the effective date of the Policy.

Your Dependent Child's coverage becomes effective on the date that your insurance becomes effective.

Termination

Your coverage terminates on the earliest of the following events:

- on the date the Policy is terminated;
- on the premium due date if GroupSource LP fails to pay the required premium, except as the result of an inadvertent error;
- on the next premium due date following the date you reach 70 years of age;
- on the next premium due date following the date you cease to be an active Employee of GroupSource LP on account of leave of absence, lay-off, maternity/parental leave, disability, resignation, dismissal, pension or retirement, except as provided under the following sections: Continuation of Coverage during Approved Leaves, Extension of Coverage;
- on the date of your death;
- on the date the Principal Sum payment for a Loss of Independent Existence claim has been paid.
- on the next premium due date following the date you give notice of cancellation to GroupSource LP.

Your insured Spouse's insurance terminates on the earliest of the following events:

- on the date the person ceases to meet the definition criteria for Spouse presented under the "*Eligibility*" section;
- on the date the Principal Sum payment for a Loss of Independent Existence claim has been paid;
- on the next premium due date following the date the Insured Spouse reaches 70 years of age;
- on the date the insured Employee's insurance is terminated.

Your insured Dependent Child's insurance terminates on the earliest of the following events:

- on the date the person ceases to meet the definition criteria for Dependent Child presented under the "*Eligibility*" section
- on the date the Principal Sum has been paid;
- on the date the insured Employee's insurance is terminated.

Critical Illness Coverage

If Diagnosed with one of the following Critical Illnesses while insured, you or your insured spouse is entitled to receive a benefit payment equivalent to the Principal Sum applicable to the person Diagnosed with the Critical Illness:

- Alzheimer's Disease
- Aortic Surgery
- Aplastic Anemia
- Bacterial Meningitis
- Benign Brain Tumour
- Blindness
- Cancer (life-threatening)
- Coma
- Coronary Artery Bypass Surgery
- Deafness
- Dilated Cardiomyopathy
- Fulminant Viral Hepatitis
- Heart Attack
- Heart Valve Replacement
- Kidney Failure
- 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
- Primary Pulmonary Hypertension
- Progressive Systemic Sclerosis
- Severe Burns
- Stroke (Cerebrovascular Accident)

The Insured Person's Your Critical Illness must meet the definition of such illness as presented under the *"Covered Critical Illnesses – (for insured Employee and insured Spouse)"* section in order to be eligible for payment.

Payment is subject to the limitations of the Survival Period as referred to under the "*Definitions*" section and to the exclusions listed under "*General exclusions*".

It should be noted that any misrepresentation of smoker status based on the answers given on the application or enrollment card will be deemed to be fraudulent and therefore coverage will become void.

Once an Insured Person has been paid a benefit for any Critical Illness, payment of any future benefit under the program is subject to limitations and exclusions as referred to in the "*Multiple event coverage*" section.

Cancer recurrence benefit

If you or your insured spouse has already been diagnosed with cancer and, while insured, a new Diagnosis of Cancer (life-threatening) is made, you, or your insured Spouse will receive a benefit equivalent to the Principal Sum applicable to the person Diagnosed with Cancer, if the following conditions have been met:

- More than 60 months have passed since the previous cancer diagnosis; and
- No treatment relating directly or indirectly to cancer has been received within that 60 month period (treatment does not include preventive medications and follow up visits to the doctor).

The Diagnosed Cancer must meet the definition of Cancer (life-threatening), as presented under the "*Covered Critical Illnesses – (For insured Employee and insured Spouse)"* section in order to be eligible for a payment under this provision.

Payment is subject to the limitations of the Survival Period as referred to under the *"Definitions"* section and to the exclusions listed under "*General exclusions*".

Once an Insured Person has been paid a benefit for any Critical Illness, payment of any future benefit under the program is subject to limitations and exclusions as referred to in the "*Multiple event coverage*" section.

Complementary benefit in case of certain illnesses

If Diagnosed with one of the following illnesses while insured, you or your spouse are entitled to receive a benefit payment equivalent to 10% of the Principal Sum applicable to the person Diagnosed with such illness, subject to a maximum of $25,000:

- Coronary Angioplasty
- Ductal Carcinoma in Situ of the Breast
- Stage A (T1a or T1b) Prostate Cancer
- Stage 1A Malignant Melanoma

Important: The Diagnosed illness must meet one of the definitions presented under section "*Illnesses covered under Complementary benefit in case of certain Illnesses – (For insured Employee and insured Spouse)"* in order to be eligible under the Critical Choice Care program.

