

Your Group Benefits Booklet

ABBVIE CORPORATION

Temporary Employees with a minimum contract duration of 6 months

abbvie

Group no. 91311

MEDAVIE BLUE CROSS™

LIST OF BENEFITS

Updated Effective Date: January 1, 2022

GENERAL INFORMATION

This booklet is aimed at giving you a description of the flex group insurance plan offered by the policyholder of the contract, ***ABBVIE Corporation*** and underwritten by ***Medavie Blue Cross***.

NOTICE CONCERNING CONFIDENTIAL INFORMATION

When you apply for coverage under the group insurance plan, ***Medavie Blue Cross*** sets up a file with personal information relevant to your coverage.

Your file is kept in the Insurer's office. Employees have access to this information when required for insurance purposes.

You have certain rights of access and correction with respect to the information in your file. A request for access or correction must be in writing and may be sent to the Insurer's office.

This notice is provided in accordance with any applicable legislation respecting the protection of personal information in the private sector.

NOTICE CONCERNING THE QUEBEC ACT RESPECTING PRESCRIPTION DRUG INSURANCE

Please note that the three levels of health insurance coverage offered in the group insurance plan comply with the minimum requirements of the Quebec Act Respecting Prescription Drug Insurance.

When you subscribe to the plan, you must choose between the three levels of health insurance offered, unless you are covered for drugs under another group insurance (for example, that of your spouse).

The plan administrator must issue, once a year, a confirmation of coverage which must be joined to your return of income. To that effect, it is paramount that we have your most recent address on file.

NOTICE CONCERNING YOUR BENEFIT SUMMARY

The Benefit Summary that follows must be read together with the benefit provisions described in the different sections of this booklet.

This booklet describes the group insurance plan in force as of January 1, 2022. This program is a flex plan offering options in most benefits. For a confirmation of the coverage you have selected and its effective date, please refer to your identification card.

BENEFIT SUMMARY

Employee eligibility:	In order to be eligible for all benefits under this contract, an employee must actively* work for the employer and belong to the following category: C. Temporary Employees with a minimum contract duration of 6 months A category C employee is eligible for coverage at the expiration of the plan waiting period. All employee applications should be completed and submitted to the Insurer within 31 days of the start of the eligibility period.
Plan waiting period:	None: you are eligible on your first day of employment.
Required minimum hours worked	21.75 hours per week
Maintaining coverage:	To maintain coverage, you must have worked the minimum hours required.
Termination of benefits:	The benefits provided herein terminate at the earlier of retirement, termination of employment, or the age specified in each benefit, if any.

** If you are not actively at work (i.e. maternity or parental leave, leave without pay, etc.), please contact your employer for details on the provisions applicable to your situation.*

STANDARD COVERAGE

Basic Life Insurance	
Amount of insurance for the Participant	2 times the annual salary rounded to the next higher $1,000
• **Maximum without proof of insurability**	$850,000 (including the Maximum without proof of insurability of the Participant's Extended Life Insurance)
• **Maximum with proof of insurability**	$1,900,000* (including the Participant's Extended Life Insurance)
Amount of insurance for the spouse	none
Amount of insurance for children	none
Termination of benefit	termination of employment or retirement

** If the Participant wishes to subscribe an amount exceeding $1,000,000, this amount can be granted subject to acceptance by the Insurer of the required evidence of insurability and provided that the total amount of Life Insurance does not exceed 10 times his annual salary.*

EXTENDED COVERAGE

Extended Life Insurance

Amount of insurance for the Participant	units of $10,000
• **Maximum without proof of insurability**	$50,000* (included in the Maximum without proof of insurability of the Participant's Basic Life Insurance)
• **Maximum with proof of insurability**	$1,900,000** (including the Basic Life Insurance)
Amount of insurance for the spouse	units of $10,000
• **Maximum without proof of insurability**	$50,000* (included in the Maximum without proof of insurability of the Participant's Basic Life Insurance)
• **Maximum with proof of insurability**	$750,000
Amount of insurance for the children	units of $5,000
• **Maximum without proof of insurability**	$50,000
• **Maximum with proof of insurability**	$50,000
Termination of benefit	
Participant	termination of employment, retirement, or age 70, whichever is earlier
Spouse	Age 70 or at the date of the Participant's termination of employment or retirement, whichever is earlier
Child	the Participant reaches age seventy (70), retires or at his termination of employment, whichever is earlier

** Proof of Health is required for any amount of coverage if the application is received by the Insurer more than 31 days after the date the Participant or Spouse became eligible (first enrollment) for coverage, or the date the Participant experiences a qualifying Life Event.*

*** If the Participant wishes to subscribe an amount exceeding $1,000,000, this amount can be granted subject to acceptance by the Insurer of the required evidence of insurability and provided that the total amount of Life Insurance does not exceed 10 times his annual salary.*

STANDARD COVERAGE

Accidental Death and Dismemberment Insurance
(underwritten by AIG Canada, please refer to the Appendix for the coverage provisions)

EXTENDED COVERAGE

Optional Accidental Death and Dismemberment Insurance
(underwritten by AIG Canada, please refer to the Appendix for the coverage provisions)

Optional Critical Illness

Amount of insurance for the Participant	units of $10,000 Maximum of $250,000
• **Maximum without proof of insurability**	$40,000
Amount of insurance for the spouse	units of $10,000 Maximum of $250,000
• **Maximum without proof of insurability**	$40,000
Amount of insurance for the children	units of $5,000 Maximum of $10,000
• **Maximum without proof of insurability**	$10,000
Partial benefit Payment	10% of the full benefit payment
Maximum Conditions payable	Up to 2 Unrelated Covered Conditions eligible for full benefit payment/lifetime 1 per covered condition eligible for partial benefit payment/lifetime 1 covered childhood condition/lifetime
Survival Period	30 consecutive days unless otherwise specified in the defined covered conditions
Termination of benefit	When the Insured receives 2 full benefit payments. Coverage also terminates the earlier of when:
Participant	- the Participant's employment terminates, the Participant retires or when he reaches age 65
Spouse	- the spouse or the Participant reaches age 65, the Participant's employment terminates, or the Participant retires
Child	- 1 childhood condition payment is received, the Participant reaches age 65, the Participant's employment terminates, or the Participant retires

BASIC COVERAGE

Drug Insurance	
Percentage of reimbursement	• Drugs produced by AbbVie and Allergan 100% • Other drugs: 65%* *Out-of-pocket maximum of $750 for the Participant and dependent children and $750 for the spouse per Plan Year.
Dispensing Fee Cap	$12/prescription
Deductible	none
List	regular
Method of payment	direct payment card
Survivor benefit	24 months, without payment of premiums
Termination of benefit	termination of employment or retirement

BASIC COVERAGE (CONTINUED)

Accident/sickness Insurance	
Deductible	**none**
Percentage of reimbursement	**Hospitalization expenses: 100%** **Vision care: 100%** **All other expenses: 65%**
Hospitalization expenses	
➢ **active care**	semi-private, unlimited duration
➢ **convalescent, physical rehabilitation or chronic care**	semi-private, 180 days per disability
➢ **drug and alcohol rehabilitation**	$80/day to a lifetime maximum of $2,500
Medical and paramedical expenses	
• **Ambulance**	unlimited
• **Private nursing care**	maximum of $5,000 per Insured, per Plan year
• **Other eligible expenses**	see benefit details
• **Vision Care**	
➢ **Eyeglasses, contact lenses and laser eye surgery**	not covered
➢ **Eye Examination**	1 eye examination per 12 months
• **Diagnostic Tests**	Not covered
• **Health professionals**	
➢ **Psychologist/ Psychotherapist/Social Worker/ Clinical Counselor (including Enhanced cognitive behaviour therapy)**	maximum of $750 per Insured, per Plan year, for all professionals combined
• **Other Health professionals**	not covered
• **Hearing aids**	not covered
• **Orthopedic shoes and podiatric shoes**	not covered
Survivor benefit	24 months, without payment of premiums
Termination of benefit	termination of employment or retirement

STANDARD COVERAGE

Drug Insurance	
Percentage of reimbursement	• Drugs produced by AbbVie and Allergan 100% • Other drugs: 80%* *Out-of-pocket maximum of $750 for the Participant and dependent children and $750 for the spouse per Plan Year.
Dispensing Fee Cap	$12/prescription
Deductible	none
List	regular
Method of payment	direct payment card
Survivor benefit	24 months, without payment of premiums
Termination of benefit	termination of employment or retirement

STANDARD COVERAGE (CONTINUED)

Accident/sickness Insurance	
Deductible	**none**
Percentage of reimbursement	**Hospitalization expenses: 100%** **Vision care: 100%** **All other expenses: 80%**
Hospitalization expenses	
➢ **active care**	semi-private, unlimited duration
➢ **convalescent, physical rehabilitation or chronic care**	semi-private, 180 days per disability
➢ **drug and alcohol rehabilitation**	$80/day to a lifetime maximum of $5,000
Medical and paramedical expenses	
• **Ambulance**	unlimited
• **Private nursing care**	maximum of $10,000 per Insured, per Plan year
• **Other eligible expenses**	see benefit details
• **Vision Care**	
➢ **Eyeglasses, contact lenses and laser eye surgery**	➢ $250/24 months/12 months for a dependent child under age 21
➢ **Eye Examination**	➢ 1 eye examination per 12 months
• **Diagnostic Tests**	$1,000 per Plan year
• **Health professionals**	
➢ **Psychologist/ Psychotherapist/Social Worker/ Clinical Counselor (including Enhanced cognitive behaviour therapy)**	maximum of $1,000 per Insured, per Plan year, for all these professionals combined
➢ **acupuncturist, audiologist, chiropodist, chiropractor, dietician, homeopath, massotherapist, naturopath, occupational therapist, osteopath, physiotherapist (or rehabilitation technician or athletic therapist), podiatrist, speech therapist**	maximum of $800 per Insured, per Plan year, for all these professionals combined
• **Hearing aids**	$500 per period of 3 Plan years
• **Orthopedic shoes and podiatric shoes**	1 pair of each per Plan year
Survivor benefit	24 months, without payment of premiums
Termination of benefit	termination of employment or retirement

EXTENDED COVERAGE

Drug Insurance	
Percentage of reimbursement	• Drugs produced by AbbVie and Allergan 100% • Other drugs: 90%* *Out-of-pocket maximum of $750 for the Participant and dependent children and $750 for the spouse per Plan Year.
Dispensing Fee Cap	$12/prescription
Deductible	none
List	regular
Method of payment	direct payment card
Survivor benefit	24 months, without payment of premiums
Termination of benefit	termination of employment or retirement

EXTENDED COVERAGE (CONTINUED)

Accident/sickness Insurance	
Deductible	**none**
Percentage of reimbursement	**Hospitalization expenses: 100%** **Vision care: 100%** **All other expenses: 90%**
Hospitalization expenses	
➢ **active care**	private, unlimited duration
➢ **convalescent, physical rehabilitation or chronic care**	private, 180 days per disability
➢ **drug and alcohol rehabilitation**	$80/day to a lifetime maximum of $10,000
Medical and paramedical expenses	
• **Ambulance**	unlimited
• **Private nursing care**	maximum of $15,000 per Insured, per Plan year
• **Other eligible expenses**	see benefit details
• **Vision Care**	
➢ **Eyeglasses, contact lenses and laser eye surgery**	➢ $400/24 months/12 months for a dependent child under age 21
➢ **Eye Examination**	➢ 1 eye examination per 12 months
• **Diagnostic Tests**	$1,500 per Plan year
• **Health professionals**	
➢ **Psychologist/ Psychotherapist/Social Worker/ Clinical Counselor (including Enhanced cognitive behaviour therapy)**	maximum of $1,500 per Insured, per Plan year, for all these professionals combined
➢ **acupuncturist, audiologist, chiropodist, chiropractor, dietician, homeopath, massotherapist, naturopath, occupational therapist, osteopath, physiotherapist (or rehabilitation technician or athletic therapist), podiatrist, speech therapist**	maximum of $1,000 per Insured, per Plan year, for all these professionals combined
• **Hearing aids**	$500 per period of 3 Plan years
• **Orthopedic shoes and podiatric shoes**	2 pairs of each per Plan year
Survivor benefit	24 months, without payment of premiums
Termination of benefit	termination of employment or retirement

THE BASIC, STANDARD AND EXTENDED HEALTH INSURANCE ALSO INCLUDE THE TRAVEL INSURANCE

Travel Insurance	
Percentage of reimbursement	100%
Hospital and Medical Travel Insurance	
• **Deductible**	none
• **Lifetime maximum per Insured**	$5,000,000
Coverage duration	First 180 days of Trip outside province of residence
Trip Cancellation and Interruption Insurance	$3,000 per trip, per Insured
Baggage Insurance	$500 per trip, per Insured
Survivor benefit	24 months, without payment of premiums
Termination of benefit	termination of employment, retirement or age 75, whichever is earlier

STANDARD COVERAGE

Dental Care Insurance	
Percentage of reimbursement	– Preventive treatment: 90% – Basic treatment: 80% – Major restorative treatment: 50% – Orthodontic treatment: not covered
Deductible	None
Maximum	
• **All treatments combined**	$2,000 per Plan year, per Insured
Dental Fee Guide	current year
Termination of benefit	termination of employment or retirement

EXTENDED COVERAGE

Dental Care Insurance	
Percentage of reimbursement	– Preventive treatment: 100% – Basic treatment: 80% – Major restorative treatment: 60% – Orthodontic treatment: 50%
Deductible	none
Maximum	
• **Orthodontic treatment**	$3,000 lifetime, per Insured
• **All other combined treatments**	$3,000 per Plan year, per Insured
Dental Fee Guide	Current year
Termination of benefit	termination of employment or retirement

BASIC AND STANDARD COVERAGE

Health Spending Account (HSA)*	
Method Payment	Reimbursement Upon Request (credits will be used to pay an HSA claim as directed by the Participant)
Credit Allocation Frequency	Annually
Benefit Details	
• **Plan year**	January 1 to December 31
• **Carry Forward Type**	Credit Carry Forward for 1 Plan Year
Specific Benefit Exclusion**	
Grace Period	
• **Active Participants**	90 days
• **Terminated Participants**	90 days
Tax status of benefits	
• **Quebec residents**	Taxable *Expenses reimbursed through the HSA are considered a taxable benefit for Quebec income tax purposes*
• **Other provinces residents**	Non taxable *Expenses reimbursed through the HSA are considered non taxable*
Termination of benefit	Termination of employment or retirement

**In the first year of coverage, if the Participant's coverage initially starts after the Plan Year begins, credits for that Benefit Year will be pro-rated based on the number of months remaining in the Plan Year.*

***Refer to the Health Spending Account (HSA) Benefit provisions for additional exclusions*.

BASIC, STANDARD AND EXTENDED COVERAGE

Personal Wellness Account (PWA) Benefit (Participant only) *	
Method Payment	Reimbursement Upon Request (credits will be used to pay a PWA claim as directed by the Participant)
Credit Allocation Frequency	Annually
Benefit Details	
• **Plan year**	January 1 to December 31
• **Carry Forward Type**	No Carry Forward
Covered Benefit Categories	Health and Wellness Support Alternative Health Treatments Fitness and Sports Activities and Equipment Other Eligible Medical Expenses, as indicated in AbbVie's HR policy.
Specific Benefit Exclusion**	
Grace Period	
• **Active Participants**	90 days
• **Terminated Participants**	90 days
Tax status of benefits	Reimbursed expenses are taxable
Termination of benefit	Termination of employment or retirement

** In the first year of coverage, if the Participant's coverage initially starts after the Plan Year begins, credits for that Benefit Year will be pro-rated based on the number of months remaining in the Plan Year.*
***Refer to the Personal Wellness Account (PWA) Benefit provisions for additional exclusions.*

Online Doctor Services

Refer to the Online Doctor Services Provisions for a detailed description.

Termination	At the Participant's termination of employment or retirement

At retirement, you become eligible under the group insurance plan applicable to retirees. A booklet describing that coverage is available at the HRConnect Portal.

DEFINITIONS

Accident means a sudden, fortuitous and unforeseeable event inflicting directly and independently of all other causes, bodily injuries certified by a physician and due exclusively to an external cause of a violent nature and unintended by the Insured.

Actively at work means that an employee performs, during any workday, all the usual duties of his occupation with the employer and for the number of hours scheduled for said day.

Dependent means a spouse or child who meets the following definition.

a) **Spouse**
person legally married to the Participant, or the person the Participant designates as his spouse and with whom he has been cohabiting for a continuous period of not less than one year; this period does not apply if a child is born to the relationship. The spouse is named on the insurance application. At any one time, only one person may be covered as the Participant's spouse.

b) **Dependent child**
a child of the Participant or of his spouse, who has no spouse, who depends on the Participant or his spouse for financial support and who satisfies at least one of the following conditions:

- is under 21 years of age;
- is under 26 years of age and attends, as a duly registered full-time student, a secondary school, college or university;
- resides with the Participant and has become totally and permanently disabled while he was considered a dependent according to the above definition.

Employee means a person who is domiciled in Canada, is employed by the employer on a permanent or full-time or part-time basis and belongs to a category of Participants specified in the Benefit Summary. (Notwithstanding the above, as of May 1st, 2011, expatriate employees as identified by the Policyholder to the Insurer are covered under the life insurance benefit only).

Employer means ABBVIE Corporation and Allergan Inc.

Flex Dollars means the amount of money given to you by your employer, to purchase part or all of your group health insurance benefits including, if any, the Health Spending Account.

Hospital means an institution designated as such by law. It must be intended for the care and treatment of sick and injured individuals, have organized facilities for diagnosis and major surgeries and provide the services of physicians and registered nurses at all times.

The term « hospital » excludes psychiatric hospitals, tuberculosis hospitals, sanatoriums, community centres, rest homes, retirement homes, health spas, dispensaries, or any facility or part thereof set up to provide supervisory care or institutions used primarily for the confinement or treatment of alcoholism or drug addiction.

Illness means a deterioration of health or bodily disorder diagnosed by a physician, which requires regular, continuous and curative care. The Insurer must consider such medical care satisfactory.

Insured means each covered family member, as specified on the identification card issued to the Participant.

Participant means an employee who has subscribed to insurance hereunder.

Physician means a member of the medical profession who is licensed to practice medicine under the laws of the jurisdiction in which he practices.

Plan year means the period of time that begins on January 1st of one year and ends December 31st that follows.

Salary means the employee's annual base salary paid by the employer.

EFFECTIVE DATE OF INITIAL COVERAGE AND SUBSEQUENT AMENDMENTS

Participant's coverage

The effective date of your coverage is determined as follows:

- for any benefit not requiring proof of insurability: the date the Insurer receives your duly completed application; otherwise you will automatically be enrolled in the *default level coverage* from your date of eligibility
- if proof of insurability is required: the date the Insurer accept such proof.

Generally, if you are not actively at work on the day your coverage should take effect, coverage will begin on the date of your return to active full-time work. If you are not actively working (i.e. maternity and parental leave, leave without pay, etc.), please contact your employer for details on the provisions applicable to your situation.

Eligible spouse's coverage

The effective date of your spouse's coverage is determined as follows:

- for any benefit not requiring proof of insurability: the date the Insurer receives the application duly completed for the spouse
- if proof of insurability is required: the date the Insurer accepts such proof.

However, if the spouse is hospitalized on the day his coverage should take effect, coverage will begin following his discharge from the hospital, except for any benefit for which the above-mentioned proof is not required.

