



# Your group insurance plan



**OLYMEL S.E.C. & UNION INTERNATIONALE DES  
TRAVAILLEURS (EUSES) UNIS DE L'ALIMENTATION ET DE  
COMMERCE SECTION LOCALE 1991-PFAT-COI-CTC-FTQ,  
TUAC CANADA**

**Policy No. Q1495**

**Unionized employees other than unionized maintenance  
employees**

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**This document is an integral part of the Insurance certificate. It is a summary of your Group Insurance Policy effective March 1, 2017. Only the Group Insurance Policy may be used to settle legal matters.**

**This electronic version of the booklet has been updated on October 1 2019. Please be advised that this electronic version is updated more frequently than the printed copy of your booklet. Therefore, there may be discrepancies between the paper and electronic copies.**

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## BENEFIT SCHEDULE

### GENERAL GUIDELINES

**Participation:** Mandatory

#### **Eligibility Requirements**

**Number of hours worked per week:** A minimum of 24 hours per week

**Eligibility Period:** The date the employee has completed 3 months of continuous service for the Employer.

#### **Waiver of Premium**

**Benefits for which premiums are waived in the event of Total Disability:**

- Basic Participant Life Insurance Benefit
- Dependent Life Insurance Benefit
- Participant Weekly Indemnity Benefit
- Participant Long Term Disability Benefit

**Beginning of Waiver of Premium:**

At the end of the Elimination Period of the Participant Long Term Disability Benefit.

## **BASIC PARTICIPANT LIFE INSURANCE BENEFIT**

**Amount of Insurance:** \* 1.5 times annual Earnings, rounded to the next higher \$1,000, if not already a multiple, up to a maximum of \$1,000,000.

**Non-Evidence Maximum of Insurability:** \$250,000

**\* Reduction of Amount:** On the 65<sup>th</sup> birthday of the Participant, the amount applicable to the Participant will be reduced by 50%.

### **Benefit Termination**

**Age Limit:** Age 70 of the Participant, or retirement whichever occurs first.

## **DEPENDENT LIFE INSURANCE BENEFIT**

**Amount of Insurance:** Spouse: \$10,000  
Each Child: \$5,000

**Commencement of  
Newborn Children  
Insurance:** From birth

### **Benefit Termination**

**Age Limit:** Age 70 of the Participant, or retirement  
whichever occurs first.

## **PARTICIPANT WEEKLY INDEMNITY BENEFIT**

<b>Percentage and Maximum of Benefit:</b>	66.67% of gross weekly Earnings, rounded to the next \$1, if not already a multiple, up to a maximum of \$1,500.
<b>Carve Out with Employment Insurance Act:</b>	Supplementary plan: the weekly benefit is reduced by any income replacement benefits payable under the Employment Insurance Act.
<b>Elimination Period:</b>	0 days in case of Accident 7 days in case of Illness Nil if Hospitalized.
<b>Payment Basis:</b>	7 days (calendar)
<b>Maximum Benefit Period:</b>	119 days
<b>Taxability of Benefits:</b>	Taxable
<b><u>Benefit Termination</u></b>	
<b>Age Limit:</b>	Age 70 of the Participant, or retirement whichever occurs first.

**PARTICIPANT LONG TERM DISABILITY BENEFIT**

<b>Percentage and Maximum of Benefit:</b>	70% of gross monthly Earnings, rounded to the next \$1, if not already a multiple, up to a maximum of \$4,000.
<b>Non-Evidence Maximum of Insurability:</b>	\$4,000
<b>Elimination Period:</b>	119 days or the end of the Maximum Benefit Period of the Weekly Indemnity Benefit, whichever is later.
<b>Maximum Benefit Period:</b>	To age 65
<b>Taxability of Benefits:</b>	Taxable
<b><u>Benefit Termination</u></b>	
<b>Age Limit:</b>	Age 65 of the Participant, or retirement whichever occurs first.



## **EXTENDED HEALTH CARE BENEFIT**

### **Deductible Amount**

<b>Drugs:</b>	\$5 co-pay per prescribed drug
<b>Hospitalization Expenses:</b>	Nil
<b>Travel Insurance:</b>	Nil
<b>Referral Treatment:</b>	Nil
<b>Eyeglasses and Contact Lenses:</b>	Nil
<b>Vision Care:</b>	Nil
<b>Other Expenses:</b>	Nil

### **Percentage of Reimbursement**

<b>Drugs:</b>	<ol style="list-style-type: none"><li>1) Generic drugs: 80% of the lowest priced equivalent drug available on the market</li><li>2) Brand name drugs:<ul style="list-style-type: none"><li>• 80% of the brand name drug if no equivalent drug is available on the market</li><li>• 80% of the lowest priced equivalent drug available on the market</li></ul></li></ol>
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**Maximum contribution  
for drugs:**

For each Calendar Year, a maximum contribution applies to Eligible Expenses for drugs listed in the *Liste des médicaments* of the *Régie de l'assurance maladie du Québec* (RAMQ). The contribution is the Deductible and any portion of Eligible Expenses not reimbursed under this Benefit.

Once the Participant's contribution reaches the maximum annual contribution set by the RAMQ, for expenses incurred by himself and his Dependent Children, the percentage of reimbursement of the drugs listed in the RAMQ list becomes 100% for the remainder of that Calendar Year, for the Participant and his Dependent Children.

Once the contribution reaches the maximum annual contribution set by the RAMQ, for expenses incurred by the Participant's Spouse, the percentage of reimbursement of the drugs listed in the RAMQ list becomes 100% for the remainder of that Calendar Year, for the Spouse.

<b>Hospitalization Expenses:</b>	100%
<b>Detoxification:</b>	100%
<b>Travel Insurance:</b>	100%
<b>Eyeglasses and Contact Lenses:</b>	100%
<b>Vision Care:</b>	100%
<b>Other Expenses:</b>	80%

**Limits for Eligible Expenses**

**Drugs:**

Reasonable and Customary Charges

**Short-Term Hospitalization Expenses:**

The cost of a semi-private room for each day of Hospitalization with no limit as to the number of days.

**Long-term Hospitalization Expenses:**

- **Palliative Care Establishment:**

Payable amount of \$40 per day and a maximum of 60 days.

- **Convalescent / Rehabilitation Centre:**

The cost of a semi-private room for each day of Hospitalization and a combined maximum of 180 days per disability.

**Travel Insurance:**

Lifetime maximum payable amount of \$5,000,000 per Insured Person.

**Nursing Care:**

Payable amount of \$5,000 per Insured Person each Calendar Year.

**Paramedical Services:**

Payable amount of \$500 for all specialists per Insured Person each Calendar Year:

- Acupuncturist
- Audiologist or Hearing Therapist
- Chiropractor
- Massage Therapist
- Naturopath
- Occupational therapist
- Osteopath
- Physiotherapist or Physiatrist
- Podiatrist or Chiropodist
- Psychologist or Social Worker
- Speech Therapist

### **Benefit Termination**

**Age Limit:**

The date of retirement.

## DEFINITIONS

Wherever used in the policy:

Accident means any event due to sudden and unforeseeable external causes that inflicts bodily injuries that are certified by a Physician, directly and independently of any other cause. It does not mean any form of disease, or degenerative process, an inguinal, femoral, umbilical or incisional hernia, or any infection other than an infection of a visible, external cut or wound accidentally sustained.

Actively At Work means, on any day, the performance by the Employee of all the usual and customary duties of his job with the Employer for the scheduled number of hours for that day.

Age means the age of the Insured Person on his last birthday when stated or calculated, or on the day when an event referred to under the policy occurs.

Child means a person who:

- 1) is under 21 years of Age, and over whom the Participant or the Spouse of the Participant exercises parental authority or exercised parental authority until he reached the Age of majority; or
- 2) has no spouse, is 25 years old or under and is, or is deemed to be, a full-time student at an accredited educational institution, and over whom the Participant or the Spouse of the Participant would exercise parental authority if he were a minor; or
- 3) has reached the Age of majority, has no spouse, and is suffering from a "functional impairment" that must have existed when the status of the person fit the definition of either 1) or 2) above. In addition, in order to be considered a "person suffering from a functional impairment," this person must be living with the Participant or the Spouse of the Participant who would exercise parental authority over him as if he were a minor.

It is understood that a functional impairment will be defined as stipulated under the regulations of any provincial legislation, when covered under such regulations.

Continuing Medical Care means the treatment a Participant receives. It must be accepted by the medical profession as an effective, appropriate and essential treatment in the diagnosis or care of the specific Illness or injury. It must be reasonable, considered as standard practice and provided or prescribed by a Physician or, when the Insurer deems necessary, by a specialist in the appropriate field. Such care is not limited to examination and tests, and must be provided at the frequency required for the specific Illness or injury.

Dependent means a Spouse or Child who is domiciled in Canada. However, if a Dependent is domiciled outside Canada, such Dependent may be deemed to be domiciled in Canada provided such individual is covered under a provincial medical plan and prior written approval is obtained from the Insurer.

Earnings means the regular rate of pay of an Employee paid by the Employer, including dividends, but excluding bonuses, overtime pay and any non regular form of remuneration.

For the Participant Weekly Indemnity Insurance benefit that is registered for premium reduction under the Employment Insurance Act, if applicable, bonuses, overtime pay or any other form of pay included in regular compensation and declared to the Insurer is part of Earnings.

Employee means a person who is domiciled in Canada and who is employed by the Employer on a permanent full-time basis for not less than the number of hours specified in the Benefit Schedule. However, if an Employee is domiciled outside Canada, such Employee may be deemed to be domiciled in Canada provided prior written approval is obtained from the Insurer. By union means "Union internationale des travailleurs (euses) unis de l'alimentation de commerce section locale 1991-PFAT-COI-CTC-FTQ, TUAC Canada".

Employer means Olymel s.e.c.

Family-Related Leave means any leave of absence from work taken by a Participant in accordance with such provincial or federal legislation, or an agreement between the Participant and the Employer.

Hospital means any hospital that is designated as such by law and is intended for the care and treatment of sick and injured individuals, and which has organized facilities for diagnosis and major surgeries as well as 24 hour nursing service. The term does not include a nursing home, home for the aged or chronically ill, rest home, Convalescent Hospital, or a place for the care and treatment of alcoholism or drug abuse.

Illness means any health deterioration or bodily disorder certified by a Physician. For the purposes of the policy, organ donations and related complications are also considered illnesses.

Immediate Family means a person who is the Spouse, son, daughter, father, mother, brother, sister, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law or sister-in-law of the Participant.

Insured Person means the Participant or one of his insured Dependents, as the case may be.

Insurer means Desjardins Financial Security Life Assurance Company.

Maternity Leave means any leave of absence from work due to pregnancy in accordance with any labour standards legislation that is applicable in the Insured Person's province of residence. Maternity Leave consists of a voluntary portion and a "health related portion". The "health related portion" of the Maternity Leave commences on the date of the delivery and lasts for at least 6 weeks (8 weeks for a Caesarean delivery). The person is considered to be on Maternity Leave during the entire period for which she is receiving maternity benefits under any provincial or federal legislation. If she is absent from work due to a Total Disability that commenced before or during pregnancy, she is considered to be on Maternity Leave in accordance with any provincial or federal legislation.

Parental Leave means any leave of absence from work taken by a Participant to take care of his newborn or adopted child, in accordance with such provincial or federal labour standards legislation, or an agreement between the Participant and the Employer.

Participant means an Employee who is insured under the policy.

Physician means a legally qualified medical practitioner lawfully entitled to practice medicine in the place where he provides the medical services.

Policyholder means the company or group indicated on the application and specified on the cover page of the policy.

Spouse means an eligible person who is domiciled in Canada and who at the time of the event giving rise to a claim:

- 1) is legally married to or living in a civil union with the Participant; or
- 2) has been living with the Participant in a conjugal relationship for at least 12 months and has not been separated from the Participant for 90 days or more as a result of a breakdown in the relationship; or
- 3) is living in a conjugal relationship with the Participant who is the natural parent of the Spouse's Child and has not been separated from the Participant for 90 days or more as a result of a breakdown in the relationship.

However, if two individuals fit the definition of Spouse, the Insurer will recognize only one Spouse for all benefits under the same plan in the following order:

- 1) the eligible Spouse whom the Participant last designated as such in writing to the Insurer, subject to approval of any evidence of insurability required under the policy; or
- 2) the Spouse to whom the Participant is legally married or with whom the Participant is living in a civil union.

At any one time, only one person may be insured as a Spouse of the Participant.

## **ELIGIBILITY**

### **EMPLOYEE ELIGIBILITY**

An Employee is eligible for insurance:

- 1) on the EFFECTIVE DATE, if he meets the Eligibility Requirements specified in the Benefit Schedule; or
- 2) after the EFFECTIVE DATE, on the date on which he meets the Eligibility Requirements specified in the Benefit Schedule.

A Participant, whose insurance under the policy terminated due to termination of employment and who is re-hired by the Employer within 6 months immediately following the termination of his insurance, will be eligible for the reinstatement of his insurance on the date he resumes employment, provided application for reinstatement is made within 31 days of eligibility.

### **DEPENDENT ELIGIBILITY**

A Participant with a Dependent on the date he becomes eligible for insurance under the policy will be eligible for Dependent insurance on such date.

A Participant without Dependents who is insured under the policy will be eligible for Dependent insurance on the date he acquires a Dependent.

### **INSURANCE APPLICATION**

An eligible Participant must complete an application or an application for exemption for himself and for his Dependents, if any, within 31 days of the date on which he becomes eligible.

### **EXEMPTION PRIVILEGE**

A Participant may decline to be insured under the Extended Health Care Benefit or Dental Care Benefit, if included in the policy, if such Participant is insured as a Dependent under the policy or another similar group insurance plan. However, if the other plan terminates or the Spouse ceases to be a member of an eligible class, the Participant will be eligible for insurance under the Benefit he previously opted out of as of the date of such termination, provided written application is made within 31 days of such eligibility.

If the written application is received more than 31 days after the eligibility date, the following conditions apply:

- 1) the Extended Health Care Benefit will be effective on the date on which the written application is signed by the Participant and no evidence of insurability will be required;
- 2) the Dental Care Benefit will be effective on the date on which the written application is signed by the Participant and evidence of insurability is replaced by a limitation of payment, as indicated in the RESTRICTIONS, EXCLUSIONS AND LIMITATIONS provision under the Dental Care Benefit.



## **INDIVIDUALS AGE 65 AND OVER**

Individuals Age 65 and over are automatically covered under the Quebec drug insurance plan for drugs and other products included on this plan's list. Individuals who would like to continue their coverage for drugs under the Extended Health Care Benefit of the policy after they turn 65 must apply in writing beforehand to the Insurer, who will determine the required insurance premium, if applicable. However, Dependents cannot continue their coverage if the Participant does not remain insured.

A request for the continuation of insurance or for the Participant and/or his Dependents to opt out, where applicable, must be made in writing to the Insurer within 31 days of the date on which the individual becomes eligible for the Quebec drug insurance plan.

## **EVIDENCE OF INSURABILITY**

Evidence of insurability means any declaration relating to an individual's physical health or to other factual information that could have a bearing on the acceptance of the risk. Only declarations that are provided on the forms approved by the Insurer will be accepted.

## **COMMENCEMENT OF INSURANCE AND WAIVER OF PREMIUM**

### **COMMENCEMENT OF PARTICIPANT INSURANCE**

The insurance of any Employee will become effective on the latest of the following dates, provided that Employee is Actively At Work on such date:

- 1) the Effective Date of the policy,
- 2) the date on which he first becomes eligible, provided his written application, completed using the form required by the Insurer, is received by the Insurer within 180 days of his date of eligibility,
- 3) the date on which the insurability of the Employee is approved by the Insurer, if the application of the Employee for insurance is received by the Insurer more than 180 days after the date of his eligibility, except for the Extended Health Care Benefit, the date on which his written application, completed using the form required by the Insurer, is signed by him.

If an Employee is not Actively At Work on the date his insurance would have otherwise commenced, such insurance will commence on the first day he is subsequently Actively At Work.

If the Employee is not Actively At Work on the date his insurance would have otherwise commenced, due solely to a paid leave or a statutory holiday, then he will be considered Actively At Work on such date.