Payment for any one of the four illnesses listed above is subject to the limitations of the Survival Period as referred to under the *"Definitions"* section and to the limitations specified in the "*Re-entry exclusions*" section and to the exclusions listed under "*General exclusions*" section. The sum payable can only be paid once in the Insured Person's lifetime. However, such sum is paid independently of any other benefit under the Critical Choice Care program, i.e., the Insurer does not deduct such complementary benefit payment from any previous or later Principal Sum payment.

Multiple event coverage

When you or your insured Spouse have been Diagnosed with one of the covered Critical Illnesses listed above for which a Principal Sum has been paid, and is then Diagnosed with another covered Critical Illness from the same list at least 90 days after the Principal Sum payment, you or your insured Spouse will then be paid another benefit equivalent to the Principal Sum applicable to the person Diagnosed with the illness, subject to the limitations and exclusions described in the "*Re-entry exclusions*" section.

For a benefit payment under the Multiple Event Coverage benefit, the Critical Illness Diagnosed must meet one of the definitions presented under the "*Covered Critical Illnesses – (For insured Employee and insured Spouse)*" section and the Diagnosis must be made at least 90 days after payment of a benefit for a covered condition was made.

Payment is subject to the limitations of the Survival Period as referred to under the *"Definitions"* section and to the exclusions listed under "*General exclusions*".

Children Coverage

You will receive a payment equivalent to your Dependent Child's Principal Sum if this Dependent Child is Diagnosed with one of the following illnesses while his coverage is in force:

- Blindness
- Cancer (life-Threatening) Cerebral Palsy
- Coma
- Congenital Heart Disease requiring Surgery
- Cystic Fibrosis
- Deafness
- Down's Syndrome
- Loss of Speech
- Major Organ Transplant Mental Deficiency Muscular Dystrophy Paralysis
- Severe Burns
- Spina Bifida Cystica

The Dependent Child's Critical Illness must meet one of the definitions presented under "Critical illnesses covered for Dependent Children" section in order to be eligible under the Critical·Choice·Care program.

The payment is subject to limitations of the Survival Period as referred to under the "*Definitions*" section and to the exclusions presented in the "General Exclusions" section.

Second Medical Opinion Service

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

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

General exclusions

The program does not cover a Critical Illness that results directly or indirectly from any one or more of the following causes or situations:

- Within 90 days following the effective date of your coverage:
  - Diagnosis of Cancer is made; or
  - any signs, symptoms or investigations that lead to a Diagnosis of Cancer, regardless of when the Diagnosis is made.
- Within 90 days following the effective date of your coverage:
  - Diagnosis of Benign Brain Tumour is made; or
  - any signs, symptoms or investigations that lead to a Diagnosis of Benign Brain Tumour, regardless of when the Diagnosis is made.
- The Insured Person does not satisfy the Survival Period limitations.
- An intentionally self-inflicted injury or sickness, whether the Insured Person is sane or insane.
- The use of illicit drugs other than as prescribed and administered by or in accordance with the instruction of a legally licensed medical practitioner.
- Any cancer that manifests itself prior to the effective date of the Insured Person's insurnce 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.
- From a Pre-existing Condition except if such Critical Illness is Diagnosed 24 months after the Insured Person's effective date of coverage

Pre-existing Condition Exclusion

The Pre-existing Condition exclusion applies only to amounts equal to or below the guaranteed issue limit applicable to the Insured Person. It does not apply to the Insured Person who was approved for a higher amount than the guaranteed issue limit.

The Principal Sum will not be paid for Critical Illness which results directly or indirectly from a Pre-existing Condition. However, if the Critical Illness is diagnosed after twenty-four (24) months from the effective date of the Insured Person's coverage, his claim will not be reduced or denied under this exclusion.

If this Policy directly replaces one with the Insurer or another insurer providing similar benefits, an Insured Person who has satisfied the time period of Pre-Existing Conditions limitation in a prior policy will be deemed to have satisfied the time period in this policy, but only to the extent of the benefit amount and Critical Illnesses covered in the prior policy. Any additional benefit amount provided in this policy will be subject to the terms of this exclusion. The prior policy must be cancelled within thirty-one (31) days prior to the date this policy came into force.