Dependent children's coverage

The effective date of a dependent child's coverage is determined as follows:

- for any benefit not requiring proof of insurability: the date the Insurer receives the application duly completed for the spouse
- if proof of insurability is required: the date the Insurer accepts such proof.

However, if the dependent child (except a newborn) is hospitalized on the day his coverage should take effect, coverage will begin following his discharge from the hospital.

Furthermore, for the Extended Life Insurance, the child must be at least 24 hours old.

If you already have employee/spouse, employee/children or employee/spouse/children coverage

The insurance for a new dependent child takes effect at the child's birth (except for the Extended Life Insurance which requires that the child be at least 24 hours old to be insured).

PARTICIPATION

Participation to the STANDARD COVERAGE in LIFE INSURANCE and to the BASIC COVERAGE in HEALTH INSURANCE is compulsory.

However, an exemption right may be exercised with respect to the HEALTH INSURANCE BENEFIT, if you are insured under another group health insurance benefit plan. Supporting proof is then required.

Participation to the DENTAL CARE INSURANCE BENEFIT is optional.

DEFAULT LEVEL OF COVERAGE

If no option is chosen, the default level of coverage provided is as follows:

Benefit	Default coverage
Life Insurance :	Standard Coverage
Health Insurance :	Individual Standard Coverage
Dental Care Insurance :	Individual Standard Coverage
Health Spending Account	Remaining Flex Dollars
Personal Wellness Account	Covered

PROOF OF INSURABILITY

For Standard Life Insurance and Optional Critical Illness Benefit, you must submit proof of insurability to apply for an amount that exceeds the maximum without proof of insurability specified in the Benefit Summary.

You must submit proof of insurability to subscribe to the Extended Life Insurance if the combined amount of Standard Life and Extended Life Insurance exceeds the maximum without proof specified in the Benefit Summary or if you apply for an amount that exceeds the maximum without proof specified in the Benefit Summary of Extended Life Insurance or increase thereof for your spouse or your dependent children.

MODIFICATION OF COVERAGE

Once your coverage has been chosen, you may modify your choices **every two years** on the renewal date of the plan, i.e., January1st, provided you are not disabled. Your request must be forwarded within 31 days following that date.

The only exception to this rule is with respect to the Health Insurance: if you were exempt from the plan and you now wish to enroll, you can go directly to the standard coverage if you so desire.

Your coverage may be modified as follows*:

Benefit	Coverage in force	Coverage requested
Life Insurance	Standard Coverage	Extended Coverage
	Extended Coverage	Standard Coverage

*No specific rules will apply to modify Health Insurance and Dental Care options.

Exception: the Participant can modify his options or request an addition of benefits within 31 days following one of the events mentioned below:

- marriage or eligibility of the common-law spouse,
- separation or divorce,
- birth or adoption of a first child,
- death of the spouse or of the last dependent child,
- the last dependent child is no longer eligible or a child over the age of 18 (but less than 26) is going back to school full time when there were not any eligible children left,
- the Participant involuntarily gains or loses access to coverage under the spouse's plan.

Once the 31 days are over, the Participant must wait for the next enrollment period to modify his choices and to cover a new dependent.

In Quebec, in accordance with the applicable legislation, the late Participant and his dependents are still granted health insurance coverage as provided in the contract.

If the Participant is unfit to work on the date the change should take effect, such change will become effective on the date he is able to return to work for a minimum of 21.75 hours per week.

Addition or increase of Extended Life Insurance amounts

These amounts of insurance may be increased at any time, for yourself and your dependents, subject to the required proof of insurability.

Note

If the Participant is disabled on the date the Extended Life Insurance increase should take effect, such increase will become effective on the date he is able to return to work for a minimum of 21.75 hours per week.

TERMINATION OF COVERAGE

Participant's coverage

A Participant's insurance terminates on the earliest of the following dates:

- the date the contract terminates;
- the date the Participant ceases to meet the definition of employee;
- the date his insurance premiums are no longer paid;
- at retirement;
- the date the Participant reaches the age set for each specific benefit, as specified in the Benefit Summary.

Dependents' coverage

A dependent's insurance terminates on the earliest of the following dates:

- the date the insurance of the Participant, of whom you are a dependent, ends, with respect to each benefit;
- the date he ceases to meet the definition of dependent;
- the date his insurance premiums are no longer paid;
- if applicable, the date the dependent reaches the age limit for a specific benefit, as specified in the Benefit Summary.

PARTICIPANT'S BASIC LIFE INSURANCE

PURPOSE OF COVERAGE

In the event of your death while your insurance is in force, the Insurer will pay to your beneficiary the amount of life insurance you subscribed to, according to the Benefit Summary, and as specified on your identification card.

BENEFICIARY

The beneficiary is the one you have designated on your application and, subject to the provisions of the law, he may be changed by way of a written request signed by you and forwarded to the Insurer.

If you have not designated a beneficiary, the death benefit will be payable to your estate.

WAIVER OF PREMIUM IN CASE OF TOTAL DISABILITY

If you become totally disabled while you are covered under this benefit and before your 65th birthday, the insurance coverage is continued without payment of premium on the first day following the expiry of 6 consecutive months of Total Disability. The amount of insurance that is subject to waiver is equal to the amount in force on the date your disability began.

The waiver terminates on the date the disability ends, without exceeding age 65.

CONVERSION PRIVILEGE

If your coverage terminates for one of the reasons listed below, which occurs **on or before attaining 65 years of age**, you may request **within 31 days** of such termination, to convert your group life insurance coverage to an individual insurance policy, without having to submit evidence of insurability, and subject to the following provisions for Covered employees residing in Quebec and Covered employees residing outside Quebec.

Conversion reasons : retirement, termination of your employment or membership in the group, termination of the insurance contract or the employee category to which you belong.

This conversion option also applies to scheduled reductions or termination of coverage which become effective at specific ages, without however exceeding age 65.

The conversion privilege is subject to the provisions of the contract, and the individual insurance premium will be determined according to the Insurer's rate schedule in force at the time of conversion, taking into consideration the amount of insurance, your age and the risk category to which you will belong at that time.

Life insurance amount that can be converted

1. If you reside in Quebec

The amount of Life insurance being converted for yourself must be at least **$10,000** and may not exceed **the lesser of the following amounts**:

a) your total Life insurance amount (including your Optional life insurance, if applicable) that terminates under your group insurance plan or

b) $400,000.

Your **Spouse** and D**ependent children** may also convert their group Life insurance to an individual insurance policy, within 31 days of your insurance termination for one of the above-listed reasons, or within 31 days of the date they cease to meet the definition of eligible Dependents under your group insurance plan.

The converted Life insurance amount per Dependent must be **at least $5,000** and may not exceed the lesser of the Dependent's total Life insurance amount that terminates, or $400,000.

2. If you reside outside Quebec

The Life insurance amount to be converted for yourself may not exceed **the lesser of the following amounts:**

a) your total Life insurance amount (including your Optional life insurance, if applicable) that terminates under your group insurance plan or

b) $200,000.

Your **Spouse** may also convert his group Life insurance to an individual insurance policy, within 31 days of your insurance termination for one of the above-listed reasons, or within 31 days of the date he ceases to meet the definition of eligible Spouse under your group insurance plan.

The Spouse's converted Life insurance amount may not exceed the lesser of his total Life insurance amount that terminates, or $200,000.

The conversion option does not apply to your Dependent children's life insurance.

TERMINATION OF BENEFIT

The PARTICIPANT'S BASIC LIFE INSURANCE coverage ends on termination of your employment or at retirement, whichever occurs first.

PARTICIPANT'S EXTENDED LIFE INSURANCE

PURPOSE OF COVERAGE

In the event of your death while your insurance is in force, the Insurer will pay to your beneficiary the amount of Extended Life Insurance you subscribed to, according to the Benefit Summary, and as specified on your identification card.

PROOF OF INSURABILITY

The benefit is equal to the amount of Extended Life Insurance benefit you selected for yourself, up to the maximum amount specified in the Benefit Summary.

You must submit evidence of insurability (Proof of Health) deemed satisfactory by the Insurer to be eligible for any amount of coverage in excess of the Maximum without proof of insurability specified in the Benefit Summary.

You may request a change in the amount of your coverage under this benefit at any time, provided you are Actively at Work. However, requests to increase coverage in excess of the Maximum without proof of insurability or more than 31 days after a Life Event will not be granted without submission of evidence of insurability (Proof of Health) deemed satisfactory by the Insurer.

EXCLUSION

If you die as a result of **suicide** or an attempt at suicide within the first **two** years following the effective date of this benefit (including the months of insurance under a previous contract, if any), its reinstatement or any increase in the amount of benefit, whether you were of sound mind or otherwise at the time of suicide or attempt at suicide, the insurance or increase will be void and the Insurer's responsibility will be limited to refunding the premiums paid.

BENEFICIARY

The beneficiary is the one you have designated on your application and, subject to the provisions of the law, he may be changed by way of a written request signed by you and forwarded to the Insurer.

If you have not designated a beneficiary, the death benefit is payable to your estate.

WAIVER OF PREMIUM IN CASE OF TOTAL DISABILITY

The provisions of the PARTICIPANT'S BASIC LIFE INSURANCE pertaining to the waiver of premiums in case of total disability also apply to the PARTICIPANT'S EXTENDED LIFE INSURANCE in effect at the date of disability.

CONVERSION PRIVILEGE

The provisions of the PARTICIPANT'S BASIC LIFE INSURANCE pertaining to the conversion privilege also apply to the PARTICIPANT'S EXTENDED LIFE INSURANCE.

TERMINATION OF BENEFIT

The PARTICIPANT'S EXTENDED LIFE INSURANCE coverage ends on termination of your employment, at retirement or when you reach age 70, whichever occurs first.

SPOUSE'S EXTENDED LIFE INSURANCE

PURPOSE OF COVERAGE

In the event of your spouse's death while this insurance is in force, the Insurer will pay you the amount of Extended Life Insurance you subscribed for your spouse, according to the Benefit Summary, and as specified on your identification card.

PROOF OF INSURABILITY

The benefit is equal to the amount of Spouse's Extended Life Insurance benefit you selected for your spouse, up to the maximum amount specified in the Benefit Summary.

Your spouse must submit evidence of insurability (Proof of Health) deemed satisfactory by the Insurer to be eligible for any amount of coverage in excess of the Maximum without proof of insurability specified in the Benefit Summary.

You may request a change in the amount of your spouse's coverage under this benefit at any time, provided you are Actively at Work. However, requests to increase coverage in excess of the Maximum without proof of insurability or more than 31 days after a Life Event will not be granted without submission of evidence of insurability (Proof of Health) deemed satisfactory by the Insurer.

EXCLUSION

If your spouse dies as a result of **suicide** or an attempt at suicide within the first **two** years following the effective date of this benefit (including the months of insurance under a previous contract, if any), its reinstatement or any increase in the amount of benefit, whether the spouse is of sound mind or otherwise at the time of suicide or attempt at suicide, the insurance or increase will be void and the Insurer's responsibility will be limited to refunding the premiums paid.

WAIVER OF PREMIUM IN CASE OF TOTAL DISABILITY

The provisions of the PARTICIPANT'S STANDARD LIFE INSURANCE pertaining to the waiver of premiums in case of total disability also apply to the SPOUSE'S EXTENDED LIFE INSURANCE in effect at the date of disability.

CONVERSION PRIVILEGE

Your spouse can exercise his conversion privilege, subject to the same conditions as those applicable to the Participant under the PARTICIPANT'S STANDARD LIFE INSURANCE BENEFIT.

Moreover, this privilege may be used by a spouse whose life insurance terminates following

a) the Participant's death, or

b) his exclusion from an eligible insurance category.

TERMINATION OF BENEFIT

The SPOUSE'S EXTENDED LIFE INSURANCE coverage ends on the earliest of the following:

- the date your spouse reaches age 70;
- the date the spouse no longer meets the definition of spouse indicated herein;
- termination of your employment, or your retirement, whichever occurs the first.

DEPENDENT CHILDREN'S EXTENDED LIFE INSURANCE

PURPOSE OF COVERAGE

In the event of a dependent child's death while this insurance is in force, the Insurer will pay you the amount of Extended Life Insurance you subscribed for your child, according to the Benefit Summary, and as specified on your identification card.

PROOF OF INSURABILITY

The benefit is equal to the amount of Dependent Children's Extended Life Insurance benefit you selected for the dependent children, up to the maximum amount specified in the Benefit Summary.

The dependent child must submit evidence of insurability (Proof of Health) deemed satisfactory by the Insurer to be eligible for any amount of coverage in excess of the Maximum without proof of insurability specified in the Benefit Summary.

You may request a change in the amount of their dependent children's coverage under this benefit at any time, provided you are Actively at Work. However, requests to increase coverage in excess of the Maximum without proof of insurability or more than 31 days after a Life Event will not be granted without submission of evidence of insurability (Proof of Health) deemed satisfactory by the Insurer.

EXCLUSION

If your dependent child dies as a result of **suicide** or an attempt at suicide within the first **two** years following the effective date of this benefit (including the months of insurance under a previous contract, if any), its reinstatement or any increase in the amount of benefit, whether the child is of sound mind or otherwise at the time of suicide or attempt at suicide, the insurance or increase will be void and the Insurer's responsibility will be limited to refunding the premiums paid.

WAIVER OF PREMIUM IN CASE OF TOTAL DISABILITY

The provisions of the PARTICIPANT'S STANDARD LIFE INSURANCE pertaining to the waiver of premiums in case of total disability also apply to the DEPENDENT CHILDREN'S EXTENDED LIFE INSURANCE in effect at the date of disability.

TERMINATION OF BENEFIT

The DEPENDENT CHILDREN'S EXTENDED LIFE INSURANCE coverage ends on the earliest of the following:

- the termination of your employment
- your retirement
- the date you reach age 70
- the date the dependent no longer meets the definition of dependent indicated herein.

OPTIONAL CRITICAL ILLNESS BENEFIT

PURPOSE OF COVERAGE

On satisfactory medical evidence that an Insured suffers from a covered condition described in this benefit, the Insurer will pay the benefit amount in effect for the Insured at the time of the claim, subject to the conditions outlined below. If there is a change in critical illness coverage, the coverage in effect when the covered condition was diagnosed is the coverage that applies to all claims for that covered condition.

Enhanced Critical Illness Insurance provides a lump sum cash payment. The benefit is paid regardless of ability to work or of expenses incurred. There are no restrictions on how the money is spent.

For example, you may use the money to:

- pay for the costs of bringing home friends or family members in your time of need;
- pay off outstanding debts; or
- help with home renovations required to accommodate new physical limitations.

AMOUNT OF COVERAGE

The benefit is equal to the amount of optional critical illness benefit selected by the Participant for themselves or their Dependents, up to the maximum amount specified in the Summary of Benefits.

The Participant and Dependent must submit Proof of Health deemed satisfactory by the Insurer to be eligible for any amount of coverage in excess of the Non-Evidence Limit specified in the Summary of Benefits.

A Participant may request a change in the amount of their coverage or their Dependent's coverage under this benefit at any time, provided the Participant is Actively at Work. However, no increase will be granted unless the Insured first submits evidence of insurability deemed satisfactory by the Insurer.

ADDITIONAL DEFINITIONS

The following definitions apply to this benefit, in addition to those found under the Definitions of this booklet.

Pre-Existing Condition: Any condition for which, during the 24 months immediately before the effective date of coverage (under this policy or a Previous Policy), the Insured has:

- had a medical consultation;
- been prescribed or taken medication; or
- received treatment, including diagnostic measures for any symptom or medical problem that leads to a diagnosis of or treatment for a covered condition.

This definition does not apply to a Child born while Child optional critical illness coverage is in force.

Specialist: A licensed medical practitioner who is certified by a specialty examining board and is trained in the specific area of medicine relevant to the covered critical illness condition for which benefit is being claimed. In the absence of a Specialist, and as approved by the Insurer, a condition may be diagnosed by a qualified Health Practitioner that practices in Canada or the United States of America.

Specialist includes, but is not limited to, cardiologist, neurologist, nephrologist, oncologist, ophthalmologist, burn Specialist and internist. The Specialist must not be:

- the Insured or the Insured's Family Member; or
- the Insured's employer or co-worker.

Any tests or examinations to satisfy the condition requirements must be performed by a medical professional who is not:

- the Insured or the Insured's Family Member; or
- the Insured's employer or co-worker.

Survival Period: The continuous period of time between the date the definition of a covered condition is met and the date the benefit is payable, as long as the Insured is still living. The Survival Period is specified in the Summary of Benefits.

Unrelated Covered Conditions: Medical conditions that are deemed to have a separate and distinct cause. All critical conditions that have the same cause will be considered related events and eligible for one benefit payment.

COVERED CONDITIONS ELIGIBLE FOR FULL BENEFIT PAYMENT

A full benefit amount is paid for up to 2 Unrelated Covered Conditions. When a benefit becomes payable for a covered condition in one Category, the Insured will not be covered for any future conditions in the same Category.

Category 1: Cancer

Category 2: Aortic Surgery, Coronary Artery Bypass Surgery, Heart Attack, Heart Valve Replacement or Repair

Category 3: Blindness, Severe Burns, Deafness, Loss of Limbs, Loss of Speech, Occupational HIV Infection

Category 4: Aplastic Anemia, Bacterial Meningitis, Benign Brain Tumour, Coma, Dementia including Alzheimer's Disease, Kidney Failure, Loss of Independent Existence, Major Organ Failure on Waiting List, Major Organ Transplant, Motor Neuron Disease, Multiple Sclerosis, Paralysis, Parkinson's Disease and Specified Atypical Parkinsonian Disorders, Stroke

All covered conditions must be the result of Illness or disease in order to be considered eligible with the exception of Severe Burns. Severe Burns are covered even if they do not result from Illness or disease.

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

This coverage excludes angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

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; or
- bone marrow transplantation.

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

Bacterial Meningitis: Definite diagnosis of meningitis, confirmed by cerebrospinal fluid showing the presence of pathogenic bacteria. The presence of pathogenic bacteria must be confirmed by culture or other generally medically accepted microbiological testing. The Bacterial Meningitis must result in objective neurological deficits persisting for at least 90 days from the date of diagnosis.

The diagnosis of Bacterial Meningitis must be made by a Specialist.

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

This coverage excludes viral meningitis.

Benign Brain Tumour: Definite diagnosis of a non-malignant tumour located in the cranial vault and limited to the brain, meninges, cranial nerves or pituitary gland. The Insured must have undergone surgery or radiation treatment or the tumour must have caused irreversible objective neurological deficits.

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

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

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

No benefit is payable under this condition for pituitary adenomas less than 10 mm, vascular malformations; cholesteatomas or infectious or inflammatory tumours.

90-Day Exclusion: No benefit is payable under this condition if, within the first 90 days following the effective date of coverage, the Participant has any of the following:

- signs, symptoms or investigations, leading directly or indirectly to a diagnosis of any benign brain tumour, regardless of when the diagnosis is made; or
- a diagnosis of any benign brain tumour.

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

Blindness: 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: Definite diagnosis of a malignant tumour. This tumour must be characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. Types of cancer include carcinoma, melanoma, leukemia, lymphoma, and sarcoma.

The diagnosis of Cancer must be made by a Specialist and must be confirmed by a pathology report.