If a Participant requests an amount of insurance that exceeds the maximum amount the Insurer will provide without evidence of insurability, as specified in the Benefit Schedule, this excess amount will become effective on the latest of the dates specified in the preceding provision or on the date on which the insurability of the Participant is approved, if later.

With respect to the Dental Care Benefit, if included in the policy, if the Employee applies more than 31 days after the date of his eligibility, evidence that the insurability of an Employee is satisfactory will not be required; however, his dental coverage will be limited as set forth in the RESTRICTIONS, EXCLUSIONS AND LIMITATIONS section of the Dental Care Benefit.

### **COMMENCEMENT OF DEPENDENT INSURANCE**

The insurance for the Dependent of a Participant will become effective on the latest of the following dates:

- 1) the date on which the insurance of a Participant first becomes effective under the policy,
- 2) the date on which a Participant insured under the policy first becomes eligible for Dependent insurance, provided written application is made within 31 days of the date of such eligibility,

- 3) the date on which the insurability of the Dependent is approved by the Insurer, if evidence of insurability is requested of a Participant because his application for insurance is received more than 31 days after the date he became eligible, except for the Extended Health Care Benefit, the date on which his written application, completed using the form required by the Insurer, is signed by him,
- 4) the date on which the insurability of the Dependent is approved by the Insurer, if the application of the Participant for Dependent insurance is made more than 31 days after the Participant first became eligible for such insurance, except for the Extended Health Care Benefit, the date on which the written application, completed using the form required by the Insurer, is signed by the Participant.

The insurance for any individual becoming an eligible Dependent of a Participant insured with Dependent insurance will become effective on the date on which such individual becomes a Dependent as defined in the policy.

If a Dependent (other than a newborn Child) is confined to a Hospital on the date his insurance would have otherwise become effective, his insurance will commence on the day immediately following his discharge from the Hospital. This does not apply to the Extended Health Care Benefit.

#### **WAIVER OF PREMIUM**

- 1) For the Benefits listed in the WAIVER OF PREMIUM provision in the BENEFIT SCHEDULE, as of the Beginning of Waiver of Premium mentioned in the WAIVER OF PREMIUM provision in the BENEFIT SCHEDULE, premiums will be waived for a Participant who becomes Totally Disabled while insured under the policy but prior to attaining Age 65, if he submits Proof of Claim satisfactory to the Insurer. Premiums will continue to be waived for as long as the Total Disability persists. For the purpose of this provision, premiums will cease to be waived on the earliest of the following dates:
  - a) the date on which the Participant is unable or unwilling to provide satisfactory proof of Total Disability to the Insurer, if such proof is not provided within 3 months of the request,
  - b) the date on which the Participant ceases to be Totally Disabled,
  - c) for the Life Insurance Benefit, the date on which the Participant converts his insurance under the CONVERSION PRIVILEGE provision,
  - d) the date on which the Participant attains Age 65 or retires, if earlier,
  - e) in respect of each of the Benefits listed in the WAIVER OF PREMIUM provision in the BENEFIT SCHEDULE, the date on which each Benefit or the policy terminates except for the Basic Participant Life Insurance Benefit, the Dependent Life Insurance Benefit and the Participant Long Term Disability Benefit.

- 2) Under the policy, any provision for an increase in coverage is suspended during a Total Disability.
- 3) A recurrence of Total Disability within 6 months after the termination of a previous period of Total Disability for which premiums have been waived under the policy shall be deemed a continuation of the previous period if due to the same or related causes.
- 4) In the case of the Life Insurance Benefit, if a Totally Disabled Participant dies more than 31 days after his insurance terminates, prior to attaining Age 65, and written notice and proof of Total Disability has not been received by the Insurer, the amount of Life Insurance applicable to such Participant in accordance with the Benefit Schedule that was in effect at the time his insurance terminated will be payable provided that
  - a) the Participant became Totally Disabled while insured under this Benefit,
  - b) the Total Disability of the Participant was uninterrupted from the onset of his Total Disability to the date of his death,
  - c) the Participant dies within 12 months from the onset of his Total Disability,
  - d) the Participant did not convert any or all of his insurance under the CONVERSION PRIVILEGE provision at the time his insurance terminated, and
  - e) satisfactory proof of the Total Disability and death of the Participant is received by the Insurer within 90 days of his death.
- 5) To be eligible for WAIVER OF PREMIUM, the Insurer must receive written notice of Total Disability within 12 months of the date the Participant becomes Totally Disabled, and proof satisfactory to the Insurer of Total Disability within 90 days following the date the Insurer received written notice.

In the event of recurrent Total Disability, the Insurer must receive written notice and proof of claim within 12 months of the date of such recurrence.

## **TERMINATION OF INSURANCE**

### **TERMINATION OF PARTICIPANT INSURANCE**

Except as specifically provided to the contrary elsewhere in the policy, the insurance of the Participant will terminate on the earliest of the following dates:

- 1) the date the Participant no longer qualifies as an Employee, as defined in the policy,
- 2) the date the Participant ceases to belong to a class of Participants eligible for insurance,
- 3) the date the Participant reaches the applicable Age Limit specified in the Benefit Schedule,
- 4) the end of the period for which required premiums were paid on behalf of the Participant,
- 5) the date the Participant retires,
- 6) the date the Participant ceases to be Actively At Work,
- 7) the date of termination of the policy.

### **TERMINATION OF DEPENDENT INSURANCE**

Except as specifically provided to the contrary elsewhere in the policy, the Dependent insurance of a Participant will terminate on the earliest of the following dates:

- 1) the date the insurance of the Participant terminates,
- 2) the date the Participant no longer has any Dependents,
- 3) the end of the period for which required premiums for Dependent insurance were paid on behalf of the Participant,
- 4) the date Dependent insurance under the policy is terminated.

The insurance of any Dependent of a Participant will terminate on the date the Dependent no longer qualifies as a Dependent, as defined in the policy.

### **CONTINUATION OF INSURANCE**

If a Participant ceases to be Actively At Work, the insurance may be continued as specified in the policy.

## **CLAIMS**

### **NOTICE AND PROOF OF CLAIM**

Notice and proof of any claim must be received by the Insurer within the time limit, if any, specified for each Benefit. However, if the policy terminates, no payment will be made unless the notice and proof of a claim is submitted to the Insurer within 120 days of the date of termination of the policy.

Failure to submit notice or proof of claim within the prescribed time limit does not invalidate the claim, provided that the notice and proof of the claim are sent as soon as reasonably possible. However, no payment will be made if the notice and proof of claim are sent more than 12 months after the expenses were incurred.

Every action or proceeding against the Insurer for the recovery of insurance money payable under the policy is absolutely barred unless commenced within the time set out in the insurance act or other legislation of the province of residence of the Participant.

### **BENEFICIARY**

With regard to life insurance only and subject to legal provisions, a Participant may designate or revoke, at any time, one or several beneficiaries of the insurance on written notice to the Head Office of the Insurer. The rights of a beneficiary who dies before the Participant revert to the latter.

The Insurer assumes no responsibility with respect to the validity of any beneficiary designation or revocation.

The death benefit payable when a Dependent dies is paid to the Participant, if alive. If the Participant is deceased, the death benefit is paid as follows:

- 1) in the event of the Spouse's death:  
to the Spouse's legal heirs;
- 2) in the event of the death of the Participant's Dependent Child:
  - a) to the Spouse, if alive, or
  - b) if the Spouse is deceased, to the legal heirs of the Dependent Child.

### **CLAIMS**

Claims under the policy must be submitted to the Insurer on the appropriate form.

Any living benefits will be paid to the Participant unless otherwise indicated in the policy.

Within 90 days of a death, the beneficiary or the Participant must submit to the Insurer proof of death, including a death certificate, proof of the Age, and Earnings of the Participant or the insured Dependent, as well as any other information deemed useful by the Insurer.

If the designated beneficiary is the estate or personal representative of the deceased, or is a minor, or dies before the Participant, or is not competent to give valid release, the Insurer reserves the right to pay, at its option and at its discretion, a part of the proceeds of the Participant Life Insurance Benefit in an amount not exceeding \$5,000 to any person the Insurer deems equitably entitled to such amount to cover the Participant's burial expenses. Such payment will fully discharge the Insurer, and the other insurers, provided this payment is made in good faith.

## **MEDICAL EXAMINATIONS**

From time to time, the Insurer will be entitled to have a claimant examined by a Physician or Physicians of its choice.

## **CO-ORDINATION OF BENEFITS**

If an individual, who is insured for a Benefit that is subject to the CO-ORDINATION OF BENEFITS provision, is also insured under another Plan that provides similar benefits, the amount of benefits payable during any calendar year will be co-ordinated.

Coordination of benefits under the policy will be done in accordance with the guidelines of the Canadian Life and Health Insurance Association so that the total payments under all Plans will not exceed the individual's total incurred eligible expenses.

As used in this provision, "Plan" means the policy and any plan providing benefits or services under

- 1) other group insurance programs;
- 2) any other arrangement of coverage for individuals in a group, whether on an insured or uninsured basis;
- 3) government programs or any insurance required by statute.

The term "Plan" will be construed separately with respect to each policy, contract, or other arrangement for benefits or services and separately with respect to that portion of any such policy, contract, or other arrangement which reserves the right to take the benefits or services of other Plans into consideration in determining its benefits and that portion which does not.

## **BASIC PARTICIPANT LIFE INSURANCE BENEFIT**

### **DEFINITIONS**

As used in this Benefit

Total Disability or Totally Disabled means

- 1) during the Elimination Period provided for in the Long Term Disability Benefit and the succeeding 24 months,  
  
a state of incapacity, resulting from an Illness or Accident, which wholly prevents the Participant from performing each and every essential duty of his regular occupation;
- 2) after the Elimination Period and the succeeding 24 months have elapsed,  
  
a state of incapacity, resulting from an Illness or Accident, which wholly prevents the Participant from working in any occupation for which he is suited by education, Training and Experience.

Whether or not any such gainful occupation is available in the area where the Participant resides does not affect his entitlement to disability benefits.

A Participant who needs a driver's licence issued by the government to perform the duties of his regular occupation is not considered disabled simply because his licence has been revoked or has not been renewed.

Training and Experience means all of the knowledge and skills the Participant acquired while in school, in the performance of his current or former professional activities or during his non-working hours.

### **EVIDENCE OF INSURABILITY**

Evidence of insurability satisfactory to the Insurer will be required of a Participant applying for any amount of Basic Participant Life Insurance in excess of the amount specified in the Benefit Schedule as the Non-Evidence Maximum of Insurability under the Basic Participant Life Insurance Benefit.

### **PAYMENT OF BENEFIT**

Upon receipt of Proof of Claim satisfactory to the Insurer that a Participant died while insured under this Benefit, the Insurer will pay the amount of Life Insurance applicable to such Participant in accordance with the Benefit Schedule and other applicable policy provisions.

### **LIVING BENEFIT**

Subject to the approval of the Insurer, any Participant whose life expectancy is less than 24 months may apply for payment of a portion of the amount of Life Insurance applicable to him, subject to the following conditions:

- 1) A Totally Disabled Participant may be required to be examined by a Physician designated by the Insurer;



- 2) A Totally Disabled Participant must qualify for approval for the Waiver of Premium under the Basic Participant Life Insurance Benefit of the policy;
- 3) Any individual having an interest in the insurance money must sign a consent to such payment on a form provided by the Insurer.

The Living Benefit is equal to 50% of the amount of Life Insurance applicable to the Participant in accordance with the Benefit Schedule. In addition, this amount may not be less than \$5,000 or more than \$100,000.

At the death of the Participant, the Value of the Living Benefit will be deducted from the amount that would otherwise have been payable under the Basic Participant Life Insurance Benefit.

The Policyholder is responsible for the premium payments for any Participant who has received an advance payment, unless a Waiver of Premium has been granted.

Value of the Living Benefit means the aggregate of the payments made under the Living Benefit, plus the reasonable costs of verifying the medical condition of the Totally Disabled Participant, plus the interest thereon from the date of payment until the date of death of the Totally Disabled Participant.

The interest rate is set according to the annual average rate of return on one-year guaranteed investment certificates issued by Canadian trust companies. The rate will be that established immediately after the payment of the Living Benefit, as published in the monthly or weekly issue of the Bank of Canada Statistical Summary.

## **LIVING BENEFIT EXCLUSION**

The Living Benefit will not be payable if there has been any material misrepresentation or non-disclosure in the application, whether within two years or not. If the application or coverage is discovered to be null and void after the Living Benefit is paid, the Value of the Living Benefit will be repaid to the Insurer by the recipient of the Living Benefit.

## **BENEFIT TERMINATION**

This Benefit terminates on the date the Participant attains the Age Limit specified in the Benefit Schedule or on the earliest of the dates indicated in the TERMINATION OF PARTICIPANT INSURANCE provision.

## **CONVERSION PRIVILEGE**

If the Life Insurance of a Participant aged 65 or younger terminates or is reduced for any reason other than due to policy termination, the Participant will be entitled to convert any amount of insurance, up to the terminated amount, to an individual policy without evidence of insurability.

In addition, the amount of insurance that may be converted will be further limited to the lesser of

- 1) the maximum amount applicable in the province of residence of the Participant; or

- 2) the difference between the amount of Life Insurance in force on the date of termination of insurance and the amount of insurance for which the Participant is eligible under another group life insurance at the time of exercising his conversion right.

If the Life Insurance of a Participant aged 65 or younger terminates because of the termination of the policy and provided that the Participant was insured under this Benefit for five consecutive years immediately prior to such policy termination, the Participant will be entitled to convert to an individual policy any amount of insurance, up to the higher of \$10,000 or 25% of the Participant's amount of insurance, without evidence of insurability. However, such amount of insurance will be reduced by any group life insurance for which the Participant becomes eligible during the 31 days following the termination of the policy.

The individual policy selected in accordance with the above will be subject to the following conditions:

- 1) The Participant must submit written application for conversion to the Insurer and must pay the first premium within 31 days of the termination of his insurance under this Benefit;
- 2) The individual policy may be insurance for a non-convertible Term to Age 65, insurance for a non-renewable 1-Year Convertible Term or any regular permanent plan issued by the Insurer at the date of conversion, excluding special permanent plans as may be designated by the Insurer from time to time. The individual policy will not include any special benefit provisions for which an extra premium is charged and will not be a plan under which the amount of insurance may or will increase in the future; at least one permanent plan will be available for conversion at all times. A Dividend Option under which dividends are used to obtain additional insurance may be elected at the time of conversion, if permitted by the Insurer;
- 3) In the event the individual policy selected is insurance for a non-renewable 1-Year Convertible Term, the Participant may elect to pay a single premium or quarterly premiums. The policy can be converted to one of the plans described above, but cannot be converted to insurance for another 1-Year Convertible Term;
- 4) The individual policy issued will conform to the conditions, terms, and amounts of individual insurance plans regularly used by the Insurer at the date of conversion;
- 5) The individual policy premium will be based on the rate used by the Insurer on the effective date of that policy and that is applicable to the plan and the amount of the policy issued, the Age of the Participant at nearest birthday and the class of risk to which he belongs;
- 6) If the amount of Life Insurance that may be converted is less than the minimum amount for which the Insurer will then normally issue the selected plan, the individual policy must be for the full amount that the Participant may convert;

- 7) The individual policy will not take effect prior to the end of the 31 day period immediately following the date of termination of insurance of the Participant under this Benefit.

The amount of Life Insurance for which a Participant who is insured under this Benefit is eligible in accordance with the Benefit Schedule will be reduced by the amount of any individual Life Insurance in force on the life of the Participant that was issued previously in accordance with the CONVERSION PRIVILEGE of the policy or the corresponding provision of any other group policy issued by the Insurer.

## **EXTENSION OF BENEFIT AFTER TERMINATION**

If a Participant dies within 31 days of termination of insurance under this Benefit, the amount of Life Insurance he was eligible to convert will be payable.

## **NOTICE AND PROOF OF CLAIM**

Before settling any death claim, the Insurer will require satisfactory written proof of the occurrence, cause and circumstances of the death, the eligibility of the deceased at the time of death, the date of birth of the deceased, and the right of the claimant to receive the proceeds.

Any death claim notice must be submitted to the Insurer within 30 days of the death and the written proof of claim must be submitted within 90 days of the death.

Subject to applicable legislation, the Insurer may request an autopsy in order to assess its liability in connection with a claim.

