ALBERTA PRECISION LABORATORIES

Leaders in Laboratory Medicine

Benefit Providers and Plan Document Numbers:

Canada Life

- Life Insurance - 17002
- Optional Life Insurance - 17202
- Short Term Disability - 57701
- Long Term Disability - 17102

Industrial Alliance Financial Group

- Accidental Death & Dismemberment - 100013108
- Optional Accidental Death & Dismemberment - 100013109

Alberta Blue Cross

- Health, Dental, Spending Accounts - 25000

Division Number: 205/206 (LTD)

Class Number: 392 - Management
393 - Exempt

Section Number: DL1 - Management
DL2 - Exempt

Employee Name: _____

Certificate Number: _____

Welcome to Your Group Benefit Program

Plan Document Effective Date: December 18, 2023

This Benefit Booklet has been specifically designed with your needs in mind, providing easy access to the information you need about the benefits to which you are entitled.

Group Benefits are important, not only for the financial assistance they provide, but for the security they provide for you and your family, especially in case of unforeseen needs.

Your employer can answer any questions you may have about your benefits, or how to submit a claim.

HBTA Health Benefit Trust of Alberta

The Health Benefit Trust of Alberta (HBTA) is a diverse, multi-employer plan. The participating employers are responsible for the HBTA and its management. The HBTA operates on a not-for-profit basis and is governed by a Policy Council whose members consist of plan beneficiaries. The HBTA Policy Council is committed to being fiscally responsible, operating in the best interests of the participants, and being accountable to the participants.

This booklet describes your benefit plan and has been prepared by the Employee Benefits and Retirement Programs Group of Alberta Health Services, acting in their role as the HBTA Plan Administrator. The HBTA Plan Administrator also provides professional consulting and administrative services to the HBTA Policy Council and employers participating in the HBTA.

The information provided herein does not create or confer any contractual rights. The application of policies, contracts, and legal plan documents will apply should a discrepancy arise.

The HBTA Policy Council is the Group Policyholder for all benefit plan policies and contracts. The authorization to distribute HBTA benefit plan policy copies has been delegated to the HBTA Plan Administrator only. Any inquiries related to copies of the contract or legal action should be directed to your Benefits Representative.

The HBTA Plan Administrator
Employee Benefits & Retirement Programs, Centre of Expertise
Alberta Health Services

Table of Contents

Benefit Summary

This Benefit Summary provides information about the specific benefits supplied by Your benefit provider that are part of your Group Plan.

Employee Life Insurance

Employee Life Insurance

The Employee Life Insurance Benefit is insured under your benefit provider's Policy 17002.

Benefit Amount - 2 times your annual earnings, to a maximum of $1,000,000

Termination Age - your benefit amount reduces by 50% at age 65 and terminates at age 71 or retirement, whichever is earlier.

Employee Optional Life Insurance

Employee Optional Life Insurance

The Employee Optional Life Insurance Benefit is insured under your benefit provider's Policy 17202.

Benefit Amount - increments of $10,000 to a maximum of $300,000

Termination Age - age 70 or retirement, whichever is earlier

Dependent Life Insurance

Dependent Life Insurance

The Dependent Life Insurance Benefit is insured under your benefit provider's Policy 17202.

Benefit Amount - $10,000 spouse; $5,000 each dependent child

Termination Age - employee's age 71 or retirement, whichever is earlier

Dependent Optional Life Insurance

Dependent Optional Life Insurance

The Dependent Optional Life Insurance Benefit is insured under your benefit provider's Policy 17202.

Benefit Amount

- Spouse - increments of $10,000 to a maximum of $300,000

- Child - increments of $2,500 to a maximum of $20,000

Termination Age - employee's age 70 or retirement, whichever is earlier

Accidental Death and Dismemberment

Accidental Death and Dismemberment

The Accidental Death and Dismemberment Benefit is insured under your benefit provider's Policy 100013108.

Benefit Amount - 2 times your annual earnings, to a maximum of $1,000,000

Termination Age - your benefit amount terminates at age 71 or retirement, whichever is earlier.

Employee Optional Accidental Death and Dismemberment

Employee Optional Accidental Death and Dismemberment

The Employee Optional Accidental Death and Dismemberment Benefit is insured under Your benefit provider's Policy 100013109.

Benefit Amount - increments of $25,000 to a maximum of $250,000

Termination Age - employee's age 71 or retirement, whichever is earlier

Dependent Optional Accidental Death and Dismemberment

Dependent Optional Accidental Death and Dismemberment

The Dependent Optional Accidental Death and Dismemberment Benefit is insured under Your benefit provider's Policy 100013109.

Benefit Amount

- Spouse - 0.5 of the amount of the Employee's Optional Accidental Death and Dismemberment Benefit if there are no children; 0.4 of the amount of the Employee's Optional Accidental Death and Dismemberment Benefit if there are children.

- Child - 0.15 of the amount of the Employee's Optional Accidental Death and Dismemberment Benefit to a maximum benefit of $37,500 if there is no spouse; 0.1 of the amount of the Employee's Optional Accidental Death and Dismemberment Benefit if there is a spouse.

Termination Age - employee's age 71 or retirement, whichever is earlier

Extended Health Care

Extended Health Care

The Extended Health Care Benefit is covered under Your benefit provider's Plan Document 25000.

The Benefit

Extended Health Care - The Benefit

Overall Benefit Maximum - Unlimited

Deductible - Nil

Drug Deductible - $8.00 per prescription

Benefit Summary

Benefit Percentage (Co-insurance)

100% for
- Hospital Care
- Vision
- Drugs
- Professional Services
- Medical Services & Supplies

Note:
The Benefit Percentage for Out-of-Canada Emergency Medical Treatment is 100%.
The Benefit Percentage for Referral outside Canada for Medical Treatment Available in Canada is 50%.
The Benefit Percentage for Emergency Travel Assistance is 100%.

Termination Age - employee's age 71 or retirement, whichever is earlier

ManuScript Generic Drug Plan 2 - Prescription Drugs

Extended Health Care - ManuScript Generic Drug Plan 2 - Prescription Drugs

Charges incurred for the following expenses are payable when prescribed in writing by a physician or dentist and dispensed by a licensed pharmacist.

- drugs for the treatment of a sickness or injury, which by law or convention require the written prescription of a physician or dentist
- oral contraceptives, intrauterine devices and diaphragms
- injectable medications (charges made by a practitioner or physician to administer injectable medications are not covered)
- life-sustaining drugs
- preventive vaccines and medicines (oral or injected)
- standard syringes, needles and diagnostic aids, required for the treatment of diabetes (charges for cotton swabs, rubbing alcohol, automatic jet injectors and similar equipment are not covered)

Charges for the following expenses are not covered:

- drugs, biologicals and related preparations which are administered in hospital on an in-patient or out-patient basis
- drugs determined to be ineligible as a result of due diligence
- fertility drugs
- anti-smoking drugs
- anti-obesity drugs
- drugs used in the treatment of a sexual dysfunction

Benefit Summary

- Drug Maximums

- Drug Maximums

All covered drug expenses - Unlimited

- Payment of Covered Expenses

- Payment of Covered Expenses

Payment of your covered drug expenses will be subject to any Drug Deductible, any Drug Dispensing Fee Maximum, the Benefit Percentage for drugs and any maximum.

Covered expenses for any prescribed drug will not exceed the price of the lower cost alternative drug that can legally be used to fill the prescription, as listed in the Provincial Drug Benefit Formulary or a lower cost alternative that provides therapeutically similar results as identified by Your benefit provider.

Your benefit provider can limit the covered expense for any drug to that of a lower cost interchangeable drug at the time the drug is purchased.

If there is no lower cost alternative drug for the prescribed drug, the amount payable is based on the cost of the prescribed drug.

- No Substitution Prescriptions

- No Substitution Prescriptions

If your prescription contains a written direction from your physician or dentist that the prescribed drug is not to be substituted with another product and the drug is a covered expense under this benefit, the full cost of the prescribed product is covered.

When you have a “no substitution prescription”, please ask your pharmacist to indicate this information on your receipt, when you pay for the prescription. This will help to ensure that your expenses will be reimbursed appropriately when your claim is submitted to Your benefit provider for payment.

Payment of your covered drug expenses will be subject to any Drug Deductible, any Drug Dispensing Fee Maximum, the Benefit Percentage for drugs and any maximum.

Payment of Drug Claims

Your Pay Direct Drug Card provides your pharmacist with immediate confirmation of covered drug expenses. This means that when you present your Pay Direct Drug Card to your pharmacist at the time of purchase, you and your eligible dependents will not incur out-of-pocket expenses for the full cost of the prescription.

The Pay Direct Drug Card is honoured by participating pharmacists displaying the appropriate Pay Direct Drug decal.

To fill a prescription for covered drug expenses:

a) present your Pay Direct Drug Card to the pharmacist at the time of purchase, and

b) pay any amounts that are not covered under this benefit.

You will be required to pay the full cost of the prescription at time of purchase if:

- you cannot locate a participating Pay Direct Drug pharmacy
- you do not have your Pay Direct Drug Card with you at that time
- the prescription is not payable through the Pay Direct Drug Card system

For details on how to receive reimbursement after paying the full cost of the prescription, please see your Plan Administrator.

Vision Care

Extended Health Care - Vision Care

- eye exams, once per 12 months
- purchase and fitting of prescription glasses or elective contact lenses, as well as repairs, or elective laser vision correction procedures, to a maximum of $100 per 12 months for persons under age 18 and $250 per 24 months for persons age 18 and over

Professional Services

Extended Health Care - Professional Services

Services provided by the following licensed practitioners:

- Chiropractor - $500 per calendar year
- Osteopath - $500 per calendar year
- Podiatrist/Chiropodist - $500 per calendar year
- Massage Therapist - $500 per calendar year
- Naturopath - $500 per calendar year
- Speech Therapist - $500 per calendar year
- Physiotherapist - $500 per calendar year
- Acupuncturist - $500 per calendar year
- Psychologist - $500 per calendar year combined for services of a psychologist and social worker
- Social Worker - $500 per calendar year combined for services of a psychologist and social worker

Dental Care

The Dental Care Benefit is covered under Your benefit provider's Plan Document 25000.

Dental Care

The Benefit

Dental Care - The Benefit

Deductible - Nil

Dental Fee Guide - Current Fee Guide for General Practitioners and Specialists for your Province of Residence

Benefit Percentage (Co-insurance)

- 80% for Level I - Basic Services

- 80% for Level II - Supplementary Basic Services

- 50% for Level III - Dentures

- 50% for Level IV - Major Restorative Services

- 50% for Level V - Orthodontics

Benefit Maximums

- $2,000 per calendar year combined for Level I, Level II, Level III and Level IV

- $2,500 per lifetime for Level V

Termination Age - employee's age 71 or retirement, whichever is earlier

Long Term Disability

Long Term Disability

The Long Term Disability Benefit is insured under Your benefit provider's Policy 17102.

Benefit Amount - 66.7% of your first $4,500 of monthly earnings, plus 50% of any excess amount, to a maximum of $10,000

Qualifying Period - 119 days

Maximum Benefit Period - to age 65

Termination Age - age 65 less the Qualifying Period, or retirement, whichever is earlier

How to Use Your Benefit Booklet

Designed with Your Needs in Mind

The Benefit Booklet provides the information you need about your Group Benefits and has been specifically designed with YOUR needs in mind. It includes:

Your Benefit Booklet includes...

- a detailed Table of Contents, allowing quick access to the information you are searching for
- Explanation of Commonly Used Terms, which provides a brief explanation of the terms used throughout this Benefit Booklet
- a clear, concise explanation of your Group Benefits
- information you need, and simple instructions, on how to submit a claim

Important Note

Important Note

The purpose of this booklet is to outline the benefits for which you are eligible as an employee of DynaLIFE Dx. The information in this booklet is a summary of the provisions of the Group Policy for the Employee Life Insurance, Employee Optional Life Insurance, Dependent Life Insurance, Dependent Optional Life Insurance, Accidental Death and Dismemberment, Employee Optional Accidental Death and Dismemberment, Dependent Optional Accidental Death and Dismemberment and Long Term Disability Benefits, and the Plan Document for the Extended Health Care and Dental Care Benefits. In the event of a discrepancy between this booklet and the Policy or Plan Document (both available from your employer), the terms of the Policy or Plan Document will apply.

The booklet is provided for information purposes only and does not create or confer any contractual rights or obligations.

Possession of this booklet alone does not mean that you or your dependents are covered. The Group Policy and Plan Document must be in effect and you must satisfy all the requirements of the Plan.

Where required by law, you or any claimant under the Group Policy and/or Plan Document has the right to request a copy of any or all of the following items:

- the Group Policy and/or Plan Document,
- your application for group benefits, and
- any Evidence of Insurability you submitted as part of your application for benefits.

In the case of a claimant, access to these documents is limited to that which is relevant to the filing of a claim, or the denial of a claim under the Group Policy and/or Plan Document.

Your benefit provider reserves the right to charge you for such documentation after your first request.

We suggest you read this Benefit Booklet carefully, then file it in a safe place with your other important documents.

How to Use Your Benefit Booklet

Your Group Benefit Card

Your Group Benefit Card

Your Group Benefit Card is the most important document issued to you as part of your Group Benefit Program. It is the only document that identifies you as a Plan Member. The Group Policy Number, Plan Document Number and your personal Certificate Number may be required before you are admitted to a hospital, or before you receive dental or medical treatment.