For purposes of this condition:

- T1a or T1b prostate cancer means a clinically inapparent tumour that was not palpable on digital rectal examination and was incidentally found in resected prostatic tissue.
- The term gastrointestinal stromal tumours (GIST) classified as AJCC Stage 1 means:
  - gastric and omental GISTs that are less than or equal to 10 cm in greatest dimension with five or fewer mitoses per 5 mm2, or 50 per HPF; or
  - small intestinal, esophageal, colorectal, mesenteric and peritoneal GISTs that are less than or equal to 5 cm in greatest dimension with 5 or fewer mitoses per 5 mm2, or 50 per HPF.
- The terms Tis, Ta, T1a, T1b, T1 and AJCC Stage 1 are as defined in the American Joint Committee on Cancer (AJCC) cancer staging manual, 8th Edition, 2018.
- The term Rai stage 0 is as defined in KR Rai, A Sawitsky, EP Cronkite, AD Chanana, RN Levy and BS Pasternack: Clinical staging of chronic lymphocytic leukemia. Blood 46:219, 1975.

No benefit is payable under this condition for the following:

- lesions described as benign, non-invasive, pre-malignant, of low or uncertain malignant potential, borderline, carcinoma in situ or tumours classified as Tis or Ta;
- malignant melanoma of skin that is less than or equal to 1.0 mm in thickness, unless it is ulcerated or is accompanied by lymph node or distant metastasis;

- any non-melanoma skin cancer, without lymph node or distant metastasis. This includes but is not limited to, cutaneous T cell lymphoma, basal cell carcinoma, squamous cell carcinoma or Merkel cell carcinoma;
- prostate cancer classified as T1a or T1b, without lymph node or distant metastasis;
- papillary thyroid cancer or follicular thyroid cancer, or both, that is less than or equal to 2.0 cm in greatest dimension and classified as T1, without lymph node or distant metastasis;
- chronic lymphocytic leukemia classified as Rai stage 0 without enlargement of lymph nodes, spleen or liver and with normal red blood cell and platelet counts;
- gastro-intestinal stromal tumours classified as AJCC Stage 1;
- grade 1 neuroendocrine tumours (carcinoid) confined to the affected organ, treated with surgery alone and requiring no additional treatment, other than perioperative medication to oppose effects from hormonal oversecretion by the tumour; or
- thymomas (stage 1) confined to the thymus, without evidence of invasion into the capsule or spread beyond the thymus.

90-Day Exclusion: No benefit is payable under this condition if, within the first 90 days following the effective date of coverage, the Insured has any of the following:

- signs, symptoms or investigations leading directly or indirectly to a diagnosis of any cancer (covered or not covered under this policy), regardless of when the diagnosis is made; or
- a diagnosis of any cancer (covered or not covered under this policy).

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

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

This coverage excludes:

- a medically induced coma;
- a coma that result directly from alcohol or drug use; and
- a diagnosis of brain death.

Coronary Artery Bypass Surgery: Heart surgery to correct narrowing or blockage of 1 or more coronary arteries with bypass graft(s). The surgery must be determined to be Medically Necessary by a Specialist.

This coverage excludes angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

Deafness: Definite diagnosis of the total and irreversible loss of hearing in both ears, with an auditory threshold of 90 decibels or greater within the speech threshold of 500 to 3,000 hertz.

The diagnosis of Deafness must be made by a Specialist.

Dementia (including Alzheimer's Disease): Definite diagnosis, made by a Specialist, of dementia which must be characterized by a progressive deterioration of memory and at least one of the following areas of cognitive function:

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

The Insured must exhibit:

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

This coverage excludes affective or schizophrenic disorders or delirium.

Reference to the Mini Mental State Exam is to Folstein MF, Folstein SE, McHugh PR, J Psychiatry Res. 1975; 12(3):189.

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

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

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

No benefit is payable under this condition for:

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

Heart Valve Replacement or Repair: Surgery to replace any heart valve with either a natural or mechanical valve or to repair heart valve defects or abnormalities. The surgery must be determined to be Medically Necessary by a Specialist.

This coverage excludes angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

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

Loss of Independent Existence: Definite diagnosis of the total inability, due to disease or injury, to independently perform at least 3 of 6 Activities of Daily Living:

- with or without the aid of assistive devices;
- with no reasonable chance of recovery; and
- for a continuous period of at least 90 days.

The diagnosis of Loss of Independent Existence must be made by a Physician and supported by an independent home care assessment made by an occupational therapist or equivalent.

No additional Survival Period is required once the conditions described above are satisfied.

Loss of Limbs: 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: 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.

This coverage excludes all psychiatric related causes.

Major Organ Failure on Waiting List: 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 must become enrolled as the recipient in a recognized transplant centre in Canada or the United States of America that performs the required form of transplant surgery. For the purposes of the Survival Period, the date of diagnosis is the date of the Insured's enrolment in the transplant centre. The diagnosis of the major organ failure must be made by a Specialist.

Major Organ Transplant: Definite diagnosis of irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, such that an organ transplant is Medically Necessary.

To qualify under Major Organ Transplant, the Insuredt 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: Definite diagnosis of one of the following: amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease), primary lateral sclerosis, progressive spinal muscular atrophy, progressive bulbar palsy, or pseudo bulbar palsy, and limited to these conditions.

The diagnosis of Motor Neuron Disease must be made by a Specialist.

Multiple Sclerosis: Definite diagnosis of at least one of the following occurring after the effective date of coverage:

- two or more separate clinical attacks confirmed by at least one magnetic resonance imaging (MRI) of the nervous system, showing multiple lesions of demyelination;

- a single attack, with objective neurological deficits lasting more than 6 months, confirmed by MRI imaging of the nervous system, showing multiple lesions of demyelination; or
- a single attack, confirmed by repeated MRI of the nervous system, which shows multiple new lesions of demyelination which have developed at intervals at least one month apart.

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

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

No benefit is payable for the following:

- solitary sclerosis;
- clinically isolated syndrome;
- radiologically isolated syndrome;
- neuromyelitis optica spectrum disorders; or
- suspected multiple sclerosis or probable multiple sclerosis.

1-Year Exclusion: No benefit will be payable under this condition if, within the first year following the effective date of coverage, the Insured has any of the following:

- signs, symptoms or investigations leading directly or indirectly to a diagnosis of multiple sclerosis regardless of when the diagnosis is made; or
- a diagnosis of multiple sclerosis.

Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to the Insurer within 6 months of the date of diagnosis. If this information is not provided within this period, the Insurer has the right to deny any claim for Multiple Sclerosis or, any critical illness caused by multiple sclerosis or its treatment.

Occupational HIV Infection: Definite diagnosis of infection with Human Immunodeficiency Virus (HIV) resulting from accidental injury during the course of the Insured's normal occupation, which exposed the person to HIV contaminated body fluids.

The accidental injury leading to the infection must have occurred after the effective date of the coverage.

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

a) The accidental injury must be reported to the Insurer within 14 days of the accidental injury;

b) A serum HIV test must be taken within 14 days of the accidental injury and the result must be negative;

c) A serum HIV test must be taken between 90 days and 180 days after the accidental injury and the result must be positive;

d) All HIV tests must be performed by a duly licensed laboratory in Canada or the United States of America; and

e) The accidental injury must have been reported, investigated and documented in accordance with current Canadian or United States of America workplace guidelines.

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

No benefit is payable under this condition if:

- The Insured has elected not to take any available licensed vaccine offering protection against HIV;
- A licensed cure for HIV infection becomes 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: Definite diagnosis of the total loss of muscle function of two or more limbs as a result of injury or disease to the nerve supply of those limbs, for a period of at least 90 days following the precipitating event.

The diagnosis of Paralysis must be made by a Specialist.

Parkinson's Disease and Specified Atypical Parkinsonian Disorders:

Parkinson's Disease: Definite diagnosis of primary Parkinson's Disease, a permanent neurologic condition which must be characterized by bradykinesia (slowness of movement) and at least one of: muscular rigidity or rest tremor. The Insured must exhibit objective signs of progressive deterioration in function for at least one year, for which the treating neurologist has recommended dopaminergic medication or other generally medically accepted equivalent treatment for Parkinson's Disease.

Specified Atypical Parkinsonian Disorders: Definite diagnosis of progressive supranuclear palsy, corticobasal degeneration or multiple system atrophy.

The diagnosis of Parkinson's Disease or a Specified Atypical Parkinsonian Disorder must be made by a neurologist.

1-Year Exclusion: No benefit is payable for Parkinson's Disease or Specified Atypical Parkinsonian Disorders if, within the first year following the effective date of coverage, the Insured has any of the following:

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

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

No benefit is payable under Parkinson's Disease and Specified Atypical Parkinsonian Disorders for any other type of parkinsonism.

Severe Burns: Definite diagnosis of third-degree burns over at least 20% of the body surface. The diagnosis of Severe Burns must be made by a Specialist.

Stroke (cerebrovascular accident resulting in persistent neurological deficits): Definite diagnosis of an acute cerebrovascular event caused by intra-cranial thrombosis, haemorrhage or embolism with:

- acute onset of new neurological symptoms; and
- new objective neurological deficits on clinical examination, persisting continuously for more than 30 days following the date of diagnosis. These new symptoms and deficits must be corroborated by diagnostic imaging testing showing changes that are consistent in character, location and timing with the new neurological deficits.

The diagnosis of Stroke must be made by a Specialist.

Neurological deficits must be detectable by a Specialist and may include, but are not restricted to, measurable loss of hearing or vision , measurable changes in neuro-cognitive function, objective loss of sensation, paralysis, localized weakness, dysarthria (difficulty with pronunciation), dysphasia, (difficulty with speech) dysphagia (difficulty swallowing), impaired gait (difficulty walking), difficulty

with balance, lack of coordination, or new-onset seizures undergoing treatment. Headache or fatigue will not be considered a neurological deficit.

No benefit is payable under this condition for:

- transient ischaemic attacks;
- intracerebral vascular events due to trauma;
- ischaemic disorders of the vestibular system;
- death of tissue of the optic nerve or retina without total loss of vision of that eye; or
- lacunar infarcts which do not meet the definition of Stroke as described above.

COVERED CHILDHOOD CONDITIONS

If a Participant has selected coverage for their Child, the benefit amount selected for a Child is payable for up to 1 covered childhood condition per lifetime.

Coverage includes the following childhood conditions:

- **Autism**: an organic defect in brain development characterized by failure to develop communicative language or other forms of social communication, with the diagnosis confirmed either by a pediatric psychiatrist or a pediatrician before the Child's third birthday.
- **Cerebral Palsy**: a definitive diagnosis of Cerebral Palsy, a non-progressive neurological defect characterized by spasticity and in coordination of movements.
- **Congenital Heart Disease**: any one or more diagnosis(es) from the following lists of heart conditions:

List A

a) Total Anomalous Pulmonary Venous Connection;

b) Transposition of The Great Vessels;

c) Atresia of any heart valve;

d) Coarctation of the Aorta;

e) Single Ventricle;

f) Hypoplastic Left Heart Syndrome;

g) Double Outlet Left Ventricle;

h) Truncus Arteriosus;

i) Tetralogy of Fallot;

j) Eisenmenger Syndrome;

k) Double Inlet Ventricle;

l) Hypoplastic Right Ventricle; or

m) Ebstein's Anomaly.

The above conditions are covered after a 30-day Survival Period, beginning from the later of the date of diagnosis or birth. The diagnosis of any of the conditions in List A must be made by a qualified pediatric cardiologist, and supported by appropriate cardiac imaging.

List B

a) Pulmonary Stenosis;

b) Aortic Stenosis;

c) Discrete Subvalvular Aortic Stenosis;

d) Ventricular Septal Defect; or

e) Atrial Septal Defect.

The above conditions are covered only when open heart surgery is performed for correction of the condition after a 30-day Survival Period from the later of the date of diagnosis or birth. The diagnosis of any of the conditions in this List B must be made by a qualified pediatric cardiologist and supported by appropriate cardiac imaging. The surgery must be recommended by a qualified pediatric cardiologist and performed by a cardiac surgeon in Canada.

- **Cystic Fibrosis**: a definitive diagnosis of Cystic Fibrosis with evidence of chronic lung disease and pancreatic insufficiency.
- **Down Syndrome**: a definitive diagnosis of Down Syndrome by a qualified Specialist.
- **Muscular Dystrophy**: a definitive diagnosis of Muscular Dystrophy, characterized by well-defined neurological abnormalities, confirmed by electromyography and muscle biopsy.

- **Type 1 Diabetes Mellitus**: a diagnosis of Type 1 Diabetes Mellitus, characterized by absolute insulin deficiency and continuous dependence on exogenous insulin for survival. The diagnosis must be made by a qualified pediatrician or endocrinologist licensed and practicing in Canada, and there must be evidence of dependence on insulin for a minimum of 3 months.

No benefit is payable if a Child is born within 10 months of the effective date of Child optional critical illness coverage, and that Child is diagnosed with a childhood condition within those 10 months.

COVERED CONDITIONS ELIGIBLE FOR PARTIAL BENEFIT PAYMENT

A partial benefit payment up to the amount specified in the Summary of Benefits is payable for any of the following non-life threatening critical conditions:

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

Insureds may be eligible for one partial benefit payment per lifetime for each covered condition eligible for partial benefit payment. A partial benefit payment does not reduce the amount of coverage available for covered conditions eligible for full benefit payment.

All covered conditions must be the result of Illness or disease in order to be considered eligible for partial benefit payment. The following conditions are covered to the partial benefit payment limits specified in the Summary of Benefits:

Coronary Angioplasty: 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: A non-invasive cancer that must be confirmed by biopsy. The diagnosis of ductal carcinoma in situ of the breast must be made by a Specialist.

90-Day Exclusion: No benefit is payable under this condition if, within the first 90 days following the effective date of coverage, the Insured has any of the following:

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

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

Stage A (T1a or T1b) Prostate Cancer: The diagnosis of stage A (T1a or T1b) prostate cancer must be made by a Specialist and confirmed by pathological examination of prostate tissue.

90-Day Exclusion: No benefit is payable under this condition if, within the first 90 days following the effective date of coverage, the Insured has any of the following:

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

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

Stage 1A Malignant Melanoma: A melanoma confirmed by biopsy to be less than or equal to 1.0 mm in thickness, not ulcerated and without Clark level IV or level V invasion. The diagnosis of state 1A malignant melanoma must be made by a Specialist.

90-Day Exclusion: No benefit is payable under this condition if, within the first 90 days following the effective date of coverage, the Insured has any of the following:

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

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

PAYMENT OF CLAIMS

The benefit amount is payable after the expiration of the Survival Period specified in the Summary of Benefits, provided the Insured is still living at that time.

The benefit amount is limited to the Benefit Maximum specified in the Summary of Benefits, regardless of the number of covered conditions a Insured may experience.

A full benefit amount is payable for up to 2 Unrelated Covered Conditions eligible for full benefit payment. Once a benefit has become payable for a covered condition in one category (Category 1, 2, 3 or 4), the Insured is not covered for any future covered condition specified under the same category. However, a Insured is eligible to receive a second full benefit amount for a covered condition specified under a different category.

A partial benefit amount is payable for up to 4 covered conditions eligible for partial benefit payment. The Insured is eligible for 1 partial benefit payment per non-life threatening covered condition.

A full benefit amount is payable for 1 covered childhood condition.

Time Limit to Submit a Claim

The Insurer must receive proof of claim within 12 months of the date of the diagnosis.

EXCLUSIONS AND LIMITATIONS

The Insurer will not pay benefits for any condition that results, directly or indirectly, from any of the following causes:

a) a Pre-Existing Condition, unless the covered condition occurs after 24 consecutive months of coverage;
b) an Accident, unless the covered condition is a Severe Burn;
c) attempted suicide or voluntary injury or Illness;
d) use of any poison, intoxicant or drug, unless prescribed by a Physician and used as directed;
e) participation in a criminal act or an attempt to commit a criminal act, regardless of whether charges are laid or a conviction is obtained;
f) any Accident or injury occurring while operating a vehicle under the influence of drugs (including marijuana) or with a blood alcohol level in excess of the legal limit in the jurisdiction in which the Accident occurs; or
g) insurrection, war (declared or not), the hostile action of the armed forces of any country or participation in any riot or civil commotion.

WAIVER OF PREMIUM IN CASE OF TOTAL DISABILITY

The provisions of the PARTICIPANT'S BASIC LIFE INSURANCE pertaining to the waiver of premiums in case of total disability also apply to the PARTICIPANT'S OPTIONAL CRITICAL ILLNESS BENEFIT in effect at the date of disability.

RIGHT TO CONVERT TO INDIVIDUAL COVERAGE

Eligibility for Conversion

The Participant has the right to purchase an individual critical illness policy from the Insurer if their optional critical illness coverage terminates on or before their 65th birthday due to retirement, termination of employment or termination of coverage for the group or class of Employees to which the Participant belongs.

On or before their 65th birthday, a Spouse has the right to purchase an individual critical illness policy from the Insurer if their optional critical illness benefit coverage terminates for any reason other than at the request of the Participant.

The Participant or Spouse must have critical illness benefit coverage in force for a minimum of 24 consecutive months (under this policy or a Previous Policy) before they are eligible to purchase an individual critical illness policy.

Terms and Conditions of the Converted Policy

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

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

- during the 31-day period that the conversion option may be exercised, the amount of coverage available through this conversion option is continued without charge;
- the effective date of coverage under the individual critical illness policy will be 31 days after the group coverage terminates;

- the individual critical illness policy will not include any disability or other supplementary benefits;
- the maximum amount of coverage available under the individual critical illness policy is the lesser of:
    - the total amount of enhanced critical illness benefit and optional critical illness benefit coverage in effect on the termination date;
    - the amount of the reduction in coverage caused by any replacement policy that is issued to the Participant within 31 days of the date of the termination; and
    - $100,000; and
- the coverage provided by the individual critical illness policy cannot be less than the minimum amount the Insurer will normally issue for the type of policy selected.

DRUG INSURANCE

This insurance benefit covers expenses for eligible drugs, incurred by you or your dependents as a result of an illness, a pregnancy or an accident, subject to the deductible and percentage of reimbursement specified in the Benefit Summary for each level of coverage.

DEDUCTIBLE

The deductible is the portion of eligible expenses that you must pay for you and your dependents before the Insurer begins to reimburse expenses eligible under this contract. The deductible applies only once per plan year.

> DEDUCTIBLE FOR THE DRUG INSURANCE BENEFIT (if any) IS COMBINED WITH THE DEDUCTIBLE APPLICABLE TO THE **ACCIDENT AND SICKNESS INSURANCE BENEFIT** DESCRIBED IN THE FOLLOWING SECTION. Only one deductible must be satisfied for both benefits.

For details concerning the deductible amount applicable to each of the three levels of coverage, please refer to the Benefit Summary.

ELIGIBLE DRUGS

Charges for drugs that are included on the Insurer's **Regular List**. This **Regular List** consists of the usual and reasonable charges for drugs or products purchased in Canada that cannot be obtained without a prescription. They must be prescribed by a physician or a dentist and dispensed by a pharmacist, for use in respect of a pregnancy, illness or injury. The quantity must not exceed a 90-day supply.

The drug or product must be sold in accordance with the Food and Drugs Act of Canada. It must bear a Drug Identification Number (D.I.N.) and be used in accordance with the official indications for which the drug or product has been authorized.