The benefit payable on the death of a Participant will be paid to the beneficiary designated by the Participant within 30 days of receipt of satisfactory proof of claim to the Insurer.

## **DEPENDENT LIFE INSURANCE BENEFIT**

### **PAYMENT OF BENEFIT**

Upon receipt of Proof of Claim satisfactory to the Insurer that a Dependent died while insured under this Benefit, the Insurer will pay the amount of Dependent Life Insurance applicable to such individual in accordance with the Benefit Schedule and other applicable policy provisions.

### **COMMENCEMENT OF NEWBORN CHILDREN INSURANCE**

Insurance for a newborn Child of a Participant with insured Dependents will commence in accordance with the terms specified in the Benefit Schedule and the policy provisions, including those that pertain to the COMMENCEMENT OF DEPENDENT INSURANCE.

### **BENEFIT TERMINATION**

This Benefit terminates on the date the Participant attains the Age Limit specified in the Benefit Schedule or on the earliest of the dates indicated in the TERMINATION OF DEPENDENT INSURANCE provision.

### **DEPENDENT CONVERSION PRIVILEGE**

If the Dependent Life Insurance of a Dependent aged 65 or younger, insured for a minimum amount of \$5,000, terminates, the Participant, or the insured Dependent in the event of the death of such Participant, may convert the Dependent Life Insurance to an individual policy, without evidence of insurability, subject to the following conditions:

- 1) The written application for conversion must be submitted to the Insurer and the first premium paid within 31 days of the date of termination of the insurance of the Dependent under this Benefit;
- 2) The individual policy may be any regular permanent plan issued by the Insurer at the date of conversion, excluding special permanent plans as may be designated by the Insurer from time to time. The individual policy will not include any special benefit provisions for which an extra premium is charged and will not be a plan under which the amount of insurance may or will increase in the future; at least one permanent plan will be available for conversion at all times;
- 3) The individual policy issued will conform to the conditions, terms and amounts of individual insurance plans regularly used by the Insurer at the date of conversion;
- 4) The individual policy premium will be based on the rate used by the Insurer on the effective date of that policy and that is applicable to the plan and the amount of the policy issued, the Dependent's Age at nearest birthday and the class of risk to which the Dependent belongs;

- 5) If the amount of Dependent Life Insurance that may be converted is less than the minimum amount for which the Insurer will normally issue the selected plan, the individual policy must be for the full amount that the Dependent may convert;
- 6) The individual policy will not take effect prior to the end of the 31 day period immediately following the date of termination of insurance on the Dependent under this Benefit.

### **EXTENSION OF BENEFIT AFTER TERMINATION**

If a Dependent dies within 31 days of the termination of his insurance under this Benefit, the amount of Dependent Life Insurance payable will be the amount that the Participant or the Dependent, in the event of the death of such Participant, was eligible to convert.

### **NOTICE AND PROOF OF CLAIM**

Before settling any death claim, the Insurer will require satisfactory written proof of the occurrence, cause and circumstances of the death, the eligibility of the deceased at the time of death, the date of birth of the deceased, and the right of the claimant to receive the proceeds.

Subject to applicable legislation, the Insurer may request an autopsy in order to assess its liability in connection with a claim.

## PARTICIPANT WEEKLY INDEMNITY BENEFIT

### DEFINITIONS

As used in this Benefit

Elimination Period means the period, as specified in the Benefit Schedule, of continuous Total Disability that must be completed before Weekly Indemnity Benefits commence under this Benefit.

If a Participant can and does continue his coverage under this Benefit throughout any absence or leave (other than a Maternity, Parental or Family-Related absence or leave) as described in the policy, and such Participant becomes Totally Disabled during such leave, the Elimination Period will be deemed to commence on the date the Participant is scheduled to return to active work.

Hospitalization means:

- 1) to be admitted to a Hospital as an in-patient for more than 18 consecutive hours; or
- 2) any Hospital stay during which the Participant undergoes surgery performed by a Physician and which required local or general anaesthesia, excluding any minor surgery that can be performed in the office of a Physician.

Maximum Benefit Period means the maximum number of weeks during which benefits are payable. This period is specified in the Benefit Schedule. If this benefit, in accordance with the Benefit Schedule, is carved out with the Employment Insurance Act (EI) as a standard wrap around plan, the Maximum Benefit Period includes the number of weeks during which EI benefits are paid by Human Resources Development Canada.

Net Weekly Earnings means the gross weekly Earnings in effect immediately prior to commencement of Total Disability less all income taxes and contributions to the Canada/Quebec Pension Plan and Employment Insurance payable thereon, or any other contribution to a public income replacement plan.

Total Disability or Totally Disabled means the inability of the Participant as a result of an Illness or Accident to perform all the usual duties of his main occupation and which requires Continuing Medical Care.

A Participant who needs a driver's licence issued by the government to perform the duties of his regular occupation is not considered disabled simply because his licence has been revoked or has not been renewed.

## PAYMENT OF BENEFIT

Upon receipt of Proof of Claim satisfactory to the Insurer that

- 1) a Participant became Totally Disabled while insured under this Benefit and remained Totally Disabled during the Elimination Period, and
- 2) the Participant is under Continuing Medical Care of a Physician, as defined under the DEFINITIONS provision of the policy,

the Insurer will pay Weekly Indemnity Benefits for as long as the Participant is Totally Disabled, in accordance with applicable policy provisions, up to the Maximum Benefit Period.

To qualify for Weekly Indemnity Benefits, any Accident causing the Total Disability, as defined in the DEFINITIONS above, must be confirmed by a Physician and sustained not more than 30 days prior to the onset of such disability.

The "health related portion" of the Maternity Leave taken by a Participant is considered to be a period of Total Disability for the purposes of benefit payment under this Benefit, whether the Participant's insurance was continued during the leave or not. The maternity benefits payable under any public or private plan are deducted from the benefits payable to the Participant for this period, in accordance with the provisions of this contract.

For a Total Disability that begins during the voluntary leave portion of a Maternity Leave, or during a Parental or Family-Related Leave, benefits are payable from the later of the following dates, provided the current benefit remained in force and provided the Participant is still Totally Disabled and insured under this Benefit:

- 1) the end of Elimination Period;
- 2) the scheduled date of return to work.

The amount of Weekly Indemnity Benefit payable under this Benefit will be the amount specified in the Benefit Schedule based on the Earnings in effect immediately prior to commencement of Total Disability.

The Weekly Indemnity payments may be taxable in accordance with the Benefit Schedule.

Weekly Indemnity Benefits are payable at the end of each weekly period of Total Disability, commencing on the date the Elimination Period is completed.

The Elimination Period is expressed in calendar days and commences on the later of the following dates:

- 1) the day after the last day the Participant was Actively At Work, if he consults a Physician within 14 days of the beginning of Total Disability; or
- 2) the first day the Participant consults a Physician if he does so more than 14 days after the Total Disability began.

Any payments for a period of less than one week will be at the daily rate of 1/7th of the Weekly Indemnity Benefit.

## **DISABILITY MANAGEMENT**

The Insurer may at any time require a Totally Disabled Participant to participate in a disability management program or to take up rehabilitative employment that is considered appropriate by the Insurer.

The Insurer will actively co-ordinate all disability management program services listed below and will also facilitate and ensure case follow-up:

- 1) co-ordination of access to health care services;
- 2) support program for returning to work;
- 3) negotiations for a gradual return to work;
- 4) rehabilitation program, which may include evaluation, treatment, training, placement and job search services.

If a Totally Disabled Participant, while receiving Weekly Indemnity Benefits, takes part in a disability management program or takes up rehabilitative employment under the supervision of his Physician and with the approval of the Insurer:

- 1) the Participant will still be considered Totally Disabled while taking part in this program, subject to the Maximum Benefit Period specified in the Benefit Schedule;
- 2) if, while taking part in this program, a Participant becomes Totally Disabled again, the terms and conditions of this Benefit will re-apply to the Participant as if he had been Totally Disabled during the rehabilitation period;
- 3) the Maximum Benefit Period during any period of Total Disability will continue to apply even if the Participant is taking part in an approved disability management program or rehabilitative employment;
- 4) if, while taking part in this program, the Participant earns any income, the Weekly Indemnity Benefits payable by the Insurer to the Participant will be reduced by the amount produced by the following formula:

$$(A \div B) \times C$$

A = Income earned from any rehabilitative activity

B = Earnings of the Participant immediately prior to commencement of Total Disability

C = Benefits otherwise payable under this Benefit



- 5) while the Participant is taking part in a disability management program, the Insurer will reduce his Weekly Indemnity Benefits so that his total income from all sources, if any, does not exceed 100% his Net Earnings immediately prior to commencement of Total Disability if this Benefit is non-taxable, or 100% of his gross Earnings immediately prior to commencement of Total Disability if this Benefit is taxable.

The Participant's total income from all sources includes any of the following listed below that he has received or is eligible to receive:

- a) any weekly benefits payable under this Benefit;
- b) any weekly Earnings or payment from the Employer;
- c) any disability benefits payable under the Canada Pension Plan or the Quebec Pension Plan, but excluding benefits payable on behalf of his Dependents and any increase in benefits after benefit payments commence due solely to the cost-of-living;
- d) any disability benefits payable under the Workers' Compensation Act or similar legislation or any other government plan, excluding benefits payable under the Employment Insurance Act;
- e) any benefits payable from a retirement or pension plan provided by the Policyholder, excluding any increase in benefits after benefit payments commence due solely to the cost-of-living;
- f) any indemnity payable for loss of time under any government plan requiring or providing automobile insurance benefits on a no-fault basis, provided that these plans have been approved as an acceptable limitation and still permit this Benefit to be registered for premium reduction under the Employment Insurance Act, as amended from time to time.

A Participant who refuses to take part in a disability management program, does not participate in such program in good faith, or does not take up rehabilitative employment considered appropriate by the Insurer will no longer be eligible for Weekly Indemnity Benefits under the policy.

## **RECURRENT TOTAL DISABILITY**

Successive periods of Total Disability occurring after the Weekly Indemnity Benefits became payable are considered to be the same period of Total Disability unless they are separated by at least:

- 1) 2 consecutive weeks of active full-time employment, if Total Disability is due to the same cause or related causes; or
- 2) 1 day of active full-time employment, if Total Disability is due to an entirely unrelated cause.

Whenever successive periods of Total Disability are considered to be the same period of Total Disability, the Elimination Period will not be applied a second time and the same amount as for the initial Total Disability minus any payments already made will be payable for the remainder of the Maximum Benefit Period.

## **REDUCTION OF WEEKLY INDEMNITY BENEFITS, LIMITATIONS AND EXCLUSIONS**

### **1) Reduction of Weekly Indemnity Benefits**

Weekly Indemnity Benefits payable under this Benefit will be reduced by

- a) any benefits the Participant is eligible to receive under any Workers' Compensation Act or similar legislation;
- b) any disability benefits the Participant is eligible to receive under the Canada Pension Plan or the Quebec Pension Plan excluding
  - i) benefits payable on behalf of his Dependents; and
  - ii) any increase in benefits due solely to the cost-of-living, after benefit payments commence;
- c) any income replacement indemnity payable to a Participant under
  - i) the Automobile Insurance Act of the Province of Quebec;
  - ii) the Ontario Motorist Protection Plan; or
  - iii) any other government no-fault automobile insurance plan

provided that these plans have been approved as an acceptable limitation and still permit this Benefit to be registered for premium reduction under the Employment Insurance Act, as amended from time to time;
- d) any income replacement benefits paid to the Participant under any other federal or provincial legislation; and
- e) any benefit paid to the Participant under any employee benefit plan established by the Policyholder,
- f) any severance or wrongful dismissal payments.

The Insurer may, at its discretion, estimate the amount of a government plan award pending notice of the actual award.

The Insurer may also reduce the Weekly Indemnity payments even if the Participant, who is required to make the necessary application, fails or refuses to exercise his rights under the above-mentioned legislation or plans.

If the Participant receives a lump-sum payment from any of the sources indicated above, the Insurer will reduce the Weekly Indemnity payments by this amount, calculated on a weekly basis.

## 2) Limitations

No benefits are payable for a Total Disability period

- a) during the voluntary leave portion of the Maternity Leave as described under the DEFINITIONS section, for a Total Disability occurring during this period;
- b) during a Parental or Family-Related Leave, for a Total Disability occurring during this period;
- c) during any work stoppage due to a strike, lock-out, Leave of Absence or lay-off, for a Total Disability occurring during this period;
- d) during the imprisonment of the Participant due to conviction of an offence;
- e) if the Participant remains outside Canada for longer than 3 months for any reason whatsoever, unless the Insurer gives prior written consent to continue paying benefits during this period.

## 3) Exclusions

No benefits are payable for a Total Disability resulting directly from any one of the following causes:

- a) war, whether the war be declared or not, or service in the armed forces of any country, or participation in a riot, insurrection or civil commotion;
- b) committing a criminal offence;
- c) cosmetic surgery or treatment, unless such surgery or treatment is required as a result of an Illness or Injury;
- d) alcohol or drug abuse unless, for such abuse, the Participant is actively taking part in a therapeutic program supervised by a Physician on an on-going basis, is receiving Continuing Medical Care or treatment for rehabilitation and is staying in an established treatment centre qualified to provide the necessary treatment or care;
- e) driving a motorized vehicle while impaired by drugs, or with an alcohol level that exceeds the limit set under the Criminal Code of Canada.

## **TERMINATION OF BENEFITS**

Weekly Indemnity Benefits payable under this Benefit will cease on the earliest of

- 1) the date the Participant ceases to be Totally Disabled;
- 2) the date the Participant engages in any gainful occupation other than an approved gainful occupation for the purpose of rehabilitation;
- 3) the date the Participant fails to furnish satisfactory proof of continued Total Disability to the Insurer;

- 4) the date payments have been paid up to the Maximum Benefit Period for any period of Total Disability;
- 5) the date the Participant refuses to participate in a disability management program or to take up rehabilitative employment considered appropriate by the Insurer; and
- 6) the date the Participant attains the Age Limit under this Benefit. However, if a Participant is Totally Disabled prior to this Age Limit and on attaining it he is still so disabled and has not yet received 15 weeks of benefit payments for that disability, notwithstanding the Age Limit of this Benefit, coverage will be extended to the earliest of
  - a) the date such Participant has received 15 weeks of benefits;
  - b) the date such Participant ceases to be Totally Disabled; or
  - c) the date such Participant retires.

#### **EXTENSION OF BENEFIT AFTER TERMINATION**

If a Participant is Totally Disabled on the date his insurance terminates, the Insurer will continue insurance for that Total Disability as if the insurance under this Benefit for that Participant were still in force, provided such Total Disability continues uninterrupted, subject to all other provisions of the policy.

#### **NOTICE AND PROOF OF CLAIM**

Written proof of a claim must be submitted to the Insurer within 60 days of the date Total Disability commenced.

Subsequent written proof satisfactory to the Insurer of continued Total Disability must be submitted to the Insurer at its request.

## PARTICIPANT LONG TERM DISABILITY BENEFIT

### DEFINITIONS

As used in this Benefit

Elimination Period means the period, as specified in the Benefit Schedule, of continuous Total Disability that must be completed before Long Term Disability Benefits commence under this Benefit.

If a Participant can and does continue his coverage under this Benefit throughout any absence or leave (other than a Maternity, Parental or Family-Related absence or leave) as described in the policy, and such Participant becomes Totally Disabled during such leave, the Elimination Period will be deemed to commence on the date the Participant is scheduled to return to active work.

Net Monthly Earnings means the gross monthly Earnings in effect immediately prior to commencement of Total Disability less all income taxes and contributions to the Canada/Quebec Pension Plan and Employment Insurance payable thereon, or any other contribution to a public income replacement plan.

Maximum Benefit Period means the maximum period during which monthly benefits are payable, as specified in the Benefit Schedule.

Total Disability or Totally Disabled means

- 1) during the Elimination Period and the succeeding 24 months,  
a state of incapacity, resulting from an Illness or Accident, that wholly prevents the Participant from performing each and every essential duty of his regular occupation;
- 2) after the Elimination Period and the succeeding 24 months have elapsed,  
a state of incapacity, resulting from an Illness or Accident, that wholly prevents the Participant from working in any occupation for which he is suited by education, Training and Experience.