The Group Policy Number, Plan Document Number and your Certificate Number are also necessary for ALL correspondence with Your benefit provider. Please note that you can print your Certificate Number on the front of this booklet for easy reference.

Your Group Benefit Card is an important document. Please be sure to carry it with you at all times.

Explanation of Commonly Used Terms

The following is an explanation of the terms used in this Benefit Booklet.

Adherence

use drug, service or supply in accordance with the terms for which it was prescribed.

Adherence

Advisory Body

Your benefit provider approved external experts that may provide Your benefit provider with recommendations, applying a pharmacoeconomic or cost effectiveness evaluation.

Advisory Body

Benefit Percentage (Co-insurance)

the percentage of Covered Expenses which is payable by your employer.

Benefit Percentage (Co-insurance)

Birth

the complete live delivery of a child from its mother.

Birth

Covered Expenses

expenses that will be considered in the calculation of payment due under your Extended Health Care or Dental Care benefit.

Covered Expenses

Deductible

the amount of Covered Expenses that must be incurred and paid by you or your dependents before benefits are payable by your employer.

Deductible

Dependent

your Spouse or Child who is covered under the Provincial Plan.

Dependent

- Spouse

your legal spouse, or a person continuously living with you in a role like that of a marriage partner for at least 12 months.

- Child

- your natural or adopted child, or stepchild, who is:

  - unmarried

  - under age 21, or under age 25 if a full-time student

  - not employed on a full-time basis, and

  - not eligible for coverage as an employee under this or any other Group Benefit Program

- a child who is incapacitated on the date he or she reaches the age when coverage would normally terminate will continue to be an eligible dependent. However, the child must have been covered under this Benefit Program immediately prior to that date.

  A child is considered incapacitated if he or she is incapable of engaging in any substantially gainful activity and is dependent on the employee for support, maintenance and care, due to a mental or physical handicap.

  Your benefit provider may require written proof of the child's condition as often as may reasonably be necessary.

- a stepchild must be living with you to be eligible
- a newborn child shall become eligible from the moment of birth

Disease Management Programs

Disease Management Programs an approach to healthcare that teaches patients how to manage a chronic disease. A system of coordinated healthcare interventions and communications for patients with conditions in which patient self-care efforts are significant in the management of their condition.

Drug

Drug a medication that has been approved for use by Health Canada and has a Drug Identification Number.

Due Diligence

Due Diligence a process employed by Your benefit provider to assess new drugs, existing drugs with new indications, services or supplies to determine eligibility under the Plan Document. This process may use pharmacoeconomics, cost effectiveness analysis reference information from existing Federal or Provincial formularies, recognized clinical practice guidelines, or an advisory body.

Earnings

Earnings your regular rate of pay from your employer (prior to deductions), excluding regular bonuses and regular overtime pay and including regular commissions and Northern Living Allowance. Earnings may include other income as agreed to in writing by your employer.

If you are paid on a commission basis, Earnings means your regular rate of pay, including commissions as shown on your T4-T4A for the previous calendar year. If you have less than one year of service with your Employer, Earnings will include an average of the total commissions paid over the period of actual employment with your Employer.

Explanation of Commonly Used Terms

For the purposes of determining the amount of your benefit at the time of claim, your earnings will be the lesser of:

- the amount reported on your claim form, or
- the amount reported by your employer to Your benefit provider and for which premiums have been paid.

Exclusive Distribution

Your benefit provider approved vendors.

Exclusive Distribution

Experimental or Investigational

not approved as an effective, appropriate and essential treatment of an illness or injury.

Experimental or Investigational

Immediate Family Member

you, your spouse or child, your parent or your spouse's parent, your brother or sister, or your spouse's brother or sister.

Immediate Family Member

Interchangeable Drug

includes but is not limited to:

Interchangeable Drug

- a generic equivalent to the brand name drug deemed to be interchangeable by law where the drug is dispensed;
- a drug that contains the same active ingredient that has not been deemed interchangeable in the province where the drug is dispensed; but has been identified as interchangeable by Your benefit provider

Licensed, Certified, Registered

the status of a person who legally engages in practice by virtue of a license or certificate issued by the appropriate authority, in the place where the service is provided.

Licensed, Certified, Registered

Life-Sustaining Drugs

non-prescription drugs which are necessary to sustain life.

Life-Sustaining Drugs

Lower Cost Alternative

if two or more drugs, supplies or services result in therapeutically similar results, or prescribing guidelines recommend alternate drugs, supplies or services be tried first that are lower in cost, the lower cost alternative will be considered.

Lower Cost Alternative

Medically Necessary

accepted and recognized by the Canadian medical profession and Your benefit provider as effective, appropriate and essential treatment of an illness or injury. Your benefit provider has the right after due diligence has been completed to determine whether the drug, service or supply is covered under the Plan Document.

Medically Necessary

Explanation of Commonly Used Terms

Non-Evidence Limit

Non-Evidence Limit

you must submit satisfactory medical evidence to Your benefit provider for Benefit Amounts greater than this amount.

Patient Assistance Program

Patient Assistance Program

a program that provides assistance to you or your dependents who are prescribed select drugs, supplies or services. Manufacturers and distributors may provide patient assistance programs that include financial support, along with education and training.

Pharmacoeconomics

Pharmacoeconomics

the scientific discipline that evaluates the value of pharmaceutical drugs, clinical services or supplies. This discipline includes but is not limited to clinical evaluations, risk analysis, economic value and the cost consequences to plans. Pharmacoeconomic studies serve to guide optimal healthcare resource allocation, in a standardized and scientifically grounded manner as determined by Your benefit provider.

Prior Authorization

Prior Authorization

a claims management feature applied to a specific list of drugs, supplies or services to determine eligibility based on predefined clinical criteria and a pharmacoeconomic or cost effectiveness evaluation.

Provincial Plan

Provincial Plan

any plan which provides hospital, medical, or dental benefits established by the government in the province where the covered person lives.

Qualifying Period

Qualifying Period

a period of continuous total disability, starting with the first day of total disability, which you must complete in order to qualify for disability benefits.

Reasonable and Customary

Reasonable and Customary

the lowest of:

- the prevailing amount charged for the same or comparable service or supply in the area in which the charge is incurred, as determined by Your benefit provider;
- the amount shown in the applicable professional association fee guide; or
- the maximum price established by law.

Take Home Pay (Net Earnings)

Take Home Pay (Net Earnings)

your earnings, less deductions normally made for federal and provincial income tax.

Waiting Period

Waiting Period

the period of continuous employment with your employer which you must complete before you are eligible for Group Benefits.

Explanation of Commonly Used Terms

Ward

a hospital room with 3 or more beds which provides standard accommodation for patients.

Ward

Why Group Benefits?

Why Group Benefits?

Government health plans can provide coverage for such basic medical expenses as hospital charges and doctors' fees. In case of disability, government plans (such as Employment Insurance, Canada/Quebec Pension Plan, Workers' Compensation Act, etc.) may provide some financial assistance.

But government plans provide only basic coverage. Medical expenses or a disability can create financial hardship for you and your family.

Private health care and disability programs supplement government plans and can provide benefits not available through any government plan, providing security for you and your family when you need it most.

Your Group Benefit Program is provided by DynaLIFE Dx, in partnership with The Manufacturers Life Insurance Company.

Your Employer's Representative

Your Employer's Representative

Your employer is responsible for ensuring that all employees are covered for the Benefits to which they are entitled by reporting all new enrolments, terminations, changes, etc., and keeping all records up to date.

As a member of this Group Benefit Program, it is up to you to provide your employer with the necessary information to perform such duties.

HR Contact Centre at1-877-511-4455

Please record the name of your representative and the contact number in the space provided.

Applying for Group Benefits

Applying for Group Benefits

To apply for Group Benefits, you must submit a completed Enrolment or Re-enrolment Application form, available from your employer. Your employer then forwards the application to Your benefit provider.

Making Changes

Making Changes

To ensure that coverage is kept up to date for yourself and your dependents, it is vital that you report any changes to your employer. Such changes could include:

- change in Dependent Coverage
- change in Beneficiary
- applying for coverage previously waived
- change in Name

The Claims Process

Naming a Beneficiary

Naming a Beneficiary

Your benefit provider does not accept beneficiary designations for any benefits other than Employee Life Insurance, Additional Employee Life Insurance, Employee Optional Life Insurance, Accidental Death and Dismemberment, Additional Accidental Death and Dismemberment and Employee Optional Accidental Death and Dismemberment.

This Plan contains a provision removing or restricting the right of the covered person to designate persons to whom or for whose benefit money is to be payable.

How to Submit a Claim

How to Submit a Claim

To submit a claim, you can do one of the following:

Submit Online (if applicable)

Sign up to use Alberta Blue Cross' Plan Member Site at www.ab.bluecross.ca.

If your health care service provider cannot send Alberta Blue Cross electronic claim transmissions, you can still submit your claim electronically online, from the Plan Member Secure Site or the Alberta Blue Cross App.

For fast, easy and secure claim payments, we encourage you to sign up for direct deposit and electronic claim statements when you set up your access on the Alberta Blue Cross Members Site. Even if you mail us your claims, by providing your banking and email information, your claim payments can be deposited quickly to your bank account and you will receive an email notification, including a link to the Alberta Blue Cross Members Site where you can sign in to view your electronic claim statement.

By Mail

You must complete the applicable claim form and mail it to Alberta Blue Cross. Mailing instructions are included on the claim form.

Claim forms are available at www.ab.bluecross.ca, or from your employer.

Time Limit on Legal Action

You may not commence legal action against the Employer or the Administrator less than 60 days after proof has been filed as outlined under Submitting a Claim. Every action or proceeding against the Employer or the Administrator for the recovery of money payable under the plan is absolutely barred unless commenced within the time set out in the Insurance Act or applicable legislation.

Payment of Extended Health Care and Dental Claims

Claim Payment

Once the claim has been processed, Your benefit provider will send a Claim Statement to you.

The top portion of this form outlines the claim or claims made, the amount subtracted to satisfy deductibles, and the benefit percentage used to determine the final payment to be made to you. If you have any questions on the amount, your employer will help explain.

The Claims Process

The bottom portion of this form is your claims payment, if applicable. Simply tear along the perforated line, endorse the back of the cheque and you can cash it at any chartered bank or trust company.

You should receive settlement of your claim within three weeks from the date of submission to Your benefit provider. If you have not received payment, please contact your employer.

Co-ordination of Extended Health Care and Dental Care Benefits

Co-ordination of Extended Health Care and Dental Care Benefits

If you or your dependents are covered for similar benefits under another Plan, this information will be taken into account when determining the amount of expenses payable under this Program.

This process is known as Co-ordination of Benefits. It allows for reimbursement of covered medical and dental expenses from all Plans, up to a total of 100% of the actual expense incurred.

Plan means:

- other Group Benefit Programs;
- any other arrangement of coverage for individuals in a group; and
- individual travel insurance plans.

Plan does not include school insurance or Provincial Plans.

Order of Benefit Payment

Order of Benefit Payment

A variety of circumstances will affect which Plan is considered as the "Primary Carrier" (i.e.., responsible for making the initial payment toward the eligible expense), and which Plan is considered as the "Secondary Carrier" (i.e.., responsible for making the payment to cover the remaining eligible expense).

- If the other Plan does not provide for Co-ordination of Benefits, it will be considered as the Primary Carrier, and will be responsible for making the initial payment toward the eligible expense.
- If the other Plan does provide for Co-ordination of Benefits, the following rules are applied to determine which Plan is the Primary Carrier.
  - For Claims incurred by you or your Dependent Spouse:

    The Plan covering you or your Dependent Spouse as an employee/member pays benefits before the Plan covering you or your Spouse as a dependent.

    In situations where you or your Spouse have coverage as an employee/member under more than one Plan, the order of benefit payment will be determined as follows:

    - The Plan where the person is covered as an active full-time employee, then
    - The Plan where the person is covered as an active part-time employee, then
    - The Plan where the person is covered as a retiree.
  - For Claims incurred by your Dependent Child:

The Plan covering the parent whose birthday (month/day) is earlier in the calendar year pays benefits first. If both parents have the same birthdate, the Plan covering the parent whose first name begins with the earlier letter in the alphabet pays first.

However, if you and your Spouse are separated or divorced, the following order applies:

° The Plan of the parent with custody of the child, then

° The Plan of the spouse of the parent with custody of the child (i.e., if the parent with custody of the child remarries or has a common-law spouse, the new spouse's Plan will pay benefits for the Dependent Child), then

° The Plan of the parent not having custody of the child, then

° The Plan of the spouse of the parent not having custody of the child (i.e., if the parent without custody of the child remarries or has a common-law spouse, the new spouse's Plan will pay benefits for the Dependent Child).

- Where you and your spouse share joint custody of the child, the Plan covering the parent whose birthday (month/day) is earlier in the calendar year pays benefits first. If both parents have the same birthdate, the Plan covering the parent whose first name begins with the earlier letter in the alphabet pays first.
- A claim for accidental injury to natural teeth will be determined under Extended Health Care Plans with accidental dental coverage before it is considered under Dental Plans.
- If the order of benefit payment cannot be determined from the above, the benefits payable under each Plan will be in proportion to the amount that would have been payable if Co-ordination of Benefits did not exist.
- If the person is also covered under an individual travel insurance plan, benefits will be coordinated in accordance with the guidelines provided by the Canadian Life and Health Insurance Association.