Limitation :

- drugs used to treat erectile dysfunction are limited to a maximum benefit of $500 per Insured, per plan year;
- drugs for the treatment of infertility are limited to a maximum lifetime benefit of $2,500 per Insured;

Are also included:

- any injectable drug or any serum prescribed by a physician for the purpose of treating an illness (varicose vein injections for medical purposes are payable to a maximum of $20 per visit);
- vaccines and immunizations for the preventive treatment of communicable diseases;
- syringes, needles, lancet devices, pen needles, urine testing supplies, alcohol swabs, test strips for the control of diabetes, as well as an aerochamber and spinhaler;

- certain drugs essential for the Insured's survival or for the treatment of a clearly diagnosed chronic illness, mainly in case of heart disease, pulmonary disease, diabetes, arthritis, Parkinson's disease, epilepsy, cystic fibrosis and glaucoma. The claim must then include, except for *Abbvie* and *Allergan*'s drugs, as corroboration, the physician's prescription and written statement giving his diagnosis and the period for which the drugs were prescribed;
- smoking cessation aids, up to the eligible amount provided for in accordance with the Act Respecting Prescription Drug Insurance (RAMQ), per Insured, per plan year;
- Botox for medical reasons.

This benefit must always include the drugs and products that appear on the List provided by the Régie de l'assurance-maladie du Québec (RAMQ) and dispensed by a pharmacist on the written prescription of a physician or a dentist. Some of these drugs are covered only in the cases, on the conditions and for the therapeutic indications specified in the regulation, namely exception drugs.

EXCLUSIONS

Expenses related to the following products or drugs are excluded:

- Products for the care of contact lenses.
- Proteins or dietary supplements, amino acids.
- Processed food for infants.
- Hygiene products, including soaps and emollients.
- Softeners and protective substances for the skin.
- Minerals.
- Homeopathic products.
- Hair growth stimulants.
- Sexual stimulants.
- Anabolic steroids.
- Growth hormones.
- Medical cannabis;
- Drugs and injections for the treatment of obesity (except Xenical and Meridia).
- Drugs administered for experimental purposes.
- Drugs and all forms of drugs without therapeutic indication and intended exclusively to improve the quality of life.
- Mouthwashes, dressings, syrups and cough drops.∗
- Shampoos, oils, creams. ∗
- Vitamins and multivitamins. ∗
- Prenatal supplements or vitamins. ∗

∗ These elements are covered when requiring a physician's prescription, as specified by Canada Health and Social Services.

<u>Furthermore, the following services are not covered.</u>

- All expenses incurred due to an illness or accident covered under any occupational health and safety board or any automobile insurance plan, if applicable.
- Services, treatments or products received free of charge by the Participant.

TERMINATION OF BENEFIT

The DRUG INSURANCE coverage ends at your retirement or the termination of employment, whichever occurs first. Coverage for your dependents ends either on the date you cease to be covered (but not upon your death) or on the date they no longer meet the definition of dependent, whichever occurs first.

SURVIVORS' BENEFITS

After your death, your dependents continue to be insured without cost and up to the earliest of the following dates:

- 24 months after the date of your death
- the date they cease to be eligible dependents
- the effective date of any similar coverage with another Insurer, or
- the termination date of the group contract.

PROVISIONS APPLICABLE TO QUEBEC RESIDENTS

When they reach the **age of 65**, the Participant and his Spouse have a decision to make regarding their drug coverage.

Decision to join the RAMQ plan at age 65
The Participant or his spouse who reaches the age of 65 may choose to be insured under the basic prescription drug insurance plan provided by the Act respecting prescription drug insurance (RAMQ's plan) rather than to maintain his drug coverage under the group insurance plan.
Such choice is then irrevocable.

If, at age 65, the Participant chooses to be insured under the RAMQ's plan, he and his dependents, regardless of their age, will no longer be eligible for coverage under the group insurance plan (except for supplementary coverage, as mentioned in 1. and 2. below).

If, at age 65, the spouse chooses to be covered under the RAMQ's plan, then he will no longer be eligible for coverage under the group insurance plan (except for supplementary coverage, as mentioned in 1. and 2. below).

However, the Participant and his dependents who have joined the RAMQ's plan remain covered under the group insurance plan for the expenses indicated below (by paying the increase in premium, if applicable, according to the Premium rates schedule of the contract) :

1. deductible and coinsurance paid by the Participant under the RAMQ's plan; and
2. **subject to the deductible and the percentage of reimbursement mentioned in the Benefit Summary for drug coverage**: reimbursement of any prescription drug which does not appear on the list provided by the RAMQ, but which is covered under the Insurer's list of drugs.

Decision to cancel registration with the RAMQ at Age 65

When a Quebec resident reaches the age of 65, he is automatically registered by the RAMQ as a beneficiary of its prescription drug coverage. The Participant or his spouse who reaches the age of 65 **must therefore cancel their automatic registration** with the RAMQ plan in order to continue the coverage under the group insurance plan.

At age 65, an **active employee** may decide to maintain his single or family coverage **without the payment of an extra premium.**

At age 65, a **retiree** may decide to maintain his coverage providing he pays **the extra premium** (the amount of the premium varying for single or family coverage), and as mentioned in the renewal conditions of the contract.

ACCIDENT/SICKNESS INSURANCE

This insurance covers eligible expenses incurred by you or your dependents as the result of an illness, pregnancy or accident, subject to the deductible applicable to each of the three levels of coverage and the percentage of reimbursement specified in the Benefit Summary.

DEDUCTIBLE

The deductible is the portion of eligible expenses that you must pay for you and your dependents before the Insurer begins to reimburse expenses eligible under this contract. The deductible applies only once per plan year.

For information regarding the deductible amount and details as to which eligible expenses it applies, please refer to the Benefit Summary.

TERMS OF REIMBURSEMENT

The eligible expenses must be:

- usual and reasonable;
- necessary expenses from a medical point of view and, unless otherwise indicated, be recommended by a physician.

Paramedical fees are payable only when services are provided by practitioners who are duly registered members of their professional order and who practice within the limits of their authority, as established by law. If no professional order is applicable to the practitioner, he must be a duly registered member of an association recognized by the Insurer and provide care and treatments within the limits of his professional competence.

ELIGIBLE EXPENSES

BASIC COVERAGE

1. Hospital expenses

- Hospitalization charges for an Insured admitted for acute care in a hospital after the effective date of his insurance, for his stay in a semi-private room, as long as he is entitled to insured services.

- Charges for a stay in a convalescent home, rehabilitation centre or a chronic care hospital, if the Insured is admitted less than 7 days after obtaining his discharge from a hospital where he received acute care for at least 5 days, up to the amount that the hospital is allowed to charge to patients for a **semi-private accommodation** and subject to a maximum of 180 days **per disability**.

  Recurrent disabilities

  A new maximum of 180 days is applicable:

  - When the Insured incurs expenses for an illness or accident that is different from and unrelated to the cause of the prior disability, or

  - When a period of 14 consecutive days has elapsed since the last disability and the Insured has not been admitted as a patient in a hospital, a convalescent home or a physical rehabilitation centre during that period.

- Drug and Alcohol Rehabilitation charges for room accommodation when the Insured is admitted to a Drug and Alcohol Rehabilitation Facility for drug addition, alcohol addiction, or both, subject to a maximum of $80 per day to a lifetime maximum of $2,500.

2. Ambulance service

- Charges for ambulance transportation to or from the nearest medical centre able to provide the emergency care required.

- When medically required, licensed ambulance service (including air ambulance) or any other means of public transport, including airport hospital transfer to transport the patient to the nearest hospital or medical facility able to provide the appropriate care.

3. Nursing care

Services of a registered nurse (or registered nursing assistant when a registered nurse is not available), who is unrelated by blood or marriage to either the Participant or any of his dependents and who does not normally reside with him nor his dependents, provided such services are rendered at the Insured's home and they are not mainly for custodial care, subject to an overall maximum reimbursement of $5,000 per Insured, per plan year.

4. Other medical expenses

- Charges for casts, trusses, surgical dressings, splints, orthopaedic supports and ortheses, as well as charges for the rental or purchase of crutches, canes or walkers;
- with the Insurer's prior approval, the purchase or rental of a wheelchair, up to the usual cost of a standard manual wheelchair or a standard manual hospital-type bed for a bedridden patient;
- oxygen and rental of appliances for the administration thereof as well as respiratory assistance devices;
- purchase of artificial limbs (including stump socks), and artificial eyes;
- purchase of mammary prostheses when required following a mastectomy, subject to a maximum reimbursement of $300 per 2 plan years. Surgical brassieres are also covered, up to a maximum of 2 brassieres per plan year.
- purchase of capillary prostheses required for medical reasons, subject to a maximum reimbursement of $500 per plan year.
- charges for medical elastic stockings, subject to a maximum reimbursement of $25 per Insured, per plan year;
- purchase of intrauterine contraceptive devices (I.U.D.),
- purchase of a reflectometre or glucometre, subject to an overall maximum reimbursement of $250 per period of 60 consecutive months;
- purchase of an insulin pump including disposable peripherals;
- purchase of supplies relating to colostomy, ileostomy and ureterostomy.

5. Intraocular lenses

The cost of intraocular lenses implanted during cataract surgery, subject to $200 per eye per period of 24 months.

6. Vision Care

Eye examination by an ophthalmologist or optometrist, subject to a reimbursement of 1 eye examination per period of twelve (12) consecutive months.

7. Dental care

Dental services required to repair and replace sound natural teeth damaged due to an accidental blow received while the person is insured under this benefit. Treatment must begin within 90 days following the accident and be rendered within two years of that date.

The eligible amounts are set in accordance with the suggested Fee Guide for Dental Services approved by the Dental Surgeons' Association of the province where the expenses have been incurred.

8. Intrauterine contraceptive device (IUD)

Charges for the purchase of an intrauterine contraceptive device (IUD).

9. Paramedical services (without medical recommendation)

The services of a psychologist, psychotherapist, Social Worker and Clinical Counselor, including Enhanced cognitive behaviour therapy (E-CBT), subject to a maximum reimbursement of $750 per Insured, per Plan Year, for all professionals combined.

STANDARD COVERAGE

1. Hospital expenses

- Hospitalization charges for an Insured admitted for acute care in a hospital after the effective date of his insurance, for his stay in a semi-private room, as long as he is entitled to insured services;

- Charges for a stay in a convalescent home, rehabilitation centre or a chronic care hospital, if the Insured is admitted less than 7 days after obtaining his discharge from a hospital where he received acute care for at least 5 days, up to the amount that the hospital is allowed to charge to patients for **a semi-private accommodation** and subject to a maximum of 180 days **per disability**.

  Recurrent disabilities

  A new maximum of 180 days is applicable:

  - When the Insured incurs expenses for an illness or accident that is different from and unrelated to the cause of the prior disability, or

  - When a period of 14 consecutive days has elapsed since the last disability and the Insured has not been admitted as a patient in a hospital, a convalescent home or a physical rehabilitation centre during that period.

- Drug and Alcohol Rehabilitation charges for room accommodation when the Insured is admitted to a Drug and Alcohol Rehabilitation Facility for drug addition, alcohol addiction, or both, subject to a maximum of $80 per day to a lifetime maximum of $5,000.

2. Ambulance service

- Charges for ambulance transportation to or from the nearest medical centre able to provide the emergency care required.

- When medically required, licensed ambulance service (including air ambulance) or any other means of public transport, including airport hospital transfer to transport the patient to the nearest hospital or medical facility able to provide the appropriate care

3. Nursing care

Services of a registered nurse (or registered nursing assistant when a registered nurse is not available), who is unrelated by blood or marriage to either the Participant or any of his dependents and who does not normally reside with him nor his dependents, provided such services are rendered at the Insured's home and they are not mainly for custodial care, subject to an overall maximum reimbursement of $10,000 per Insured, per plan year.

4. Vision Care

- The cost of eyeglasses or contact lenses, when prescribed by an ophthalmologist or optometrist, as well as laser eye surgery, subject to an overall maximum reimbursement of $250 per Insured, per period of 24 consecutive months or per period of twelve (12) consecutive months for a dependent children under age 21.

Are excluded:
Charges for non-corrective sunglasses and safety glasses.

- Eye examination
  Eye examination by an ophthalmologist or an optometrist, subject to a reimbursement of 1 eye examination per period of twelve (12) consecutive months.

5. Diagnostic and screening tests, health assessments, subject to a maximum of $1,000 per Plan year

- Diagnostic and screening tests
  When they are judged necessary to screen for a disease or following an accident:

  - laboratory analyses, radiographs, scans, electrocardiograms, ultrasounds in a private office, Prenatest (including ultrasound and blood sample) and magnetic resonance imaging.

- Health assessments
  Health assessments, excluding administrative fees charged by the clinic, are limited to one health assessment per Plan year.

6. Other medical expenses

- Charges for casts, trusses, surgical dressings, splints, orthopaedic supports and ortheses, as well as charges for the rental or purchase of crutches, canes or walkers;
- with the Insurer's prior approval, the purchase or rental of a wheelchair, up to the usual cost of a standard manual wheelchair or a standard manual hospital-type bed for a bedridden patient;
- oxygen and rental of appliances for the administration thereof as well as respiratory assistance devices;
- purchase of artificial limbs (including stump socks), and artificial eyes;
- purchase of mammary prostheses when required following a mastectomy, subject to a maximum reimbursement of $300 per 2 plan years. Surgical brassieres are also covered, up to a maximum of 2 brassieres per plan year.
- purchase of capillary prostheses required for medical reasons, subject to a maximum reimbursement of $500 per plan year.
- charges for medical elastic stockings, subject to a maximum reimbursement of $25 per Insured, per plan year;
- purchase of intrauterine contraceptive devices (I.U.D.),
- purchase of a reflectometre or glucometre, subject to an overall maximum reimbursement of $250 per period of 60 consecutive months;
- purchase of an insulin pump including disposable peripherals;
- purchase of supplies relating to colostomy, ileostomy and ureterostomy.

7. Intraocular lenses

The cost of intraocular lenses implanted during cataract surgery, subject to $200 per eye per period of 24 months.

8. Dental care

Dental services required to repair and replace sound natural teeth damaged due to an accidental blow received while the person is insured under this benefit. Treatment must begin within 90 days following the accident and be rendered within two years of that date.

The eligible amounts are set in accordance with the suggested Fee Guide for Dental Services approved by the Dental Surgeons' Association of the province where the expenses have been incurred.

9. Intrauterine contraceptive device (IUD)

Charges for the purchase of an intrauterine contraceptive device (IUD).

10. Paramedical services (without medical recommendation)

The services of a psychologist, psychotherapist, Social Worker and Clinical Counselor, including Enhanced cognitive behaviour therapy (E-CBT) subject to a combined maximum reimbursement of $1,000 per Insured, per Plan Year.

Subject to a different combined maximum of $800 per Insured, per Plan Year, the services of an acupuncturist, audiologist, chiropodist, chiropractor, dietician, homeopath, massotherapist, naturopath, occupational therapist, osteopath, physiotherapist (or physical therapist or athletic therapist – added May 14, 2012), podiatrist and speech therapist.

Also included are charges for x-rays taken by a professional mentioned above, up to an eligible maximum of $50 per Insured, per plan year, for all professionals combined.

11. Hearing aids

Purchase and repair of hearing aids, subject to a maximum reimbursement of $500 per 3 plan years.

12. Orthopaedic shoes

Purchase of orthopaedic shoes, namely deep shoes and custom-made shoes, as well as podiatric ortheses, subject to a maximum of one pair of shoes and one pair of ortheses per Insured, per plan year. Purchases must be made from a recognized orthopaedic supplier. A medical recommendation must be presented to the Insurer with the initial purchase and with all subsequent purchases.

EXTENDED COVERAGE

1. Hospital expenses

- Hospitalization charges for an Insured admitted for acute care in a hospital after the effective date of his insurance, for his stay in a private room, as long as he is entitled to insured services;

- Charges for a stay in a convalescent home, rehabilitation centre or a chronic care hospital, if the Insured is admitted less than 7 days after obtaining his discharge from a hospital where he received acute care for at least 5 days, up to the amount that the hospital is allowed to charge to patients for a **private accommodation** and subject to a maximum of 180 days **per disability**.

  Recurrent disabilities

  A new maximum benefit period of 180 days is applicable if the Insured incurs the expenses described below:

  - When the Insured incurs expenses for an illness or accident that is different from and unrelated to the cause of the prior disability, or

  - When a period of 14 consecutive days has elapsed since the last disability and the Insured has not been admitted as a patient in a hospital, a convalescent home or a physical rehabilitation centre during that period.

- Drug and Alcohol Rehabilitation charges for room accommodation when the Insured is admitted to a Drug and Alcohol Rehabilitation Facility for drug addition, alcohol addiction, or both, subject to a maximum of $80 per day to a lifetime maximum of $10,000.

2. Ambulance service

- Charges for ambulance transportation to or from the nearest medical centre able to provide the emergency care required.

- When medically required, licensed ambulance service (including air ambulance) or any other means of public transport, including airport hospital transfer to transport the patient to the nearest hospital or medical facility able to provide the appropriate care

3. Nursing care

Services of a registered nurse (or registered nursing assistant when a registered nurse is not available), who is unrelated by blood or marriage to either the Participant or any of his dependents and who does not normally reside with him nor his dependents, provided such services are rendered at the Insured's home and they are not mainly for custodial care, subject to an overall maximum reimbursement of $15,000 per Insured, per plan year.

4. Vision Care

- The cost of eyeglasses or contact lenses, when prescribed by an ophthalmologist or optometrist, as well as laser eye surgery, subject to an overall maximum reimbursement of $400 per Insured, per period of 24 consecutive months or per period of twelve (12) consecutive months for a dependent children under age 21.

  Are excluded:
  Charges for non-corrective sunglasses and safety glasses.

- Eye examination
  Eye examination by an ophthalmologist or an optometrist, subject to a reimbursement of 1 eye examination per period of twelve (12) consecutive months.

5. Diagnostic and screening tests, health assessments, subject to a maximum of $1,500 per Plan year

- Diagnostic and screening tests
  When they are judged necessary to screen for a disease or following an accident:

  - laboratory analyses, radiographs, scans, electrocardiograms, ultrasounds in a private office, Prenatest (including ultrasound and blood sample) and magnetic resonance imaging.

- Health assessments
  Health assessments, excluding administrative fees charged by the clinic, are limited to one health assessment per Plan year.

6. Other medical expenses

- Charges for casts, trusses, surgical dressings, splints, orthopaedic supports and ortheses, as well as charges for the rental or purchase of crutches, canes or walkers;
- with the Insurer's prior approval, the purchase or rental of a wheelchair, up to the usual cost of a standard manual wheelchair or a standard manual hospital-type bed for a bedridden patient;
- oxygen and rental of appliances for the administration thereof as well as respiratory assistance devices;
- purchase of artificial limbs (including stump socks), and artificial eyes;
- purchase of mammary prostheses when required following a mastectomy, subject to a maximum reimbursement of $300 per 2 plan years. Surgical brassieres are also covered, up to a maximum of 2 brassieres per plan year.
- purchase of capillary prostheses required for medical reasons, subject to a maximum reimbursement of $500 per plan year.
- charges for medical elastic stockings, subject to a maximum reimbursement of $25 per Insured, per plan year;
- purchase of intrauterine contraceptive devices (I.U.D.),
- purchase of a reflectometre or glucometre, subject to an overall maximum reimbursement of $250 per period of 60 consecutive months;
- purchase of an insulin pump including disposable peripherals;

- purchase of supplies relating to colostomy, ileostomy and ureterostomy.