Whether or not any such gainful occupation is available in the area where the Participant is domiciled does not affect his entitlement to Long Term Disability Benefits.

A Participant who needs a driver's licence issued by the government to perform the duties of his regular occupation is not considered Totally Disabled simply because his licence has been revoked or has not been renewed.

Training and Experience means all of the knowledge and skills the Participant acquired while in school, in the performance of his current or former professional activities or during his non-working hours.

## **EVIDENCE OF INSURABILITY**

Evidence of insurability satisfactory to the Insurer will be required of a Participant applying for any benefit amount of Long Term Disability in excess of the amount specified in the Benefit Schedule as the Non-Evidence Maximum of Insurability under the Participant Long Term Disability Benefit.

## **PAYMENT OF BENEFIT**

Upon receipt of Proof of Claim satisfactory to the Insurer that

- 1) a Participant became Totally Disabled while insured under this Benefit and remained Totally Disabled during the Elimination Period; and
- 2) the Participant is under Continuing Medical Care of a Physician, as defined under the DEFINITIONS provision of the policy;

the Insurer will pay monthly Long Term Disability Benefits for as long as the Participant is Totally Disabled, in accordance with applicable policy provisions, up to the Maximum Benefit Period.

The "health related portion" of the Maternity Leave taken by a Participant is considered to be a period of Total Disability for the purposes of benefit payment under this Benefit, whether the Participant's insurance was continued during the leave or not. The maternity benefits payable under any public or private plan are deducted from the benefits payable to the Participant for this period, in accordance with the provisions of this contract.

For a Total Disability that begins during the voluntary leave portion of a Maternity Leave, or during a Parental or Family-Related Leave, benefits are payable from the later of the following dates, provided the current benefit remained in force and provided the Participant is still Totally Disabled and insured under this Benefit:

- 1) the end of Elimination Period;
- 2) the scheduled date of return to work.

The amount of Long Term Disability Benefit payable will be the amount specified in the Benefit Schedule based on the monthly Earnings in effect immediately prior to the initial date of Total Disability.

Long Term Disability Benefits are payable at the end of each monthly period of Total Disability, commencing on the date the Elimination Period is completed.

The Elimination Period commences on the later of the following dates:

- 1) the day after the last day the Participant was Actively At Work, if he consults a Physician within 14 days of the beginning of Total Disability; or
- 2) the first day the Participant consults a Physician if he does so more than 14 days after the Total Disability began.

Any payments for a period of less than one month will be at the daily rate of 1/30 of the monthly benefit.

Long Term Disability Benefits may be taxable in accordance with the Benefit Schedule.

## **REDUCTION OF LONG TERM DISABILITY BENEFITS, LIMITATIONS AND EXCLUSIONS**

### **1) Direct Offset**

Long Term Disability Benefits otherwise payable to the Participant under this Benefit will be reduced by

- a) any benefits the Participant is eligible to receive under any Workers' Compensation Act or similar legislation; and
- b) any disability benefit the Participant is eligible to receive under the Canada Pension Plan or the Quebec Pension Plan excluding
  - i) benefits payable on behalf of his Dependents; and
  - ii) any increase in benefits due solely to cost-of-living, after benefit payments commence; and
- c) any indemnity payable for loss of time under any government plan requiring or providing automobile insurance benefits on a no-fault basis;
- d) any disability benefit payable by a private pension plan.

### **2) Indirect Offset**

In addition, the Insurer will further reduce Long Term Disability Benefits by any amount by which the total monthly income of the Participant from all sources exceeds

- a) 80% of his gross monthly Earnings immediately prior to Total Disability, if the Long Term Disability Benefits are included in his income under the Income Tax Act (Canada); or
- b) 80% of his Net Monthly Earnings immediately prior to Total Disability, if the Long Term Disability Benefits are not included in his income under the Income Tax Act (Canada).

The total monthly income of a Participant from all sources, whether he receives or is eligible to receive this income, will include all of the following:

- a) any Long Term Disability payments under this Benefit;
- b) any monthly Earnings or payments from the Employer;
- c) any disability benefits payable under the Quebec Pension Plan, excluding benefits payable on behalf of Dependents and any increase in benefits after benefit payments commence due solely to the cost-of-living;

- d) any disability benefits payable under the Canada Pension Plan, excluding benefits payable on behalf of Dependents and any increase in benefits after benefit payments commence due solely to the cost-of-living;
  - e) any disability benefits payable under any Workers' Compensation Act or similar legislation or any other government plan, excluding the Employment Insurance Act;
  - f) any disability benefits payable under any other group or association insurance plan;
  - g) any disability benefit payable by a private pension plan, excluding any increase in benefits after benefit payments commence due solely to cost of living;
  - h) any indemnity for loss of time payable under any government plan requiring or providing automobile insurance benefits on a no-fault basis.
- 3) In the event that a lump-sum payment is made under any of the above-mentioned sources in 1) and 2) in lieu of monthly payments, monthly benefits will be reduced by the equivalent monthly payment over a period of 60 months or by the number of months of disability for which the lump sum is paid, whichever is the lesser.

The Insurer may also reduce the monthly Long Term Disability payments even if the Participant, who is required to make the necessary application, fails or refuses to exercise his rights under the above-mentioned legislation or plans.

The Insurer may, at its discretion, estimate the amount of a government plan award pending notice of the actual award.

#### 4) Limitations

No benefits are payable for a period of Total Disability

- a) during which the Participant is not under Continuing Medical Care, for the Illness or bodily injury causing the Total Disability;
- b) during the voluntary leave portion of the Maternity Leave as described under the DEFINITIONS section, for a total disability occurring during this period;
- c) during a Parental or Family-related Leave taken by a Participant, as provided for under provincial or federal legislation, for Total Disability occurring during this period;
- d) during any work stoppage due to a strike, lock-out, Leave of Absence or lay-off, for a Total Disability occurring during this period;
- e) during the imprisonment of the Participant due to conviction of an offence;



- f) if the Participant remains outside Canada for longer than 3 months for any reason whatsoever, unless the Insurer gives prior written consent to continue paying benefits during this period.

No benefits are payable for any period of Total Disability beginning during the first 12 months of coverage of a Participant, if such Total Disability was directly or indirectly the result of an Illness or Accident that was treated by a Physician or for which prescribed drugs were taken during the 3 month period immediately prior to the effective date of such coverage.

However, if the policy has been in force for less than 12 months, and the Participant has been covered under a comparable benefit under the Employer's previous group insurance policy, for any period of time immediately prior to the Effective Date of the policy, that period of time will apply in determination of the 12 month coverage period.

## 5) Exclusions

No benefits are payable for a Total Disability resulting directly or indirectly from any one of the following:

- a) war, whether the war be declared or not, or service in the armed forces of any country, or participation in a riot, insurrection or civil commotion;
- b) committing, or attempting to commit a criminal offence;
- c) cosmetic surgery or treatment, unless such surgery or treatment is required as a result of an Accident that occurred while the Participant was insured under this Benefit;
- d) alcohol or drug abuse unless, for such abuse, the Participant is actively taking part in a therapeutic program supervised by a Physician on an on-going basis, is receiving Continuing Medical Care or treatment for rehabilitation and is staying in an established treatment centre qualified to provide the necessary treatment or care;
- e) driving a motorized vehicle while impaired by drugs, or with an alcohol level that exceeds the limit set under the Criminal Code of Canada.

## RECURRENT TOTAL DISABILITY

Successive periods of Total Disability due to the same cause or related causes are considered to be the same period of Total Disability unless they are separated by at least

- 1) 2 consecutive weeks of active full-time employment during the Elimination Period; or
- 2) 6 consecutive months of active full-time employment immediately following a period of Total Disability for which Long Term Disability Benefits were paid under this Benefit.

Successive periods of Total Disability due to entirely unrelated causes are considered to be the same period of Total Disability, unless they are separated by at least 1 day of active full-time employment.

Whenever successive periods of Total Disability are considered to be the same period of Total Disability, the Elimination Period will not be applied a second time and the same amount as for the initial Total Disability minus any payments already made will be payable for the remainder of the Maximum Benefit Period.

## **DISABILITY MANAGEMENT**

The Insurer may at any time require a Totally Disabled Participant to participate in a disability management program or to take up rehabilitative employment that is considered appropriate by the Insurer.

The Insurer will actively co-ordinate all disability management program services listed below and will also facilitate and ensure case follow-up:

- 1) co-ordination of access to health care services;
- 2) support program for returning to work;
- 3) negotiations for a gradual return to work,
- 4) rehabilitation program, which may include evaluation, treatment, training, placement and job search services.

If a Totally Disabled Participant, while receiving Long Term Disability Benefits, takes part in a disability management program or takes up rehabilitative employment under the supervision of his Physician and with the approval of the Insurer:

- 1) the Participant will still be considered Totally Disabled while taking part in this program, subject to a maximum of 24 months;
- 2) if, while taking part in this program, a Participant becomes Totally Disabled again, the terms and conditions of this Benefit will re-apply to the Participant as if he had been Totally Disabled during the rehabilitation period;
- 3) the Maximum Benefit Period during any period of Total Disability will continue to apply even if the Participant is taking part in an approved disability management program or rehabilitative employment;

- 4) if, while taking part in this program, the Participant earns any income, the Long Term Disability Benefits payable by the Insurer to the Participant will be reduced by the amount produced by the following formula:

$$(A \div B) \times C$$

A = Income earned from any rehabilitative activity

B = Earnings of the Participant immediately prior to the commencement of Total Disability

C = Benefits otherwise payable under this Benefit

- 5) while the Participant is taking part in a disability management program, the Insurer will reduce his Long Term Disability Benefits so that his total income from all sources, if any, as listed in the INDIRECT OFFSET provision of the REDUCTION OF LONG TERM DISABILITY BENEFITS, LIMITATIONS AND EXCLUSIONS section of this Benefit, does not exceed 100% of his Net Earnings immediately prior to the commencement of Total Disability if this Benefit is non-taxable, or 100% of his gross Earnings immediately prior to the commencement of Total Disability if this Benefit is taxable.

A Participant who refuses to take part in a disability management program, does not participate in such program in good faith or does not take up rehabilitative employment considered appropriate by the Insurer will no longer be eligible for monthly benefits payable under this Benefit.

## **TERMINATION OF BENEFITS**

Long Term Disability Benefits will cease on the earliest of

- 1) the date the Participant ceases to be Totally Disabled;
- 2) the date the Participant engages in any gainful occupation other than an approved gainful occupation for the purpose of rehabilitation;
- 3) the date set by the Insurer the participant was required to provide satisfactory proof of total disability or to undergo a medical examination requested by the Insurer, but neglected or refused to do so;
- 4) the date payments have been paid up to the Maximum Benefit Period for any one period of Total Disability;
- 5) the date the Participant refuses to participate in a disability management program or to take up rehabilitative employment considered appropriate by the Insurer; and
- 6) the date the Participant attains the Age Limit specified in the Benefit Schedule.

## **EXTENSION OF BENEFIT AFTER TERMINATION**

If a Participant is Totally Disabled on the date his insurance terminates, the Insurer will continue insurance for that Total Disability as if the insurance under this Benefit for that Participant were still in force, provided such Total Disability continues uninterrupted, subject to all other provisions of the policy.

## **NOTICE AND PROOF OF CLAIM**

Initial written notice of a claim must be submitted to the Insurer within 30 days of the expiry of the Elimination Period and initial written proof, within 60 days of the expiry of the Elimination Period.

In the event of the recurrence of Total Disability, written notice of a claim must be submitted to the Insurer within 30 days of the date of such recurrence and written proof within 60 days of the date of such recurrence.

Subsequent written proof satisfactory to the Insurer of continuing Total Disability must be submitted to the Insurer at its request.

## EXTENDED HEALTH CARE BENEFIT

### DEFINITIONS

As used in this Benefit

Calendar Year means the period extending from January 1<sup>st</sup> to December 31<sup>st</sup> inclusive.

Convalescent/Rehabilitation Centre means any facility or institution in Canada which is licensed as a convalescent hospital by the licensing body having jurisdiction for the care and treatment of sick and injured persons who require supervision of either a Physician or a registered nurse. This institution must provide nursing care 24 hours a day by a registered nurse and maintain a daily record of each patient under the care of a Physician. However, it does not include a nursing home, home for the aged, or the chronically ill, home for the mentally ill, rest home, or an institution for the care and treatment of alcoholism or drug addiction.

Day Surgery means any surgery performed by a Physician that requires local or general anaesthesia, with the exception of any minor surgery performed in the office of the Physician.

Dentist means a person who is licensed to practise dentistry by the appropriate authority of the jurisdiction where the services are provided.

Drugs available on prescription means drugs prescribed by a Physician or a dental surgeon. This will also include certain drugs requiring a prescription when prescribed by other health practitioners where permitted to do so by provincial law.

Equivalent drug means a brand or generic drug, deemed interchangeable under the provincial law applicable where the drug is sold.

Hospitalization means

- 1) to be admitted to a Hospital as an In-patient for more than 18 consecutive hours; or
- 2) any Hospital stay in order to receive Day Surgery.

In-patient means a person admitted to and assigned a bed in a Hospital In-patient area on the order of a Physician.

Medical Emergency means any acute and unexpected condition, illness or injury requiring immediate medical treatment.

Medical Recommendation means the order to provide medication or care given by a Physician, dental surgeon or a podiatrist duly authorized to do so in the normal performance of his profession.

Orthesis means any orthopaedic appliance constructed of rigid material, such as metal or plastic, used to maintain a part of the body in the correct position. Elastic supports are not included in this category.

Palliative Care Establishment means any establishment in Canada designated as such by law that provides, under the supervision of a Physician, care and treatment to patients, mainly during the terminal phase of their Illness, and that provides nursing care 24 hours a day by a registered nurse and maintains daily records of each patient under the care of a Physician. An active treatment Hospital designated as such by law, extended care facility, rest home, Convalescent or Rehabilitation Centre, home for the aged or the chronically ill, home for the mentally ill, sanatorium, convalescent hospital, or institution for the care and treatment of alcoholism or drug addiction is not considered a Palliative Care Establishment.

Patient assistance program means the program offered by some drug manufacturers to provide Insured Persons with information, education and financial assistance if they are prescribed certain drugs.

**Exclusion:** If an Insured Person refuses to enrol in such a program, this person might not be eligible for reimbursement of the drug expenses.

Patient support program means the program providing support to help Insured Persons manage their health and medication.

**Exclusion:** If an Insured Person refuses to enrol in such a program, this person might not be eligible for reimbursement of the drug expenses.

Period Of Hospitalization means any continuous period of Hospitalization in a Canadian Hospital or successive periods of Hospitalization resulting from the same Illness or Accident and separated by less than 60 consecutive days during which the Insured Person was not hospitalized. If, during a given period, Hospitalization results from an Illness or Accident entirely unrelated to the Illness or Accident that resulted in the previous Hospitalization, this Hospitalization will be treated as a new Period Of Hospitalization.

Prosthesis means an appliance used to replace all, or part, of a limb or organ.

Reasonable and Customary Charges means the charges generally paid in the area where the services or supplies are provided for a like service or supply and limited to the prevailing charge in the area for the like service or supply. A like service or supply is one of the same nature and duration, that requires the same skill and is performed by a provider of similar training and experience.

Sound Tooth means a natural tooth that is not afflicted with any pathology either itself or in the adjacent structures. In addition, a tooth that has been treated or repaired and restored to normal function will be considered sound.

Stable refers to the health condition of an Insured Person who, within 30 days prior to the trip departure date, is not affected by any medical condition, or is affected by a medical condition that:

- 1) does not require a change or for which no change was recommended in the treatment or dosage of prescribed drugs; and
- 2) does not demonstrate any symptoms that would indicate a deterioration of the medical condition in the course of the trip.

Vehicle means a car, a motor home or a van with a maximum load of 1,000 kilograms.

## **PAYMENT OF BENEFIT**

Upon receipt of Proof of Claim satisfactory to the Insurer that a Participant, or one of his Dependents, while insured under this Benefit, incurred Eligible Expenses, the Insurer will reimburse the portion of expenses in excess of the Deductible, where applicable, subject to the applicable Percentage of Reimbursement and the limits specified in the Benefit Schedule, and in accordance with the other applicable provisions of this Benefit and the policy.