Submitting a Claim for Co-ordination of Benefits

Submitting a Claim for Co-ordination of Benefits

To submit a claim when Co-ordination of Benefits applies, refer to the following guidelines:

- As per the Order of Benefit Payment section, determine which Plan is the Primary Carrier and which is the Secondary Carrier.
- Submit all necessary claim forms and original receipts to the Primary Carrier.
- Keep a photocopy of each receipt or ask the Primary Carrier to return the original receipts to you once your claim has been settled.
- Once your claim has been settled by the Primary Carrier, you will receive a statement outlining how your claim has been handled. Submit this statement along with all necessary claim forms and receipts to the Secondary Carrier for further consideration of payment, if applicable.

Who Qualifies for Coverage?

Eligibility

Eligibility

You are eligible for Group Benefits if you:

- are a regular employee of DynaLIFE Dx and work at least the required Full-Time Equivalent (FTE),
- are a member of an eligible class,
- are younger than the Termination Age,
- are residing in Canada, and
- have completed the Waiting Period.

The Termination Age and Waiting Period may vary from benefit to benefit. For this information, please refer to each benefit in the section entitled Your Group Benefits.

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

Required Number of Hours

Required Number of Hours

Regular Employee - normal work schedule of at least 15 hours per week and .40 FTE (Full-Time Equivalent)

Medical Evidence

Medical Evidence

Medical evidence is required for all benefits, except Dental, when you make a Late Application for coverage on any person. Medical evidence is required when you apply for coverage in excess of the Non-Evidence Limit.

Late Application

Late Application

An application is considered late when you:

- apply for coverage on any person after having been eligible for more than 31 days; or
- re-apply for coverage on any person whose coverage had earlier been cancelled.

If you apply for benefits that were previously waived because you were covered for similar benefits under your spouse's plan, your application is considered late when you:

- apply for benefits more than 31 days after the date benefits terminated under your spouse's plan; or
- apply for benefits, and benefits under your spouse's plan have not terminated.

Medical evidence can be submitted by completing the Evidence of Insurability form, available from your employer. Further medical evidence may be requested by Your benefit provider.

Who Qualifies for Coverage?

Late Dental Application

Late Dental Application

If you apply for coverage for Dental coverage for yourself or your dependents late, the benefit will be limited to $125 for each covered person for the first 12 months of coverage.

Effective Date of Coverage

Effective Date of Coverage

- If medical evidence is not required, your Group Benefits will be effective on the date you are eligible.
- If medical evidence is required, your Group Benefits will be effective on the date you become eligible or the date the evidence is approved by Your benefit provider, whichever is later.

You must be actively at work for plan benefit coverage to become effective. If you are not actively at work on the date your coverage would normally become effective, your coverage will take effect on the next day on which you are again actively at work.

Your dependent's coverage becomes effective on the date the dependent becomes eligible, or the date any required medical evidence on the dependent is approved by Your benefit provider, whichever is later.

Your dependent's coverage will not be effective prior to the date your coverage becomes effective.

Termination of Coverage

Termination of Coverage

Your Group Benefit coverage will terminate on the earliest of:

- the date you cease to be an eligible employee
- the date you cease to be actively at work, unless the Group Policy or the Plan Document allows for your coverage to be extended beyond this date
- the date your employer terminates coverage
- the date you enter the armed forces of any country on a full-time basis
- the date the Group Policy or Plan Document terminates or coverage on the class to which you belong terminates
- the date you reach the Termination Age
- the date of your death

Your dependents' coverage terminates on the date your coverage terminates or the date the dependent ceases to be an eligible dependent, whichever is earlier.

Your Group Benefits

Employee Life Insurance

Employee Life Insurance

The Employee Life Insurance Benefit is insured under Your benefit provider's Policy 17002.

If you die while insured, this benefit provides financial assistance to your beneficiary. If your beneficiary dies before you or if there is no designated beneficiary, this benefit is payable to your estate.

The Benefit

Employee Life - The Benefit

Benefit Amount - 2 times your annual earnings, to a maximum of $1,000,000

Non-Evidence Limit - $800,000

Qualifying Period for Waiver of Premium - 119 days

Termination Age - your benefit amount reduces by 50% at age 65 and terminates at age 71 or retirement, whichever is earlier.

Waiting Period

none for employees hired on or prior to the Group Policy Effective Date
none for all other employees

Naming a Beneficiary

Employee Life Insurance - Naming a Beneficiary

You have the right to designate and/or change a beneficiary, subject to governing law. The necessary forms are available from your Plan Administrator.

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

Submitting a Claim

Employee Life Insurance - Submitting a Claim

To submit an Employee Life Insurance claim, your beneficiary must complete the Life Claim form which is available from your Plan Administrator.

Documents necessary to submit with the form are listed on the form.

A completed claim form must be submitted within 90 days from the date of the loss.

To submit a claim for the Waiver of Premium benefit you must complete a Waiver of Premium claim form which is available from your benefit provider. Your attending physician must also complete a portion of this form.

A completed claim form must be submitted within 180 days from the end of the qualifying period.

Waiver of Premium

Employee Life Insurance - Waiver of Premium

If you become Totally Disabled while insured and prior to age 65 and meet the Entitlement Criteria outlined below, your Life Insurance will continue without payment of premium.

Definition of Totally Disabled

Employee Life Insurance - Totally Disabled

Totally Disabled means a restriction or lack of ability due to an illness or injury which prevents you from performing the essential duties of:

- your own occupation, during the Qualifying Period and the 2 years immediately following the Qualifying Period
- any occupation for which you are qualified, or may reasonably become qualified by training, education or experience, after the 2 years specified above

The availability of work will not be considered by Your benefit provider in assessing your disability.

If you must hold a government permit or license to perform the duties of your job, you will not be considered Totally Disabled solely because your permit or license has been withdrawn or not renewed.

Entitlement Criteria

Employee Life Insurance - Entitlement Criteria

To be entitled to Waiver of Premium, you must meet the following criteria:

- you must be continuously Totally Disabled throughout the Qualifying Period. If you cease to be Totally Disabled during this period and then become disabled again within 3 weeks due to the same or related illness or injury, your Qualifying Period will be extended by the number of days during which you ceased to be Totally Disabled
- Your benefit provider must receive medical evidence documenting how your illness or injury causes restrictions or lack of ability, such that you are prevented from performing the essential duties of:

  - your own occupation, during the Qualifying Period and the following 2 years, and

  - any occupation for which you are qualified, or may reasonably become qualified by training, education or experience, after the 2 years specified above

- you must be receiving from a physician, regular, ongoing care and treatment appropriate for your disabling condition, as determined by Your benefit provider

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

Termination of Waiver of Premium

Employee Life Insurance - Termination of Waiver of Premium

Your Waiver of Premium will cease on the earliest of:

- the date you cease to be Totally Disabled, as defined under this benefit
- the date you do not supply Your benefit provider with appropriate medical evidence documenting how your illness or injury causes restrictions or lack of ability, such that you are prevented from performing the essential duties of:

  - your own occupation, during the Qualifying Period and the following 2 years, and

  - any occupation for which you are qualified, or may reasonably become qualified by training, education or experience, after the 2 years specified above
- the date you are no longer receiving from a physician, regular, ongoing care and treatment appropriate for the disabling condition, as determined by Your benefit provider
- the date you do not attend an examination by an examiner selected by Your benefit provider
- the date of your death
- the date of your 65th birthday

Recurrent Disability

Employee Life Insurance - Recurrent Disability

If you become Totally Disabled again from the same or related causes as those for which premiums were previously waived, and such disability recurs within 6 months of cessation of the Waiver of Premium benefit, Your benefit provider will waive the Qualifying Period.

Your amount of insurance on which premiums were previously waived will be reinstated.

If the same disability recurs more than 6 months after cessation of your Waiver of Premium benefit, such disability will be considered a separate disability.

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

Conversion Privilege

Employee Life Insurance - Conversion Privilege

If your Group Benefits terminate or reduce, you may be eligible to convert your Employee Life Insurance to an individual policy, without medical evidence. Your application for the individual policy along with the first monthly premium must be received by Your benefit provider within 31 days of the termination or reduction of your Employee Life Insurance. If you die during this 31-day period, the amount of Employee Life Insurance available for conversion will be paid to your beneficiary or estate, even if you didn't apply for conversion.

For more information on the conversion privilege, please see your Plan Administrator. Provincial differences may exist.

Employee Optional Life Insurance

Employee Optional Life Insurance

The Employee Optional Life Insurance Benefit is insured under Your benefit provider's Policy 17202.

If you die while insured, this benefit provides financial assistance to your beneficiary, in addition to your Employee Life Insurance Benefit. If your beneficiary dies before you or if there is no designated beneficiary, this benefit is payable to your estate.

The Benefit

Employee Optional Life Insurance - The Benefit

Benefit Amount - increments of $10,000 to a maximum of $300,000

Non-Evidence Limit - All amounts are subject to Evidence of Insurability.

Qualifying Period for Waiver of Premium - 119 days

Termination Age - age 70 or retirement, whichever is earlier

Waiting Period

none for employees hired on or prior to the Group Policy Effective Date
none for all other employees

To apply for Employee Optional Life Insurance you must complete the Application for Optional Life form which is available from Your benefit provider.

For details on **Naming a Beneficiary**, **Submitting a Claim** and **Conversion Privilege**, please refer to Employee Life Insurance.

Waiver of Premium

Employee Optional Life Insurance - Waiver of Premium

If your Employee Life Insurance premium is waived because you are totally disabled, the premium for this benefit will also be waived. (See Employee Life Insurance...Waiver of Premium).

Exclusions

Employee Optional Life Insurance - Exclusions

If death results from suicide any amount of Optional Life Insurance that has been in effect for less than one year will not be payable.

Dependent Life Insurance

Dependent Life Insurance

The Dependent Life Insurance Benefit is insured under Your benefit provider's Policy 17202.

If one of your dependents dies while insured, the amount of this benefit is paid to you.

The Benefit

Dependent Life - The Benefit

Benefit Amount - $10,000 spouse; $5,000 each dependent child

Qualifying Period for Waiver of Premium - 119 days

Termination Age - employee's age 71 or retirement, whichever is earlier

Waiting Period

none for employees hired on or prior to the Group Policy Effective Date
none for all other employees

Submitting a Claim

Dependent Life Insurance - Submitting a Claim

To submit a Dependent Life Insurance claim, you must complete the Life Claim form which is available from your Plan Administrator. Documents necessary to submit with the form are listed on the form.

A completed claim form must be submitted within 90 days from the date of loss.

Waiver of Premium

Dependent Life Insurance - Waiver of Premium

If your Employee Life Insurance premium is waived because you are totally disabled, the premium for this benefit will also be waived. (See Employee Life Insurance...Waiver of Premium).

Conversion Privilege

Dependent Life Insurance - Conversion Privilege

If your spouse's insurance terminates, you may be eligible to convert the terminated insurance to an individual policy, without medical evidence. Your spouse's application for the individual policy, along with the first monthly premium, must be received by Your benefit provider, within 31 days of the termination date. If your spouse dies during this 31-day period, the amount of spousal Life Insurance available for conversion will be paid to you, even if you didn't apply for conversion. If you reside in the province of Quebec and if your dependent child's insurance terminates, you may be eligible to convert the terminated insurance as outlined above by the Conversion Privilege for spousal coverage.

For more information on the conversion privilege, please see your Plan Administrator. Provincial differences may exist.

Dependent Optional Life Insurance

Dependent Optional Life Insurance

The Dependent Optional Life Insurance Benefit is insured under Your benefit provider's Policy 17202.

If one of your dependents dies while insured, the amount of this benefit will be paid to you.

The Benefit

Dependent Optional Life Insurance - The Benefit

Benefit Amount

- Spouse - increments of $10,000 to a maximum of $300,000

- Child - increments of $2,500 to a maximum of $20,000

Non-Evidence Limit - All amounts are subject to Evidence of Insurability.

Qualifying Period for Waiver of Premium - 119 days

Termination Age - employee's age 70 or retirement, whichever is earlier

Waiting Period

none for employees hired on or prior to the Group Policy Effective Date
none for all other employees

To apply for Dependent Optional Life Insurance you must complete the Application for Optional Life form which is available from Your benefit provider.

Submitting a Claim

Dependent Optional Life Insurance - Submitting a Claim

To submit a Dependent Optional Life Insurance claim, you must complete the Life Claim form which is available from your Plan Administrator. Documents necessary to submit with the form are listed on the form.

A completed claim form must be submitted within 90 days from the date of loss.

Waiver of Premium

Dependent Optional Life Insurance - Waiver of Premium

Please refer to Employee Life Insurance for details on the Waiver of Premium provision.

Conversion Privilege

Dependent Optional Life Insurance - Conversion Privilege

If your spouse's insurance terminates, he or she may be eligible to convert the terminated insurance to an individual policy, without medical evidence. Your spouse's application for the individual policy, along with the first monthly premium, must be received by Your benefit provider, within 31 days of the termination date. If your spouse dies during this 31-day period, the amount of Dependent Optional Life Insurance available for conversion will be paid to you, even if your spouse didn't apply for conversion.