7. Intraocular lenses

The cost of intraocular lenses implanted during cataract surgery, subject to $200 per eye per period of 24 months.

8. Dental care

Dental services required to repair and replace sound natural teeth damaged due to an accidental blow received while the person is insured under this benefit. Treatment must begin within 90 days following the accident and be rendered within two years of that date.

The eligible amounts are set in accordance with the suggested Fee Guide for Dental Services approved by the Dental Surgeons' Association of the province where the expenses have been incurred.

9. Intrauterine contraceptive device (IUD)

Charges for the purchase of an intrauterine contraceptive device (IUD).

10. Paramedical services (without medical recommendation)

The services of a psychologist, psychotherapist, Social Worker and Clinical Counselor, including Enhanced cognitive behaviour therapy (E-CBT) subject to a combined maximum reimbursement of $1,500 per Insured, per Plan Year.

Subject to a different combined maximum of $1,000 per Insured, per Plan Year, the services of an acupuncturist, audiologist, chiropodist, chiropractor, dietician, homeopath, massotherapist, naturopath, occupational therapist, osteopath, physiotherapist (or physical therapist or athletic therapist – added May 14, 2012), podiatrist and speech therapist.

Also included are charges for x-rays taken by a professional mentioned above, up to an eligible maximum of $50 per Insured, per plan year, for all professionals combined.

11. Hearing aids

Purchase and repair of hearing aids, subject to a maximum reimbursement of $500 per 3 plan years.

12. Orthopaedic shoes

Purchase of orthopaedic shoes, namely deep shoes and custom-made shoes, as well as podiatric ortheses, subject to a maximum of two pairs of shoes and two pairs of ortheses per Insured, per plan year. Purchases must be made from a recognized orthopaedic supplier. A medical recommendation must be presented to the Insurer with the initial purchase and with all subsequent purchases.

EXCLUSIONS

The following expenses are not reimbursed under the plan:

- Medical care to which you or your dependents are entitled under any federal or provincial government legislation or that is covered under such legislation.
- Services, treatments or products received free of charge.
- Services, treatments or products for experimental purposes.
- Preventive care (except vaccines and the eligible annual health assessment).
- Cosmetic treatment or prostheses.
- Services of a nurse, at home, when acting as a midwife or psychotherapist, or when services other than nursing care are provided.
- Dental services, with the exception of treatment rendered after an accident.
- With the exception of intrauterine contraceptive devices (I.U.D.), all processes relating to family planning, including artificial insemination and laboratory, drugs or any other charges incurred in any infertility treatment.
- Charges incurred to obtain medical certificates.
- All charges, services, articles or supplies that do not appear on the above ELIGIBLE EXPENSES list.
- Services rendered by a person who usually resides with the Insured, or who is related to the Insured by blood or marriage.
- All charges that would not have been made if no insurance coverage had existed.
- Charges for any care, treatment, services or products other than those declared necessary by competent authorities.
- All expenses incurred due to an illness or accident covered under any Workers' Compensation statute or similar legislation.
- <u>Eligible charges incurred because of</u>
  - bodily injuries the Insured self-inflicts intentionally, whether sane or not;
  - injury sustained during active participation in a civil commotion, riot or insurrection, except while performing the duties of your occupation, or injury sustained during war;
  - the commission or attempt to commit a criminal act.

TERMINATION OF BENEFIT

The ACCIDENT/SICKNESS INSURANCE coverage ends at your retirement or the termination of employment, whichever occurs first. Coverage for your dependents ends either on the date you cease to be covered (but not upon your death) or on the date they no longer meet the definition of dependent, whichever occurs first.

SURVIVORS' BENEFITS

After your death, your dependents continue to be insured without cost and up to the earliest of the following dates:

- 24 months after the date of your death
- the date they cease to be eligible dependents
- the effective date of any similar coverage with another Insurer, or
- the termination date of the group contract.

TRAVEL INSURANCE

TO BE COVERED UNDER THIS BENEFIT, YOU AND YOUR DEPENDENTS MUST AT ALL TIMES BE COVERED UNDER THE GOVERNMENT HEALTH INSURANCE PROGRAM IN YOUR PROVINCE OF RESIDENCE.

The Travel Insurance includes three sections:

i. Hospital and Medical Travel Insurance
ii. Trip Cancellation and Interruption Insurance
iii. Baggage Insurance

Payment of eligible expenses is limited to amounts that are in excess of coverage provided by any other plan. Where a court determines that the policy and any other plan(s) provide primary coverage, this benefit will be coordinated with the other plan.

To be reimbursed, incurred eligible expenses must first be authorized by Canassistance.

All amounts of money mentioned below, as well as all sums payables under this benefit, are in the legal currency of Canada.

Specific definition

In this benefit **Emergency or Emergency situation** means an illness or injury that requires immediate medical treatment due or related to:

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

Stable means the Participant, in the 90 days before the departure date (or 90 days before the booking date for Trip Cancellation and Interruption Insurance), has not:

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

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

HOSPITAL AND MEDICAL HEALTH INSURANCE

This insurance benefit covers emergency expenses occurring when you and your dependents are travelling outside of your province of residence.

The plan reimburses all usual and reasonable expenses incurred following an emergency situation resulting from an accident or an illness, up to a lifetime maximum of $5,000,000 per Insured.

Eligible treatments are those declared necessary to stabilize the medical condition and benefits are additional to those provided for by government plans.

Hospital, medical and paramedical expenses

- The cost of hospital services that exceeds the amount refundable under the government health program in your province of residence.
- Expenses inherent (telephone, television, parking, etc.), to hospitalization up to a maximum of $100 per hospitalization.
- The difference between the fees charged by a physician and the benefits provided under the government health program in your province of residence.
- The purchase or rental cost of crutches, canes or splints and the rental cost of standard manual wheelchairs, orthopaedic devices and other medical appliances, when prescribed by the attending physician.
- Fees of a registered nurse (other than a relative) for private care while hospitalized and when prescribed by the attending physician.
- Charges for laboratory tests and X-rays when prescribed by the attending physician.
- The cost of drugs prescribed by a physician when they are required for an emergency treatment.
- Dental treatment required to repair or replace sound natural teeth damaged as the result of an accidental blow to the mouth, up to a maximum refund of $2,000 per accident for each Insured. Treatment must begin during the period of coverage and be completed within six months of the accident.
- Fees of a dental surgeon for any other emergency treatment required to relieve pain are reimbursed up to a maximum of $200 per Insured.

Transportation expenses

The following services must be approved and planned by Canassistance:

- The cost of ground or air ambulance for transportation to the nearest qualified medical facility, including inter-hospital transfer when the attending physician and Canassistance determine that existing facilities are inadequate to treat or stabilize the patient's condition.
- The cost of repatriating the Insured to his province of residence to receive immediate medical attention, following authorization of the attending physician and Canassistance.

- The cost of simultaneously repatriating a travelling companion or any member of the Insured's immediate family also covered under this benefit, if he is unable to return to the departure point by means of the transportation initially planned for such return.
- The economy class-round trip fare for transportation of a family member going to
  - the hospital where the Insured has been confined for more than 7 days, or
  - to identify the deceased, where required, prior to disposal of the body.
- The cost of returning an Insured's vehicle, either private or rental, by a commercial agency, subject to a maximum refund of $1,000. A medical certificate is required from the attending physician, stating that the Insured is incapable of using his vehicle.
- Up to $7,500 for the cost of preparing and transporting the mortal remains (excluding the cost of a coffin), or for the cost of cremation or burial at the place of death.

Subsistence allowance

Up to $3,000 (maximum of $150 per day for up to 20 days) for accommodation and meals in a commercial establishment, when your return must be delayed due to sickness or bodily injury to yourself, or to an accompanying member of your immediate family, or to a travelling companion.

Travel Assistance

The Insurer provides you, through Canassistance, with a toll free emergency hotline, 24 hours a day, seven days a week, to assist you if you must consult a physician or require hospitalization following an accident or sudden illness. Canassistance will intervene where required and provide the following supportive services :

- For the State of Florida, direct the Insured to an appropriate clinic or hospital in the Preferred Patient Care network.
- For the State of South Carolina, direct the Insured to an appropriate clinic or hospital in the Preferred Personal Care network.
- For all other destinations, direct the Insured to an appropriate clinic or hospital and advance funds to the hospital, if necessary.
- Confirm the medical insurance coverage to spare the Insured a substantial monetary deposit.
- Ensure follow-up of the medical file and communicate with the family physician.
- Co-ordinate repatriation, when necessary.
- Co-ordinate the safe return home of dependent children, if a parent is hospitalized.
- Make the necessary arrangements for transporting a family member to the patient's bedside if you are hospitalized for at least seven days and if the attending physician advises such attendance.

- Co-ordinate the return of your vehicle if you are unable to bring it back due to illness or accident.

You will also be provided with the following services:

- Toll-free assistance lines available 24 hours a day and seven days a week
- Transmittal of urgent messages
- Co-ordination of claims
- Services of an interpreter for emergency calls
- Referral to legal counsel in the event of a serious accident
- Settlement of formalities in the event of death
- Assistance in the event of loss or theft of identity papers
- Information regarding embassies and consulates.

Canassistance may also provide pre-travelling information with regard to visas and vaccines.

TRIP CANCELLATION AND INTERRUPTION INSURANCE

The amount of benefits of the Trip Cancellation and Interruption Insurance is limited to expenses that cannot be reimbursed at the time of the event causing the cancellation, subject to a maximum of $3,000 per Insured and per event.

Notification

Upon the occurrence, prior to the departure date, of an event listed amongst the insured risks, the Insured must contact the travel agent or carrier, as the case may be, within 48 hours of the event in order to cancel the trip. The Insurer must also be notified within the same time limit.

Risks insured

Coverage applies when you must either cancel your trip altogether, or interrupt or prolong it after it has begun, for any of the following reasons.

- Illness, hospitalization, bodily injury, as well as your death or the death of a member of your family, the death of a travelling companion or of a member of his family.
- Illness, hospitalization, bodily injury, death of a business associate or key employee.
- Diagnosis of pregnancy after the date of purchase or of the non-refundable initial deposit for the trip or ticket, if the departure or return date of the trip falls within eight weeks preceding or following the expected date of delivery.
- Summons for jury duty, quarantine, or hijacking.
- Disaster that renders your main residence inhabitable.
- A transfer requested by your employer and requiring that you relocate your permanent residence.

- Summons to police officers, voluntary firefighters, reservists and members of the armed forces (excluding military service during a war, declared or not or participation to peace efforts).
- Delay due to mechanical failure of your vehicle, bad weather, a traffic accident or an emergency roadblock set up by the police which results in the Insured missing a connection or preventing him to continue the trip as planned, provided the vehicle was due to arrive at the transfer point at least two hours before the scheduled departure time.
- Death or hospitalization, prior to departure of your host at destination.
- Subpoena to appear as a witness in a trial to be heard during the trip, excluding law enforcement officers.
- Involuntary loss of your permanent job held with the same employer for at least one year.
- An event in the country of destination that incites the Government of Canada to issue a general recommendation to its citizens urging them to avoid travelling within that country during a period that includes the scheduled trip. Travel arrangements must have been made before the recommendation was disclosed.
- Cancellation of a business meeting due to illness, hospitalisation or bodily injury of the person being met.
- Rejection of your visa application to stay in the country to be visited, provided that you were eligible for such visa and that rejection is not due to late submittal of the application or subsequent to a previous refusal.

ELIGIBLE EXPENSES

In the event of trip cancellation, the plan guarantees reimbursement of the following expenses:

- Pre-paid, non-refundable travel expenses.
- Additional expenses incurred for new occupancy charges when you decide to travel as originally planned when your travelling companion must cancel his trip for a cause that is covered, subject to an amount equal to the cancellation penalty applicable at the time the travelling companion must cancel.
- The additional cost of an economy-air-fare to the point of departure and the unused, non-refundable portion of pre-paid travel expenses, upon the occurrence of a covered risk.

The benefit also guarantees reimbursement of the following expenses:

- Non-refundable, unused pre-paid travel costs, if weather conditions prevent you from transferring from one carrier to another causing an interruption of your trip of at least 30% of the total duration initially planned and if you decide not to pursue your trip.
- The additional cost of an economy-fare (by airline, bus or train) to the destination or vacation point when you miss a connection for one of the following reasons:
  - Delay of the connecting carrier.

- A traffic accident involving your private or rental vehicle or taxi you occupy.

- Economy-fare to join an excursion or group if you miss part of the trip due to the occurrence, after departure, of one of the risks covered.
- Economy air-fare (one way only) to the point of departure, whenever you must delay your return due to illness or bodily injury sustained by yourself, or a member of your immediate family accompanying you, or a travelling companion.

BAGGAGE INSURANCE

The Baggage Insurance covers the loss or damage to the baggage owned by the Insured during a trip in or outside the province of residence, within the period of coverage, subject to a combined maximum of $500.

In the event the checked baggage is delayed by the carrier for 12 hours or more while en route and before returning to the point of departure, the Insurer will reimburse a maximum of $250, for the purchase of necessary toiletries and clothing. Proof of delay of checked baggage from the carrier along with receipts of purchases must accompany the claim upon presentation to the Insurer when returning from the trip.

This insurance covers expenses to replace passport, driver's license, birth certificate or travel visa in case these documents are lost or stolen, up to a maximum of $50.

Conditions particular to this insurance

- Where loss is due to theft, burglary, vandalism or disappearance, the Insured must notify the police upon discovery of the loss. Failure to report the said loss to the authorities invalidates any claim under this insurance for such loss.
- In the event of loss, the Insured must notify the Insurer as promptly as possible and take all reasonable precautions to protect, safeguard or recover his property and must also promptly notify the police and obtain from them written confirmation regarding such loss. The Insured must obtain written confirmation from the hotel manager, tour guide or transportation authorities. He must furnish proof of loss or damage and value with a sworn statement within 90 days of the date of loss. Failure to comply with these conditions invalidates claims under this benefit.
- If the covered property is checked with a public carrier and delivery is delayed until after expiry of the coverage, coverage will continue until such property is delivered by the public carrier.
- The Insurer is not liable beyond the actual cash value of the property at the time any loss or damage occurs and may elect to repair or replace any damaged or lost property with other of like quality or value.
- Upon the occurrence of any loss for which a claim is made, the amount of the applicable limit of liability is reduced by the amount equivalent to such loss.
- This insurance may not profit, directly or indirectly, any carrier or guarantor.

EXCLUSIONS AND LIMITATIONS

a) ***Applicable to sections i. and ii.***

No benefits are paid to Insureds in the following cases:

- Failure to communicate with Canassistance in the event of medical consultation or hospitalization or an event giving rise to a claim.
- Expenses incurred after you have been repatriated for medical reasons.
- Expenses incurred due to pregnancy or complications arising from it within eight weeks prior to the expected date of delivery.
- Accident sustained while participating in a sport for remuneration, any kind of motor-vehicle or speed contest, gliding or hang-gliding, mountain climbing (routes graded 4 ou 5 according to the *Yosemite Decimal System - YDS*), parachuting or skydiving or bungee jumping.
- Abuse of medication or use of drugs, and driving a motor vehicle, an aircraft or a boat while under the influence of drugs or with an alcohol level exceeding 80 milligrams in 100 millilitres of blood.
- Expenses for any care other than those declared medically necessary.
- Nurses' fees for custodial care or services rendered mainly for the patient's convenience.
- Expenses incurred for cosmetic purposes.
- Expenses incurred outside your province of residence, when such expenses could have been incurred in your province of residence without endangering your life or health.
- Expenses incurred when travelling outside your province of residence primarily or incidentally to seek medical advice or treatment, even if such a trip is on the recommendation of a physician.
- Medical or hospital costs incurred outside your province of residence that are not covered under the government health program in your province of residence.
- The following products are not covered under this plan, even when obtained with a prescription:

  Processed food for infants, dietary or food supplements or substitutes of any kind, including proteins, so-called « natural » products, multivitamins and « over the counter » drugs, antacids, digestives, laxatives, antidiarrheals, decongestants, antitussives, expectorants and any other flu or cold medications, gargles, oils, shampoos, lotions, soaps and all other dermatological products.

- Eligible expenses arising from:
  - Suicide, attempted suicide or self-inflicted injury, whether the Insured is sane or not.
  - Injury sustained during the Insured's participation in a public confrontation, a riot or an insurrection;
  - Injury sustained during a war or an act of war, declared or not;
  - Injury or illness resulting directly or indirectly from any force or threat entailing the use of nuclear, chemical or biological agents or weapons by a person, a group of persons or an organization for a political, religious or ideological purpose;
  - Committing or attempting to commit a criminal act.
- Expenses refunded or liable for refund through the government health program in your province of residence.
- For Trip Cancellation and Interruption Insurance, expenses for a trip undertaken to visit or care for a sick or injured person, when this person's medical condition or death is the cause of cancellation, early return or late return.
- For Trip Cancellation and Interruption Insurance, the inability to obtain the desired accommodation, financial difficulties, fear of flying or aversion to the trip.

b) ***Applicable to section iii.***

The benefits are reduced or not payable in the event of or with regard to:

- Loss of or damage to automobiles or automobile equipment, motorcycles, bicycles (unless registered with the carrier), boats, motors or other conveyances or their accessories, household furnishings or accessories, false teeth, artificial limbs, glasses, contact lenses, cash notes, securities, tickets and documents, professional equipment or property, goods brought with the intent of trading them, antiques and collectors items, perishable articles, cosmetics, personal effects, animals or any item that is not part of the usual baggage.
- Breakage of fragile or brittle articles unless caused by fire or theft.
- Loss or damage due to confiscation or damage by order of any government or public authority, or to illegal transportation or trade, war, demonstration or insurrection or hostilities between nations (whether or not war is declared).
- Loss or damage caused by wear and tear, gradual deterioration, moths or vermin or while the article is actually being worked upon or processed.
- Theft from an unattended automobile, trailer or other vehicle, unless such vehicle was securely locked or was equipped with a closed compartment which was securely locked and the theft occurred as a result of forcible entry (of which there must be visible marks).
- The maximum amount payable for loss or damage for each item comprising the Insured's baggage is $125.

For the purpose of calculating the maximum, the following items are grouped in categories, and each category is considered, pursuant to the contract, as a single article:

- **jewelry :** jewelry, watches, silver, gold or platinum items ;
- **furs :** fur or fur-trimmed articles
- **photography equipment :** cameras and photography equipment, video cameras and video or audio equipment.

In addition, the maximum amount payable for loss or damage of the total of the 3 categories mentioned above is $250.

- In the event of the loss of an article which is part of a set, the measure of loss will be in reasonable and fair proportion to the total value of the set, giving consideration to the importance of such article and with the understanding that such loss cannot be construed to mean total loss of the set.
- Loss or damage caused by any imprudent action or omission by the Insured. When an article or personal property in question cannot be located and the circumstances of its disappearance cannot be explained or do not lend themselves to a reasonable conclusion that a theft occurred.
- Loss or damage to articles specifically insured under any other insurance contract at the time this benefit is in effect.

TERMINATION OF BENEFIT

The Travel Insurance coverage ends at your retirement, the termination of employment or when you reach age 75, whichever occurs first. Coverage for your dependents ends either on the date you cease to be covered (but not upon your death) or on the date they no longer meet the definition of dependent, whichever occurs first.