An Insured Person who has not satisfied the time period of Pre-Existing Conditions limitation in a prior policy will be allowed to apply any amount of time satisfied under the pre-existing conditions limitation of the prior policy toward the satisfaction of the time period requirement of this Pre-existing Conditions Exclusion, but only to the extent of the benefit amount and Critical Illnesses covered in the prior policy. Any additional benefit amount provided in this policy will be subject to the terms of this exclusion. The prior policy must be cancelled within thirty-one (31) days prior to the date this policy came into force.

If at any time while the Policy is in force,the Principal Sum is increased to a higher amount, the additional benefit amount will be subject to the terms of this exclusion from the start of the increase of the Principal Sum. The Insured Person's effective date of individual coverage for the additional benefit will be the effective date of the increase of Principal Sum.

Re-entry exclusions

When a benefit is paid to you or your insured spouse for a Critical Illness and required premium payment is continued, individual insurance continues and a subsequent claim can be made in the event of another Diagnosis, subject to the following:

If a claim was made for a Critical Illness shown in the left column of the table below, no claim can be made for an illness listed in the right column.

Critical illnesses claimed for	Re-Entry exclusions (Illnesses for which the Insured Person cannot claim)
Alzheimer's Disease	Alzheimer's disease or Loss of independent existence.
Aortic Surgery	Alzheimer's disease, Aortic surgery, Coma, Coronary angioplasty, Coronary artery bypass surgery, Heart attack, Heart valve replacement, Kidney failure, Liver failure of advanced stage, Loss of independent existence, Major organ failure on waiting list, Major organ transplant or Stroke (cerebrovascular accident).
Aplastic Anemia	Aplastic anemia, Cancer (life-threatening), Ductal carcinoma in situ of the breast, Loss of independent existence, Stage 1A malignant melanoma or Stage A (T1a or T1b) prostate cancer.
Bacterial Meningitis	Bacterial meningitis, Blindness, Coma, Deafness, Loss of independent existence, Loss of speech, Paralysis or Stroke (cerebrovascular accident).
Benign Brain Tumour	Bacterial meningitis, Benign brain tumour, Blindness, Coma, Deafness, Loss of independent existence, Loss of speech, Paralysis or Stroke (cerebrovascular accident).
Blindness	Blindness or Loss of independent existence.

Cancer (life-threatening)	Aplastic anemia, Cancer (life-threatening) unless all the requirements in the "Cancer Recurrence Benefit" section have been met, Ductal carcinoma in situ of the breast, Liver failure of advanced stage, Loss of independent existence, Stage 1A malignant melanoma or Stage A (T1a or T1b) prostate cancer.
Coma	Blindness, Coma, Deafness, Loss of independent existence, Loss of speech, Paralysis or Stroke (cerebrovascular accident).
Coronary Artery Bypass Surgery	Alzheimer's disease, Aortic surgery, Coma, Coronary angioplasty, Coronary artery bypass surgery, Heart attack, Heart valve replacement, Kidney failure, Liver failure of advanced stage, Loss of independent existence, Major organ failure on waiting list, Major organ transplant or Stroke (cerebrovascular accident).
Deafness	Deafness or Loss of independent existence.
Dilated Cardiomyopathy	Alzheimer's disease, Aortic surgery, Coma, Coronary angioplasty, Coronary artery bypass surgery, Dilated cardiomyopathy, Heart attack, Heart valve replacement, Kidney failure, Liver failure of advanced stage, Loss of independent existence, Major organ failure on waiting list, Major organ transplant or Stroke (cerebrovascular accident).
Fulminant Viral Hepatitis	Cancer (life-threatening), Ductal carcinoma in situ of the breast, Fulminant viral hepatitis, Liver failure of advanced stage, Loss of independent existence, Major organ failure on waiting list, Major organ transplant, Stage 1A malignant melanoma or Stage A (T1a or T1b) prostate cancer.
Heart Attack	Alzheimer's disease, Aortic surgery, Coma, Coronary angioplasty, Coronary artery bypass surgery, Heart attack, Heart valve replacement, Kidney failure, Liver failure of advanced stage, Loss of independent existence, Major organ failure on waiting list, Major organ transplant or Stroke (cerebrovascular accident).
Heart Valve Replacement	Alzheimer's disease, Aortic surgery, Coma, Coronary angioplasty, Coronary artery bypass surgery, Heart attack, Heart valve replacement, Kidney failure, Liver failure of advanced stage, Loss of independent existence, Major organ failure on waiting list, Major organ transplant or Stroke (cerebrovascular accident).
Kidney Failure	Coma, Heart attack, Kidney failure, Liver failure of advanced stage, Loss of independent existence, Major organ failure on waiting list, Major organ transplant or Stroke (cerebrovascular accident).
Liver Failure of Advanced Stage	Aortic surgery, Blindness, Cancer (life-threatening), Coma, Coronary angioplasty, Coronary artery bypass surgery, Ductal carcinoma in situ of the breast, Heart attack, Kidney failure, Liver failure of advanced stage, Loss of independent existence, Major organ failure on waiting list, Major organ transplant, Multiple sclerosis, Paralysis, Progressive systemic sclerosis, Stage 1A malignant melanoma, Stage A (T1a or T1b) prostate cancer or Stroke (cerebrovascular accident).
Loss of Independent Existence	Any other Critical Illness. The Critical Illness insurance coverage terminates.
Loss of Limbs	Loss of independent existence or Loss of limbs.
Loss of Speech	Loss of independent existence or Loss of speech.
Major Organ Failure on	Aplastic anemia, Cancer (life-threatening), Coma, Ductal carcinoma in