For more information on the conversion privilege, please contact Your benefit provider.

Exclusions

Dependent Optional Life Insurance - Exclusions

If death results from suicide any amount of Dependent Optional Life Insurance that has been in effect for less than one year will not be payable.

Accidental Death and Dismemberment

Accidental Death and Dismemberment

The Accidental Death and Dismemberment Benefit is insured under Your benefit provider's Policy 100013108.

If you sustain an accidental injury while insured and suffer a loss specified in the Schedule of Losses below, this benefit provides financial assistance to you or your beneficiary. In the event of your death, the benefit is payable to your beneficiary. If your beneficiary dies before you or if there is no designated beneficiary, this benefit is payable to your estate. For losses other than Loss of Life, the benefit is payable to you.

The Benefit

AD& D - The Benefit

Aggregate Limit - $1,000,000

Benefit Amount - 2 times your annual earnings, to a maximum of $1,000,000

Non-Evidence Limit - $1, 000,000

Qualifying Period for Waiver of Premium - 119 days

Termination Age - your benefit amount terminates at age 70 or retirement, whichever is earlier

Waiting Period

none for employees hired on or prior to the Group Policy Effective Date
none for all other employees

Schedule of Losses

AD& D - Schedule of Losses

A loss shown in this schedule is covered provided it:

- is a direct result of the accidental injury
- occurs within 365 days from the date of the accidental injury
- is total and irreversible or irrecoverable

In the case of loss of speech or hearing, or loss of use of an arm, hand or leg, the loss must be continuous for 12 months and determined to be permanent, after which time the benefit is payable.

The amount payable for each loss is a percentage of your Accidental Death and Dismemberment benefit amount which was in effect as of the date of the injury.

- Loss of Life - 100%
- Loss of or Loss of Use of Both Hands or Both Feet - 100%
- Loss of Sight of Both Eyes - 100%
- Loss of One Hand and One Foot - 100%
- Loss of One Hand and Sight of One Eye - 100%
- Loss of One Foot and Sight of One Eye - 100%
- Loss of Hearing in Both Ears and Speech - 100%
- Loss of or Loss of Use of One Arm or One Leg - 75%
- Loss of or Loss of Use of One Hand or One Foot - 66 2/3%
- Loss of Sight of One Eye - 66 2/3%
- Loss of Speech or Hearing in Both Ears - 66 2/3%
- Loss of Thumb and Index Finger or at least Four Fingers of One Hand - 33 1/3%
- Loss of All Toes of One Foot - 25%
- Loss of Hearing in One Ear - 25%
- Hemiplegia, Paraplegia or Quadriplegia - 200%

Only one percentage, the largest, will be paid for multiple losses to the same limb due to any one accident.

No more than 100% will be paid for all losses due to any one accidental Injury, except in the case of hemiplegia, paraplegia or quadriplegia, where the total amount paid will not exceed 200% (provided the benefit is paid while you are living).

Exposure and Disappearance

AD& D - Exposure and Disappearance

If a loss occurs due to unavoidable exposure to the elements, after a conveyance in which you were travelling made a forced landing, or was lost, wrecked, stranded or sank, a benefit will be payable for that loss. The amount payable will be determined in accordance with the Schedule of Losses.

If you disappear after a conveyance in which you were travelling made a forced landing, or was lost, wrecked, stranded or sank, a benefit for loss of life will be payable if your body is not found within 365 days after the incident occurred.

Rehabilitation Expenses

AD& D - Rehabilitation Expenses

If, as a direct result of an accidental injury, you suffer a loss specified in the Schedule of Losses and require participation in a formal rehabilitation program in order to return to gainful employment, Your benefit provider will pay incurred expenses, provided the expenses are:

- reasonable and necessary, as determined by Your benefit provider
- incurred within a period of 3 years from the date of the accidental injury

The amount payable is subject to a maximum of $10,000.

No amount will be paid for room and board expenses, or other living, travelling or clothing expenses.

Repatriation Expenses

AD& D - Repatriation Expenses

If you die as a direct result of an accidental injury which occurs while travelling 150 kilometers or more from your place of residence, Your benefit provider will pay for expenses incurred for the preparation and transportation of your body to your place of residence.

The amount payable is subject to a maximum of $10,000.

Seat Belt Benefit

AD& D - Seat Belt Benefit

If you die as a direct result of an accidental injury sustained while driving or riding in an automobile, Your benefit provider will pay an additional amount equal to 10% of your Accidental Death and Dismemberment benefit, provided you were wearing your seat belt and it was properly fastened at the time of the accidental injury.

Permanent and Total Disability

AD& D - Permanent and Total Disability

If, as a direct result of an accidental injury, you become permanently and totally disabled while insured for this benefit, Your benefit provider will pay a lump sum benefit, provided:

- you become permanently and totally disabled within 365 days after the date of the accidental injury

- you have been permanently and totally disabled for a continuous period of 12 months and remain so disabled at the end of this period

The amount of benefit payable is equal to your Accidental Death and Dismemberment benefit amount.

- Definition of Permanent and Total Disability

- Permanent and Total Disability

You are considered permanently and totally disabled if you are wholly and continuously disabled due to an accidental injury which is severe enough, in Your benefit provider's opinion, to permanently prevent you from working for remuneration or profit.

Non-Duplication of Expenses

AD& D - Non-Duplication of Expenses

Expenses which are eligible under this benefit and for which you are also eligible under any other benefit, policy, or plan providing similar coverage will be paid first under such other benefit, policy or plan. Any expenses not paid will then be considered under this benefit, subject to any stated maximum.

The total amount of payments from all coverages combined will not exceed 100% of the eligible expenses incurred.

Naming a Beneficiary

AD&D - Naming a Beneficiary

See Employee Life Insurance... Naming a Beneficiary.

Submitting a Claim

AD& D - Submitting a Claim

To submit an Accidental Death Claim, your beneficiary must complete a Life Claim form.

To submit a Dismemberment Claim, you must complete an Accidental Dismemberment Claim form.

Both forms are available from your Plan Administrator, and require a physician's statement.

A completed claim form must be submitted within 90 days from the date of loss.

Waiver of Premium

AD& D - Waiver of Premium

If, while the Group Policy is in force, your Employee Life Insurance premium is waived because you are totally disabled, the premium for this benefit will also be waived. (See Employee Life Insurance...Waiver of Premium). Waiver of Premium for this benefit ceases if the benefit terminates.

Exclusions

AD& D - Exclusions

No Accidental Death & Dismemberment benefits are payable if the loss results from:

- suicide or self-inflicted injuries
- war or insurrection, the hostile actions of any armed forces, or participation in a riot or civil commotion
- an infection (except pyogenic infections from an accidental cut or wound), illness or disease, or the medical treatment of any illness or disease, or bodily or mental infirmity
- riding in, boarding or leaving, or descending from, any aircraft as a pilot, operator or member of the crew
- riding in, boarding or leaving, or descending from, any aircraft which is owned, operated or leased by or on behalf of your employer
- committing or attempting to commit an assault or criminal offence
- injuries sustained while operating a motor vehicle while under the influence of any intoxicant, including alcohol

Employee Optional Accidental Death and Dismemberment

Employee Optional Accidental Death and Dismemberment

The Employee Optional Accidental Death and Dismemberment Benefit is insured under Your benefit provider's Policy 100013109.

If you sustain an accidental injury while insured and suffer a loss specified in the Schedule of Losses below, this benefit provides financial assistance to you or your beneficiary. In the event of your death, the benefit is payable to your beneficiary. If your beneficiary dies before you or if there is no designated beneficiary, this benefit is payable to your estate. For losses other than Loss of Life, the benefit is payable to you.

The Benefit

Employee Optional AD& D - The Benefit

Aggregate Limit - $1,000,000

Benefit Amount - increments of $25,000 to a maximum of $250,000

Qualifying Period for Waiver of Premium - 119 days

Termination Age - age 70 or retirement, whichever is earlier

Waiting Period

none for employees hired on or prior to the Group Policy Effective Date
none for all other employees

Schedule of Losses

Employee Optional AD& D - Schedule of Losses

A loss shown in this schedule is covered provided it:

- is a direct result of the accidental injury
- occurs within 365 days from the date of the accidental injury
- is total and irreversible or irrecoverable

In the case of loss of speech or hearing, or loss of use of an arm, hand or leg, the loss must be continuous for 12 months and determined to be permanent, after which time the benefit is payable.

The amount payable for each loss is a percentage of your Employee Optional Accidental Death and Dismemberment benefit amount which was in effect as of the date of the injury.

- Loss of Life - 100%
- Loss of or Loss of Use of Both Hands or Both Feet - 100%
- Loss of Sight of Both Eyes - 100%
- Loss of One Hand and One Foot - 100%
- Loss of One Hand and Sight of One Eye - 100%
- Loss of One Foot and Sight of One Eye - 100%
- Loss of Hearing in Both Ears and Speech - 100%
- Loss of or Loss of Use of One Arm or One Leg - 75%
- Loss of or Loss of Use of One Hand or One Foot - 66 2/3%
- Loss of Sight of One Eye - 66 2/3%
- Loss of Speech or Hearing in Both Ears - 66 2/3%
- Loss of Thumb and Index Finger or at least Four Fingers of One Hand - 33 1/3%
- Loss of All Toes of One Foot - 25%
- Loss of Hearing in One Ear - 25%
- Hemiplegia, Paraplegia or Quadriplegia - 200%

Only one percentage, the largest, will be paid for multiple losses to the same limb due to any one accident.

No more than 100% will be paid for all losses due to any one accidental Injury, except in the case of hemiplegia, paraplegia or quadriplegia, where the total amount paid will not exceed 200% (provided the benefit is paid while you are living).

Exposure and Disappearance

Employee Optional AD& D - Exposure and Disappearance

If a loss occurs due to unavoidable exposure to the elements, after a conveyance in which you were travelling made a forced landing, or was lost, wrecked, stranded or sank, a benefit will be payable for that loss. The amount payable will be determined in accordance with the Schedule of Losses.

If you disappear after a conveyance in which you were travelling made a forced landing, or was lost, wrecked, stranded or sank, a benefit for loss of life will be payable if your body is not found within 365 days after the incident occurred.

Rehabilitation Expenses

Employee Optional AD& D - Rehabilitation Expenses

If, as a direct result of an accidental injury, you suffer a loss specified in the Schedule of Losses and require participation in a formal rehabilitation program in order to return to gainful employment, Your benefit provider will pay incurred expenses, provided the expenses are:

- reasonable and necessary, as determined by Your benefit provider
- incurred within a period of 3 years from the date of the accidental injury

The amount payable is subject to a maximum of $10,000.

No amount will be paid for room and board expenses, or other living, travelling or clothing expenses.

Repatriation Expenses

Employee Optional AD& D - Repatriation Expenses

If you die as a direct result of an accidental injury which occurs while travelling 150 kilometers or more from your place of residence, Your benefit provider will pay for expenses incurred for the preparation and transportation of your body to your place of residence.

The amount payable is subject to a maximum of $10,000.

Dependent Education Expenses

Employee Optional AD& D - Dependent Education Expenses

If you die as a direct result of an accidental injury, Your benefit provider will pay the tuition for each child who is enrolled as a full-time student:

- in a school for higher learning above the secondary school level, or
- at the secondary school level, but who enrolls as a full-time student in a school for higher learning within 365 days after your death

A school for higher learning means any accredited university, private college, collèges d'enseignement général et professionel (CEGEP), community college or trade school.

The maximum payable each year for each child is the lesser of:

- 5% of your Employee Optional Accidental Death and Dismemberment benefit amount, or
- $5,000

The benefit is payable for up to a maximum of 4 years.

No payment will be made for:

- tuition expenses incurred prior to your death
- room and board expenses, or other living, travelling or clothing expenses

Spousal Occupational Training Expenses

Employee Optional AD& D - Spousal Occupational Training Expenses

If you die as a direct result of an accidental injury and your spouse must participate in a formal occupational training program to become qualified for employment for which he or she would not otherwise have sufficient qualifications, Your benefit provider will pay for expenses incurred by your spouse, provided the expenses are:

- reasonable and necessary, as determined by Your benefit provider
- incurred within a period of 3 years from the date of the accidental injury

The amount payable is subject to a maximum of $10,000.

No amount will be paid for room and board expenses, or other living, travelling or clothing expenses.

Home Alteration and Vehicle Modification Expenses

Employee Optional AD& D - Home Alteration and Vehicle Modification Expenses

If, as a direct result of an accidental injury, you:

- suffer a loss of, or loss of use of, both feet or both legs, or
- become a hemiplegic, paraplegic, or quadriplegic

and require the use of a wheelchair to be ambulatory, Your benefit provider will pay for incurred expenses, provided the expenses are:

- reasonable and necessary, as determined by Your benefit provider
- incurred within 3 years from the date of the accidental injury

- for alterations to your home for the purpose of making it wheelchair accessible
- for modifications to one motor vehicle for the purpose of making it wheelchair accessible

The amount payable is subject to a maximum of $10,000.

Permanent and Total Disability

Employee Optional AD& D - Permanent and Total Disability

If, as a direct result of an accidental injury, you become permanently and totally disabled while insured for this benefit, Your benefit provider will pay a lump sum benefit, provided:

- you become permanently and totally disabled within 365 days after the date of the accidental injury
- you have been permanently and totally disabled for a continuous period of 12 months and remain so disabled at the end of this period

The amount of benefit payable is equal to your Employee Optional Accidental Death and Dismemberment benefit amount.