Coverage for any Insured ceases when he no longer is covered under the government health program in his province of residence.

SURVIVORS' BENEFITS

After your death, your dependents continue to be insured without cost and up to the earliest of the following dates:

- 24 months after the date of your death
- the date they cease to be eligible dependents
- the effective date of any similar coverage with another Insurer, or
- the termination date of the group contract.

TRAVEL ASSISTANCE LINES

In the event of a medical EMERGENCY outside your province of residence, you or your representative must call CANASSISTANCE as soon as possible at one of the following numbers:
From Canada or the United States: 1-866-491-7726
From anywhere else: 514 286-7726 (collect)

For better service, be sure to give your name, the number of the phone from which you are calling and your Blue Cross group and certificate numbers.

If calling collect is not possible, BLUE CROSS will reimburse the cost of the call.

The guidelines and the numbers you must dial to contact CANASSISTANCE appear on the back of your identification card. Do not leave without it.

DENTAL CARE INSURANCE

This insurance covers eligible expenses incurred by you or one of your dependents for dental services recommended by a dentist and performed by

- a dentist, or
- a dental hygienist under the supervision of a dentist, or
- a denturist.

Expenses are subject to the deductible, percentages of reimbursement and overall maximums specified in the Benefit Summary for each of the two levels of coverage.

CALCULATION OF ELIGIBLE EXPENSES

The eligible amount for insured services is the amount indicated in the *Suggested Fee Guide for Dental Services* approved by the *Dental Surgeons' Association* or the *Denturists' Fee Guide* of the province where the expenses have been incurred (current year edition).

PREDETERMINATION OF BENEFITS

If the cost of the proposed dental treatment exceeds $500, have your dentist complete the predetermination section of the claim form and forward it to the Insurer before the start of treatment. You will thus know, beforehand, the exact amount of the reimbursement. If you change dentist in the course of treatment, you will be required to submit a new treatment plan to the Insurer.

ELIGIBLE EXPENSES

STANDARD COVERAGE

Preventive treatment

- examinations and diagnostics
  - Complete oral examination (once every 24 months)
  - Recall oral examination (once every 6 months)
  - Emergency oral examination
  - Specific oral examination
- X-rays
  - Intra-oral films - periapical
  - Intra-oral films – occlusal and bitewings
  - Extra-oral films
  - Sialography
  - Panoramic film (once every 24 months)
  - Radiopaque dyes
- Laboratory tests and examinations
  - Bacterial culture
  - Biopsy
  - Cytological examination
- Preventive treatment
  - Polishing (once every 6 months)
  - Scaling:
    - Insureds under 13 years of age: once per period of 6 consecutive months;
    - Other insureds: Unlimited
  - Application of fluoride (once every 6 months)
  - Oral hygiene instruction (lifetime maximum of two instructions)
  - Pit and fissure sealants (for Insureds under 18 years old)
- Space maintainers (for Insureds under 18 years old).

Basic treatment

- Restorations
  - Amalgam, acrylic, silicate or composite
  - Retentive pins
  - Pre-formed steel or plastic crowns
- Endodontic services
  - Pulp capping
  - Pulpotomy and emergency pulpotomy
  - Endodontic traumatism
  - Root-canal therapy
  - Endodontic surgery
  - Bleaching (endodontically treated teeth)
  - Apexification
- Periodontics
  - Periodontal surgery
  - Provisional splinting
  - Management of acute infections
  - Desensitization (maximum of 3 teeth per period of 12 consecutive months)
  - Other adjunctive periodontal services
  - Periodontal curettage and root planning
- Removable denture adjustments
  - Minor adjustments
  - Rebasing and relining
  - Prophylaxis and polishing
- Oral surgery
  - Removal of erupted tooth (uncomplicated)
  - Complicated surgical removal: Pre-determination of benefits or x-rays is required
  - Surgical excision of cysts and tumours
- General adjunctive services
  - Anaesthesia (related to surgery)
- Temporary dressing for the emergency relief of pain
- Finishing restorations

Major restorative treatment

- Restorations
  - Gold foil (if no other material can be used)
  - Inlays
  - Porcelain inlays (if no other material can be used)
- Other restorative services
  - Cast post
  - Prefabricated metal post
  - Recementation of inlay or crown
  - Removal of crown or inlay
- Crowns (single restorations only), other than pre-formed stainless steel and polycarbonate crowns and replacement of an existing crown if such crown is at least four years old.
- Prosthodontic appliances (e.g. fixed bridgework and permanent removable partial or complete dentures) other than dentures with precision or stress-breaker attachments or precision attachments and telescoping crown units for fixed bridgework, as follows:
  - If such appliance was necessary because of the extraction of at least one natural tooth while insured under this benefit,
  - if the existing appliance is at least five years old, or
  - if the existing appliance is temporary and is replaced by a permanent appliance within twelve months of the installation date of the temporary one.
- Denture repairs (two per 12-month period).

Preventive treatment

- examinations and diagnostics
  - Complete oral examination (one every 24-months)
  - Recall oral examination (one every 6 months)
  - Emergency oral examination
  - Specific oral examination
- X-rays
  - Intra-oral films - periapical
  - Intra-oral films – occlusal and bitewings
  - Extra-oral films
  - Sialography
  - Panoramic film (one every 24 months)
  - Radiopaque dyes
- Laboratory tests and examinations
  - Bacterial culture
  - Biopsy
  - Cytological examination
- Preventive treatment
  - Polishing (once every 6 months)
  - Scaling:
    - Insureds under 13 years of age: once per period of 6 consecutive months;
    - Other insureds: unlimited
  - Application of fluoride (once every 6 months)
  - Oral hygiene instruction (lifetime maximum of two instructions)
  - Pit and fissure sealants (for Insureds under 18 years old)
- Space maintainers (for Insureds under 18 years old).

Basic treatment

- Restorations
  - Amalgam, acrylic, silicate or composite
  - Retentive pins
  - Pre-formed steel or plastic crowns
- Endodontic services
  - Pulp capping
  - Pulpotomy and emergency pulpotomy
  - Endodontic traumatism
  - Root-canal therapy
  - Endodontic surgery
  - Bleaching (endodontically treated teeth)
  - Apexification
- Periodontics
  - Periodontal surgery
  - Provisional splinting
  - Management of acute infections
  - Desensitization (maximum of 3 teeth per period of 12 consecutive months)
  - Other adjunctive periodontal services
  - Periodontal curettage and root planning
- Removable denture adjustments
  - Minor adjustments
  - Rebasing and relining
  - Prophylaxis and polishing
- Oral surgery
  - Removal of erupted tooth (uncomplicated)
  - Complicated surgical removal: Pre-determination of benefits or x-rays is required
  - Surgical excision of cysts and tumours
- General adjunctive services
  - Anaesthesia (related to surgery)
- Temporary dressing for the emergency relief of pain
- Finishing restorations

Major restorative treatment

- Restorations
  - Gold foil (if no other material can be used)
  - Inlays
  - Porcelain inlays (if no other material can be used)
- Other restorative services
  - Cast post
  - Prefabricated metal post
  - Recementation of inlay or crown
  - Removal of crown or inlay
- Crowns (single restorations only), other than pre-formed stainless steel and polycarbonate crowns and replacement of an existing crown if such crown is at least four years old.
- Prosthodontic appliances (e.g. fixed bridgework and permanent removable partial or complete dentures) other than dentures with precision or stress-breaker attachments or precision attachments and telescoping crown units for fixed bridgework, as follows:
  - If such appliance was necessary because of the extraction of at least one natural tooth while insured under this benefit,
  - if the existing appliance is at least five years old, or
  - if the existing appliance is temporary and is replaced by a permanent appliance within twelve months of the installation date of the temporary one.
- Denture repairs (two per 12-month period).

Orthodontic treatment

The plan reimburses reasonable charges for orthodontic treatment when incurred to correct dental irregularities of an Insured at the time treatment begins.

Eligible charges include:

- Oral examination
- Unmounted diagnostic casts
- Removable active appliances for tooth guidance
- Fixed or cemented appliances
- Appliances to control harmful oral habits
- Retention appliances
- Comprehensive treatment

EXCLUSIONS

The following expenses are not covered:

- Treatment or appliance, related directly or indirectly to full mouth reconstruction, or to correct vertical dimension and temporomandibular joint dysfunction.
- Services rendered by a dental hygienist but not administered under the supervision of a dentist.
- Dental services eligible under the Accident/Sickness Insurance.
- Services and supplies relating to any appliance worn in the practice of a sport.
- Expenses that are payable under a public or private plan or that would normally be so if a claim had been submitted.
- All expenses incurred due to an illness or accident covered under any Workers' Compensation statute or similar legislation.
- Services that are not medically required, that are given for cosmetic purposes or that exceed the ordinary services given in accordance with current therapeutic practice (this exclusion does not apply to composite restoration).
- Care or services rendered free of charge, or that would be if there were no insurance coverage, or that are not chargeable to the Insured.
- Expenses incurred for implants.
- Splinting for periodontal reasons, where crowns or inlays are used for this purpose, with or without onlays.
- Expenses incurred as the result of
  - any suicide attempt or any self-inflicted injury, whether the Insured is sane or not,
  - any injury or illness resulting from active participation to civil unrest, riot, insurrection, unless while performing work-related functions, or injury sustained in a war.
- All charges, services, articles or items that are not included in the list of eligible expenses described in this benefit.

Restriction

No reimbursement will be made for any portion of the charge that is over the suggested fee in the appropriate fee guide for the least expensive treatment that will provide a professionally adequate result.

TERMINATION OF BENEFIT

The Dental Care Insurance coverage ends at your retirement or the termination of employment, whichever occurs first. Coverage for your dependents ends either on the date you cease to be covered or on the date they no longer meet the definition of dependent, whichever occurs first.

HEALTH SPENDING ACCOUNT

The Health Spending Account is an account set up in the name of the Participant by the Insurer. The Participant must deposit, at the beginning of the Plan year, the Flex Dollars allocated by ABBVIE that are leftover once the level of coverage has been selected. That money can be used to pay medical or dental expenses with dollars before taxes.

To comply with the tax rules, the Health Spending Account must meet the following criteria:

a) only the Employer's money (Flex Dollars) can be deposited;
b) the Participant must use the money during the same Plan year it is deposited in the account or during the following Plan year (otherwise the unused amount is forfeited);
c) if the Participant ceases to work for ABBVIE, any amount that is unused within 30 days with respect to expenses incurred before the termination date is forfeited.

* The Participant's surviving spouse, if applicable, will benefit from Flex Dollars unused by the Participant on the date of his death, until such amount is exhausted or until the date limit as specified in item b) above, whichever occurs first.

DEFINITION OF DEPENDENTS

The definition of dependents is the same as appears in the section DEFINITIONS of this booklet.

EXPENSES ELIGIBILITY CRITERIA

The expenses that can be considered under the Health Spending Account must

- qualify as tax deductible under the Canadian Income Tax Act
- not be paid under any other private or government plan.

ELIGIBLE EXPENSES

The Health Spending Account can reimburse the following expenses:

- deductible;
- portion of expenses not reimbursed under the Health and Dental Care Insurance benefits;
- health or dental expenses in excess of maximum coverage amounts;
- expenses not covered under the Health and Dental Care Insurance benefits.

The expenses eligible for reimbursement under the Health Spending Account are the following:

- over-the-counter drugs, provided they are prescribed by a physician;
- insulin infusion pumps, or devices to mesure the blood sugar level of an Insured with diabetes;
- supplies required by reason of incontinence caused by illness, injury or affliction;
- prescribed eyeglasses or contact lenses ;
- laser eye surgery;
- injections for the treatment of varicose veins;
- in vitro fertilization procedures and follow-up visits;
- artificial limbs; artificial kidney machine, charges for the repair and maintenance of the appliance and supplies;
- services of practitioners such as a dietician and dental hygienist;
- services of a dental prosthesis maker or denturologist;
- ambulance transportation;
- rocking bed for poliomyelitis patients;
- power-operated wheel chair, scooter and geriatric chair on wheels;
- mechanical device or equipment to assist a person to enter or leave a bathtub or shower, or to get on or off a toilet ;
- renovations and alterations to a home when the Insured has a severe and prolonged mobility impairment;
- power-operated lift or transportation equipment designed exclusively for use by, or for, an Insured who is disabled to allow him access to a building or to a vehicle;
- a laryngeal speaking aid and artificial larynx;
- rehabilitative therapy, including training in lip reading and sign language to adjust for the patient's hearing or speech loss;
- device or equipment designed exclusively for use by an Insured suffering from a severe chronic respiratory ailment or a severe chronic immune system disregulation, but not including an air conditioner, humidifier, dehumidifier, heat pump or heat or air exchanger;
- seeing-eye dog for the blind and the deaf;
- teletypewriter or similar device, including a telephone ringing indicator, that enables an Insured who is deaf or mute to make and receive telephone calls;
- optical scanner or similar device designed to enable an individual who is blind to read print;
- device designed to be attached to an infant diagnosed as being prone to sudden infant death syndrome in order to sound an alarm if the infant ceases to breathe;
- any other expense qualifying as a medical expense tax credit.

PERSONAL WELLNESS ACCOUNT (PWA) BENEFIT

PURPOSE OF COVERAGE

The Personal Wellness Account (PWA) benefit is administered by the Insurer on behalf of the Policyholder, who assumes the sole legal and financial liability for this benefit, subject to the conditions outlined below.

WHAT BLUE CROSS WILL PAY

The Insurer will pay expenses that meet the eligibility requirements of the covered benefit categories specified in the Summary of Benefits.

The expenses listed below are examples only and should not be considered an exhaustive list. The Insurer reserves the right to make exceptions for expenses not explicitly listed in this policy but which fall into one of the following categories.

Health and Wellness support

Nutritional Counselling: Charges for nutritional counselling for eating disorders and weight management, including educational courses, workshops and seminars.

Stress Management: Charges for stress management counselling, including educational courses, workshops and seminars.

Smoking Cessation: Charges for over-the-counter smoking cessation products such as gum, patches and lozenges, as well as hypnotherapy, support programs and educational courses, workshops and seminars.

This coverage excludes purchase of electronic cigarettes.

Health Assessment: Charges for online personal health assessments and personal health assessment workshops.

Prenatal Class: Charges for doula services, prenatal classes, birth plan counselling services and educational courses, workshops and seminars.

This coverage excludes birth pool rentals and postpartum services such as birth trauma counselling.

Alternative Health Treatments

Mind/Body Therapy: Charges for herbalists, homeopaths, athletic therapists, traditional Chinese medical practitioners, Shiatsu therapists, hypnotherapy, meditation, electrotherapy, reflexology, mind/body therapy retreats, renewal centres and addiction treatment.

Fitness and Sports activities

Fitness and Sports Fees: Charges for fitness centre memberships and drop-in fees, sports leagues and team registration fees, golfing fees, registration fees for marathons, triathlons and other race events, ski-lift passes and locker fees.

Instructed Fitness or Sports Class: Charges for fitness and sports-related classes and clinics, such as dance, swimming, gymnastics, rock climbing, yoga, martial arts, golf, tennis, hockey and skiing.

Personal Trainer: Charges for the services of a certified personal fitness trainer, including Members of Certified Strength and Conditioning Specialist (CSCS), Members of the American Council on Exercise (ACE), Members of "Fédération des kinésiologues du Québec" and Members of Canadian Kinesiology Alliance.

Fitness and Sports Equipment: Charges for purchase or rental of:

- stationary exercise equipment, including treadmills, ellipticals, rowers and weight machines;
- fitness-related equipment, including bicycles, rollerblades, trampolines, weights, yoga mats and fitness balls and bands;
- sporting equipment and protective gear, including hockey sticks, golf clubs, rackets, balls, helmets, pads and goggles;
- equipment bags, gloves and footwear (including cleats) for a specific sport activity;
- active footwear; and
- human-powered boats, including canoes and kayaks.

This coverage excludes athletic apparel.

Other Eligible Medical Expenses

Health and Dental Medical Expenses: Charges for expenses which have been partially covered or otherwise not covered by an existing health and/or dental plan, as indicated in AbbVie's HR policy.

PWA CREDITS

The Policyholder pre-determines the amount of credits allocated to the PWA at the beginning of each Plan year specified in the Summary of Benefits. In the first year of coverage, if your coverage initially starts after the Plan year begins, credits for that Benefit year will be pro-rated based on the number of months remaining in the Plan year. Credits represent the monetary value allocated to the PWA by the Policyholder and the amount that may be reimbursed by the Insurer on the Policyholder's behalf.

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

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

PWA credit allocation may only change in the case of a change in the employment status.

If a Participant's coverage is terminated, the Policyholder may adjust the credits allocated to the PWA for that Plan year. The Policyholder must promptly notify the Insurer of the adjusted amount of credits.

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

PAYMENT OF CLAIMS

How Payments are Made

Eligible PWA claims will only be reimbursed upon request. The Participant will pay the expense at the time of purchase and submit the PWA claim to the Insurer with proof of payment. PWA credits will then be used to pay the claim as directed by the Participant.

CARRY FORWARD TYPE

No Carry Forward

This plan does not allow unused credits to be carried forward into the next Plan year.

Credits may be used to reimburse eligible expenses incurred in the same Plan year in which the credits were allocated. At the end of a Plan year, any unused credits are forfeited.

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

EXCLUSIONS AND LIMITATIONS

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

a. expenses incurred by Participants prior to the effective date of this benefit or following termination, in accordance with this policy;
b. expenses for services which have already been paid by any other private health care plans or any Government Health Care Coverage;
c. firearms and ammunition;
d. alcohol, recreational drugs and paraphernalia;
e. prepaid credit cards, gift cards, payments with rewards cards or points;
f. charitable donations;
g. all services or fees other than the entrance fee to a spa;
h. gardening and arts and crafts courses;
i. services, treatments, articles or supplies that do not fall within the categories of eligible expenses listed in this benefit;
j. print and media purchases such as books and magazines;
k. pre-owned equipment or supplies;
l. streaming service fees and subscription fees;
m. purchase of food, including meals associated with weight management programs, unless otherwise specified as a covered expense in this benefit; or
n. any expenses specifically noted as excluded within the PWA benefit categories.

ONLINE DOCTOR SERVICES

PURPOSE OF COVERAGE

Online Doctor Services provide Insureds with access to a Physician from a computer, phone or tablet for diagnosis, medical advice and treatment of an Eligible Condition. These services are available 24 hours a day, 7 days a week (including holidays).

ADDITIONAL DEFINITIONS

The following definitions apply to Online Doctor Services, in addition to those found under the Definitions provision of this booklet.

Eligible Condition: A non-emergency medical condition that, in the opinion of the Physician, can be lawfully and appropriately treated through an online consultation.

Physician: A doctor of medicine who is licensed as a general practitioner to prescribe and administer medical treatment and drugs within the scope of their license. It does not include a specialist licensed physician (such as a dermatologist).

Service Provider: The company, individual or other legal entity retained by the Insurer to provide an online platform to access and provide Online Doctor Services.

SERVICES PROVIDED

Eligible Conditions

Insureds will have access to a Physician for online consultations with respect to Eligible Conditions.