To be eligible, the expenses must have been incurred as a result of Illness, pregnancy or an Accident, and cover care:

- 1) which is medically necessary to treat the Insured Person;
- 2) which is generally provided for an Illness or injury of similar type or seriousness; and
- 3) which, unless otherwise indicated, was on the prior recommendation of the attending Physician.

In addition, the Eligible Expenses will be limited to the reasonable and customary charges generally paid in the area where the services are provided.

Eligible Expenses will be considered to have been incurred on the date the service or supply was provided.

## **Preferred providers network**

The Insurer may select suppliers for the distribution of drugs and supplies and may restrict payment for Eligible Expenses incurred at another supplier.

## **DEDUCTIBLE**

The Deductible is the amount of Eligible Expenses that the Participant must pay in any Calendar Year before reimbursement will be made under this Benefit. The Deductible is specified in the Benefit Schedule.

Eligible Expenses incurred during the last 3 months of a Calendar Year and used to satisfy all or part of the annual Deductible are also deducted from the Deductible for the following year.

## **CO-PAY**

The Co-pay is the portion of Eligible Expenses that the Participant must pay for each drug for which expenses were incurred before reimbursement will be made under this Benefit. The Co-pay is specified in the Benefit Schedule.

## PERCENTAGE OF REIMBURSEMENT

The Percentage of Reimbursement specified in the Benefit Schedule is the percentage of Eligible Expenses in excess of the Deductible that will be reimbursed by the Insurer, in accordance with the provisions of this Benefit.

## ELIGIBLE EXPENSES IN CANADA – EXTENDED HEALTH CARE

Eligible Expenses include charges for the following and must be incurred:

- 1) in the Participant's province of residence; and
- 2) outside the Participant's province of residence, but in Canada, for any reason other than a Medical Emergency.

## HOSPITALIZATION EXPENSES

Hospital: Hospital charges for active treatment for each day of Hospitalization, with no limit as to the number of days, up to the maximum specified in the Benefit Schedule.

Palliative Care Establishment: Hospital charges for palliative care, up to the maximum specified in the Benefit Schedule.

Convalescent/Rehabilitation Centre: semi-private accommodation and meals in a licensed Convalescent or Rehabilitation Centre, provided that the Insured Person was admitted within 14 days of discharge from a Hospital to which he was confined as an In-patient and that this stay was primarily required for rehabilitation and not custodial care, up to the maximum specified in the Benefit Schedule.

## DRUGS

- 1) Drugs that are necessary for treatment in respect of an Illness or injury and that are available only on prescription from a Physician or a dental surgeon (code "PR", "C" or "N" in the Compendium of Pharmaceuticals and Specialties) and dispensed by a pharmacist, or by a Physician, if there is no pharmacist.

Also eligible are drugs available on prescription that are necessary for the treatment of certain pathological conditions, excluding homeopathic preparations, and for which the therapeutic indication suggested by the manufacturer in the Compendium of Pharmaceuticals and Specialties is directly linked to the treatment of the following pathological conditions:

cardiac problems;

pulmonary problems;

diabetes;

arthritis;

Parkinson's disease;

epilepsy;



cystic fibrosis;

glaucoma.

- 2) For an Insured Person aged 65 or over and covered under the Quebec drug insurance plan, the drugs described in paragraph 1) that are necessary for treatment in respect of an illness or injury, that are not covered under the Quebec drug insurance plan, and that are available only on prescription and dispensed by a pharmacist, or by a Physician, if there is no pharmacist.

Eligible drug expenses that are used to cover the Deductible and Co-insurance under the Quebec drug insurance plan are also eligible, subject to the Deductible and Percentage of Reimbursement under this Benefit.

- 3) Injectable drugs and vaccines prescribed by a Physician for preventing or treating an illness. Preventive vaccines are limited to a payable amount of \$100 per Calendar Year per Insured Person.
- 4) Sclerosing injections used in the treatment of varicosities, when this treatment is primarily for therapeutic and not cosmetic purposes, up to a payable amount of \$20 per visit per Insured Person.
- 5) Anaesthetic administered during surgery that is not performed in a Hospital, up to a payable amount of \$20 per operation.

#### PRIOR AUTHORIZATION DRUGS

Prior authorization by the Insurer is required for certain drugs listed on the Insurer's website. A prior authorization form completed by the Physician must be submitted to the Insurer in order to determine whether the prescribed drug meets the prior authorization criteria established by the Insurer. The criteria are based, in particular, on clinical practice guidelines and recommendations issued by health technology assessment agencies and they include verification that:

- 1) the drug is prescribed for a therapeutic indication approved by Health Canada, and
- 2) the drug's effectiveness is satisfactory compared to its associated cost.

Proof of the effectiveness of the approved drug, including medical results, may be requested during the course of treatment to determine if the drug is having the desired effect so that it may remain eligible for reimbursement.

The Insurer reserves the right to reimburse an equivalent or biosimilar drug when a less expensive equivalent or biosimilar drug is available on the market.

#### PATIENT SUPPORT PROGRAM AND PATIENT ASSISTANCE PROGRAM

The Insurer may require Insured Persons to enrol in such programs.

## HEALTH PROFESSIONALS

Nursing Care: Services of a registered nurse, a licensed practical nurse or a registered nursing assistant are eligible, up to the amount specified in the Benefit Schedule per Insured Person, provided the patient is not confined in a Hospital and the services are medically necessary, are not rendered solely for custodial care, supervision or companionship and psychotherapy, and come within the competence of such nurse. In addition, the nurse must not be related to the Participant or to any of his Dependents by birth or marriage, and must not ordinarily reside in his or his Dependent's home.

Paramedical Services: Services of the practitioner disciplines specified in the Benefit Schedule and up to the maximum amount specified, provided that the practitioner is operating within his recognized field. He must be a member in good standing of his professional association that must be recognized by the Insurer. Unless otherwise indicated in the Benefit Schedule, these services do not require prior Medical Recommendation.

Imaging techniques ordered by a chiropractor, a podiatrist or an osteopath are covered, up to a payable amount of \$50 per Insured Person each Calendar Year for each of these specialists.

## AMBULANCE

In the event of a Medical Emergency, or if the Insured Person must be transferred to another Hospital, transportation by a licensed ground ambulance

- 1) from the place of the Accident or Illness to the nearest Hospital where adequate medical treatment is available;
- 2) between Hospitals; and
- 3) from the Hospital to the place of residence of the Insured Person, when his condition warrants it.

Medical Emergency transportation by a licensed air ambulance to the nearest Hospital where adequate treatment is available, or to another Hospital when certified as medically necessary by the attending Physician.

## MOBILITY AIDS

Conventional wheelchair: Rental or purchase, at the discretion of the Insurer.

Walkers or crutches: Purchase or rental, at the discretion of the Insurer.

Mechanical or hydraulic patient lift: Purchase, up to a payable amount of \$2,000 per patient lift and one patient lift per Insured Person, for any period of 5 consecutive years.

## ORTHOPAEDIC SUPPLIES

Spinal brace: Purchase, but not repair.

Brace for a limb, truss and plaster: Purchase, but not the repair or replacement.

Conventional hospital bed: Purchase or rental, at the discretion of the Insurer.

Orthopaedic shoes: Purchase, up to a payable amount of \$300\* per Insured Person for any period of 12 consecutive months. Orthopaedic shoes are defined as custom-molded shoes specifically designed for an individual to correct a foot defect, as well as open-toed shoes, in-flare or out-flare shoes, straight-laced shoes and shoes required for Denis Browne braces; these appliances are eligible provided they are manufactured and billed by laboratories licensed under the Public Health Protection Act. The cost of modifications or adjustments to stock item footwear is also eligible; in-depth shoes and off-the-shelf shoes that are regular stock are excluded.

\* The maximum applies to all expenses incurred for Podiatric Orthosis and Arch Support described below.

## ORTHESIS AND PROTHESIS

Expenses incurred for a Prosthesis or an Orthosis are eligible, provided these appliances are manufactured (and billed in the case of podiatric orthoses and arch supports) by laboratories licensed under the Public Health Protection Act.

Podiatric Orthosis or Arch Support: Purchase, up to a payable amount of \$300\* per Insured Person for any period of 12 consecutive months.

\* The maximum applies to all expenses incurred for Orthopaedic Shoes described above.

Artificial limb: Purchase; the cost for the repair is also eligible; replacement is included when required due to physiological change.

Artificial eye: Purchase, including reimbursement for one polishing or one re-making of the artificial eye each Calendar Year, per Insured Person.

External breast Prosthesis: Purchase of one external breast Prosthesis per Insured Person for any period of 12 consecutive months, when required because of total or radical mastectomy that has been performed while the Insured Person is covered under this Benefit or a comparable benefit in force immediately before the effective date of this Benefit.

Surgical brassieres: Purchase of 2 surgical brassieres per Insured Person for any period of 12 consecutive months.

Hearing aids: Purchase on the written prescription of a licensed otolaryngologist, up to a payable amount of \$500 per Insured Person for any period of 60 consecutive months.

Wigs: Purchase of wigs required as a result of chemotherapy, up to a lifetime payable amount of \$200 per Insured Person.

Myoelectric arm: Purchase, the cost for the repair is also eligible, up to a payable amount of \$10,000 per prosthesis each Calendar Year, per Insured Person.

## THERAPEUTIC EQUIPMENT

Glucometer or reflectant meter: Purchase, or rental, upon medical recommendation, up to a payable amount of \$200 per Insured Person for any period of 36 consecutive months.

Oxygen, and equipment required for its administration: Purchase or rental, at the discretion of the Insurer.

Apnea monitor: Purchase or rental, at the discretion of the Insurer.

Drainage pump and chest percussion accessories: Purchase.

Extremity pump for lymphedema or postphlebitic syndrome: Purchase, up to a lifetime payable amount of \$1,500 per Insured Person.

TENS nerve stimulators: Purchase or rental, at the discretion of the Insurer, up to a lifetime payable amount of \$700 per Insured Person.

Other therapeutic equipment: Purchase or rental, at the discretion of the Insurer, provided such equipment is medically required and is intended to cure or treat the affliction, up to a lifetime payable amount of \$10,000 per Insured Person. This category of equipment includes, for example, non-union bone stimulators, insulin pumps, aerosol therapy equipment and intermittent positive pressure breathing machines.

## MEDICAL SUPPLIES

Colostomy, ileostomy or urethrostomy supplies: Purchase.

Elastic support stockings: Purchase of medium or firm (over 20 mm/Hg) support stockings dispensed in a pharmacy or a medical facility, up to 4 pairs per Insured Person for any period of 12 consecutive months.

Intra-uterine devices: Purchase, up to a payable amount of \$50 per Insured Person each Calendar Year.

Supplies for paraplegics: Purchase, provided such supplies are required for the treatment and the care of a paraplegic Insured Person.

Catheter: Purchase.

Medical supplies for gavage: Purchase.

Medical supplies necessary following a tracheotomy: Purchase.

Opaque glass necessary during radiotherapy or psoriasis treatments: Purchase.

Compressive garments for the treatment of burns: Purchase.

Medicated dressings: Purchase.

## DIAGNOSTIC SERVICES

Imaging techniques and diagnostic laboratory tests, up to a payable amount of \$1,000 per Insured Person each Calendar Year. Such procedures do not include services received in a Hospital.

## DENTAL TREATMENT DUE TO AN ACCIDENT

The services of a dentist required to repair and replace healthy teeth as a result of an accidental blow to the mouth received while the Insured Person is covered under this Benefit or a comparable benefit in force immediately before the effective date of this Benefit, but not as a result of voluntarily or involuntarily putting food or any other object in his mouth. Dental services must be rendered within 12 months of the accident; otherwise, a treatment plan deemed satisfactory by the Insurer will be required before that deadline. No benefit is payable for services provided more than 2 years after the date of the accident.

## OTHER TREATMENTS

Detoxification: Room and board charges in a licensed centre or a licensed private clinic specialized in the treatment of alcoholism and drug addiction, provided that the condition of the Insured Person requires treatment under the supervision and control of a Physician and that treatment has been approved by the Insurer, up to a payable amount of \$80 per day and a lifetime payable amount of \$2,500 per Insured Person.

## VISION CARE

Eye examinations: Including eye refraction, provided they are performed by a qualified ophthalmologist or a licensed optometrist, up to a payable amount of \$50 per Insured Person for any period of 24 consecutive months in the case of adults, and 12 months in the case of children under Age 18.

Artificial crystalline lenses: Purchase of crystalline lenses implanted surgically as a replacement for natural crystalline if the Insured Person has cataracts, up to a payable amount of \$200 per Insured Person each Calendar Year.

One pair of eyeglasses or contact lenses required following non-refractive eye surgery, up to a lifetime payable amount of \$250 per Insured Person.

## EYEGLASSES AND CONTACT LENSES

Eyeglasses or contact lenses and their replacement, provided they are prescribed in writing by a qualified ophthalmologist or a licensed optometrist and dispensed by a qualified ophthalmologist, a licensed optometrist or a qualified optician; or surgery to correct myopia, hypermetropia and astigmatism, up to a payable amount of \$100 per Insured Person for any period of 24 consecutive months in the case of adults, and 12 months in the case of children under Age 18.

## HEALTH ASSISTANCE

Health Assistance is a confidential telephone service that is available 24 hours a day enabling the Insured Person to speak with experienced health care professionals and to obtain information immediately.

This telephone service provides the Insured Person with information on the following topics:

- health
- nutrition
- physical fitness
- availability of local resources
- immunization
- lifestyle
- child care

Health Assistance should be considered as a complement to medical consultations and emergency medical services (911 or other); it is not intended to replace the regular health care provider of the Insured Person, nor the emergency medical services of a municipality.

This information service may be of use in improving the quality of life of the Participant and of his Dependents.

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The Insured Person may contact HEALTH ASSISTANCE at any time.

### **Calls from**

### **Dial**

Anywhere in Canada

1 877 875-2632

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## ELIGIBLE EXPENSES - REFERRAL TREATMENT

Eligible Expenses incurred outside the province of residence of the Insured Person as a result of a referral include those provided for in the TRAVEL INSURANCE section below, subject to the following provisions:

- 1) This service or treatment must not be available in Canada or in the normal province of residence of the Insured Person;
- 2) The Insured Person must provide the Insurer with a letter of referral from a Physician in his normal province of residence, indicating that he is being referred to another Physician;
- 3) The Insurer must give prior written approval;
- 4) The provincial health and/or hospital insurance plans must pay a portion of the Eligible Expenses.

The maximum amount payable by the Insurer under this provision is limited to the percentage specified in the Benefit Schedule and the following Eligible Expenses:

- 1) Expenses incurred outside the province of residence, but in Canada - no maximum limitation;

- 2) Expenses incurred outside Canada - up to an eligible amount of \$50,000 per Insured Person each Calendar Year.

## **ELIGIBLE EXPENSES - TRAVEL INSURANCE**

If an Insured Person incurs Medical Emergency expenses during the first 180 days of a stay outside his province of residence, the Insurer will reimburse the Eligible Expenses in accordance with the Benefit Schedule and the following conditions:

- 1) the Insured Person must be covered under government health and hospital insurance plans;
- 2) expenses must be eligible under the Extended Health Care Benefit; and
- 3) expenses must be related to a Stable health condition prior to the trip departure date.

The Participant must contact the Insurer if the duration of the stay outside the province of residence is, or may be, longer than 180 days. Otherwise the Insured Person may not be covered under the Travel Insurance benefit.

### **1) Eligible Health Care Expenses**

- a) Hospital services and room and board charges in a semi-private room until the Insured Person is discharged from the Hospital;
- b) Services of a Physician, a surgeon and an anaesthetist;
- c) All other Eligible Expenses that are covered under this Benefit in the normal province of residence of the Insured Person, excluding Hospital and Convalescent Care Eligible Expenses, if insured.