- Definition of Permanent and Total Disability

- Permanent and Total Disability

You are considered permanently and totally disabled if you are wholly and continuously disabled due to an accidental injury which is severe enough, in Your benefit provider's opinion, to permanently prevent you from working for remuneration or profit.

Non-Duplication of Expenses

Employee Optional AD& D - Non-Duplication of Expenses

Expenses which are eligible under this benefit and for which you are also eligible under any other benefit, policy, or plan providing similar coverage will be paid first under such other benefit, policy or plan. Any expenses not paid will then be considered under this benefit, subject to any stated maximum.

The total amount of payments from all coverages combined will not exceed 100% of the eligible expenses incurred.

Naming a Beneficiary

Employee Optional AD&D - Naming a Beneficiary

See Employee Life Insurance... Naming a Beneficiary.

Submitting a Claim

Employee Optional AD& D - Submitting a Claim

To submit an Employee Optional Accidental Death Claim, your beneficiary must complete a Life Claim form. To submit an Employee Optional Dismemberment Claim, you must complete an Accidental Dismemberment Claim form. Both forms are available from your Plan Administrator, and require a physician's statement.

A completed claim form must be submitted within 90 days from the date of loss.

Waiver of Premium

Employee Optional AD& D - Waiver of Premium

If, while the Group Policy is in force, your Employee Life Insurance premium is waived because you are totally disabled, the premium for this benefit will also be waived. (See Employee Life Insurance...Waiver of Premium). Waiver of Premium for this benefit ceases if the benefit terminates.

Exclusions

Employee Optional AD& D - Exclusions

No Employee Optional Accidental Death & Dismemberment benefits are payable if the loss results from:

- suicide or self-inflicted injuries
- war or insurrection, the hostile actions of any armed forces, or participation in a riot or civil commotion
- an infection (except pyogenic infections from an accidental cut or wound), illness or disease, or the medical treatment of any illness or disease, or bodily or mental infirmity
- riding in, boarding or leaving, or descending from, any aircraft as a pilot, operator or member of the crew
- riding in, boarding or leaving, or descending from, any aircraft which is owned, operated or leased by or on behalf of your employer
- committing or attempting to commit an assault or criminal offence
- injuries sustained while operating a motor vehicle while under the influence of any intoxicant, including alcohol

Dependent Optional Accidental Death and Dismemberment

Dependent Optional Accidental Death and Dismemberment

The Dependent Optional Accidental Death and Dismemberment Benefit is insured under Your benefit provider's Policy 100013109.

If one of your dependents sustains an accidental injury while insured and suffers a loss specified in the Schedule of Losses below, this benefit provides financial assistance.

The Benefit

Dependent Optional AD& D Insurance - The Benefit

Aggregate Limit - $1,000,000

Benefit Amount

- Spouse - 0.5 of the amount of the Employee's Optional Accidental Death and Dismemberment Benefit if there are no children; 0.4 of the amount of the Employee's Optional Accidental Death and Dismemberment Benefit if there are children.

- Child - 0.15 of the amount of the Employee's Optional Accidental Death and Dismemberment Benefit to a maximum benefit of $37,500 if there is no spouse; 0.1 of the amount of the Employee's Optional Accidental Death and Dismemberment Benefit if there is a spouse.

Qualifying Period for Waiver of Premium - 119 days

Termination Age - employee's age 70 or retirement, whichever is earlier

Waiting Period

none for employees hired on or prior to the Group Policy Effective Date
none for all other employees

Schedule of Losses

Dependent Optional AD& D - Schedule of Losses

A loss shown in this schedule is covered provided it:

- is a direct result of the accidental injury
- occurs within 365 days from the date of the accidental injury
- is total and irreversible or irrecoverable

In the case of loss of speech or hearing, or loss of use of an arm, hand or leg, the loss must be continuous for 12 months and determined to be permanent, after which time the benefit is payable.

The amount payable for each loss is a percentage of your Dependent Optional Accidental Death and Dismemberment benefit amount which was in effect as of the date of the injury.

- Loss of Life - 100%
- Loss of or Loss of Use of Both Hands or Both Feet - 100%
- Loss of Sight of Both Eyes - 100%
- Loss of One Hand and One Foot - 100%

- Loss of One Hand and Sight of One Eye - 100%
- Loss of One Foot and Sight of One Eye - 100%
- Loss of Hearing in Both Ears and Speech - 100%
- Loss of or Loss of Use of One Arm or One Leg - 75%
- Loss of or Loss of Use of One Hand or One Foot - 66 2/3%
- Loss of Sight of One Eye - 66 2/3%
- Loss of Speech or Hearing in Both Ears - 66 2/3%
- Loss of Thumb and Index Finger or at least Four Fingers of One Hand - 33 1/3%
- Loss of All Toes of One Foot - 25%
- Loss of Hearing in One Ear - 25%
- Hemiplegia, Paraplegia or Quadriplegia - 200%

Only one percentage, the largest, will be paid for multiple losses to the same limb due to any one accident.

No more than 100% will be paid for all losses due to any one accidental Injury, except in the case of hemiplegia, paraplegia or quadriplegia, where the total amount paid will not exceed 200% (provided the benefit is paid while the insured person is living).

Exposure and Disappearance

Dependent Optional AD& D - Exposure and Disappearance

If a loss occurs due to unavoidable exposure to the elements, after a conveyance in which the insured person was travelling made a forced landing, or was lost, wrecked, stranded or sank, a benefit will be payable for that loss. The amount payable will be determined in accordance with the Schedule of Losses.

If the insured person disappears after a conveyance in which he was travelling made a forced landing, or was lost, wrecked, stranded or sank, a benefit for loss of life will be payable if the insured person's body is not found within 365 days after the incident occurred.

Repatriation Expenses

Dependent Optional AD& D - Repatriation Expenses

If the insured person dies as a direct result of an accidental injury which occurs while travelling 150 kilometers or more from his place of residence, Your benefit provider will pay for expenses incurred for the preparation and transportation of the insured person's body to his place of residence.

The amount payable is subject to a maximum of $10,000.

Home Alteration and Vehicle Modification Expenses

Dependent Optional AD& D - Home Alteration and Vehicle Modification Expenses

If, as a direct result of an accidental injury, the insured person:

- suffers a loss of, or loss of use of, both feet or both legs, or
- becomes a hemiplegic, paraplegic, or quadriplegic

and requires the use of a wheelchair to be ambulatory, Your benefit provider will pay for incurred expenses, provided the expenses are:

- reasonable and necessary, as determined by Your benefit provider
- incurred within 3 years from the date of the accidental injury
- for alterations to the insured person's home for the purpose of making it wheelchair accessible
- for modifications to one motor vehicle for the purpose of making it wheelchair accessible

The amount payable is subject to a maximum of $10,000.

Non-Duplication of Expenses

Dependent Optional AD& D - Non-Duplication of Expenses

Expenses which are eligible under this benefit and for which the insured person is also eligible under any other benefit, policy, or plan providing similar coverage will be paid first under such other benefit, policy or plan. Any expenses not paid will then be considered under this benefit, subject to any stated maximum.

The total amount of payments from all coverages combined will not exceed 100% of the eligible expenses incurred.

Submitting a Claim

Dependent Optional AD& D - Submitting a Claim

To submit a Dependent Optional Accidental Death Claim, a Life Claim form must be submitted. To submit a Dependent Optional Dismemberment Claim, you must complete an Accidental Dismemberment Claim form. Both forms are available from your Plan Administrator, and require a physician's statement.

A completed claim form must be submitted within 90 days from the date of loss.

Waiver of Premium

Dependent Optional AD& D - Waiver of Premium

If, while the Group Policy is in force, your Employee Life Insurance premium is waived because you are totally disabled, the premium for this benefit will also be waived. (See Employee Life Insurance...Waiver of Premium). Waiver of Premium for this benefit ceases if the Group Policy terminates.

Exclusions

No Dependent Optional Accidental Death & Dismemberment benefits are payable if the loss results from:

Dependent Optional AD& D - Exclusions

- suicide or self-inflicted injuries
- war or insurrection, the hostile actions of any armed forces, or participation in a riot or civil commotion
- an infection (except pyogenic infections from an accidental cut or wound), illness or disease, or the medical treatment of any illness or disease, or bodily or mental infirmity
- riding in, boarding or leaving, or descending from, any aircraft as a pilot, operator or member of the crew
- riding in, boarding or leaving, or descending from, any aircraft which is owned, operated or leased by or on behalf of your employer
- committing or attempting to commit an assault or criminal offence
- injuries sustained while operating a motor vehicle while under the influence of any intoxicant, including alcohol

Extended Health Care

Extended Health Care

The Extended Health Care Benefit is covered under Your benefit provider's Plan Document 25000.

Your Extended Health Care Benefit is provided directly by DynaLIFE Dx. Your benefit provider has been contracted to adjudicate and administer your claims for this benefit following the standard insurance rules and practices. Payment of any eligible claim will be based on the provisions and conditions outlined in this booklet and your employer's Benefit Plan.

If you or your dependents incur charges for any of the Covered Expenses specified, your Extended Health Care benefit can provide financial assistance.

Payment of Covered Expenses is subject to any maximum amounts shown below under The Benefit and in the expenses listed under Covered Expenses.

Claim amounts that will be applied to the maximum are the amounts paid after applying the Deductible, Benefit Percentage, and any other applicable provisions.

The Benefit

Extended Health Care - The Benefit

Overall Benefit Maximum - Unlimited

Deductible - Nil

Drug Deductible - $8.00 per prescription

Benefit Percentage (Co-insurance)

100% for
- Hospital Care
- Vision
- Drugs
- Professional Services
- Medical Services & Supplies

Note:

The Benefit Percentage for Out-of-Canada Emergency Medical Treatment is 100%.

The Benefit Percentage for Referral outside Canada for Medical Treatment Available in Canada is 50%.

The Benefit Percentage for Emergency Travel Assistance is 100%.

Termination Age - employee's age 71 or retirement, whichever is earlier

Waiting Period

none for employees hired on or prior to the Plan Document Effective Date
none for all other employees

Covered Expenses

Extended Health Care - Covered Expenses

The expenses specified are covered to the extent that they are reasonable and customary, as determined by Your benefit provider, provided they are:

- medically necessary for the treatment of an illness or injury and recommended by a physician
- incurred for the care of a person while covered under this Group Benefit Program
- reasonable taking all factors into account
- not covered under the Provincial Plan or any other government-sponsored program
- legally insurable
- used as prescribed or recommended by a physician
- associated with any drug, supply or service that was subject to the due diligence process, the process has been completed with the result that expenses for that drug, supply or service are eligible under the plan as of the date of approval as determined by the administrator and shared with your employer as required.

In the event that a Provincial Plan or government-sponsored program or plan or legally mandated program excludes, discontinues or reduces payment for any services, treatments or supplies formerly covered in full or in part by such plan or program, this Plan will not automatically assume coverage of the charges for such treatments, services or supplies, but will reserve the right to determine, at the time of change, whether the expenses will be considered eligible or not.

This plan will not automatically assume eligibility for all drugs, services and supplies. New drugs, existing drugs with new indications, services and supplies are reviewed by Your benefit provider using the due diligence process. Once this process has been completed, the decision will be made by Your benefit provider to include as a covered expense, include with prior authorization criteria, exclude or apply maximum limits.

Your benefit provider maintains a list of drugs, services and supplies that require prior authorization. Prior authorization is applied to ensure that the therapy prescribed is medically necessary. Where there are lower cost alternative treatments or prescribing guidelines recommend alternative drugs be tried first that are lower in cost, you or your eligible dependents will be required to have tried an alternative treatment unless medical contraindications to alternative treatments exist.

At Your benefit provider's discretion, medical information, test results or other documentation will be required from your physician to determine the eligibility of the drug, service or supply.

Your benefit provider has the right to ensure you or your dependents access Your benefit provider's exclusive distribution channels where applicable when purchasing a drug, service or supply. Your benefit provider may decline a drug, service or supply purchased from a provider outside the exclusive distribution channel.

Adherence

Adherence

Non-compliance may result in the drug, service or supply no longer being eligible for reimbursement.

Patient Assistance Programs

Patient Assistance Programs

Your benefit provider may require you or your dependents to apply to and participate in any patient assistance program to which you or your dependents are entitled. Your benefit provider reserves the right to reduce the amount of a covered expense by the amount of financial assistance you or your dependents are entitled to receive under a patient assistance program.

Disease Management Programs

Disease Management Programs

Participation in a disease management program may be required. Participation will be at the discretion of Your benefit provider.

Advance Supply Limitation

Extended Health Care - Advance Supply Limitation

Payment of any Covered Expenses under this benefit which may be purchased in large quantities will be limited to the purchase of up to a 3 months' supply at any one time.

- Drug Expenses

- Drug Expenses

The maximum quantity of drugs that will be payable for each prescription will be limited to the lesser of:

a) the quantity prescribed by your physician or dentist, or

b) a 34 day supply.

A quantity of up to a 100 day supply may be payable in long term therapy cases, where the larger quantity is recommended as appropriate by your physician and pharmacist.

