



# **Benefits Booklet**

**Group Benefits Program**

Prepared for the employees of  
**FELLOWSHIP OF CHRISTIAN ASSEMBLIES**

Your Group Insurance Program has been arranged for you by:

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As a leading managing general agent in Canada, Victor Insurance Managers Inc. develops and administers insurance programs and distributes them through a nationwide network of independent plan advisors and brokers to individuals, professionals, organizations and employers.

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# Getting Started

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## Understanding Your Group Benefits Program

This information booklet has been prepared to give you an informal summary of the main features of your group benefits program. Please read this booklet carefully and keep it for future reference.

Along with this benefits booklet, you will be issued a personalized Certificate of Insurance, which will confirm the effective date of your coverage, your identification number, your specific benefit coverage and levels and, if applicable, your insured dependents.

As you may not be insured for all of the benefits referenced in the booklet, please consult your Certificate of Insurance.

## How to Register at [www.victorinsurance.ca/gbconnect](http://www.victorinsurance.ca/gbconnect)

Go to [www.victorinsurance.ca/gbconnect](http://www.victorinsurance.ca/gbconnect), click on the "Register here" button at the bottom of the screen, and follow the instructions to register.

## Victor Now App

**Victor Now** is a free app designed to make your life easier. It lets you view your health and dental care benefit information in real time. Show your benefits card, submit health care claims, find a provider in your area and more, right from your phone or mobile device!

Download the app from an App Store on your Apple or Android devices.



Note: You must be registered for the Group Benefits Plan Member Connect in order to access the **Victor Now** mobile app. Depending on your wireless plan, data charges may apply.

## Your Plan Administrator

Your Plan Administrator is the person within your organization who manages your company's group benefits program. This is the person you should contact if you need assistance with a benefit issue.

You will need to update your account at [www.victorinsurance.ca/gbconnect](http://www.victorinsurance.ca/gbconnect), or inform your Plan Administrator, if the following changes occur:

- Dependent or coverage changes. These changes must be communicated within 31 days of the occurrence and include marriage, divorce, birth or adoption of a child, death of a family member and the loss of a spouse's coverage.
- A change of home address. This address should be kept up-to-date for claims payment purposes.
- A change in email address. Important plan updates will be communicated via email.

# Schedule of Benefits

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## Benefits Providers

Your group benefits program, provided to you by your employer and administered by Victor Insurance Managers Inc., is underwritten by the following companies:

### Manulife

- Basic Life Insurance
- Dependent Life Insurance
- Optional Life and Spousal Optional Life Insurance
- Weekly Indemnity
- Long Term Disability

### Industrial Alliance Insurance and Financial Services Inc. ("iA Financial Group")

- Basic Accidental Death & Dismemberment
- Optional Accidental Death & Dismemberment
- Critical Illness Insurance

### Green Shield Canada ("GSC")

- Extended Health Care
- Emergency Travel Assistance
- Dental Care

## Plan Effective Date

Coverage for your employer's company first becomes effective on a specific day, known as the plan effective date. This is the earliest date you may join the plan. This plan was effective on February 1, 2017.

## Eligibility

You become eligible to join the plan on the later of the plan effective date or the first day of your employment following 3 month(s) of continuous service with your employer. You must also be a permanent, full-time or part-time employee working a minimum of 20 hours per week and a resident of Canada.

Retired employees are not eligible for coverage.

Please refer to the General Provisions section in the back of this booklet for further information, including:

- When your insurance starts.
- When your insurance terminates.

## Basic Life Insurance

You are eligible for \$25,000 of Basic Life Insurance.

Your benefit reduces by 50% at age 65 .

**Note:** If you have been declined for benefit coverage in the past, coverage can only be increased by providing evidence of insurability, satisfactory to the insurer.

Coverage terminates on the date you attain age 80 or retirement, whichever is earlier, and as outlined in the General Provisions section.

## Basic Accidental Death & Dismemberment

In the event of accidental death, you are covered for the same amount as determined under the Basic Life Insurance Schedule of Benefits. Evidence of insurability is not required. Coverage terminates on the date you attain age 80 or retirement, whichever is earlier.

## Dependent Life Insurance

Spouse	\$10,000
Each Child	\$5,000

A child is eligible for coverage from live birth.

Coverage terminates on the date you attain age 80 or retirement, whichever is earlier, and as outlined in the General Provisions section.

## Optional Life Insurance

If you are under age 65, you may apply for this coverage:

- for yourself;
- for your spouse, provided he/she is under age 65; or
- for both you and your spouse.

Coverage is available in units of \$10,000, subject to a maximum benefit of \$250,000.

Evidence of insurability, satisfactory to the insurer, shall be required for all amounts of Optional Life. This coverage is available in addition to, not in lieu of, Basic Life and/or Dependent Life Insurance.

Coverage terminates: on the date you attain age 65 or retirement, whichever is earlier; coverage for your spouse terminates on the date your spouse attains age 65; or as outlined in the General Provisions section.