Waiting List	situ of the breast, Heart attack, Kidney failure, Liver failure of advanced stage, Loss of independent existence, Major organ failure on waiting list, Major organ transplant, Stage 1A malignant melanoma, Stage A (T1a or T1b) prostate cancer or Stroke (cerebrovascular accident).
Major Organ Transplant	Aplastic anemia, Cancer (life-threatening), Coma, Ductal carcinoma in situ of the breast, Heart attack, Kidney failure, Liver failure of advanced stage, Loss of independent existence, Major organ failure on waiting list, Major organ transplant, Stage 1A malignant melanoma, Stage A (T1a or T1b) prostate cancer or Stroke (cerebrovascular accident).
Motor Neuron Disease	Blindness, Coma, Deafness, Heart attack, Loss of independent existence, Loss of speech, Motor neuron disease, Paralysis or Stroke (cerebrovascular accident).
Multiple Sclerosis	Blindness, Coma, Deafness, Kidney failure, Loss of independent existence, Loss of speech, Multiple sclerosis, Paralysis or Stroke (cerebrovascular accident).
Muscular Dystrophy	Blindness, Coma, Deafness, Dilated cardiomyopathy, Heart attack, Heart valve replacement, Kidney failure, Liver failure of advanced stage, Loss of independent existence, Loss of speech, Major organ failure on waiting list, Major organ transplant, Muscular dystrophy, Paralysis or Stroke (cerebrovascular accident).
Occupational HIV Infection	Blindness, Cancer (life-threatening), Coma, Deafness, Ductal carcinoma in situ of the breast, Kidney failure, Liver failure of advanced stage, Loss of independent existence, Loss of speech, Occupational HIV infection, Paralysis, Stage 1A malignant melanoma, Stage A (T1a or T1b) prostate cancer or Stroke (cerebrovascular accident).
Paralysis	Coma, Loss of independent existence, Loss of speech or Paralysis.
Parkinson’s Disease	Coma, Loss of independent existence, Loss of speech, Paralysis or Parkinson's disease.
Primary Pulmonary Hypertension	Aortic surgery, Coma, Coronary angioplasty, Coronary artery bypass surgery, Dilated cardiomyopathy, Heart attack, Heart valve replacement, Kidney failure, Loss of independent existence, Major organ failure on waiting list, Major organ transplant, Primary pulmonary hypertension or Stroke (cerebrovascular accident).
Progressive systemic sclerosis	Coma, Heart attack, Kidney failure, Liver failure of advanced stage, Loss of independent existence, Major organ failure on waiting list, Major organ transplant, Progressive systemic sclerosis or Stroke (cerebrovascular accident).
Severe Burns	Loss of independent existence, Paralysis or Severe burns.
Stroke (Cerebrovascular Accident)	Alzheimer's disease, Aortic surgery, Coma, Coronary angioplasty, Coronary artery bypass surgery, Heart attack, Heart valve replacement, Kidney failure, Liver failure of advanced stage, Loss of independent existence, Major organ failure on waiting list, Major organ transplant or Stroke (cerebrovascular accident).

Continuation of coverage during approved leaves

Individual coverage under the Policy will be continued for an Insured Employee and his Insured Spouse and/or his Insured Dependent Children during any approved leave of absence, temporary lay-off, maternity/parental leave or disability leave of the Insured Employee, provided payment of premium is continued.