Extended Health Care - Hospital Care

Hospital Care

- charges, in excess of the hospital's public ward charge, for semi-private accommodation, provided:

  - the person was confined to hospital on an in-patient basis, and

  - the accommodation was specifically elected in writing by the patient

- semi-private accommodation for confinement in a chronic care facility which starts within 14 days of discharge from a hospital confinement of at least 5 days, up to a maximum of $25 per day

- charges for any portion of the cost of ward accommodation, utilization or co-payment fees (or similar charges) are not covered

Extended Health Care - ManuScript Generic Drug Plan 2 - Prescription Drugs

ManuScript Generic Drug Plan 2 - Prescription Drugs

Charges incurred for the following expenses are payable when prescribed in writing by a physician or dentist and dispensed by a licensed pharmacist.

- drugs for the treatment of a sickness or injury, which by law or convention require the written prescription of a physician or dentist

- oral contraceptives, intrauterine devices and diaphragms

- injectable medications (charges made by a practitioner or physician to administer injectable medications are not covered)

- life-sustaining drugs

- preventive vaccines and medicines (oral or injected)

- standard syringes, needles and diagnostic aids, required for the treatment of diabetes (charges for cotton swabs, rubbing alcohol, automatic jet injectors and similar equipment are not covered)

Charges for the following expenses are not covered:

- drugs, biologicals and related preparations which are administered in hospital on an in-patient or out-patient basis
- drugs determined to be ineligible as a result of due diligence
- fertility drugs
- anti-smoking drugs
- anti-obesity drugs
- drugs used in the treatment of a sexual dysfunction

- Drug Maximums

- Drug Maximums

All covered drug expenses - Unlimited

- Payment of Covered Expenses

- Payment of Covered Expenses

Payment of your covered drug expenses will be subject to any Drug Deductible, any Drug Dispensing Fee Maximum, the Benefit Percentage for drugs and any maximum.

Covered expenses for any prescribed drug will not exceed the price of the lower cost alternative drug that can legally be used to fill the prescription, as listed in the Provincial Drug Benefit Formulary or a lower cost alternative that provides therapeutically similar results as identified by Your benefit provider.

Your benefit provider can limit the covered expense for any drug to that of a lower cost interchangeable drug at the time the drug is purchased.

If there is no lower cost alternative drug for the prescribed drug, the amount payable is based on the cost of the prescribed drug.

- No Substitution Prescriptions

- No Substitution Prescriptions

If your prescription contains a written direction from your physician or dentist that the prescribed drug is not to be substituted with another product and the drug is a covered expense under this benefit, the full cost of the prescribed product is covered.

When you have a “no substitution prescription”, please ask your pharmacist to indicate this information on your receipt, when you pay for the prescription. This will help to ensure that your expenses will be reimbursed appropriately when your claim is submitted to Your benefit provider for payment.

Payment of your covered drug expenses will be subject to any Drug Deductible, any Drug Dispensing Fee Maximum, the Benefit Percentage for drugs and any maximum.

Payment of Drug Claims

Your Pay Direct Drug Card provides your pharmacist with immediate confirmation of covered drug expenses. This means that when you present your Pay Direct Drug Card to your pharmacist at the time of purchase, you and your eligible dependents will not incur out-of-pocket expenses for the full cost of the prescription.

The Pay Direct Drug Card is honoured by participating pharmacists displaying the appropriate Pay Direct Drug decal.

To fill a prescription for covered drug expenses:

a) present your Pay Direct Drug Card to the pharmacist at the time of purchase, and

b) pay any amounts that are not covered under this benefit.

You will be required to pay the full cost of the prescription at time of purchase if:

- you cannot locate a participating Pay Direct Drug pharmacy
- you do not have your Pay Direct Drug Card with you at that time
- the prescription is not payable through the Pay Direct Drug Card system

For details on how to receive reimbursement after paying the full cost of the prescription, please see your Plan Administrator.

Vision Care

Extended Health Care - Vision Care

- eye exams, once per 12 months
- purchase and fitting of prescription glasses or elective contact lenses, as well as repairs, or elective laser vision correction procedures, to a maximum of $100 per 12 months for persons under age 18 and $250 per 24 months for persons age 18 and over

Professional Services

Extended Health Care - Professional Services

Services provided by the following licensed practitioners:

- Chiropractor - $500 per calendar year
- Osteopath - $500 per calendar year
- Podiatrist/Chiropodist - $500 per calendar year
- Massage Therapist - $500 per calendar year
- Naturopath - $500 per calendar year
- Speech Therapist - $500 per calendar year
- Physiotherapist - $500 per calendar year
- Acupuncturist - $500 per calendar year
- Psychologist - $500 per calendar year combined for services of a psychologist and social worker
- Social Worker - $500 per calendar year combined for services of a psychologist and social worker

Expenses for some of these Professional Services may be payable in part by Provincial Plans. Coverage for the balance of such expenses prior to reaching the Provincial Plan maximum may be prohibited by provincial legislation. In those provinces, expenses under this Benefit Program are payable after the Provincial Plan's maximum for the benefit year has been paid.

Medical Services and Supplies

Extended Health Care - Medical Services and Supplies

For all medical equipment and supplies covered under this provision, Covered Expenses will be limited to the cost of the device or item that adequately meets the patient's fundamental medical needs.

Private Duty Nursing

- Private Duty Nursing

Services which are deemed to be within the practice of nursing and which are provided in the patient's home by:

- a registered nurse, or
- a registered nursing assistant (or equivalent designation) who has completed an approved medications training program

Covered Expenses are subject to a maximum of $10,000 per calendar year.

Charges for the following services are not covered:

- service provided primarily for custodial care, homemaking duties, or supervision
- service performed by a nursing practitioner who is an immediate family member or who lives with the patient
- service performed while the patient is confined in a hospital, nursing home, or similar institution
- service which can be performed by a person of lesser qualification, a relative, friend, or a member of the patient's household

Pre-Determination of Benefits

Before the services begin, it is advisable that you submit a detailed treatment plan with cost estimates. You will then be advised of any benefit that will be provided.

Ambulance

- Ambulance

- licensed ambulance service provided in the patient's province of residence, including air ambulance, to transfer the patient to the nearest hospital where adequate treatment is available

- Medical Equipment

Medical Equipment

- rental or, when approved by Your benefit provider, purchase of:

  - Mobility Equipment: crutches, canes, walkers, and wheelchairs

  - Durable Medical Equipment: manual hospital beds, respiratory and oxygen equipment, and other durable equipment usually found only in hospitals

- Non-Dental Prostheses, Supports and Hearing Aids

Non-Dental Prostheses, Supports and Hearing Aids

- external prostheses
- surgical stockings, up to a maximum of 4 pairs per calendar year
- surgical brassieres, up to a maximum of 4 per calendar year
- braces (other than foot braces), trusses, collars, leg orthosis, casts and splints
- stock-item orthopaedic shoes and modifications or adjustments to stock-item orthopaedic shoes or regular footwear (recommendation of either a physician or a podiatrist is required) and custom-made shoes which are required because of a medical abnormality that, based on medical evidence, cannot be accommodated in a stock-item orthopaedic shoe or a modified stock-item orthopaedic shoe (must be constructed by a certified orthopaedic footwear specialist), up to a maximum of $300 per calendar year combined with custom-made orthotics
- casted, custom-made orthotics, up to a maximum of $300 per calendar year combined with stock-item orthopaedic shoes and custom-made shoes (recommendation of either a physician or a podiatrist is required)
- cost, installation, repair and maintenance of hearing aids, (including charges for batteries) to a maximum of $500 per 5 calendar years

- Other Supplies and Services

Other Supplies and Services

- ileostomy, colostomy and incontinence supplies
- medicated dressings and burn garments
- wigs and hairpieces for patients with temporary hair loss as a result of medical treatment, up to a maximum of $250 per lifetime
- oxygen
- microscopic and other similar diagnostic tests and services rendered in a licensed laboratory in the province of Quebec
- charges for the treatment of accidental injuries to natural teeth or jaw, provided the treatment is rendered within 12 months of the accident, excluding injuries due to biting or chewing

Out-of-Province/Out-of-Canada

- treatment required as a result of a medical emergency which occurs while temporarily outside the province of residence, provided the covered person who receives the treatment is also covered by the Provincial Plan during the absence from the province of residence, up to a maximum of $5,000,000 per lifetime.

  A Medical Emergency is

  - a sudden, unexpected injury or a new medical condition which occurs while a covered person (you or your dependent) is travelling outside of his province of residence, or

  - a specific medical problem or chronic condition that was diagnosed but medically stable prior to departure.

  Stable means that, in the 90 days before departure, the covered person (you or your dependent) has not:

  - been treated or tested for any new symptoms or conditions

  - had an increase or worsening of any existing symptoms

  - changed treatments or medications (other than normal adjustments for ongoing care)

  - been admitted to the hospital for treatment of the condition

  Coverage is not available if you (or your dependents) have scheduled non-routine appointments, tests or treatments for the condition or an undiagnosed condition.

  Coverage is also available for medical emergencies related to pregnancy as long as travel is completed at least 4 weeks before the due date.

  A medical emergency ends when the attending physician feels that, based on the medical evidence, a patient is stable enough to return to his home province or territory.

- referral outside Canada for treatment which is available in Canada to a maximum of $3,000 per 3 calendar year(s)

  If, while outside Canada on referral for medical treatment, the covered person requires treatment for a medical condition which is related directly or indirectly to the referral treatment, the total expenses payable for all treatment are subject to the maximum of $3,000 every 3 calendar year(s).

  For all non-emergency medical treatment out of Canada:

  – the treatment must be recommended by a physician practicing in Canada, and

  – it is advisable that you submit a detailed treatment plan with cost estimates before treatment begins. You will then be notified of any benefit that will be provided.

Charges for the following are payable under this expense:

- physician's services
- hospital room and board at standard ward rates. Charges in excess of ward rates are payable, if hospital coverage is provided under this Benefit Program.
- the cost of special hospital services
- hospital charges for out-patient treatment
- licensed ambulance services, including air ambulance, to transfer the patient to the nearest medical facility or hospital where adequate treatment is available
- medical evacuation for admission to a hospital or medical facility in the province where the patient normally resides

The amount payable for these expenses will be the reasonable and customary charges less the amount payable by the Provincial Plan.

Charges incurred outside the province of residence for all other Covered Extended Health Care Expenses are payable on the same basis as if they were incurred in the province of residence.

Emergency Travel Assistance

Extended Health Care - Emergency Travel Assistance

Emergency Travel Assistance provides travel assistance for you and your dependents while you are temporarily outside your province of residence. The assistance services are delivered through an international organization, specializing in travel assistance.

Assistance is provided for both Medical and Non-Medical travel emergencies. Services are available during the period that you are covered for Out-of-Province/Out-of-Canada emergency medical treatment, provided under this benefit.

In addition, Emergency Travel Assistance also provides you and your dependents with Health Advice and Assistance, whenever and wherever such services are needed - whether at home or while travelling.

Medical Emergency Assistance

A Medical Emergency is:

- a sudden, unexpected injury or a new medical condition which occurs while a covered person (you or your dependent) is travelling outside of his province of residence, or
- a specific medical problem or chronic condition that was diagnosed but medically stable prior to departure

Stable means that, in the 90 days before departure, the covered person (you or your dependent) has not:

- been treated or tested for any new symptoms or conditions
- had an increase or worsening of any existing symptoms
- changed treatments or medications (other than normal adjustments for ongoing care)
- been admitted to the hospital for treatment of the condition

Coverage is not available if you (or your dependents) have scheduled non-routine appointments, tests or treatments for the condition or an undiagnosed condition.

Coverage is also available for medical emergencies related to pregnancy as long as travel is completed at least 4 weeks before the due date.

A medical emergency ends when the attending physician feels that, based on the medical evidence, a patient is stable enough to return to his home province or territory.

a) **24-Hour Access**

Multilingual assistance is available 24 hours a day, seven days a week, through telephone (toll-free or call collect), telex or fax.

b) **Medical Referral**

Referral to the nearest physician, dentist, pharmacist or appropriate medical facility, and verification of coverage, is provided.

c) **Claims Payment Service**

If a hospital or other provider of medical services requires a deposit or payment in full for services rendered, and the expenses exceed $200 (Canadian), payment of such expenses will be arranged and claims coordinated on behalf of the covered person.

Payment and co-ordination of expenses will take into account the coverage that the covered person is eligible for under a Provincial Plan and this benefit. If such payments are subsequently determined to be in excess of the amount of benefits to which the covered person is entitled, the administrator shall have the right to recover the excess amount by assignment of Provincial Plan benefits and/or refund from you.

d) **Medical Care Monitoring**

Medical care and services rendered to the covered person will be monitored by medical staff who will maintain contact, as frequently as necessary, with the covered person, the attending physician, the covered person's personal physician and family.

e) **Medical Transportation**

If medically necessary, arrangements will be made to transfer a covered person to and from the nearest medical facility or to a medical facility in the covered person's province of residence. Expenses incurred for the medical transportation will be paid, as described under Medical Services and Supplies - Out-of-Province or Out-of-Canada.

If medically necessary for a qualified medical attendant to accompany the covered person, expenses incurred for round-trip transportation will be paid.

f) **Return of Dependent Children**

If dependent children are left unattended due to the hospitalization of a covered person, arrangements will be made to return the children to their home. The extra costs over and above any allowance available under pre-paid travel arrangements will be paid.