### **2) Eligible Transportation Expenses**

- a) Expenses incurred for the repatriation of the Insured Person to his place of residence by a suitable means of public transportation to receive appropriate care as soon as his state of health allows it, provided the means of transportation originally arranged for the return trip cannot be used; repatriation must be approved and arranged by "Voyage Assistance". Furthermore, if "Voyage Assistance" recommends repatriation and the Insured Person declines, his insurance under the Travel Insurance provision will terminate.
- b) Expenses incurred for the repatriation (at the same time as the repatriation provided for above) of any Immediate Family member insured under this Benefit, if he cannot return to the point of departure by the means of transportation originally arranged for the return trip; repatriation must be approved and arranged by "Voyage Assistance".
- c) Round-trip economy transportation for a qualified medical attendant who is not a family member, a friend, or a travelling companion, provided the presence of this attendant is ordered by the attending Physician and approved by "Voyage Assistance".

- d) Round-trip economy air, bus or train transportation by the most direct route for one Immediate Family member to the Hospital where the Insured Person must be confined for at least 7 days (expenses will be reimbursed only if the Insured Person remains in Hospital for at least 7 days). This visit is eligible for reimbursement provided that the Insured Person is not accompanied by an Immediate Family member age 18 or over. The cost of meals and accommodation for the Immediate Family member up to \$500 are also covered. The visit must be considered beneficial to the patient by the attending Physician, and prior approval must be obtained from "Voyage Assistance".
- e) Cost of returning the personal or rented Vehicle of the Insured Person if the Insured Person suffers from a disability as a result of a Medical Emergency, certified by a Physician, that prevents him from operating this Vehicle and none of the Immediate Family members accompanying him are able to return it. A commercial agency may be hired to return the Vehicle, but the return must be arranged and approved by "Voyage Assistance". The amount reimbursed is limited to \$1,000 per Participant.
- f) If the Insured Person should die, round-trip economy air, bus or train transportation by the most direct route for one Immediate Family member of the deceased to identify the body before repatriation (the trip must be pre-approved and arranged by "Voyage Assistance"). These expenses are not reimbursed if the Insured Person was accompanied by an Immediate Family member age 18 or over.
- g) If the Insured Person should die, the costs of preparation and the return of the body or ashes to the place of residence by the most direct route (plane, bus or train), up to \$5,000; the cost of the burial coffin is not covered. The return must be pre-approved and arranged by "Voyage Assistance".

### 3) Eligible Daily Allowance

The cost of meals and accommodations for an Insured Person who must delay his return because of an Illness or bodily injury suffered by the Insured Person himself, an accompanying member of his Immediate Family or a travelling companion, as well as additional child care expenses for Children not accompanying the Insured Person. Eligible Expenses are limited to \$200 per day per Participant for a maximum of 10 days and the Illness or injury must be certified by a Physician.

### 4) Eligible Long-distance Telephone Charges

Long-distance telephone charges to reach a member of the Immediate Family if the Insured Person is hospitalized, provided that the transportation allowance, provided under section d) above, to visit that person is not used and that the Insured Person is not accompanied by an Immediate Family member age 18 or over - up to \$50 per day, and up to an overall maximum of \$200 per Period Of Hospitalization.



5) Medical Decisions

Decisions by a Physician or other health care professional employed by, under contract to, or designated by "Voyage Assistance", regarding the medical need for providing any of the covered services outlined above are medical decisions based on medical factors and, as such, will be conclusive in determining the need for these services.

6) Voyage Assistance service

"Voyage Assistance" will take the necessary steps to provide the following services to any Insured Person who requires them:

- a) 24 hour toll-free telephone assistance;
- b) referral to Physicians or health-care facilities;
- c) assistance for Hospital admission;
- d) cash advances to the Hospital when required by the facility;
- e) repatriation of the Insured Person to his home city, as soon as his state of health permits it;
- f) establishing and staying in contact with the Insurer;
- g) handling arrangements in the event of death;
- h) repatriation of the Children of the Insured Person, if the Insured Person cannot be moved;
- i) delivery of medical assistance and drugs to an Insured Person who is too far from health care facilities to be transported there;
- j) arrangements to bring a member of the Immediate Family to the bedside of the Insured Person if he must be confined to Hospital for at least 7 days, provided that such visit is ordered by the attending Physician;
- k) assistance in replacing lost or stolen travel documents so that the Insured Person can continue his trip;
- l) referral to lawyers if legal problems arise;
- m) translation services for emergency calls;
- n) transmission of urgent messages to close friends or family in case of emergency; or
- o) information prior to departure concerning passports, visas and vaccinations required in the country of destination.

In the event of a Medical Emergency, the insured must contact the travel assistance firm immediately.

<b>Calls from</b>	<b>Dial</b>
Montreal area	(514) 875-9170
Canada and United States	1-800-465-6390 (toll-free)
Elsewhere (excluding North and South America)	overseas code + 800 29485399 (toll-free)
Collect call (Anywhere worldwide)	(514) 875-9170

## **RESTRICTIONS, EXCLUSIONS AND LIMITATIONS**

- 1) Eligible Expenses are subject to the limitations and maximums indicated in the Benefit Schedule or this benefit.
- 2) No reimbursement will be made under this Benefit for the following:
  - a) services or treatment that a government health plan prohibits from being paid in whole or in part, except to the extent that it permits reimbursement of the excess amount;
  - b) services, treatment or supplies that a person receives without charge or that are reimbursed under a provincial or federal law. If a person is not covered under the laws in question, the Insurer will not reimburse the expenses that would normally be covered under the hospital or health insurance legislation in force in the Insured Person's province of residence;
  - c) services, treatment or supplies which are experimental in nature;
  - d) expenses incurred for surgically implanted prostheses;
  - e) services, treatment or supplies provided to the Participant by the Employer;
  - f) wheelchairs adapted or designed for sports activities;
  - g) electric beds;
  - h) monitoring devices such as stethoscopes, sphygmomanometers and similar equipment, and domestic appliances such as air purifiers, humidifiers, air conditioners, whirlpools and other similar equipment;
  - i) equipment such as "Obus form" type;

- j) training, exercise programs, physical fitness programs using equipment or floor exercises, floating baths, mud baths, therapeutic baths, relaxation exercises, gym exercises, stretching and strengthening exercises, postural evaluations and ear candling;
- k) diapers for incontinence;
- l) dental services, except those provided for in this Benefit;
- m) dental services and supplies for the purposes of full mouth reconstructions, for vertical dimension correction or for any other temporomandibular joint dysfunction;
- n) travel for health reasons or for medical examinations required for insurance, consultation or assessment purposes;
- o) services, treatment or supplies not included in the list of Eligible Expenses;
- p) Eligible Expenses which result directly or indirectly from the following:
  - i) cosmetic treatment;
  - ii) committing, or attempting to commit a criminal offence;
  - iii) any cause for which payment is provided under any Workers' Compensation Act or similar legislation or under any other government plan;
  - iv) war, whether the war be declared or not, or service in the armed forces of any country, or participation in a riot, insurrection or civil commotion;
  - v) driving a motorized Vehicle while impaired by drugs, or with an alcohol level that exceeds the limit set under the Criminal Code of Canada; the Eligible Expenses incurred for detoxification treatment and the expenses incurred for the purchase of medication covered under the Quebec drug insurance plan are not subject to this exclusion;
- q) services, treatment or supplies for fertility treatment;
- r) sunglasses or safety glasses.

Benefits may be limited or no reimbursement made for services or supplies available at a supplier of the preferred providers network but obtained from another supplier.

### 3) Exclusions applicable to drugs

No reimbursement will be made under this Benefit for the following:

- a) products and drugs, including hormones and injections, used in the treatment of obesity;

- b) contraceptives (prophylactics and contraceptive jellies and foams) except those provided for under this Benefit;
- c) the following products, whether or not prescribed:
  - i) shampoos and other scalp care products, including hair growth products;
  - ii) beauty-care products;
  - iii) cosmetics;
  - iv) so-called "natural" products and homeopathic preparations;
  - v) sun-tan emulsions (sunscreens);
  - vi) soaps;
  - vii) over-the-counter laxatives;
  - viii) over-the-counter antacids;
  - ix) skin softeners;
  - x) disinfectants and ordinary dressings;
  - xi) mineral water;
  - xii) any infant milk formulas;
  - xiii) proteins and food supplements (i.e. products used to supplement or complement a diet);
- d) sclerosing injections used in the treatment of varicosities, telangiectasia and minor dilation when this treatment is primarily for cosmetic and not therapeutic purposes;
- e) products and drugs used in the treatment of sexual dysfunctions;
- f) products or drugs used as smoking cessation aids that are not covered under the Quebec drug insurance plan and expenses in excess of the maximum provided for smoking cessation aids under the Quebec drug insurance plan related to products or drugs used as smoking cessation aids;
- g) products used in fertility treatment, except those covered under the Quebec drug insurance plan;
- h) expenses incurred for services, products or drugs that are used to treat specific conditions other than those for which they are approved by Health Canada, or
- i) expenses incurred for services, products or drugs that are taken in a higher dose, greater quantity or at a frequency that exceeds the insurer's criteria of good clinical practice.

Benefits may be limited or no reimbursement made for drugs or supplies available at a supplier of the preferred providers network but obtained from another supplier.

Under no circumstances can the exclusions under the policy make this plan less extensive than the Quebec drug insurance plan.

4) Exclusions applicable to drugs requiring prior authorization

The Insurer reserves the right to apply certain restrictions, exclusions and limitations namely to services, products or drugs that do not meet the Insurer's prior authorization criteria as of the date the expense is incurred.

5) Additional drug restrictions

- a) the Insurer reserves the right to apply certain restrictions for the reimbursement of drugs for which a less expensive equivalent drug is available on the market;
- b) drugs and medicines dispensed must not be in excess of a 34 day supply and a 100 day supply in the case of maintenance drugs.

6) Additional Limitations Applicable to Drugs

For biologic drugs, the Insurer reserves the right to reimburse a less expensive biosimilar drug if available on the market.

7) Additional Exclusions Applicable to Drugs

No reimbursement is made for:

- a) Drugs or products that are on the Insurer's list of excluded drugs or products. This list is available on the Insurer's website. In part, the list is based on the drug or product's effectiveness and cost, clinical practice guidelines and recommendations issued by health technology assessment agencies.
- b) Drugs or products that are or should be administered in a hospital or hospital setting, as determined by the Insurer. This includes drugs or products that require special supervision during treatment due to the severity of the patient's condition, the complexity of the treatment or for safety reasons. In part, the Insurer uses information from Health Canada approved product monographs and recommendations issued by health technology assessment agencies to make its determination.

8) Exclusions and limitations applicable to Travel Insurance

If an Insured Person fails to contact "Voyage Assistance" immediately when he requires Medical Emergency services that require Hospitalization outside the country, the Insurer may reduce or deny reimbursement of a portion of the incurred Eligible Expenses. It is understood that the Insurer is not responsible for the availability or quality of such services.

Exclusions applicable to the Extended Health Care Benefit also apply to the Travel Insurance provision. Furthermore, the Insurer will not pay any of the benefits provided for under the Travel Insurance provision in the following circumstances:

- a) if the Insured Person is not covered under government health and hospital insurance plans;
- b) if the purpose of the trip is to receive medical or paramedical treatment or Hospital services, unless the Insured Person was referred to another Physician, in accordance with the provisions of the REFERRAL TREATMENT section of this Benefit;
- c) for elective, non-emergency treatment or surgery, when this service could have been provided in the province of residence of the Insured Person without endangering his life or health, even if such service is provided as a result of a Medical Emergency;
- d) if the Insured Person does not agree to repatriation as recommended by "Voyage Assistance";
- e) for health care and Hospital expenses incurred for an Insured Person who cannot be repatriated in his province of residence and who refuses medical treatment prescribed by the Physician, and approved by "Voyage Assistance";
- f) for any Medical Emergency incurred in a country or region for which the Canadian government issued, prior to the trip departure date, one of the following travel warnings:
  - i) avoid non-essential travel; or
  - ii) avoid all travel.

The Insured Person who is in the country or region for which a travel warning is issued during his trip is not subject to this exclusion. However, he must make the necessary arrangements to leave the country or region as soon as possible;

- g) if the Insured Person refuses to disclose to the Insurer necessary information regarding other insurance plans under which he also has travel insurance coverage, or if he refuses the use of such information by the Insurer;
- h) if the expenses incurred are related to a health condition that was not Stable prior to the trip departure date.

Travel Insurance benefits are limited to the maximum specified in the Benefit Schedule.

## **CO-ORDINATION OF BENEFITS**

This Benefit is subject to the CO-ORDINATION OF BENEFITS provision in the CLAIMS section of the policy.

## **BENEFIT TERMINATION**

This Benefit terminates on the date the Participant attains the Age Limit specified in the Benefit Schedule or on the earliest of the dates indicated in the TERMINATION OF PARTICIPANT INSURANCE provision.

## **DEPENDENT BENEFIT EXTENSION AFTER PARTICIPANT'S DEATH**

In the event of the death of the Participant and subject to policy provisions, insurance under this Benefit will continue for insured Dependents, without premium payment, until the earliest of the following dates:

- 1) 24 months following the death of the Participant;
- 2) the date on which the Dependent ceases to be eligible as a Dependent for a reason other than the death of the Participant;
- 3) the date on which Dependent insurance would have terminated if the Participant had not died; or
- 4) the date on which this Benefit or policy terminates.

## **NOTICE AND PROOF OF CLAIM**

All claims, other than drug claims, must be submitted to the Insurer along with any receipts every 120 day period, if the amount claimed justifies it, and within 12 months of the date the expense was incurred. In the event of an Accident for which the Participant must submit a claim, written notice must be sent to the Insurer within the 30 days immediately following the Accident.

## **DRUG CLAIMS**

When incurring drug expenses, the Insured Person must show his payment card to the pharmacist. With this method of payment, which is referred to as "direct", the Insured Person only pays the pharmacist for the uninsured portion of the drug expenses incurred and, therefore, the Participant is not required to submit a claim to the Insurer.

## YOU SHOULD KNOW

### HEALTH INQUIRIES

There are 2 ways to reach us for any question about Eligible Expenses under the Extended Health Care Benefit:

**By e-mail at:** Groupservic@dfs.ca

**By phone at:** 1 800 263-1810

For a better experience, it is important to have the policy number and the certificate number ready when an agent is available to take the call.

### GENERAL INQUIRIES

To obtain any other information, visit the “Contact us” section of Desjardins Financial Security’s website at [www.desjardinslifeinsurance.com](http://www.desjardinslifeinsurance.com).

### BENEFICIARY

**This provision removes or restricts the right of the Participant to designate persons to whom or for whose amounts are to be payable for some benefits:**

Only the benefits that include a benefit payment in the event of the Participant's death are subject to the designation of beneficiary(ies), and the same designation applies to all these benefits.

### ACCESS TO THE POLICY

Upon request to Desjardins Financial Security, the Participant may obtain a copy of his application, his insurability report and the policy.



## HOW TO FILE A COMPLAINT

If a Participant is unhappy about something we've said or done, feels they've been wronged or wants us to take corrective action he can file a complaint with the Dispute Resolution Officer at Desjardins Financial Security. The role of the Officer is to evaluate the merit of the decisions and practices of the company when one of its customers believes he has not received the service to which he was entitled.

There are 3 ways to reach the Dispute Resolution Officer

**In writing, at the following address:**

Dispute Resolution Officer  
Desjardins Financial Security  
200, rue des Commandeurs  
Lévis (Québec) G6V 6R2

**By e-mail at: [disputeofficer@dfs.ca](mailto:disputeofficer@dfs.ca)**

**By phone at: 1 877 838-8185**

For further information on the procedure to follow in case of complaint, or to obtain the complaint form, visit the "Contact us" section of Desjardins Financial Security's website at [www.desjardinslifeinsurance.com](http://www.desjardinslifeinsurance.com).

## **ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE**

**SSQ INSURANCE COMPANY INC.**

**Policy # 1NN90**

**OLYMEL, SOCIÉTÉ EN COMMANDITE**

**Mandatory and Voluntary**

**Accidental Death and Dismemberment Insurance**

Updated: February 1, 2016

This Booklet is an important document

Please keep it in a safe place

Throughout this booklet, the male pronoun will be construed as the feminine when the person is a female.