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

- with respect to any leave of absence approved by the Policyholder, on the first (1st) day of the month following the completion of a twelve (12) month period that started on the date such approved leave of absence began or on the date the Insured Employee returns to work in any capacity for the Policyholder or any other employer, including self-employment, whichever is earlier. Continuation of coverage for periods in excess of twelve (12) months may be granted, provided written request is submitted by the Policyholder to the Insurer;
- with respect to any temporary lay-off approved by the Policyholder, on the first (1st) day of the month following the completion of a six (6) month period that started on the date such approved temporary lay-off began or on the date the Insured Employee returns to work in any capacity for the Policyholder or any other employer, including self-employment, whichever is earlier. Continuation of coverage for periods in excess of six (6) months may be granted, provided written request is submitted by the Policyholder to the Insurer;
- with respect to strike, on the thirty-first (31st) day following the commencement of the strike;
- with respect to any maternity/parental leave approved by the Policyholder, on the date the Insured Employee returns to work in any capacity for the Policyholder or any other employer, including self-employment; and
- with respect to any disability leave approved by the Policyholder, on the date the Insured Employee reaches seventy (70) years of age, qualify for a waiver of premium or returns to work in any capacity, whichever is earlier.

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

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

Conversion to an individual insurance contract

If, with the exception of Policy termination, your insurance and/or the insurance of your Insured Spouse's is terminated due to:

- termination of your employment; or
- cessation of eligibility for insurance under this Policy; or
- cessation of a period of total disability after which you did not return to work for the Policyholder,

and prior to attainment of age of sixty-five (65), the insured Employee or Insured Spouse makes a written application to the Insurer within thirty-one (31) days of said termination, the Insurer will, without evidence of insurability, issue on the life of such Insured Person an individual Critical Illness policy that will consist of 4 illnesses [Cancer (life-threatening), Coronary artery bypass surgery, Heart Attack and Stroke].

You and/or your Spouse may only convert if you have never received a Critical Illness coverage 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 Insured Person's amount of insurance then in effect on the date of termination or a total aggregate of one hundred and fifty thousand dollars ($150,000) for all such conversions with the Insurer.

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

Area of diagnosis

Should a Critical Illness occur or be diagnosed outside of Canada, payment of the Principal Sum may be considered upon the Insured Person's return to Canada for medical assessment and confirmation of the Diagnosis of a Critical Illness.

Notice of claim and proof of illness

In the event of a Diagnosis of Critical Illness, a notice of this Critical Illness must be given to the your Client Services Co-ordinator at GroupSource LP, who will then give notice of the claim to the Insurer in a timely manner.

The notice must be received by the Insurer within 30 days of the Diagnosis.

The Insurer, upon receipt of such notice will furnish to you such forms as are usually furnished by it for filing proofs of a Critical Illness. If such forms are not furnished by the Insurer within 15 days after the receipt of such notice, you will be deemed to have complied with the requirements of the insurance program as to proof of such Critical Illness upon submitting, within the 90 days time fixed for filing proofs of Critical Illness, written proof covering the occurrence, character and extent of the Critical Illness for which claim a notice has been given.

Written proof of Critical Illness must be furnished to the Insurer within 90 days after the date of Diagnosis.

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 1 year after the date of the Diagnosis.

The Insurer reserves the right to confirm the Diagnosis by appointing a medical practitioner to examine the Insured Person.

The benefit provided under the insurance program's coverage will be paid immediately after receipt of due proof.

All moneys payable under the insurance program are payable in Canadian dollars.

Benefit payment

With respect to you or your insured Spouse, benefits payable in the event of a Critical Illness or as specified in the *"Complementary benefit in case of certain illnesses"* section will be paid to the Insured Person who was Diagnosed with the illness.

Accrued benefits unpaid at the time you or your insured Spouse become unable to legally receive payment of benefits, if any, will be paid to the estate of the person who was Diagnosed with the illness.

NOTE: The payment of the benefit is subject to the limitations of the Survival Period as defined in this document under the *"Definitions"* section.

Legal recourse

To take any legal action in order to recover a benefit amount under this program, you must wait 60 days after having submitted proof of claim to the Insurer. Thereafter, you will be limited to a one year period [3 years in the province of Quebec] during which legal action may be taken.

If any time limitation specified in the Policy for giving notice of claim, or undertaking legal action is less than that permitted by law of the province in which the Insured Person is residing at the time of claim, then the time limitation will not be less than that provided for by provincial law.