Common Eligible Conditions may include, but are not limited to:

- abrasions
- acne
- asthma
- bacterial vaginosis
- bites and stings
- body aches
- bronchitis
- bruises
- cough
- dehydration
- diarrhea
- earache
- fever
- flu
- frostbite
- headache
- migraine
- hives
- insomnia
- itchy eyes
- lice
- mild laceration
- mental health
- nasal congestion
- nausea
- pinkeye
- respiratory infection
- sexually transmitted infection
- sinus infection
- skin infection
- sore throat
- sprains and strains
- urinary tract infection
- vomiting
- yeast infection

Treatment

The Physician will provide treatment deemed appropriate by the Physician for Eligible Conditions. Treatment may include, but is not limited to:

- prescriptions;
- sick notes;
- referrals;
- laboratory requisitions; and
- diagnostic imaging requisitions.

Services Outside Canada

Insureds have access to Online Doctor Services while travelling outside of Canada. Physicians cannot prescribe medication outside of Canada, but they can:

- determine if an Eligible Condition needs to be seen by a local doctor; and
- recommend over-the-counter treatments likely to be available in that country.

ADDITIONAL SERVICES

Specialty Services may also be provided to Insureds for an additional charge. The Specialty Services available and applicable charges are specified on the Service Provider's website.

Specialty Services are subject to change at any time and vary by province. They may include, but are not limited to:

- dermatology
- diabetes counselling
- diet and nutrition
- endocrinology
- lactation and breastfeeding
- life coaching
- naturopathy
- oncology
- pediatrics
- psychiatry
- psychotherapy
- sleep therapy

Charges for some Specialty Services may be eligible for reimbursement under a group health plan, if applicable.

HOW IT WORKS

The Insured can access and register for Online Doctor Services by visiting www.medaviebc.ca/app and following these steps:

- download the mobile app "Medavie Mobile";
- enter their plan information to login to their profile;
- click on "Check My Coverages";
- click on "Online Doctors"; and
- follow the instructions on "How to access my account".

The Insured creates an account on the Service Provider's website, describes their symptoms, and requests a consultation with a Physician. The Physician determines, at their sole discretion, whether the request is for an Eligible Condition. If the request is for an Eligible Condition, the Physician provides services to the Insured by phone, text or video.

Following the consultation:

- the Insured receives any applicable sick notes or requisitions digitally;
- any applicable prescriptions are automatically sent to the pharmacy of the Insured's choice; and
- a nurse may conduct follow-ups for laboratory requisition and diagnostic imaging, if applicable.

Details about the consultation, including prescriptions and laboratory requisitions, are stored in the Service Provider's application. The Insured can access this information at any time and share it with their family doctor directly from the Service Provider's application.

Insureds can create their own online health record by adding information such as their medical history, medical records and test results.

EXCLUSIONS AND LIMITATIONS

Online Doctor Services are limited to online consultations with a Physician as described herein.

Services will not be provided for the following:

a) medical emergencies;
b) prescription of medication designated as controlled medication by Health Canada;
c) completion of worker's compensation board/commission forms or other types of disability forms;
d) backdated sick notes; or
e) any condition deemed by the Physician, at their sole discretion, to be inappropriate for an online consultation.

ADDITIONAL INFORMATION

The Insurer has the right, at its sole discretion, to replace or substitute the Service Provider at any time with an alternate Service Provider capable of providing a similar level of service.

EXTENSION OF ONLINE DOCTOR SERVICES

Termination of this policy or the Online Doctor Services will not impact services that have already been initiated or that are currently in progress.

If Online Doctor Services are terminated under this policy, the Insured's information and history remains available through the Service Provider's website or mobile application.

HOW TO SUBMIT A CLAIM

How to Obtain a Claim Form?

Health benefit (Drug insurance, Accident/Sickness insurance, Travel in Canada insurance, Dental care insurance), Health Spending Account and Personal Wellness Account claim forms can be obtained from any one of the following sources:

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

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

How to Submit a Claim?

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

- ***Provider eClaims***

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

- ***Member eClaims***

  You can quickly and easily submit your health benefit (Drug insurance, Accident/Sickness insurance, Travel in Canada insurance, Dental care insurance) and Health Spending Account claims through our secure plan member website. Simply take or scan a digital image of your paid-in-full receipts and submit it through the applicable link on our plan member website.

- ***Mobile App***

  Filing a claim has never been quicker or easier! Submit your claims through the Medavie Mobile app and have your reimbursement deposited directly to your bank account.
  Visit **www.medavie.bluecross.ca/app** for more information or to download the app.

- ***Quick Pay®***

  Quick Pay® is a unique service of Blue Cross. Through Quick Pay, you may submit all your Health benefit (Drug insurance, Accident/Sickness insurance, Travel in Canada insurance, Dental care insurance) and Health Spending Account claims and receive immediate adjudication and reimbursement.

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

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

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

For insurance purposes, you and your dependents are deemed covered under the Hospital and Health Insurance acts of Quebec or of any other province, and under no circumstances will the amount paid by the Insurer to an insured without such coverage ever exceed the amount that would have been paid had he been insured under such acts, unless specified otherwise.

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

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

Plan Member Website

The plan member website is a secure, user-friendly website that is available 24 hours a day, 7 days a week. The website provides additional information regarding your coverage and other useful options including:

- ***Coverage inquiry:*** Detailed information about your group benefits plan;
- ***Forms:*** Printable versions of Blue Cross forms;
- ***Requests for new identification cards;***
- ***Addition/updating of banking information*** for direct deposit of claim payments;
- ***Member statements:*** view claims history for you and your Dependents;

- ***Record of payments:*** view transactions issued to yourself or the service provider;
- ***Submit claims*** electronically.

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

What is the time limit to Submit a Claim?

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

Drug/Health Insurance
The duly completed claim form must be sent to the Insurer no later than 12 months after the date expenses are incurred.

Travel Insurance in Canada
The duly completed claim form must be filed with the Insurer no later than six months after the date expenses are incurred.

Health Spending Account
Claims under the Health Spending Account must be submitted no later than 90 days following the end of the Plan year during which expenses were incurred.

Personal Wellness Account
Claims under the Personal Wellness Account must be submitted no later than 90 days following the end of the Plan year during which expenses were incurred.

Who has access to my confidential information file?

The personal information transmitted to us will be kept in your Medavie Inc. and Blue Cross Life Insurance Company of Canada insurance file. This information will be used solely in the settlement of your claims. Only duly authorized employees and representatives of the insurer will have access to this information in the course of the company's current business practices.

Upon a 30-day written notice, you will be entitled to access the information contained in your file and, if necessary, request that it be corrected, according to the provisions of the provincial or federal legislation regarding Privacy applicable in your province of residence.

COORDINATION OF BENEFITS

The total amount of benefits from all plans can never exceed the amount of expenses.

If you or your dependents are entitled under any other insurance contract to compensation for expenses otherwise payable hereunder, the amount of compensation payable under such other contract will be deducted from the benefits payable hereunder.

The benefits payable under any coverage include benefits to which the Insured would have been entitled had he duly submitted a claim.

Applicable rules

- the expenses incurred by the spouse covered as an employee under another insurance contract, are first reimbursed by his own group plan, and the balance if any by the present plan;
- the expenses incurred by children covered as dependents of both parents are first reimbursed by the plan of the parent with the earlier birth date in the calendar year.

If you and your spouse are separated or divorced, the plan which will pay benefits for your children will be determined in the following order:

1. the plan of the parent with custody of the child;
2. the plan of the spouse of the parent with custody of the child;
3. the plan of the parent without custody of the child;
4. the plan of the spouse of the parent without custody of the child.

LIMITATION OF BENEFITS

For insurance purposes, all Insureds are deemed covered under the Hospital and Health Insurance acts of Quebec or of any other province, and under no circumstances will the amount paid by the Insurer to an Insured without such coverage ever exceed the amount that would have been paid had he been insured under such acts, unless specified otherwise.

APPENDIX

BUSINESS TRAVEL ACCIDENT PLAN
(This plan is provided by ABBVIE and not underwritten by any Insurer in Canada)

DEATH

In the event of your death as a result of injuries sustained in an accident, while traveling on company business, within 365 days of that date, this plan pays your beneficiary:

5 x your salary to a maximum of $1,000,000 US

The premiums are paid by the Company.

DISMEMBERMENT

This insurance also provides coverage in case serious accidental injuries sustained during business travel (i.e., loss of use of a hand or foot, paralysis). The benefit paid is a percentage of the principal sum payable if accidental loss of life occurs: this percentage varies according to injury severity.

Basic Accidental Death & Dismemberment Insurance Plan
For: ABBVIE CORPORATION
Policy No.: BSC 9138194

Why You Need Accident Insurance

A serious accidental injury or death can have tremendous consequences. A serious injury may prevent you from meeting your financial obligations and your loss of life may leave your spouse with insufficient financial resources to fulfill their financial responsibilities.

Your Employer has provided you with Accident Insurance coverage underwritten by AIG Insurance Company of Canada. The policy provides a lump sum benefit to help ease the financial impact and assure your family's needs are met if you suffer loss of life as a result of an accident. Your accident coverage also provides you with 'living benefits' should an accident leave you paralyzed or should you lose through severance, or loss of use of a limb, sight, speech or hearing.

How It Works

You are automatically covered for an amount equal to the Standard Group Life Insurance up to a maximum of $1,000,000.

Here's What You Get

Broad Accident Insurance Coverage - Your plan provides generous Accidental Death & Dismemberment benefits for injuries as a result of covered accidents.

Guaranteed Acceptance - Coverage is provided regardless of your health history.

24/7 Worldwide Coverage - Your coverage is in force around-the-clock—at work, at home or at play, anywhere in the world.

Definitions

"Insured Employee" means you, if you are a permanent or temporary employee of the Policyholder who is under the age of 70.

Beneficiary Designation

In the event of accidental loss of life, the benefit will be paid to the beneficiary you have designated in writing under your Employer's current Group Life policy. If there is no written designation then the benefit will be paid to your estate.

All other benefits will be payable to you.

Benefits and Coverages

Accidental Death, Dismemberment, Paralysis and Loss of Use

If a covered loss occurs within 365 days after the date of the covered accident causing the loss, the Company will pay in one installment the indicated percentage of the Principal Sum as set out in the following Table of Losses. If more than one loss is sustained, only one benefit shall be payable, the largest.

Table of Losses

Loss of life	The Principal Sum
Loss of both hands or both feet	The Principal Sum
Loss of entire sight of both eyes	The Principal Sum
Loss of one hand and one foot	The Principal Sum
Loss of one hand and the entire sight of one eye	The Principal Sum
Loss of one foot and the entire sight of one eye	The Principal Sum
Loss of one arm or one leg	Four-fifths of the Principal Sum
Loss of one hand or one foot	Three-quarters of the Principal Sum
Loss of the entire sight of one eye	Three-quarters of the Principal Sum
Loss of thumb and index finger of the same hand	One-third of the Principal Sum
Loss of speech and hearing	The Principal Sum
Loss of speech or hearing	Three-quarters of the Principal Sum
Loss of hearing in one ear	Two-thirds of the Principal Sum
Loss of four fingers of one hand	One-third of the Principal Sum
Loss of all toes of one foot	One-quarter of the Principal Sum

Loss of Use

Loss of use of both arms or both hands.....The Principal Sum
Loss of use of one hand or one foot .....Three-quarters of the Principal Sum
Loss of use of one arm or one leg ..... Four-fifths of the Principal Sum

Paralysis

Quadriplegia (total paralysis of both upper and lower limbs).....
Two times The Principal Sum up to a maximum of one million dollars
Paraplegia (total paralysis of both lower limbs) .....
Two times The Principal Sum up to a maximum of one million dollars
Hemiplegia (total paralysis of upper and lower limbs of one side of the body).....
Two times The Principal Sum up to a maximum of one million dollars

If you sustain more than one loss as a result of the same accident, only one amount, the largest, will be paid.

"Loss" when used with reference to “Quadriplegia”, “Paraplegia”, and “Hemiplegia” means the complete and irreversible paralysis of such limbs; “Hand” or “Foot” means the complete severance through or above the wrist or ankle joint, but below the elbow or knee joint; “Arm” or “Leg” means the complete severance through or above the elbow or knee joint; “Thumb and Index Finger” means the complete severance through or above the first phalange; “Fingers” means the complete severance through or above the first phalange of all Four Fingers of One Hand; “Toes” means the complete severance of both phalanges of all the Toes of One Foot; “The Entire Sight of One Eye” means the total and irrecoverable Loss of Sight such that corrected visual acuity must be 20/200 or less in such eye; “The Entire Sight of Both Eyes” means the total and irrecoverable Loss of Sight in Both Eyes such that corrected visual acuity must be 20/200 or less and the field of vision must be less than 20 degrees in both eyes. A Physician certified in Ophthalmology must clinically confirm the diagnosis in writing; “Hearing in One Ear” means the diagnosis of permanent Loss of Hearing in One Ear, with an auditory threshold of more than 90 decibels. A Physician certified in Otolaryngology must confirm the diagnosis in writing; “Hearing” means the diagnosis of permanent Loss of Hearing in Both Ears, with an auditory threshold of more than 90 decibels in each ear. A Physician certified in Otolaryngology must confirm the diagnosis in writing; “Speech” means complete and irrecoverable Loss of the ability to utter intelligible sounds; and "Loss of Use" means the total and irrecoverable Loss of Use provided the Loss is continuous for 12 consecutive months and such Loss of Use is determined to be permanent. “Loss” when used herein may also include “Loss of Life”.

Rehabilitation Benefit

Pays the expenses incurred for occupational training to a maximum of $15,000 if such expenses are incurred within 2 years of and as a result of an injury for which you receive a benefit under the Plan.

Home Alteration and Vehicle Modification Benefit

Pays a one-time benefit of up to $15,000 for modification to your home or vehicle if you suffer an injury for which you receive a benefit under the Plan and require a wheelchair to be ambulatory.

Workplace Modification and Accommodation Benefit

Pays a benefit of up to $5,000 to your Employer if you suffer an injury for which you receive a benefit under the Plan and require special adaptive equipment or workplace modification in order for you to return to work full-time.

Psychological Therapy

Pays a benefit of up to $5,000 if you suffer an injury for which you receive a benefit under the Plan and require psychological therapy within 2 years of the injury.

In-Hospital Benefit

Pays a benefit of (i) 1% of the Principal Sum to a maximum of $2,500 per month for hospital confinements of more than 30 nights, or (ii) 1/30th of the amount determined under (i) for hospital confinements of more than 5 but less than 30 nights, if you suffer an injury for which you receive a benefit under the Plan and are confined to hospital as a result of such injury, for a maximum of twelve months.

Family Transportation

Pays a benefit of up to $15,000 for the expenses incurred for the transportation of an immediate family member to your hospital if you suffer an injury for which you receive a benefit under the Plan and as a result are confined to a hospital more than 100 kilometres from home.

Repatriation Benefit

Pays a benefit of up to $15,000 to cover the expenses to return your body to your city of residence if you suffer a covered accidental death while at least 50 kilometres from home.

Identification Benefit
Pays a benefit of up to $5,000 for the transportation and commercial lodging of an immediate family member to identify your body if you suffer a covered accidental death at least 150 kilometres from home and a law enforcement agency requests such identification.

Seat Belt Benefit
Pays an additional benefit of 10% of the Principal Sum to a maximum of $50,000 if you suffer a covered accidental death while operating or riding as a passenger in a private passenger automobile in which your seat belt was properly fastened.

Day Care Benefit
Pays an annual benefit of up to 5% of the Principal Sum to a maximum of $5,000 per year for the day care costs of each Dependent Child under age 13 who is enrolled, or who enrolls within 90 days, in a day care facility if you suffer a covered accidental death. The benefit is payable for up to four consecutive years.

Dependent Child Educational Benefit
Pays an annual benefit of up to 5% of the Principal Sum to a maximum of $5,000 per school year for the tuition costs of each Dependent Child who is enrolled in post-secondary education if you suffer a covered accidental death. The benefit is payable for up to four consecutive years.

Spousal Educational Benefit
Pays a benefit of up to $15,000 for your Spouse's expenses in enrolling in a professional or trades training program for the purpose of obtaining an independent source of income, if you suffer a covered accidental death and such expenses are incurred within 30 months of your death.

Funeral Expense
Pays a benefit of up to $5,000 to reimburse funeral expenses if you suffer a covered accidental death.

Bereavement Benefit
Pays a benefit of up to $1,000 if you suffer loss of life in a covered accident and your eligible dependents require counselling within one year of the accident.

Felonious Assault Benefit
Pays an additional benefit of 10% of the Principal Sum if you suffer an injury for which you receive a benefit under the Plan as a result of a deliberate felonious act of another person directed at you as an employee of the Policyholder, unless such an act was committed by a fellow employee or a member of your family or household.

Serious Illness Benefit (Non-Cancer)
Pays an additional benefit of 10% of the Principal Sum to a maximum of $5,000 if you are diagnosed with the following covered serious illness:

- ✓ Major Burns (3rd degree)
- ✓ Multiple Sclerosis
- ✓ Necrotizing Fasciitis
- ✓ Parkinson's Disease
- ✓ Major Organ Failure Requiring Transplant
- ✓ Motor Neuron Disease
- ✓ Major Organ Transplant

Please see the Policy for specific diagnosis requirements. You must be confined to a hospital for at least 48 hours as a result of the serious illness, survive at least 30 days after the diagnosis and be under the age of 65 at the time of the diagnosis. This is a one-time benefit even if you are diagnosed with more than one covered serious illness.

Coma Benefit
Pays a monthly benefit of 1% of your Principal Sum for a maximum of 100 months after 6 months in a continuous coma caused by an accident.

Burn Benefit
Pays a percentage of the Principal Sum up to a maximum of $25,000 if you suffer a 3rd degree burn by means of exposure to fire, heat, caustics, electricity or radiation.

Waiver of Premium
Waives premium payments under the Plan if you are receiving disability benefits under the group life insurance policy provided by the Policyholder.

Continuance of Coverage
If you are no longer employed or actively working, your coverage shall continue in the following circumstances: (1) during a statutory leave, as set out in applicable provincial, territorial or federal employment standards legislation or equivalent, but not more than the period required under such legislation, or (2) during the notice period for termination of employment as required by law, provided premiums continue to be paid.

Conversion Privilege Benefit
If you leave your job for any reason, you have 90 days to convert your coverage under the Plan to an individual insurance policy providing comparable coverage and with a coverage amount not greater than the Principal Sum at individual rates in force at that time.