## Schedule of Benefits

### Mandatory coverage

Division	Principal Sum	Reduction of Benefit at Age 65	Termination of Insurance
A TRAHAN	1 time and a half the annual salary (1.5)	50%	The earlier of age 70 or retirement

### Voluntary coverage

Amount of insurance	According to the amount paid Coverage selected in multiples of \$10,000 Minimum number of units: 1 Maximum number of units: 10
Termination of insurance	The earlier of age 65 or retirement

### Aggregate Limit of Indemnity (Mandatory coverage):

\$5,000,000

#### A) Mandatory coverage

Insurance as to each eligible Employee becomes effective:

- on the effective date of the policy with respect to an Employee insured under the Policyholder's Basic Group Life Insurance program on or before the Effective Date of the Policy;
- on the date insurance under the Policyholder's Basic Group Life Insurance program becomes effective with respect to an Employee who becomes insured under such program after the Effective Date of the Policy.

An Employee who is insured under the previous AD&D policy is automatically covered under the new Policy. If such Employee is absent from active full-time work for any reason other than bona fide vacation or maternity or parental leave on the Effective Date of the Policy, the Employee will remain insured

under the terms and conditions of the previous policy until the Employee's return to active full-time work, upon which the new Policy becomes effective.

**B) Voluntary coverage**

Insurance as to each Employee who applies for voluntary coverage becomes effective:

- a) on the Effective Date of the Policy with respect to an Employee who applied for coverage on or before the Effective Date of the Policy.
- b) on the date the Employee's application is received by the Policyholder, if such application was submitted after the Effective Date of the Policy.

An Employee who is insured under the previous AD&D policy or not yet insured under the previous AD&D policy is automatically covered under the new Policy even if an application for coverage was previously submitted by or for the Employee. If such Employee is absent from active full-time work for any reason other than bona fide vacation or maternity or parental leave on the Effective Date of the Policy, the Employee will remain insured under the terms and conditions of the previous policy until the Employee's return to active full-time work, upon which the new Policy becomes effective.

**Definitions**

Wherever used in this policy:

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

"Accommodation" means lodging at a hotel, motel, inn, bed and breakfast or other like establishment as well as food reasonably required during the lodging, provided however that no indemnity will be paid for lodging at a private residence or for food not consumed as meals by the person seeking reimbursement of expenses.

"Commencement of Total Disability" means the date of commencement of the Insured Person's Total Disability, as determined by a Physician, which date must be subject to the satisfaction of the Insurer that, on that date, the Insured Person has met all criteria for Total Disability.

"Dependent Child" means a natural child, adopted child, stepchild or child who is in a parent-child relationship with the Employee. The child must be dependant upon the Employee for maintenance and support and:

- a) be under 21 years of age; or
- b) under 26 years of age and in attendance at an Institution for Higher Learning on a full time basis; or
- c) no matter his age on the date of the claim, have been struck with a functional disability while satisfying the criteria under paragraphs a) or b) above. Proof of existence of this functional disability, including the determination by a Physician that the disability exists and when it occurred, must be presented to the Insurer within 31 days after the child reaches the age at which he would otherwise no longer qualify as a Dependent Child under paragraph a) or b) above. Thereafter, the Insurer may periodically require that other proof be submitted establishing to its satisfaction that the Functional Disability still

exists and that the child otherwise meets the definition of Dependent Child, failing which, the Insurer may determine that the child no longer qualifies as a Dependent Child under the Policy.

“Fare” means the regular fare charged for:

- a) an economy class seat on a regular flight by a domestic or international scheduled air carrier;
- b) a coach seat on a passenger train;
- c) a regular seat on a passenger bus;
- d) an economy class accommodation on a boat.

Each of those carriers must hold a current and valid certificate issued by Transport Canada or, if subject to regulation in another country by a similar governmental authority having jurisdiction in that country.

“Hospital” means an institution licensed as a hospital within the jurisdiction in which it operates. To qualify under this definition, a hospital must be an active treatment hospital open at all times for the care and treatment of sick and injured persons, have a staff of one or more Physicians available at all times, provide twenty-four hour nursing service by graduate registered nurses and have organized facilities for diagnostics and surgery. A facility which is primarily a clinic, rest home, nursing home, convalescent hospital or similar establishment is not a Hospital. For the purposes of this definition, a Hospital will include a facility or part of a facility used for rehabilitative care.

“Immediate Family Member” means a person at least 18 years of age, who is the son, daughter, father, mother, brother, sister, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, sister-in-law, uncle, aunt, nephew, niece, grandson, granddaughter, grandfather, grandmother (all of the above include natural, adopted or step relationships) or the spouse of an insured Employee.

“Injury” means bodily injury caused by an Accident occurring while this policy is in force as to the Insured Person whose injury is the basis of claim and resulting directly and independently of all other causes in loss covered by this policy, 24 hours a day, anywhere in the world but in no event shall Injury mean Sickness or Disease howsoever caused unless caused by an Accident.

“Institution for Higher Learning” means but is not limited to universities, colleges, CEGEPs and professional or vocational schools.

“Insured” or “Insured Person” means an insured Employee whose individual coverage under the Policy is effective.

“Motorized Vehicle” means a passenger car, van, jeep-type automobile, sports utility vehicle (SUV), any truck-type automobile, truck, ambulance, or any type of motorized vehicle used by municipal, provincial or federal police forces.

“Principal Sum” means the amount indicated herein as being applicable to the Insured Person and provided on the Employee's signed application form stored in the Policyholder's files if applicable.

"Physician" means an individual who is legally licensed to practice medicine and provide treatment within the scope of his licence by:

- a) a recognized medical licensing organization in the jurisdiction where the treatment is rendered, provided he is a member in good standing of such licensing body, or
- b) a governmental agency having jurisdiction over such licensing where the treatment was rendered.

The Physician must not ordinarily reside in the Insured Person's residence. The Physician must not be an Insured Person, an Immediate Family Member or business associate of an Insured Person.

"Policy" means Policy #1NN90 as well as the attached Master Application, any endorsements and attached papers.

"Regular Care and Attendance" means observation and treatment to the extent necessary under existing and recognized standards of medical practice, in order to help the Employee recover from the injury requiring treatment or hospitalization.

"Spouse" means an individual:

- a) who is married to the Employee through a civil union or other legally recognized marriage;
- b) who is publicly presented by the Employee as his spouse and with whom the Insured Employee has continuously cohabited in a conjugal relationship for a minimum of one year immediately before the date of the event insured against.

However, when the individual is the biological or adoptive mother or father of at least one of the Employee's children and is cohabitating with the Employee, the individual shall be deemed a Spouse from the date of birth or adoption of that child, if that date precedes the end of the period of one year of cohabitation.

Only one individual is eligible as the Spouse of the Employee. If the Employee is legally married or in a civil union but is also cohabiting with an individual as described under item b) above, the Employee may elect in writing which one of the individuals will qualify as a Spouse under the Policy. This election must be filed with the Policyholder. The Insurer will not be bound by an election not filed before the occurrence of the event insured against. If an election is not filed, the Spouse will be the individual to whom the Employee is legally married or in a civil union with.

"Total Disability" or "Totally Disabled" means or directly refers to a continuous state of incapacity preventing the Employee from performing all of the usual and customary duties of his occupation.

An insured Employee will be deemed Totally Disabled only if he does not receive any income from any occupation after the Commencement of Total Disability, directly or indirectly, except in the context of a rehabilitation program approved by the Insurer.

For a Total Disability to be recognized, the state of the insured Employee must require Regular Care and Attendance by a Physician or an appropriate specialist. Proof of Regular Care and Attendance must be satisfactory to the Insurer.

“Transportation” means conveyance from one place to another by private or public Motorized Vehicle, bus, train, boat, ferry, airplane or helicopter.

**Specific Loss Accident Indemnity**

When Injury results in any of the following losses within 365 days after the date of an Accident, the Insurer will pay:

**For Loss of**

Life .....	The Principal Sum
The Entire Sight of Both Eyes .....	The Principal Sum
Speech and Hearing in Both Ears .....	The Principal Sum
One Hand and the Entire Sight of One Eye.....	The Principal Sum
One Foot and the Entire Sight of One Eye .....	The Principal Sum
The Entire Sight of One Eye.....	Two-Thirds of the Principal Sum
Speech .....	Two-Thirds of the Principal Sum
Hearing in Both Ears .....	Two-Thirds of the Principal Sum
Hearing in One Ear.....	One-Third of the Principal Sum
All Toes of One Foot .....	One-Third of the Principal Sum

**For Loss or Loss of Use of**

Both Hands.....	The Principal Sum
Both Feet.....	The Principal Sum
One Hand and One Foot .....	The Principal Sum
One Arm .....	Three-Fourths of the Principal Sum
One Leg.....	Three-Fourths of the Principal Sum
One Hand .....	One-Third of the Principal Sum
One Foot .....	Two-Thirds of the Principal Sum
Thumb and Index Finger or at Least Four Fingers of One Hand .....	One-Third of the Principal Sum
Thumb or Big Toe.....	One-Sixth of the Principal Sum

**For Paralysis of**

Both Upper and Lower Limbs (Quadriplegia) .....	Two Times the Principal Sum
Both Lower Limbs (Paraplegia) .....	Two Times the Principal Sum
Upper and Lower Limbs of One Side of Body (Hemiplegia).....	Two Times the Principal Sum

However, in the case of Quadriplegia, Paraplegia and Hemiplegia, if the Insured Person dies within 90 days after the date of the Accident, the indemnity payable by the Insurer will be limited to the Principal Sum.

Indemnity provided under this section for all Specific Losses sustained by an Insured Person as the result of any one Accident will not exceed the following:

- a) the Principal Sum, with the exception of Quadriplegia, Paraplegia and Hemiplegia; or
- b) with respect to Quadriplegia, Paraplegia and Hemiplegia, two times the Principal Sum, provided that the Insured Person lives longer than 90 days after the date of the Accident.

Under this section, in no event will the Insurer pay more than two times the Principal Sum as the result of the same Accident, regardless of the combination of losses suffered.

If, as the result of the same Accident, the Insured Person sustains multiple Injuries to the same limb or appendage, the Insurer will pay only one Indemnity, for the most important Specific Loss.

“Specific Loss” means Loss of Life, Loss, Loss of Use, Quadriplegia, Paraplegia or Hemiplegia, all as defined below.

“Loss of Life” means the death of the Insured Person.

“Loss” means:

- a) as used with reference to a hand or foot, the complete and irrecoverable severance through or above the wrist or ankle joint, but below the elbow or knee joint;
- b) as used with reference to an arm or leg, the complete and irrecoverable severance through or above the elbow or knee joint;
- c) as used with reference to a thumb, the complete and irrecoverable severance of one entire phalanx of the thumb;
- d) as used with reference to a finger, the complete and irrecoverable severance of two entire phalanges of the finger;
- e) as used with reference to toes, the complete and irrecoverable severance of one entire phalanx of the big toe and irrecoverable severance of all phalanges of the other toes;
- f) as used with reference to an eye, the irrecoverable loss of the entire sight thereof, and determined by a Physician to be irrecoverable;
- g) as used with reference to speech, the complete and irrecoverable loss of the ability to utter intelligible sounds, and determined by a Physician to be irrecoverable;
- h) as used with reference to hearing, the complete and irrecoverable loss of hearing, and determined by a Physician to be irrecoverable.

“Loss” as above used with reference to 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 by a Physician to be permanent at the end of such period.

“Paralysis” means the loss of ability to move all or part of the body.



“Quadriplegia” means the permanent Paralysis and functional loss of use of both upper and lower limbs.

“Paraplegia” means the permanent Paralysis and functional loss of use of both lower limbs.

“Hemiplegia” means the permanent Paralysis and functional loss of use of upper and lower limbs on the same side of the body.

### **Repatriation Benefit**

In the event an Insured Person suffers a Loss of Life resulting from Injury more than fifty kilometres from that Insured Person's normal place of residence and indemnity for such loss becomes payable under the section entitled “Specific Loss Accident Indemnity”, the Insurer will pay the reasonable and necessary expenses actually incurred for the transportation of the body of the deceased Insured Person to a resting place (including but not limited to a funeral home or the place of interment) in proximity to the normal place of residence of the deceased Insured Person, including charges for the preparation of the body for such transportation, not to exceed, in the aggregate, the amount of \$10,000 for all such expenses paid under this section as a result of one Accident.

The indemnity payable under this section will be payable to the person who actually incurred the expenses.

The amount payable under this section will be co-ordinated with any amount which is paid or payable for a same or similar benefit provided under any other policies issued to the Policyholder by the Insurer.

### **Education Benefit**

In the event an Insured Employee suffers a Loss of Life resulting from an Injury and indemnity for such loss becomes payable under the section entitled “Specific Loss Accident Indemnity”, the Insurer will pay the reasonable and necessary tuition fees for any Dependent Child who, on the date of or within the following 365 days of the Insured Person's death, is enrolled or enrolls as a full-time student in any Institution for Higher Learning, up to the lesser of the following amounts:

- a) 5% percent of such deceased Insured Person's Principal Sum; or
- b) \$5,000,

for each year (up to four consecutive years) per Dependent Child during which such Dependent Child remains enrolled as a full-time student in an Institution for Higher Learning.

The total maximum payable under this section will not exceed \$5,000 per year per Dependent Child.

The indemnity will be paid each year upon receipt of proof satisfactory to the Insurer that the Dependent Child is enrolled as a full-time student in an Institution for Higher Learning. Payment will not be made for expenses incurred prior to the Loss of Life of such Insured Person, nor for room, board, or other living, travelling or clothing expenses.

The indemnity payable under this section will be payable to the person who actually incurred the expenses.

The amount payable under this section will be co-ordinated with any amount which is paid or payable for a same or similar benefit provided under any other policies issued to the Policyholder by the Insurer.

If the Insured Person's Dependent Child satisfies the above requirements, the Dependent Child will be considered the beneficiary of the indemnity payable under this section. If none of the Insured Person's Dependent Children satisfy the above requirements or the requirements as shown under the section entitled "Day-Care Benefit", the Insurer will pay to the Insured Employee's beneficiary an amount equivalent to 5% of the deceased Insured Person's Principal Sum, up to a maximum amount of \$2,500, under only one of the policies issued by the Insurer.

### **Day-Care Benefit**

In the event an Insured Employee suffers a Loss of Life resulting from an Injury and indemnity for such loss becomes payable under the section entitled "Specific Loss Accident Indemnity", the Insurer will pay the reasonable and necessary expenses actually incurred for Day-Care Centre attendance for any Dependent Child under 13 years of age at the date of the Insured Person's death and who on the date of or within the following 365 days after such Insured Person's death, is enrolled or enrolls in a Day-Care Centre, to the lesser of the following amounts:

- a) 5% of the deceased Insured Person's Principal Sum; or
- b) \$5,000,

for each year (up to four consecutive years) per Dependent Child during which such Dependent Child remains enrolled in a Day-Care Centre.

The total maximum payable under this section will not exceed \$5,000 per year per Dependent Child.

The indemnity will be paid each year upon receipt of proof satisfactory to the Insurer that the Dependent Child is enrolled in a Day-Care Centre. Payment will not be made for expenses incurred prior to the Loss of Life of such Insured Person, nor for room, board, or other living, travelling or clothing expenses.

The indemnity payable under this section will be payable to the person who actually incurred the expenses.

The amount payable under this section will be co-ordinated with any amount which is paid or payable for a same or similar benefit provided under any other policies issued to the Policyholder by the Insurer.

"Day-Care Centre" means a facility, which is run according to the law, including laws and regulations applicable to day-care facilities, and which provides care and supervision for children in a group setting on a regular basis. A Day-Care Centre will not include a hospital, the child's home or school if the only care at such school is provided during normal school hours while the Dependent Child is attending school from grades one through twelve, or if the services provided by the Day-Care Centre are free of charge.

If none of the Insured Person's Dependent Children satisfy the above requirements or the requirements as shown under the section entitled "Education Benefit", the

Insurer will pay to the Insured Employee's beneficiary the lesser of the following amounts:

- a) 5% of the deceased Insured Person's Principal Sum; or
- b) \$2,500,

under only one of the policies issued by the Insurer.

### **Rehabilitation Benefit**

In the event an Insured Employee suffers a Specific Loss resulting from an Injury and indemnity for such loss becomes payable under the section entitled "Specific Loss Accident Indemnity" and such Injury requires that the Insured Employee participate in a rehabilitation program in order to be qualified to engage in an occupation in which he would not have engaged except for such Injury, the Insurer will pay the reasonable and necessary expenses actually incurred by the Insured Employee for such program within 3 years after the date of such loss. Payment will not be made for room, board or other ordinary living, travelling or clothing expenses.