Covered Critical Illnesses

With respect to the insured Employee and the insured Spouse, "Critical Illness" means one of the following illnesses, conditions or surgical operations:

Alzheimer's Disease
A definite Diagnosis of a progressive degenerative disease of the brain. The Insured Person must exhibit the loss of intellectual capacity involving impairment of memory and judgement, which results in a significant reduction in mental and social functioning, and requires a minimum of eight hours of daily supervision. The Diagnosis of Alzheimer's Disease must be made by a Specialist.

Exclusion: No benefit will be payable under this condition for all other dementing organic brain disorders and psychiatric illnesses.

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

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

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

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

Bacterial Meningitis
A definite Diagnosis of meningitis, confirmed by cerebrospinal fluid showing growth of pathogenic bacteria in culture, resulting in neurological deficit 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
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 condition for pituitary adenomas less than 10 mm.

Moratorium Period Exclusion
No benefit will be payable under this condition if within the first 90 days following the later of:

- the Effective Date of the Insured Person's insurance coverage; or
- the effective date of last reinstatement of the Insured Person's insurance coverage,

such person has any of the following:

- signs, symptoms or investigations that lead to a diagnosis of benign brain tumour, regardless of when the diagnosis is made; or
- a diagnosis of benign brain tumour.

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

Blindness
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)
A definite Diagnosis of a tumour characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. The Diagnosis of Cancer must be made by a Specialist.

Exclusion: No benefit will be payable under this condition for the following non-life-threatening cancers:

- carcinoma in situ; or
- Stage 1A malignant melanoma (melanoma less than or equal to 1.0 mm in thickness, not ulcerated and without Clark level IV or V invasion); or
- any non-melanoma skin cancer that has not metastasized; or
- Stage A (T1a or T1b) prostate cancer.

Moratorium Period Exclusion
No benefit will be payable under this condition if within the first 90 days following the later of:

- the Effective Date of the Insured Person's insurance; or
- the effective date of last reinstatement of the Insured Person's insurance,

such person 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).

This medical information as described above must be reported to the Insurer within six months of the date of the Diagnosis. If this information is not provided, the Insurer has the right to deny any claim for Cancer or, any Critical Illness caused by any cancer or its treatment.

Coma
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 four or less. The Diagnosis of Coma must be made by a Specialist.

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

- 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
The undergoing of heart Surgery to correct narrowing or blockage of one or more coronary arteries with bypass graft(s), excluding any non-surgical or trans-catheter techniques such as balloon angioplasty or laser relief of an obstruction. The Surgery must be determined to be medically necessary by a Specialist.

Deafness
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.

Dilated Cardiomyopathy
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 made by a Specialist and must be confirmed by new abnormal cardiac function demonstrated in echocardiographic with a persistent low ejection fraction (less than 40%) for at least 3 months.

NYHA 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 nonprescription drug use) of dilated cardiomyopathy.

Fulminant Viral Hepatitis
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.

The Diagnosis of Fulminant Viral Hepatitis must be made by a Specialist.

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

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

Heart Attack
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 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 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.

Heart Valve Replacement
The undergoing of Surgery to replace any heart valve with either a natural or mechanical valve. The Surgery must be determined to be medically necessary by a Specialist.

Exclusion: No benefit will be payable under this condition for heart valve repair.

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

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

- Permanent jaundice;
- Ascites;
- Encephalopathy.

The Diagnosis of liver failure of advanced stage must be made by a Specialist.

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
A definite Diagnosis of:

- A total inability to perform, by oneself, at least two of the following six Activities of Daily Living; or
- Cognitive Impairment, as defined below,

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 equipment.
- Dressing — the ability to put on and remove necessary clothing including braces, artificial limbs or other surgical appliances.
- Toileting — the ability to get on and off the toilet and maintain personal hygiene.
- 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 use of equipment.
- Feeding — the ability to consume food or drink that already has been prepared and made available, with or without the use of adaptive utensils.

Cognitive Impairment means a mental deterioration and loss of intellectual ability, evidenced by deterioration in memory, orientation and reasoning, which are measurable and result from demonstrable organic cause as Diagnosed by a Specialist. The degree of cognitive impairment must be sufficiently severe as to require a minimum of eight hours of daily supervision.

Determination of a cognitive impairment will be made on the basis of clinical data and valid standardized measures of such impairments.

Exclusion: No benefit will be payable under this condition for any mental or nervous disorder without a demonstrable organic cause.

Loss of Limbs
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
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. The Diagnosis of Loss of Speech must be made by a Specialist.

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

Major Organ Failure on Waiting List
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 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. The Diagnosis of the major organ failure must be made by a Specialist.