Policy Exclusions
The Plan will not cover any losses caused in whole or in part by, or resulting in whole or in part from, the following:

(a) suicide or any attempt thereat by you while sane;
(b) self inflicted injury or any attempt thereat by you while sane or insane;
(c) declared or undeclared war or any act thereof;
(d) sickness, disease, or bodily infirmity whether the loss or claim results directly or indirectly from any of these;
(e) mental incapacity whether the Loss or claim results directly or indirectly from any mental incapacity;
(f) injury sustained while you are undergoing the medical or surgical treatment of sickness, disease, or bodily or mental infirmity;
(g) stroke or cerebrovascular accident or event; cardiovascular accident or event; myocardial infarction or heart attack; coronary thrombosis; aneurysm;
(h)
  (i) travel or flight in or on (including getting in or out of, or on or off of) any Aircraft, if the Insured Employee is:
    a. riding as a passenger in any Aircraft not intended or licensed for the transportation of passengers; or
    b. performing, learning to perform or instructing others to perform as a pilot or crew member of any Aircraft; or
    c. riding as a passenger on an Owned Aircraft, Leased Aircraft or on a Charter Flight;
  (ii) travel or flight in or on (including getting in or out of, or on or off of) any Aircraft or any craft designed to fly or glide above the Earth's surface:
    a. except as a passenger on a regularly scheduled commercial airline; or
    b. being used for crop dusting, spraying or seeding, fire-fighting, traffic patrol, air ambulance, pipeline or power line inspection, aerial photography or exploration, racing, endurance tests, stunt or acrobatic flying; or
    c. operating to or from off-shore landing sites; or
    d. used in any operation that requires a special permit from the Civil Aviation Branch of Transport Canada, even if it is granted (this does not apply if the permit is required only because of the territory flown over or landed on);
(i) infections of any kind regardless of how contracted, except bacterial infections that are directly caused by botulism, ptomaine poisoning or an accidental cut or wound independent and in the absence of any underlying sickness, disease or condition including but not limited to diabetes;
(j) injury or Loss sustained if you are on full-time active duty in the armed forces or organized reserve corps of any country or international authority. (Unearned premium for any period for which you are on full-time active duty shall, upon application to the Company by the Policyholder, be refunded);
(k) injury or Loss sustained while you are under the influence of alcohol and operating any vehicle or means of transportation or conveyance while your blood alcohol is over 80 milligrams in 100 millilitres of blood;
(l) injury or Loss sustained while you are under the influence of a drug or substance which is controlled as specified under the Controlled Drug and Substances Act (Canada) unless taken pursuant to the advice of and in strict accordance with the instructions of a duly licensed physician;
(m) the commission or attempted commission by you or injury incurred while you are in the course of committing or attempting to commit any act which if adjudicated by a court would be an indictable offence under the laws of the jurisdiction where the act was committed; and
(n) an act, attempted act or omission taken or made by you, or an act, attempted act or omission taken or made with your consent, for the purposes of interrupting the blood flow to your brain or to cause asphyxiation to you whether with intent to cause harm or not; and

(o) natural causes.

Aggregate Limit Per Accident

The maximum amount the Company will pay for two or more Insured Employees injured in one accident is the amount of the Aggregate Limit Per Accident set out in the policy, if any. If the total of the benefits which would be paid by the Company would exceed the Aggregate Limit Per Accident, each Insured Employee shall receive their proportionate share of the amount of the Aggregate Limit Per Accident paid by the Company.

Effective Date

Your coverage begins on the date you satisfy the definition of “Insured Employee”.

Termination Date

Coverage ends on the earliest of:

1. the date the policy is terminated;
2. the premium due date if premiums are not paid when due;
3. the date you no longer satisfy the definition of an Insured Employee; or
4. the first day of the month following the date you no longer belong to an Eligible Class of Employees as set out in the Policy.

This brochure provides only brief descriptions of the coverage available. The full details of the coverage are contained in the Policy including limitations, exclusions and termination provisions. If there are any conflicts between this document and the Policy, the Policy shall govern. Insurance is underwritten by AIG Insurance Company of Canada.

Printed in November 2021

Voluntary Accidental Death & Dismemberment Plan
Policyholder: ABBVIE CORPORATION
Policy No.: PAI 9138195

Why You Need Personal Accident Insurance

A serious accidental injury or death can have tremendous consequences, even for a two-income family. You may not have sufficient financial resources to pay for the care you or a loved one may require. Without a reliable source of income, you may not be able to make home mortgage payments, cover college costs or save for retirement.

Now your employer is offering you, through the benefit of group buying power, the opportunity to purchase simple and affordable Personal Accident Insurance coverage underwritten by AIG Insurance Company of Canada, for you and your eligible dependents. The policy provides a lump sum benefit to help ease the financial impact and assure your family's needs are met if you or your eligible insured dependents should suffer loss of life, or 'living benefits' should a covered accident result in paralysis, or the loss of or loss of use of a limb, sight, speech or hearing.

How It Works

You choose a Principal Sum amount for yourself from a minimum of $10,000 up to a maximum of $650,000 in increments of $10,000.

If you elect family coverage, you can select your Spouse's Principal Sum from a minimum of $10,000 up to a maximum of $500,000 in increments of $10,000. You may also select your Dependent children's Principal Sum from a minimum of $5,000 up to a maximum of $25,000 in increments of $5,000.

Enrolling is Easy

You're eligible to enroll if you are a permanent, or temporary employee of the Policyholder. To include your dependent family members for coverage, select the family plan option.

To learn more about this valuable benefit offering or if you're ready to enroll, contact your Human Resources Department today.

Here's What You Get

Broad Accident Insurance Coverage - Your plan provides generous Accidental Death & Dismemberment benefits for injuries as a result of covered accidents.

Guaranteed Acceptance - Coverage is provided regardless of your health history.

24/7 Worldwide Coverage - Your coverage is in force around-the-clock - at work, at home or at play, anywhere in the world.

Economical Cost - Group buying power allows you to purchase coverage at reduced rates, well below that of an individual policy.

Convenient Payroll Deductions - For your convenience, the insurance premiums are automatically deducted.

Definitions

"Insured Person" means you, if you are a permanent or temporary employee of the Policyholder who is under the age of 70, and if you have selected family coverage, includes your Spouse and your Dependent Children, also referred as eligible dependents.

Eligible Dependents:
"Spouse" means a person who is under the age of 70 and who is either legally married to you, or if there is no such person, is a person who, although not legally married to you, is cohabitating with you for a period of at least one year and is publicly represented as your domestic partner in the community in which you reside.

"Dependent Child" means a person who is either your natural child, adopted child or step-child or a child to whom you are *in loco parentis* and who is (i) under 23 years of age, unmarried and dependent upon you for maintenance and support and not employed for more than 25 hours per week; or (ii) under 26 years of age, unmarried and enrolled in post-secondary education and dependent upon you for maintenance and support and not employed for more than 25 hours per week; or (iii) by reason of mental or physical infirmity is incapable of self-sustaining employment and who is considered your Dependent Child within the terms of the Income Tax Act (Canada).

Beneficiary Designation

In the event of accidental loss of life, the benefit will be paid to the beneficiary you have designated in writing under your Employer's current Group Life policy. If there is no written designation then the benefit will be paid to your estate. The amount payable for the loss of life of your insured dependents is payable to you.

All other benefits will be payable to you.

Benefits and Coverages

Accidental Death, Dismemberment, Paralysis and Loss of Use

If a covered loss occurs within 365 days after the date of the covered accident causing the loss, the Plan will pay in one sum the indicated percentage of the Principal Sum as set out in the following Table of Losses:

Table of Losses

Loss of life	The Principal Sum
Loss of both hands or both feet	The Principal Sum
Loss of entire sight of both eyes	The Principal Sum
Loss of one hand and one foot	The Principal Sum
Loss of one hand and the entire sight of one eye	The Principal Sum
Loss of one foot and the entire sight of one eye	The Principal Sum
Loss of one arm or one leg	Four-fifths of the Principal Sum
Loss of one hand or one foot	Three-quarters of the Principal Sum
Loss of the entire sight of one eye	Three-quarters of the Principal Sum
Loss of thumb and index finger of the same hand	One-third of the Principal Sum
Loss of speech and hearing	The Principal Sum
Loss of speech or hearing	Three-quarters of the Principal Sum
Loss of hearing in one ear	Two-thirds of the Principal Sum
Loss of four fingers of one hand	One-third of the Principal Sum
Loss of all toes of one foot	One-quarter of the Principal Sum

Loss of Use

Loss of use of both arms or both hands	The Principal Sum
Loss of use of one hand or one foot	Three-quarters of the Principal Sum
Loss of use of one arm or one leg	Four-fifths of the Principal Sum

Paralysis

Quadriplegia (total paralysis of both upper and lower limbs)	Two times The Principal Sum up to a maximum of one million dollars
Paraplegia (total paralysis of both lower limbs)	Two times The Principal Sum up to a maximum of one million dollars
Hemiplegia (total paralysis of upper and lower limbs of one side of the body)	Two times The Principal Sum up to a maximum of one million dollars

If you sustain more than one loss as a result of the same accident, only one amount, the largest, will be paid.

"Loss" when used with reference to "Quadriplegia", "Paraplegia", and "Hemiplegia" means the complete and irreversible paralysis of such limbs; "Hand" or "Foot" means the complete severance through or above the wrist or ankle joint, but below the elbow or knee joint; "Arm" or "Leg" means the complete severance through or above the elbow or knee joint; "Thumb and Index Finger" means the complete severance through or above the first phalange; "Fingers" means the complete severance through or above the first phalange of all Four Fingers of One Hand; "Toes" means the complete severance of both phalanges of all the Toes of One Foot; "The Entire Sight of One Eye" means the total and irrecoverable Loss of Sight such that corrected visual acuity must be 20/200 or less in such eye; "The Entire Sight of Both Eyes" means the total and irrecoverable Loss of Sight in Both Eyes such that corrected visual acuity must be 20/200 or less and the field of vision must be less than 20 degrees in both eyes. A Physician certified in Ophthalmology must clinically confirm the diagnosis in writing; "Hearing in One Ear" means the diagnosis of permanent Loss of Hearing in One Ear, with an auditory threshold of more than 90 decibels. A Physician certified in Otolaryngology must confirm the diagnosis in writing; "Hearing" means the diagnosis of permanent Loss of Hearing in Both Ears, with an auditory threshold of more than 90 decibels in each ear. A Physician certified in Otolaryngology must confirm the diagnosis in writing; "Speech" means complete and irrecoverable Loss of the ability to utter intelligible sounds; and "Loss of Use" means the total and irrecoverable Loss of Use provided the Loss is continuous for 12 consecutive months and such Loss of Use is determined to be permanent. "Loss" when used herein may also include "Loss of Life".

Rehabilitation Benefit
Reimburses your expenses for occupational training to a maximum of $15,000 if such expenses are incurred within two years of and as a result of an injury for which you receive a benefit under the Plan.

Home Alteration and Vehicle Modification Benefit
Pays a benefit of up to $15,000 for modification to your home or vehicle if you or your eligible insured dependents suffer an injury for which you receive a benefit under the Plan and require a wheelchair to be ambulatory.

Workplace Modification and Accommodation Benefit
Pays a benefit of up to $5,000 if you suffer an injury for which you receive a benefit under the Plan and require special adaptive equipment or workplace modification in order to return to full-time work with the Policyholder.

Psychological Therapy
Pays a benefit of up to $5,000 if you or your eligible insured dependents suffer an injury for which you receive a benefit under the Plan and require psychological therapy within 2 years of the injury.

In-Hospital Benefit
Pays a benefit of (i) 1% of the Principal Sum to a maximum of $2,500 per month for hospital confinements of more than 30 nights, or (ii) 1/30th of the amount determined under (i) for hospital confinements of more than 5 but less than 30 nights, if you or your eligible insured dependents suffer an injury for which you receive a benefit under the Plan and are confined to hospital as a result of such injury, for a maximum of twelve months.

Family Transportation
Pays a benefit of up to $15,000 for the expenses incurred for the transportation of an immediate family member to your hospital if you or your eligible insured dependents suffer an injury for which you receive a benefit under the Plan and as a result are confined to a hospital more than 100 kilometres from home.

Repatriation Benefit
Pays a benefit of up to $15,000 to cover the expenses to return your body to your city of residence if you or your eligible insured dependents suffer a covered accidental death while at least 50 kilometres from home.

Identification Benefit
Pays a benefit of up to $5,000 for the transportation of an immediate family member to identify your body if you or your eligible insured dependents suffer a covered accidental death at least 150 kilometres from home and a law enforcement agency requests such identification.

Seat Belt Benefit
Pays an additional benefit of 10% of the Principal Sum to a maximum of $50,000 if you or your eligible insured dependents suffer a covered accidental death while operating or riding as a passenger in a private passenger automobile in which your seat belt was properly fastened.

Day Care Benefit
Pays an annual benefit of up to 5% of the Principal Sum to a maximum of $5,000 per year for the day care costs of each Dependent Child under age 13 who is enrolled, or who enrolls within 90 days, in a day care facility if you or your insured Spouse suffer a covered accidental death. The benefit is payable for up to four consecutive years.

Dependent Child Educational Benefit
Pays an annual benefit of up to 5% of the Principal Sum to a maximum of $5,000 per school year for the tuition costs of each Dependent Child who is enrolled in post-secondary education if you or your insured Spouse suffer a covered accidental death. The benefit is payable for up to four consecutive years.

Spousal Educational Benefit
Pays a benefit of up to $15,000 for your Spouse’s expenses in enrolling in a professional or trades training program for the purpose of obtaining an independent source of income, if you suffer a covered accidental death and such expenses are incurred within 30 months of your death.

Funeral Expense
Pays a benefit of up to $5,000 to reimburse funeral expenses if you or your eligible insured dependents suffer a covered accidental death.

Bereavement Benefit
Pays a benefit of up to $1,000 if you have selected single coverage and you suffer loss of life in a covered accident and your eligible dependents require counseling within one year of the accident. Pays a benefit of up to $2,000 if you have selected family coverage and you or your eligible insured dependents suffer loss of life in a covered accident and you or your eligible dependents require counseling within one year of the accident.

Felonious Assault Benefit
Pays an additional benefit of 10% of the Principal Sum if you suffer an injury for which you receive a benefit under the Plan as a result of a deliberate felonious act of another person directed at you as an employee of the Policyholder, other than an act of a fellow employee or a member of your family or household.

Serious Illness Benefit (Non-Cancer)
Pays an additional benefit of 10% of the Principal Sum to a maximum of $5,000 if you are diagnosed with the following covered serious illness:

- ✓ Major Burns (3rd degree)
- ✓ Multiple Sclerosis
- ✓ Necrotizing Fasciitis
- ✓ Parkinson's Disease
- ✓ Major Organ Failure Requiring Transplant
- ✓ Motor Neuron Disease
- ✓ Major Organ Transplant

Please see the Policy for specific diagnosis requirements. You must be confined to a hospital for at least 48 hours as a result of the serious illness, survive at least 30 days after the diagnosis and be under the age of 65 at the time of the diagnosis. This benefit is payable only once even if you are diagnosed with more than one covered serious illness.

Coma Benefit
Pays a monthly benefit of 1% of the difference between the Principal Sum and any other amount payable under the Plan in connection with the injury for up to 100 months.

Burn Benefit
Pays a percentage of the Principal Sum up to a maximum of $25,000 if you or your eligible insured dependents suffer a 3rd degree burn.

Waiver of Premium
Waives premium payments under the Plan if you are receiving disability benefits under the group life insurance policy provided by the Policyholder.

Continuance of Coverage
If you are no longer employed or actively working, your coverage shall continue in the following circumstances: (1) during a statutory leave, as set out in applicable provincial, territorial or federal employment standards legislation or equivalent, but not more than the period required under such legislation, or (2) during the notice period for termination of employment as required by law, provided premiums continue to be paid.

Extended Family Coverage
If you die, the coverage of your insured Spouse and/or insured Dependent Children will continue for up to 6 months, subject to payment of premium.

Conversion Privilege Benefit
If you leave your job for any reason, you have 90 days to convert your coverage under the Plan to an individual insurance policy providing comparable coverage and with a coverage amount not greater than the Principal Sum at individual rates in force at that time.

Policy Exclusions

The Plan will not cover any losses caused in whole or in part by, or resulting in whole or in part from, the following:

(a) suicide or any attempt thereat by you while sane;
(b) self inflicted injury or any attempt thereat by you while sane or insane;
(c) declared or undeclared war or any act thereof;
(d) sickness, disease, or bodily infirmity whether the loss or claim results directly or indirectly from any of these;
(e) mental incapacity whether the Loss or claim results directly or indirectly from any mental incapacity;
(f) injury sustained while you are undergoing the medical or surgical treatment of sickness, disease, or bodily or mental infirmity;
(g) stroke or cerebrovascular accident or event; cardiovascular accident or event; myocardial infarction or heart attack; coronary thrombosis; aneurysm;
(h)
  (i) travel or flight in or on (including getting in or out of, or on or off of) any Aircraft, if the Insured Employee is:
    a. riding as a passenger in any Aircraft not intended or licensed for the transportation of passengers; or
    b. performing, learning to perform or instructing others to perform as a pilot or crew member of any Aircraft; or
    c. riding as a passenger on an Owned Aircraft, Leased Aircraft or on a Charter Flight;
  (ii) travel or flight in or on (including getting in or out of, or on or off of) any Aircraft or any craft designed to fly or glide above the Earth's surface:
    a. except as a passenger on a regularly scheduled commercial airline; or
    b. being used for crop dusting, spraying or seeding, fire-fighting, traffic patrol, air ambulance, pipeline or power line inspection, aerial photography or exploration, racing, endurance tests, stunt or acrobatic flying; or
    c. operating to or from off-shore landing sites; or
    d. used in any operation that requires a special permit from the Civil Aviation Branch of Transport Canada, even if it is granted (this does not apply if the permit is required only because of the territory flown over or landed on);
(i) infections of any kind regardless of how contracted, except bacterial infections that are directly caused by botulism, ptomaine poisoning or an accidental cut or wound independent and in the absence of any underlying sickness, disease or condition including but not limited to diabetes;
(j) injury or Loss sustained if you are on full-time active duty in the armed forces or organized reserve corps of any country or international authority. (Unearned premium for any period for which you are on full-time active duty shall, upon application to the Company by the Policyholder, be refunded);
(k) injury or Loss sustained while you are under the influence of alcohol and operating any vehicle or means of transportation or conveyance while your blood alcohol is over 80 milligrams in 100 millilitres of blood;
(l) injury or Loss sustained while you are under the influence of a drug or substance which is controlled as specified under the Controlled Drug and Substances Act (Canada) unless taken pursuant to the advice of and in strict accordance with the instructions of a duly licensed physician;
(m) the commission or attempted commission by you or injury incurred while you are in the course of committing or attempting to commit any act which if adjudicated by a court would be an indictable offence under the laws of the jurisdiction where the act was committed; and
(n) an act, attempted act or omission taken or made by you, or an act, attempted act or omission taken or made with your consent, for the purposes of interrupting the blood flow to your brain or to cause asphyxiation to you whether with intent to cause harm or not; and
(o) natural causes.

Aggregate Limit Per Accident

The maximum amount the Company will pay for two or more Insured Persons injured in one accident is the amount of the Aggregate Limit Per Accident set out in the Policy, if any. If the total of the benefits which would be paid by the Company would exceed the Aggregate Limit Per Accident, each Insured Person shall receive their proportionate share of the amount of the Aggregate Limit Per Accident paid by the Company.

Effective Date

Coverage for an Insured Employee, Spouse, or Dependent Child begins on the latest of: (1) the policy effective date; (2) the first day of the month following receipt of your completed application by your Human Resources Department; or (3) the date such person satisfies the definition of "Insured Employee", "Spouse" or "Dependent Child".

Termination Date

Coverage for an Insured Employee, Spouse, or Dependent Child ends on the earliest of:

1. the date the policy is terminated;
2. the premium due date if premiums are not paid when due;
3. the date such person no longer satisfies the definition of Insured Employee, Spouse, or Dependent Child; or
4. the first day of the month following the date the Insured Employee no longer belongs to an Eligible Class of Employees as set out in the Policy.

This brochure provides only brief descriptions of the coverage available. The full details of the coverage are contained in the Policy including limitations, exclusions and termination provisions. If there are any conflicts between this document and the Policy, the Policy shall govern. Insurance is underwritten by AIG Insurance Company of Canada.

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