If necessary for a qualified escort to accompany the dependent children, expenses incurred for round-trip transportation will be paid.

g) **Trip Interruption/Delay**

If a trip is interrupted or delayed due to an illness or injury of a covered person, one-way economy transportation will be arranged to enable each covered person and a Travelling Companion (if applicable) to rejoin the trip or return home. Expenses incurred, over and above any allowance available under pre-paid travel arrangements will be paid.

A Travelling Companion is any one person travelling with the covered person, and whose fare for transportation and accommodation was pre-paid at the same time as the covered person's fare.

If the covered person chooses to rejoin the trip, further expenses incurred which are related directly or indirectly to the same illness or injury, will not be paid.

If a covered person must return home due to the hospitalization or death of an immediate family member, one-way economy transportation will be arranged and expenses incurred, over and above any allowance available under pre-paid travel arrangements, will be paid.

h) **After Hospital Convalescence**

If a covered person is unable to travel due to medical reasons following discharge from a hospital, expenses incurred for meals and accommodation after the originally scheduled departure date will be paid, subject to the maximum shown in part l) of this provision.

i) **Visit of Family Member**

Expenses incurred for round-trip economy transportation will be paid for an immediate family member to visit a covered person who, while travelling alone, becomes hospitalized and is expected to be hospitalized for longer than 7 days. The visit must be approved in advance by the administrator.

j) **Vehicle Return**

If a covered person is unable to operate his owned or rented vehicle due to illness, injury or death, expenses incurred for a commercial agency to return the vehicle to the covered person's home or nearest appropriate rental agency will be paid, up to a maximum of $1,000 (Canadian).

k) **Identification of Deceased**

If a covered person dies while travelling alone, expenses incurred for round-trip economy transportation will be paid for an immediate family member to travel, if necessary, to identify the deceased prior to release of the body.

l) **Meals and Accommodation**

Under the circumstances described in parts f),g),h),i), and k) of this provision, expenses incurred for meals and accommodation will be paid, subject to a combined maximum of $2,000 (Canadian) per medical emergency.

Non-Medical Assistance

a) **Return of Deceased to Province of Residence**

In the event of the death of a covered person, the necessary authorizations will be obtained and arrangements made for the return of the deceased to his province of residence. Expenses incurred for the preparation and transportation of the body will be paid, up to a maximum of $5,000 (Canadian). Expenses related to the burial, such as a casket or an urn, will not be paid.

b) **Lost Document and Ticket Replacement**

Assistance in contacting the local authorities is provided, to help a covered person in replacing lost or stolen passports, visas, tickets or other travel documents.

c) **Legal Referral**

Referral to a local legal advisor, and if necessary, arrangement for cash advances from the covered person's credit cards, family or friends, is provided.

d) **Interpretation Service**

Telephone interpretation service in most major languages is provided.

e) **Message Service**

Telephone message service is provided for messages to or from family, friends or business associates. Messages will be held for up to 15 days.

f) **Pre-trip Assistance Service**

Up-to-date information is provided on passport and visa, vaccination and inoculation requirements for the country where the covered person plans to travel.

Health Advice and Assistance

The following services are available for a covered person when required as a result of an illness or injury:

a) **After Hours Access to a Registered Nurse**

Toll free telephone access to a registered nurse is available seven days a week, during the hours that a family physician is not readily accessible.

b) **Medical Advice**

Medical advice will be provided on:

i) whether the illness or injury can be safely treated at home or will require a visit to a physician or hospital emergency room;

ii) the type of side effect to expect from a prescribed drug; and

iii) other health related services that may be requested or required by the covered person.

c) **Link to 911**

If necessary, a covered person will be immediately linked to their local 911 emergency service for medical assistance.

d) **Follow-Up Call**

Where appropriate, to monitor the care of the covered person, the registered nurse will follow-up with the covered person within 24 hours after the medical advice is provided.

Exceptions

The administrator, and the company contracted by the administrator to provide the travel assistance services described in this benefit, will not be responsible for the availability, quality, or results of any medical treatment, or the failure of a covered person to obtain medical treatment or emergency assistance services for any reason.

Emergency assistance services may not be available in all countries due to conditions such as war, political unrest or other circumstances which interfere with or prevent the provision of any services.

How to Access Emergency Travel Assistance - Your Emergency Travel Assistance Card

Your Emergency Travel Assistance card lists the toll free numbers to call in case of an emergency, while travelling outside your province. The toll free number will put you in touch with the international travel assistance organization.

Your Emergency Travel Assistance card also lists your I.D. number and plan document number, which the travel assistance organization needs to confirm that you are covered by Emergency Travel Assistance.

If you do not have an Emergency Travel Assistance Card, please contact your employer.

Submitting a Claim

Extended Health Care - Submitting a Claim

To submit an Extended Health Care claim, you must complete an Extended Health Care Claim form, except when claiming for physician or hospital expenses incurred outside your province of residence. For these expenses, you must complete an Out-of-Province/Out-of-Canada claim form. Claim forms are available from your employer.

All applicable receipts must be attached to the completed claim form when submitting it to Your benefit provider.

All claims must be submitted within 12 months after the date the expense was incurred.

Claims for Out-of-Canada expenses must first be submitted to the Provincial Plan for payment. Any outstanding balance should be submitted to Your benefit provider, along with the explanation of payment from the Provincial Plan.

Subrogation (Third Party Liability)

Subrogation (Third Party Liability)

If your medical expenses result from an injury caused by another person and you have the legal right to recover damages, Your benefit provider may request that you complete a subrogation reimbursement agreement when you submit a claim for such expenses.

On settlement or judgement of your legal action, you will be required to reimburse Your benefit provider those amounts you recover which, when added to the payments you received from Your benefit provider, exceed 100% of your incurred expenses.

Exclusions

Extended Health Care - Exclusions

No Extended Health Care benefits are payable for expenses related to:

- for Out-of-Province/Out-of-Canada and Emergency Travel Assistance only, self-inflicted injuries, either directly or indirectly, unless medical evidence establishes that the injuries are related to a mental health illness
- war, insurrection, the hostile actions of any armed forces or participation in a riot or civil commotion
- committing or attempting to commit an assault or criminal offence
- injuries sustained while operating a motor vehicle while under the influence of any intoxicant, including alcohol
- an illness or injury for which benefits are payable under any government plan or workers' compensation
- charges for periodic check-ups, broken appointments, third party examinations, travel for health purposes, or completion of claim forms
- services or supplies provided by an employer's medical or dental department
- services or supplies for which no charge would normally be made in the absence of coverage

- services and supplies where reimbursement would have been made under a government-sponsored plan, in the absence of coverage
- services or supplies which are not permitted by law to be paid
- services or supplies which are required for recreation or sports
- services or supplies which would have been payable by the Provincial Plan if proper application had been made
- medical treatment which is not usual or customary, or is experimental or investigational in nature
- medical or surgical care which is cosmetic
- services or supplies which are performed or provided by the covered person, an immediate family member or a person who lives with the covered person
- services or supplies which are provided while confined in a hospital on an in-patient basis
- services or supplies which are not specified as a covered expense under this benefit

Dental Care

Dental Care

The Dental Care Benefit is covered under Your benefit provider's Plan Document 25000.

Your Dental Care Benefit is provided directly by DynaLIFE Dx. Your benefit provider has been contracted to adjudicate and administer your claims for this benefit following the standard insurance rules and practices. Payment of any eligible claim will be based on the provisions and conditions outlined in this booklet and your employer's Benefit Plan.

If you or your dependents require any of the dental services specified under Covered Expenses, your Dental Care benefit can provide financial assistance.

Payment of Covered Expenses is subject to any maximum amounts shown below under The Benefit and in the expenses listed under Covered Expenses.

Claim amounts that will be applied to the maximum are the amounts paid after applying the Deductible, Benefit Percentage, and any other applicable provisions.

The Benefit

Dental Care - The Benefit

Deductible - Nil

Dental Fee Guide - Current Fee Guide for General Practitioners and Specialists for your Province of Residence

Benefit Percentage (Co-insurance)

- 80% for Level I - Basic Services

- 80% for Level II - Supplementary Basic Services

- 50% for Level III - Dentures

- 50% for Level IV - Major Restorative Services

- 50% for Level V - Orthodontics

Benefit Maximums

- $2,000 per calendar year combined for Level I, Level II, Level III and Level IV

- $2,500 per lifetime for Level V

Termination Age - employee's age 71 or retirement, whichever is earlier

Waiting Period

none for employees hired on or prior to the Plan Document Effective Date
none for all other employees

Covered Expenses

Dental Care - Covered Expenses

The following expenses are covered if they:

- are incurred for the necessary dental care of a covered person while covered under this benefit
- are incurred for services provided by a dentist, a dental hygienist working within the scope of his license, or a denturist working within the scope of his license
- are reasonable as determined by Your benefit provider, taking all factors into account
- do not exceed the fees recommended in the Dental Fee Guide, or reasonable and customary charges as determined by Your benefit provider, if the expenses are not listed in the Dental Fee Guide

Alternate Treatment

Dental Care - Alternate Treatment

Where any two or more courses of treatment covered under this benefit would produce professionally adequate results for a given condition, your employer will pay benefits as if the least expensive course of treatment were used. Your administrator will determine the adequacy of the various courses of treatment available, through a professional dental consultant.

Your Group Benefits

Level I - Basic Services

Dental Care - Level I - Basic Services

- complete oral exam, one per 2 calendar years
- full-mouth x-rays, one per 2 calendar years
- one unit of light scaling and one unit of polishing once every 9 months, when the service is performed outside Quebec, or prophylaxis (polishing) once every 9 months, when the service is performed in Quebec
- recall exams, bitewing x-rays, and fluoride treatments, once every 9 months
- routine diagnostic and laboratory procedures
- initial oral hygiene instruction, plus one recall
- fillings, retentive pins and pit and fissure sealants. Replacement fillings are covered provided:
  - the existing filling is at least 12 months old and must be replaced either due to significant breakdown of the existing filling or recurrent decay, or
  - the existing filling is amalgam and there is medical evidence indicating that the patient is allergic to amalgam
- prefabricated full coverage restorations (metal and plastic)
- space maintainers (appliances placed for orthodontic purposes are not covered)
- minor surgical procedures and post-surgical care
- extractions (including impacted and residual roots)
- consultations, anesthesia, and conscious sedation
- denture repairs, relines and rebases, only if the expense is incurred later than 3 months after the date of the initial placement of the denture
- injection of antibiotic drugs when administered by a Dentist in conjunction with dental surgery

Level II - Supplementary Basic Services

Dental Care - Level II - Supplementary Basic Services

- surgical procedures not included in Level I (excluding implant surgery)
- periodontal services for treatment of diseases of the gums and other supporting tissue of the teeth, including:

  - scaling not covered under Level I, and root planing, up to a combined maximum of 8 units per calendar year

  - provisional splinting

  - occlusal equilibration, up to a maximum of 4 units per calendar year

- endodontic services which include root canals and therapy, root amputation, apexifications and periapical services
  - root canals and therapy are limited to one initial treatment plus one re-treatment per tooth per lifetime
  - re-treatment is covered only if the expense is incurred more than 12 months after the initial treatment

Level III - Dentures

Dental Care - Level III - Dentures

- initial provision of full or partial removable dentures
- replacement of removable dentures, provided the dentures are required because:

  - a natural tooth is extracted and the existing appliance cannot be made serviceable

  - the existing appliance is at least 60 months old and cannot be made serviceable, or

  - the existing appliance is temporary and is replaced with the permanent dentures within 12 months of its installation

- expenses for dentures required solely to replace a natural tooth which was missing prior to becoming covered for this expense are not payable

Level IV - Major Restorative Services

Dental Care - Level IV - Major Restorative Services

- crowns and onlays when the function of a tooth is impaired due to cuspal or incisal angle damage caused by trauma or decay

- inlays, covering at least 3 surfaces, provided the tooth cusp is missing
- initial provision of fixed bridgework
- replacement of bridgework, provided the new bridgework is required because:

  - a natural tooth is extracted and the existing appliance cannot be made serviceable

  - the existing appliance is at least 60 months old and cannot be made serviceable, or

  - the existing appliance is temporary and is replaced with the permanent bridge within 12 months of its installation

- expenses for bridgework required solely to replace a natural tooth which was missing prior to becoming covered for this expense are not payable

Level V - Orthodontics

Dental Care - Level V - Orthodontics

- orthodontic services for dependent children under 19 only, provided treatment commences between the ages of 6 and 18

Pre-Determination of Benefits

Dental Care - Pre-Determination of Benefits

If the cost of any proposed dental treatment is expected to exceed $500, it is suggested that you submit a detailed treatment plan, available from your dentist, before the treatment begins. You can then be advised of the amount you are entitled to receive under this benefit.

Work in Progress When Coverage Terminates

Dental Care - Work in Progress When Coverage Terminates

Covered expenses related to dental treatment that was in progress at the time your dental benefits terminate (for reasons other than termination of the Plan Document or the Dental Care Benefit) are payable, provided the expense is incurred within 31 days after your benefit terminates.

Submitting a Claim

Dental Care - Submitting a Claim

To submit a claim, you and your dentist must complete a Dental Claim form available from your employer.

All claims must be submitted within 12 months after the date the expense was incurred.