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

Motor Neuron Disease
A definitive Diagnosis of one of the following:

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

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

Multiple Sclerosis
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 or demyelination; or
- well-defined neurological abnormalities lasting more than six 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
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.

The Diagnosis of Muscular Dystrophy must be made by a Specialist.

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

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

- The accidental injury must be reported to the Insurer within fourteen days of the accidental injury;
- A serum HIV test must be taken within fourteen days of the accidental injury and the result must be negative;
- A serum HIV test must be taken between 90 days and 180 days after the accidental injury and the result must be positive;
- All HIV tests must be performed by a duly licensed laboratory in Canada or United States;
- The accidental injury must have been reported, investigated and documented in accordance with current Canadian or United States workplace guidelines.

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

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

Parkinson's Disease
A definite Diagnosis of primary idiopathic Parkinson's disease, which is characterized by a minimum of two or more of the following clinical manifestations:

- muscle rigidity;
- tremor; or
- bradykinesis (abnormal slowness of movement, sluggishness of physical and mental responses).

The Diagnosis of Parkinson's disease must be made by a Specialist.

Exclusion: No benefit will be payable under this condition for all other types of Parkinsonism.

Primary Pulmonary Hypertension
(idiopathic pulmonary arterial hypertension and familial pulmonary arterial hypertension)
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 Diagnosis of Primary Pulmonary Hypertension must be made by a Specialist.

The NYHA 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 all other types of pulmonary arterial hypertension.

Progressive Systemic Sclerosis
A definite Diagnosis of Progressive systemic scleroderma with systemic involvement of the heart, lungs or kidneys. The Diagnosis must be unequivocally supported by biopsy and serological evidence. The Diagnosis of progressive systemic sclerosis must be made by a Specialist.

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

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

Severe Burns
A definite Diagnosis of third (3rd) degree burns over at least 20% of the body surface. The Diagnosis of Severe Burns must be made by a Specialist.

Stroke (Cerebrovascular Accident)
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 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 condition for:

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

Illnesses covered for "Complementary benefit in case of certain illnesses" – (for insured Employee and insured Spouse)

Under the Complementary benefit in case of certain illnesses, only the four (4) illnesses and surgical operations presented below are covered for an insured Employee or an insured Spouse:

Coronary Angioplasty
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.

Ductal Carcinoma in Situ of the Breast
The Diagnosis of this illness must be made by a Specialist and must be confirmed by biopsy.

Stage A (T1a or T1b) Prostate Cancer
The Diagnosis of this illness must be made by a Specialist and must be confirmed by pathological examination of prostate tissue.

Stage 1A Malignant Melanoma
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 made by a Specialist and must be confirmed by biopsy.

Critical Illnesses covered for Dependent Children

With respect to any insured Dependent Child, "Critical Illness", with respect to an Insured Employee or an Insured Spouse, means one of the following illnesses, conditions or surgical operations:

Blindness
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)

A definite Diagnosis of a tumour characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. The Diagnosis of Cancer must be made by a Specialist.

Exclusion: No benefit will be payable under this condition for the following non-life-threatening cancers:

- carcinoma in situ; or
- Stage 1A malignant melanoma (melanoma less than or equal to 1.0 mm in thickness, not ulcerated and without Clark level IV or V invasion); or
- any non-melanoma skin cancer that has not metastasized; or
- Stage A (T1a or T1b) prostate cancer.

Moratorium Period Exclusion
No benefit will be payable under this condition if within the first 90 days following the later of:

- the Effective Date of the Insured Person's insurance; or
- the effective date of last reinstatement of the Insured Person's insurance,
- such person 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).

This medical information as described above must be reported to the Insurer within six months of the date of the Diagnosis. If this information is not provided, the Insurer has the right to deny any claim for Cancer or, any Critical Illness caused by any cancer or its treatment.

Cerebral Palsy
The definite Diagnosis of a chronic disorder that appears in the first few years of life, caused by damage to the motor areas of the brain, characterized by varying degrees of limb weakness, involuntary movements and speech problems. The Diagnosis of Cerebral Palsy must be made by a Specialist.

Coma
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 four or less. The Diagnosis of Coma must be made by a Specialist.

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

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

Congenital Heart Disease requiring Surgery
The definite Diagnosis of any serious cardiac malformation present at birth, for which corrective Surgery has been performed. The Diagnosis of congenital heart disease must be made by a Specialist.

Cystic fibrosis
The definite Diagnosis of a genetic disease affecting the sweat and mucous glands particularly in the lungs and digestive system, characterized by excess production of thick mucous leading to chronic progressive respiratory disease and nutritional problems. The Diagnosis of Cystic Fibrosis must be made by a Specialist.