Payment by the Insurer for the total of all expenses incurred by any Insured Employee under this section will not exceed \$10,000 as the result of any one Accident.

The amount payable under this section will be co-ordinated with any amount which is paid or payable for a same or similar benefit provided under any other policies issued to the Policyholder by the Insurer.

### **Occupational Training Benefit**

In the event an Insured Employee suffers a Loss of Life resulting from an Injury and indemnity for such loss becomes payable under the section entitled "Specific Loss Accident Indemnity", the Insurer will pay the reasonable and necessary expenses actually incurred within the following 3 years after the date of such loss by the Spouse who engages in a formal occupational training program in order to become specifically qualified for active employment in an occupation for which he would not otherwise have sufficient qualifications. Payment will not be made for room, board or other ordinary living, travelling or clothing expenses.

Payment by the Insurer for the total of all expenses incurred by the Spouse under this section will not exceed \$10,000.

The indemnity payable under this section will be payable to the person who actually incurred the expenses.

The amount payable under this section will be co-ordinated with any amount which is paid or payable for a same or similar benefit provided under any other policies issued to the Policyholder by the Insurer.

### **Enhanced Child Benefit (Voluntary AD&D Program only)**

In the event an Insured Dependent Child suffers a Specific Loss resulting from an Injury and indemnity for such loss becomes payable under the section entitled "Specific Loss Accident Indemnity", the Insurer will pay two times the applicable indemnity with exception of Loss of Life.

This provision is not applicable if the Insured Dependent Child dies as a result of the Injury or from any cause within ninety (90) days after the date of the Accident.

## **Family Transportation Benefit**

In the event an Insured Person suffers a Specific Loss resulting from an Injury and indemnity for such loss becomes payable under the section of this booklet entitled «Specific Loss Accident Indemnity» and such Insured Person is under the Regular Care and Attendance of a Physician, the Insurer will pay the reasonable and necessary expenses actually incurred by one Immediate Family Member or family representative for Transportation to the bedside of such Insured Person by the most direct route from the normal place of residence of the Immediate Family Member or family representative, Accommodation in the vicinity, and return to the normal place of residence of such Immediate Family Member or family representative by the most direct route if the Insured Person had been travelling unaccompanied by an Immediate Family Member. Payment will not be made for other ordinary living, travelling or clothing expenses.

The Insurer will not pay any indemnity under this section unless such Insured Person is confined as an inpatient in a Hospital located more than 150 kilometres from his normal place of residence.

If Transportation occurs in a Motorized Vehicle other than one operated under a license for the conveyance of passengers, then reimbursement of Transportation expenses will be limited to a maximum of \$0.20 per kilometre travelled for such return trip.

The total maximum amount payable under this section by the Insurer will not exceed \$10,000 as a result of any one Accident.

The indemnity payable under this section will be payable to the person who actually incurred the expenses.

The amount payable under this section will be co-ordinated with any amount which is paid or payable for a same or similar benefit provided under any other policies issued to the Policyholder by the Insurer.

## **Identification Benefit**

In the event an Insured Person suffers a Loss of Life resulting from an Injury and indemnity for such loss becomes payable under the section of this booklet entitled "Specific Loss Accident Indemnity" and the police or similar governmental authority requires identification of the Insured Person's body, the Insurer will pay the reasonable and necessary expenses actually incurred by one Immediate Family Member or family representative for Transportation to the location of the Insured Person's body by the most direct route from the normal place of residence of the Immediate Family Member or family representative, Accommodation in the vicinity for a maximum duration of 3 consecutive nights, and return to the normal place of residence of such Immediate Family Member or family representative by the most direct route, if, at the time of death, the Insured Person had been travelling unaccompanied by an Immediate Family Member. Payment will not be made for other ordinary living, travelling or clothing expenses.

The Insurer will not pay any indemnity under this section unless the Insured Person's body is located more than 150 kilometres from the Insured Person's normal place of residence.

Reimbursement of Transportation expenses under this section is limited to the cost of a single return trip to identify the deceased Insured Person. If Transportation occurs in a Motorized Vehicle other than one operated under a license for the conveyance of passengers, then reimbursement of Transportation expenses will be limited to a maximum of \$0.20 per kilometre travelled for such return trip.

The total maximum amount payable under this section by the Insurer will not exceed \$5,000 as a result of any one Accident.

The indemnity payable under this section will be payable to the person who actually incurred the expenses.

The amount payable under this section will be co-ordinated with any amount which is paid or payable for a same or similar benefit provided under any other policies issued to the Policyholder by the Insurer.

### **Common Disaster Benefit (Voluntary AD&D Program only)**

In the event an Insured Employee and his Insured Spouse both suffer a Loss of Life resulting from an Injury and indemnity for such losses becomes payable under the section entitled «Specific Loss Accident Indemnity» as a result of a Common Accident, the indemnity for such Loss of Life applicable to the Insured Spouse will be increased up to the Insured Employee's Principal Sum amount, but in no event will the amount payable under the Policy exceed, in the aggregate, one million dollars (\$1,000,000).

«Common Accident» means a single Accident or multiple Accidents occurring within the same twenty-four (24) hour period.

### **Seat Belt Benefit**

In the event an Insured Person suffers a Specific Loss resulting from an Injury and indemnity for such loss becomes payable under the section of this booklet entitled "Specific Loss Accident Indemnity", the Insurer will pay an additional indemnity equal to ten percent (10%) of the applicable indemnity payable under the section of this booklet entitled "Specific Loss Accident Indemnity", subject to a maximum of \$25,000, if at the time of the Accident causing such Injury, the Insured Person was driving or riding in a Motorized Vehicle and wearing a properly fastened Seat Belt.

At the time of the Accident, the driver of the Motorized Vehicle must hold a current and valid driver's license of a rating authorizing him to operate such Motorized Vehicle and neither be Intoxicated nor Under the Influence of Drugs.

Proof of Seat Belt use to the satisfaction of the Insurer must be provided as part of the written proof of loss.

"Intoxicated" and "Under the Influence of Drugs" mean that the driver has a blood alcohol content and/or is impaired due to the use of alcohol, narcotics or other drugs such that he could be subject to proceedings under provincial, state or federal law, even if he has not been subject to such proceedings.

"Seat Belt" means a belt that forms a restraint system in a Motorized Vehicle.

For the purposes of this definition, a Seat Belt includes infant and child restraint systems used in Motorized Vehicles and the restraining belts which are part of a stretcher used in the transportation of sick or injured persons by ambulance.

### **Home Alteration and/or Vehicle Modification Benefit**

In the event an Insured Person suffers a Specific Loss listed below resulting from an Injury:

- 1) Loss of both feet or legs; or
- 2) Loss of Use of both feet or legs; or
- 3) Quadriplegia, Paraplegia or Hemiplegia,

and indemnity for such loss becomes payable under the section of this booklet entitled "Specific Loss Accident Indemnity" and such Insured Person requires the use of a wheelchair, as result of such loss, in order to be ambulatory, the Insurer will pay the reasonable and necessary expenses actually incurred by the Insured Person within three years following the date of Loss for home alteration and/or vehicle modification as provided under this section.

To be covered under this section, the alteration or modification must enable the Insured Person to access his residence and/or his vehicle in a wheelchair and must be approved, where required by law, by licensing authorities.

The total maximum amount payable under this section by the Insurer will not exceed \$10,000 as a result of any one Accident.

The amount payable under this section will be co-ordinated with any amount which is paid or payable for a same or similar benefit provided under any other policies issued to the Policyholder by the Insurer, or any amount to which the Insured is entitled under any government plan of automobile insurance or any other plan providing a similar type of indemnity.

### **Hospital Indemnity**

In the event an Insured Person suffers a Specific Loss resulting from an Injury and indemnity for such loss becomes payable under the section of this booklet entitled "Specific Loss Accident Indemnity" and such Injury requires the Insured Person to stay in a Hospital and under the Regular Care and Attendance of a Physician for at least four consecutive days, the Insurer will pay a Daily Indemnity provided such Period of Hospitalization is necessary for the treatment of such Injury. Such Daily Indemnity will be paid from the first Day of Hospitalization, but in no event for more than 365 days per Accident.

Notwithstanding anything contained to the contrary in the Policy, a Period of Hospitalization which becomes necessary for the treatment of an Injury which resulted in a Specific Loss will be covered in accordance with the terms of this section, provided such Period of Hospitalization commences:

- 1) within 365 days after the date of the Accident causing such Injury; and
- 2) while this Insured Person's individual coverage under the Policy is in force.

Only one Period of Hospitalization will be payable for all Injuries sustained by the Insured Person as the result of one Accident.

“Daily Indemnity” means one-thirtieth of one percent (1/30 of 1%) of the Insured Person’s Principal Sum, subject to a maximum monthly indemnity of \$2,500.

“Period of Hospitalization” means a single uninterrupted confinement in a Hospital or several successive confinements in a Hospital as a result of the same Accident, provided each such confinement is separated by a period of less than 90 consecutive days and all such confinements occur within 730 days of the date of the Accident.

“Day of Hospitalization” means a necessary Period of Hospitalization in a Hospital as an inpatient for which a full day’s room and board is charged.

### **Aircraft Coverage**

Insurance provided under the Policy includes coverage for loss when such loss results from Injury sustained while and as a result of the Insured Person:

- a) riding as a passenger, and not as a pilot, operator or member of the crew, in or on any aircraft having a current and valid certificate of airworthiness and being piloted by a person who then holds a current and valid pilot’s license of a rating authorizing him to pilot such aircraft
- b) riding as a passenger, and not as a pilot, operator or member of the crew, in or on any aircraft operated by the Canadian Armed Forces or by a similar military service of any duly constituted governmental authority of any other recognized country.
- c) boarding or alighting from or being struck by any aircraft.

Coverage is excluded from Injury sustained while and as a result of riding in or on any aircraft owned, operated, leased or chartered by or on behalf of the Policyholder.

### **Exposure and Disappearance Coverage**

In the event an Insured Person undergoes unavoidable exposure to natural elements and, as a direct result, suffers a Specific Loss for which indemnity would have been payable under the section of this booklet entitled “Specific Loss Accident Indemnity” if it had been caused by an Accident, the Insurer will pay the amount specified for the same loss as in the section of this booklet entitled “Specific Loss Accident Indemnity”.

In the event the Insured Person is not found within one year following the date of the disappearance or sinking or wrecking of the conveyance in which he was riding at the time of such disappearance or sinking or wrecking and under such circumstances as would otherwise be covered under the section of this booklet entitled “Specific Loss Accident Indemnity”, it will be presumed the Insured Person suffered a Loss of Life resulting from an Injury at the time of such disappearance, sinking or wrecking.

### **Aggregate Limit of Indemnity (Mandatory coverage):**

The Insurer’s aggregate limit of indemnity for all indemnities payable as a result of any one Accident for which indemnities are payable under the “Specific Loss Accident Indemnity” section of this booklet is stated below. In the event said limit

of indemnity for any one Accident is insufficient to pay the full amount of indemnity for each Insured Person, then the amount payable for each Insured Person will be in the proportion that the limit of indemnity for any one Accident bears to the total amount of indemnity that would have been payable, not taking into consideration such limit of indemnity.

This section only applies to indemnities payable under the following section:

- Specific Loss Accident Indemnity

### **Indemnity Payment and Beneficiaries**

Indemnity payable in the event of an Insured Employee's Loss of Life will be paid to the beneficiary or beneficiaries designated in writing by such Employee on his basic group life insurance application on file with the Policyholder or basic group life insurance carrier, as the case may be on the Employee's most recently signed enrollment card or beneficiary designation card on file with the Policyholder, or if there is no such beneficiary designation, such indemnity will be paid to the Employee's estate. All other indemnities payable will be paid to the Employee, with the exception of indemnities payable under the following sections of this booklet, for which, indemnity will be paid to the person who actually incurred the expenses giving rise to the indemnity:

- Repatriation Benefit
- Education Benefit
- Day-Care Benefit
- Occupational Training Benefit
- Identification Benefit

### **Individual Terminations**

The insurance of an insured Employee will immediately terminate on the earlier of the following dates:

- a) on the date the Policy is terminated;
- b) on the premium due date if the Policyholder fails to pay the required premium for the Insured Person;
- c) on the date stated in the Collective Agreement;
- d) on the date the Employee ceases to be an active Employee of the Policyholder on account of leave of absence, lay-off, maternity/parental leave, disability, resignation, dismissal, pension or retirement, except as provided under the following sections of this booklet:

Waiver of Premium

Continuation of Coverage During Approved Leaves



## **Waiver of Premium**

When, under the Policyholder's basic group life insurance policy, an Insured Employee's life insurance coverage is extended under a waiver of premium provision as the result of total disability resulting from a Sickness or Disease, from a Sickness or Disease related to pregnancy, from an Injury or from an Accident, coverage under the Policy will also be extended and waiver of premium granted.

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

- a) the date the Policy is terminated; or
- b) the date the Insured Employee reaches age 65; or
- c) the date the Insured Employee ceases to be Totally Disabled.

The coverage which is continued under this section is subject to the terms and provisions of the Policy which are in effect on the date prior to commencement of Total Disability, including any provision providing for reductions in amounts of insurance or any indemnity.

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

The Insurer has the right to request proof of total disability or the continuation thereof from time to time, as the Insurer may reasonably require. Failure to provide proof satisfactory to the Insurer may result in termination of the waiver of premium.

## **Continuation of Coverage during Approved Leaves**

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

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

- a) with respect to any leave of absence approved by the Policyholder, on the first day of the month following the completion of a 12-month period that started on the date such approved leave of absence began or on the date the Insured Employee returns to work in any capacity for the Policyholder or any other employer, including self-employment, whichever is earlier. Continuation of coverage for periods in excess of 12 months may be granted, provided written request is submitted by the Policyholder to the Insurer;
- b) with respect to any disability leave approved by the Policyholder, on the date the Insured Employee reaches age 65, qualifies for a waiver of premium or returns to work in any capacity, whichever is earlier.

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

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

## **Exclusions**

No benefit will be paid for any loss, fatal or non-fatal, caused or contributed to by:

- (a) self-inflicted injuries, suicide or attempted suicide, regardless of the state of mind of the insured;
- (b) war, whether declared or undeclared, and whether or not the Insured Person was actually participating therein;
- (c) civil commotion, riot, insurrection, armed conflict, if the Insured Person was participating therein;
- (d) the Insured Person's service, whether as a combatant or non-combatant, in the armed forces of any country;
- (e) the Insured Person riding as a passenger or otherwise in any vehicle or device for aerial navigation, other than as provided in the section entitled "Aircraft Coverage";
- (f) medical treatment or surgery on the Insured Person, except if the medical treatment or surgery was needed because of an Accident.

if the benefit amount that would be normally payable exceeds \$1,000,000, then the excess portion of such amount will not be paid.

## **Claims Provisions**

**Notice of Claim** Written notice of Injury on which claim is based must be given to the Insurer within 30 days after the date of the Accident resulting in such Injury. Such notice must be given in writing by or on behalf of the Insured Person, his beneficiary or the person who is entitled the indemnity under the Policy, as the case may be, to the Insurer at 2020 University Street, Suite 1800, Montreal (Quebec), H3A 2A5, or to any Regional Office of the Insurer or to any authorized agent of the Insurer, with particulars sufficient to identify the Insured Person whose loss is the basis of such notice. Failure to give such notice within the time provided in the Policy will not invalidate any claim if it is shown not to have been reasonably possible to give such notice during such time and that such notice was given as soon as was reasonably possible, but in no event later than one year after the date of the Accident.

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

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

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

**Payment of Claims** All indemnities provided in the Policy for loss will be paid after customary proof of loss satisfactory to the Insurer has been given in accordance with the requirements of the Policy. With respect to Insured Persons of the Policyholder for whom premium is paid in Canadian funds, all moneys payable under the Policy are payable in the lawful money of Canada. With respect to Insured Persons of a Policyholder who pays the premium in U.S. funds, all moneys payable under the Policy are payable in the lawful money of the United States of America.

## Our commitment to you

We will always be here to answer your questions. You can rely on our knowledgeable team to deliver outstanding service and process your claims efficiently. We are here to help you stay healthy and to give you advice and financial support when you need them most.

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