Subrogation (Third Party Liability)

Subrogation (Third Party Liability)

If your dental expenses result from an injury caused by another person and you have the legal right to recover damages, your employer may request that you complete a subrogation reimbursement agreement when you submit a claim for such expenses.

On settlement or judgement of your legal action, you will be required to reimburse your employer those amounts you recover which, when added to the payments you received from your employer, exceed 100% of your incurred expenses.

Exclusions

Dental Care - Exclusions

No Dental Care benefits will be payable for expenses resulting from:

- war, insurrection, the hostile actions of any armed forces or participation in a riot or civil commotion
- committing or attempting to commit an assault or criminal offence
- injuries sustained while operating a motor vehicle while under the influence of any intoxicant, including alcohol

- dental care which is cosmetic, unless required because of an accidental injury which occurred while the patient was covered under this benefit
- anti-snoring or sleep apnea devices
- broken dental appointments, third party examinations, travel to and from appointments, or completion of claim forms
- services which are payable by any government plan
- services or supplies provided by an employer's medical or dental department
- services or supplies for which no charge would normally be made in the absence of coverage
- treatment rendered for a full mouth reconstruction, for a vertical dimension or for a correction of temporomandibular joint dysfunction
- replacement of removable dental appliances which have been lost, mislaid or stolen
- laboratory fees which exceed reasonable and customary charges
- services or supplies which are performed or provided by the covered person, an immediate family member or a person who lives with the covered person
- implants, or any services rendered in conjunction with implants
- treatment which is not generally recognized by the dental profession as an effective, appropriate and essential form of treatment for the dental condition
- services or supplies which are not specified as a covered expense under this benefit

Health Care Spending Account

Health Care Spending Account

Your benefit program includes a health care spending account, which provides you and your dependents with financial assistance for medical and dental expenses. Please refer to your **Health Care Spending Account - Plan Member Guide** for complete details on this benefit.

Your Health Care Spending Account (HCSA) plan number is **25000**.
Be sure to use your HCSA number on all HCSA claims.

Survivor Extended Benefit

Survivor Extended Benefit

If you die while your dependents are covered under this Group Benefit Program, Your benefit provider will continue the Dependent Life, Extended Health Care and Dental Care benefits without payment of premium, until the earliest of:

- the date your dependent is no longer a dependent, according to the definition of dependent (see Explanation of Commonly Used Terms)
- the date similar coverage is obtained elsewhere
- the date which is 24 months from your death, or
- the date the Plan Document terminates

Taxable Spending Account

Taxable Spending Account

Your plan includes a Taxable Spending Account.

Your Taxable Spending Account (TSA) plan number is **25000**.
Be sure to use your TSA number on all TSA claims.

You and your dependents can use the money in this account to cover the remaining portion of, or even the full cost of a treatment or service that your plan does not include as part of the base coverage.

Taxable Spending Account money may also be used to subsidize personal/lifestyle choices or requirements (such as Childcare or Fitness Club Memberships), but only if your plan sponsor has pre-defined these uses. You should check with your plan sponsor for a complete list of eligible expenditures for your Taxable Spending Account.

Any amounts paid from your Taxable Spending Account will be reflected on your T4 as taxable income.

Long Term Disability

Long Term Disability

The Long Term Disability Benefit is insured under Your benefit provider's Policy 17102.

If you become Totally Disabled while insured and meet the Entitlement Criteria for this benefit, Your benefit provider will pay a disability benefit.

Definition of Totally Disabled

Long Term Disability - Definition of Totally Disabled

Totally Disabled means a restriction or lack of ability due to an illness or injury which prevents you from performing the essential duties of:

- your own occupation, during the Qualifying Period and the 2 years immediately following the Qualifying Period
- any occupation for which you are qualified, or may reasonably become qualified, by training, education or experience, after the 2 years specified above

The availability of work will not be considered by Your benefit provider in assessing your disability.

If you must hold a government permit or license to perform the duties of your job, you will not be considered Totally Disabled solely because your permit or license has been withdrawn or not renewed.

The Benefit

Long Term Disability - The Benefit

Benefit Amount - 66.7 % of your first $4,500 of monthly earnings, plus 50 % of any excess amount, to a maximum of $10,000

Non-Evidence Limit - $10,000

Qualifying Period - 119 days

- Benefits are payable from the end of the Qualifying Period. Benefits are not payable for or during the Qualifying Period.
- You must be receiving regular, ongoing care and treatment from a physician during the Qualifying Period in order for benefits to be payable at the end of the Qualifying Period.

Maximum Benefit Period - to age 65

Termination Age - age 65 less the Qualifying Period, or retirement, whichever is earlier

Waiting Period

none for employees hired on or prior to the Group Policy Effective Date
none for all other employees

Entitlement Criteria

Long Term Disability - Entitlement Criteria

To be entitled to disability benefits, you must meet the following criteria:

- you must be continuously Totally Disabled throughout the Qualifying Period. If you cease to be Totally Disabled during this period and then become disabled again within 3 weeks due to the same or related illness or injury, your Qualifying Period will be extended by the number of days during which you ceased to be Totally Disabled.

- Your benefit provider must receive medical evidence documenting how your illness or injury causes restrictions or lack of ability, such that you are prevented from performing the essential duties of:

  - your own occupation, during the Qualifying Period and the following 2 years, and

  - any occupation for which you are qualified, or may reasonably become qualified by training, education or experience, after the 2 years specified above

- you must be receiving from a physician, regular, ongoing care and treatment appropriate for your disabling condition, as determined by Your benefit provider

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

Periods for Which You are Not Entitled to Benefits

You are not entitled to benefit payments for any period that you are:

Long Term Disability - Periods for Which You are Not Entitled to Benefits

- not receiving from a physician, regular, ongoing care and treatment appropriate for your disabling condition, as determined by Your benefit provider
- receiving Employment Insurance maternity or parental benefits
- on lay-off during which you become Totally Disabled
- on leave of absence during which you become Totally Disabled, unless your employer is required to pay benefits during this period as a result of legislation, regulation or case law
- receiving benefits under an employer-sponsored salary continuance or short term wage loss replacement plan
- working in any occupation, except as provided for under the Rehabilitation Assistance provision
- incarcerated in a prison, correctional facility, or mental institution by order of authority of a criminal court

Amount of Disability Benefit Payable

Long Term Disability - Amount of Disability Benefit Payable

The amount of disability benefit payable to you is the Benefit Amount shown above reduced by any disability benefits you receive or are entitled to receive from the following sources for the same or related disability:

- Workers' Compensation or similar coverage
- Canada or Quebec Pension Plans, excluding dependent benefits
- any government motor vehicle automobile insurance plan or policy, unless prohibited by law

If necessary, the amount of your benefit will be further reduced so that your total income from all sources does not exceed 85% of your pre-disability gross earnings (net earnings, if your benefit is non-taxable). All sources include those sources stated above and any benefit you are entitled to receive from:

- any group, association or franchise plan
- any retirement or pension plan
- earnings or payments from any employer, including severance payments and vacation pay
- self-employment
- any government plan, excluding Employment Insurance Benefits
- Canada or Quebec Pension Plans' dependent benefits

Once benefits become payable, the amount of your benefit will not be affected by any subsequent cost of living increase in benefits you are receiving from other sources.

Benefit Calculation Rules

Long Term Disability - Benefit Calculation Rules

Your benefit provider will apply the following rules in determining your disability benefit:

- benefits payable from other sources which began before the commencement of your current Disability will not be taken into account
- benefits payable from other sources will not be adjusted to take into account any difference between the tax status of those benefits and the benefit payable by Your benefit provider
- subsequent changes in benefits from other sources, other than cost of living increases, will be taken into consideration and a new benefit amount may be established
- benefits payable under individual disability income insurance will not be taken into account
- for benefits payable other than on a monthly basis, a monthly equivalent of such benefit will be estimated by Your benefit provider, and
- if you do not apply for a benefit for which you are eligible, the amount of such benefit will be estimated by Your benefit provider and assumed to be paid

Subrogation

Long Term Disability - Subrogation

If your disability is caused by another person and you have a legal right to recover damages, Your benefit provider will request that you complete a subrogation reimbursement agreement when you submit your Long Term Disability claim.

On settlement or judgement of your legal action, you will be required to reimburse Your benefit provider those amounts you recover which, when added to the disability benefits that Your benefit provider paid to you, exceed 100% of your lost income.

Tax Status of Benefits

Long Term Disability - Tax Status

The tax position of any payments you receive under this benefit depends on whether you or your employer pays the cost of the benefit.

If your employer pays a portion or all of the cost, then any disability benefit payments you receive will be taxable. If you pay the full cost of the benefit, then any disability benefit payments you receive will be non-taxable.

Payment of Disability Benefits

Long Term Disability - Payment of Disability Benefits

Disability benefit payments will be made monthly in arrears. Any payment for a period of less than one month will be made at a daily rate of one-thirtieth of your monthly benefit amount.

Rehabilitation Assistance

Long Term Disability - Rehabilitation Assistance

Once Your benefit provider determines that you are Totally Disabled, if appropriate, and at Your benefit provider's discretion, you may be offered rehabilitation to assist you in returning to gainful employment, either to your pre-disability occupation or to another occupation.

In considering whether Rehabilitation Assistance is appropriate for you, Your benefit provider will take into account:

- the nature, extent and expected duration of your disability
- your level of education, training or experience
- the nature, scope, objectives and cost of a Vocational Plan

- Vocational Plan

- Vocational Plan

A Vocational Plan is a training or job placement program that is expected to facilitate your return to gainful employment.

If it is determined that Rehabilitation Assistance is appropriate for you, in partnership with you and your employer, Your benefit provider will provide a structured Vocational Plan that will prepare you for a return to work, either:

- with your employer
- with an alternate employer
- in a self-employed capacity

- Disability Benefits During Rehabilitation

- Disability Benefits During Rehabilitation

You will continue to be entitled to disability benefits while participating in the Vocational Plan. If you receive any earnings as part of the plan, your disability benefit will be reduced once your total income (your disability benefit plus your earnings) exceeds 100% of your pre-disability gross earnings; net earnings if your benefit is not taxable.

If you cease to participate in the Vocational Plan because of a change in your medical status, Your benefit provider will require medical evidence documenting how your current medical status prevents you from continuing with the Vocational Plan.

If you are not available or do not co-operate or participate in the Vocational Plan, you will no longer be entitled to disability benefits.

Termination of Benefit Payments

Long Term Disability - Termination of Benefit Payments

Your disability benefit payments will cease on the earliest of:

- the date you cease to be Totally Disabled, as defined under this benefit
- the date you do not supply Your benefit provider with appropriate medical evidence documenting how your illness or injury causes restrictions or lack of ability such that you are prevented from performing the essential duties of:

  - your own occupation, during the Qualifying Period and the following 2 years, and

  - any occupation for which you are qualified, or may reasonably become qualified by training, education or experience, after the 2 years specified above
- the date you do not attend an examination by an examiner selected by Your benefit provider
- the date on which benefits have been paid up to the Maximum Benefit Period for this benefit
- the date of your death

Recurrent Disability

Long Term Disability - Recurrent Disability

If you become Totally Disabled again from the same or related causes within 6 months from the end of the period for which Long Term Disability benefits were paid, Your benefit provider will treat the disability as a continuation of your previous disability.

You will not be required to satisfy the Qualifying Period again. The benefit payable to you will be based on your earnings as at the date of your previous disability. Benefits for all such recurrent disabilities will not be paid for a combined period longer than the Maximum Benefit Period for this benefit.

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

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

Waiver of Premium

Long Term Disability - Waiver of Premium

The premium for your Long Term Disability benefit will be waived during any period you are entitled to receive Long Term Disability benefit payments.

Survivor Benefit

Long Term Disability - Survivor Benefit

If you die while disability benefits are payable, Your benefit provider will pay a benefit to your surviving dependents. If there are no surviving dependents, the benefit is payable to your estate.

The amount of the Survivor Benefit payable is 3 times your last monthly benefit payment, less the amount of any outstanding benefit overpayments.

Submitting a Claim

Long Term Disability - Submitting a Claim

To submit a claim, you must complete the Long Term Disability claim form which is available from your Plan Administrator. Your attending physician must also complete a portion of this form.

A completed claim form must be submitted to Your benefit provider within 180 days from the end of the Qualifying Period.

Exclusions

Long Term Disability - Exclusions

No benefits are payable for any disability related to:

- self-inflicted injuries, unless medical evidence establishes that the injuries are related to a mental health illness
- war, insurrection, the hostile actions of any armed forces or participation in a riot or civil commotion
- medical or surgical care which is not medically necessary
- the committing of or the attempt to commit an assault or criminal offence
- injuries sustained while operating a motor vehicle while under the influence of any intoxicant, including alcohol
- abuse of addictive substances, including drugs and alcohol, unless you are actively participating and co-operating in an in-patient medical treatment program for substance abuse which has been approved by Your benefit provider
- a Pre-Existing Condition which causes disability within the first 12 months of your Long Term Disability coverage. A Pre-Existing Condition is any injury or illness (whether diagnosed or not) for which you were treated or attended by a physician, or for which drugs were prescribed, within 90 days prior to the effective date of your coverage.

Notes

This page has been provided to allow you to make notes regarding your Group Benefit Program, or how to best access your Group Benefits.