Deafness
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.

Down's Syndrome
A definite Diagnosis of a congenital condition caused by an extra copy of chromosome 21, primarily characterized by varying degrees of mental retardation, though other defects, particularly congenital heart disease, may be present. The Diagnosis of Down's Syndrome must be made by a Specialist.

Loss of Speech
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. The Diagnosis of Loss of Speech must be made by a Specialist.

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

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

Mental Deficiency
The definite Diagnosis of an intellectual deficiency as demonstrated by an intelligence quotient (IQ) on standardized testing of less than 70. The Diagnosis of Mental Deficiency must be made by a Specialist.

Muscular Dystrophy
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.

The Diagnosis of Muscular Dystrophy must be made by a Specialist.

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

Severe Burns
A definite Diagnosis of third (3rd) degree burns over at least 20% of the body surface. The Diagnosis of Severe Burns must be made by a Specialist.

Spina Bifida Cystica
Definite Diagnosis of a congenital defect caused by failure of the spine to close properly allowing the spinal cord and its protective covering (meninges) to protrude through the skin, characterized by varying degrees of the following:

- hydrocephalus;
- paralysis;
- bowel problems; and bladder problems.

The Diagnosis of Spina Bifida Cystica must be made by a Specialist.

Exclusion: No benefit will be payable under this condition for Spina Bifida Occulta

Frequently-asked questions

Will we remain entitled to long term disability (LTD) benefits if we receive a benefit for a covered illness?

Critical Choice Care benefits will not affect your long term disability benefit payments.

How do we file a claim?

Filing a claim is a very simple process. You should notify GroupSource LP of your claim, either in writing or verbally, as soon as a covered illness is diagnosed. GroupSource LP verifies the coverage and notifies the Insurer that they received a notice of claim. The Insurer will then send you a letter and claim forms to be completed pertaining to the diagnosed illness.

Can we make a claim even if we have a Pre-Existing Condition?

The Critical·Choice·Care program covers 31 illnesses. The Pre-existing Condition limitation applies only when diagnosed with an illness that is linked to the Pre-Existing Condition. Nevertheless, a claim should be submitted because each claim is reviewed on its own merits.

Are we still covered after having received a benefit under this program?

Yes, coverage remains in force after payment of a benefit, subject to the limitations specified in the "*Re-entry exclusions*" section.

What is the Second Medical Opinion Program?

The Insurer, in cooperation with AXA Assistance Canada, agrees to provide the Second Medical Opinion Program to Insured Persons of GroupSource LP.

The Second Medical Opinion Program provides:

- the following services free of charge (unless stated otherwise) to any Insured Person diagnosed with one of the Critical Illnesses covered under this Critical Choice Care insurance program:
    - Selection of the specialist which is best suited to provide medical services included in the Second Medical Opinion Program pertaining to the Insured Person's diagnosed Critical Illness;

- Transmission, to the selected specialist, of necessary and pertinent medical documents received from the Insured Person or attending physician;
- Communication of the second medical opinion's schedule, as established after evaluation;
- Arrangements for a meeting with the selected specialist, if deemed necessary and if the Insured Person agrees to the meeting. The expenses incurred will be charged to the Insured Person;
- Analysis of the medical documents and rendering of a diagnosis by the selected specialist as well as recommendations on treatment options, all registered in a medical report;
- Transmission of the medical report to the Insured Person and the attending physician;
- At the Insured Person's request, referral to 3 specialists medically qualified to treat the Insured Person.

- The services listed below for out-of-country medical care to any Insured Person diagnosed with a Critical Illness covered under this Critical Choice Care insurance program. Incurred expenses will be charged to the Insured Person:
  - Arrangements to set up medical appointments with attending physicians or specialists outside of Canada;
  - Admission to medical clinics located outside Canada;
  - Hotel reservations;
  - Travel arrangements;
  - Referrals to translation services or interpreter services when appropriate;
  - Administrative assistance for settlement of medical fees and claims, associated with medical services or treatments received outside of Canada, if such assistance is requested by the Insured Person.

When in need of the Second Medical Opinion Program services, the individual contacting AXA Assistance must be prepared to provide the following information:

- the name of the person calling, telephone number and relationship to the Insured Employee;
- the Insured Employee's name, and the Policy number;
- the name, address and telephone number of the attending physician and/or any other specialist if applicable.

The telephone number to call is **1-877-266-6550**.