## Optional Accidental Death & Dismemberment

Optional Accidental Death & Dismemberment benefits are available in units of \$25,000 up to a maximum of \$250,000.

This coverage is available in addition to Basic Accidental Death & Dismemberment.

Coverage terminates on the date you attain age 70 or retirement, whichever is earlier.

## Weekly Indemnity

This benefit is equal to 66.67% of weekly earnings up to \$1,000 per week.

Benefits begin on the first day of a disability due to an accident and on the eighth day of a disability due to sickness. Benefits begin on the first day you are hospitalized for sickness.

The maximum duration of benefits is 16 weeks of continuous disability following the date the benefit period commenced.

Note: This plan pays benefits during the post-natal recovery period of maternity leave.

Taxable Benefits Status:

As you pay the full premium cost of this benefit, any benefits you receive are not taxable.

Coverage terminates on the date you attain age 65 or retirement, whichever is earlier, and as outlined in the General Provisions section. If you attain age 65 while receiving benefits, benefits will continue to be paid until you have received a total of 15 weeks of benefits or until you are no longer disabled, whichever occurs first.

## Long Term Disability

This benefit is equal to 66.67% of monthly earnings. Your benefit amount is subject to the 85% All Source Maximum described under the All Source Maximum section in the Long Term Disability section later in this booklet.

The maximum benefit payable is \$5,000 per month.

The Elimination Period starts when you first become totally disabled and ends:

- a) after 16 week(s) of continuous disability; or
- b) at the end of the benefit period provided under the Weekly Indemnity benefit;

whichever is longer, provided you are under age 65. If the disability is not continuous, the days you are disabled will be accumulated to satisfy the Elimination Period provided:

- a) no interruption is longer than two weeks;
- b) the disabilities arise from the same or related disease or injury.

**Note:** If you have been declined for benefit coverage in the past, coverage can only be increased by providing evidence of insurability, satisfactory to the insurer.



**Taxable Benefits Status:**

As you pay the full premium cost of this benefit, any benefits you receive are not taxable.

Coverage terminates on the date you attain age 65, less the Elimination Period, or retirement, whichever is earlier, and as outlined under the General Provisions section.

**Critical Illness Insurance**

You are eligible for \$10,000 of Critical Illness Insurance.

Your coverage terminates on the earlier of the date you attain age 80 or you retire, and as outlined in the General Provisions section.

**Extended Health Care**

The following shows which expenses are considered eligible and the applicable coinsurance:

Hospital	100%	Semi-private
Drugs	80%	Generic - Pay Direct Drug Plan included
Vision Care	100%	
Supplementary Medical	80%	

The coinsurance percentage is the amount you will be reimbursed for eligible expenses in excess of the deductible. The deductible, which is shown below, is the portion of eligible expenses that you must pay before you receive benefits.

**Extended Health Care Deductible:**

- There is a \$5.00 per prescription deductible.

The paramedical practitioner maximums are listed in the Extended Health Care section of this booklet.

The vision care maximum is \$150 every 24 consecutive months for adults and \$150 every 12 consecutive months for dependent children 18 years of age and under.

The prescription drug maximum is \$3,500 per person per calendar year.

The lifetime maximum for your Extended Health Care benefit is unlimited.

You must be insured under the provincial health plan to be eligible for Extended Health Care benefits. You must be insured for Extended Health Care in order to be eligible for Emergency Travel Assistance, Employee Assistance Program, Maple Virtual Care, WorldCare Ally Service and WorldCare Medical Second Opinion Service benefits.

Coverage terminates on the date you attain age 80 or retirement, whichever is earlier, and as outlined under the General Provisions section.

## Emergency Travel Assistance

The GSC Emergency Travel Assistance has been made available to provide you with timely, efficient medical or travel assistance when you are out of province. If your provincial health insurance plan includes out-of-Canada benefits, the medical services are eligible only if that plan provides payment toward the cost of the incurred services.

Coinsurance	100%
Deductible	Nil
Lifetime Maximum	Unlimited

Coverage is limited to the first 60 days of travel. However, for students who are studying out of province or out of country, coverage is limited to 12 months of travel, beginning in September and ending in August of the following year.

The maximum benefit per individual is as follows:

Emergency Services:	\$5,000,000 per person per calendar year.
Out-of-province Referral Services:	\$50,000 per person per calendar year.

In the event of an emergency, you must contact GSC Travel Assistance within 48 hours of the commencement of treatment.

Coverage terminates on the date you attain age 80 or retirement, whichever is earlier, and as outlined in the General Provisions section.

## Dental Care

The following shows which expenses are considered eligible and the applicable coinsurance:

Basic Services	80%
Major Restorative Services	50%
Orthodontics	50%

The coinsurance percentage is the amount you will be reimbursed for eligible expenses in excess of the deductible. The deductible, which is shown below, is the portion of eligible expenses that you must pay before you receive benefits.

Dental Care Deductible:  
Nil

Fee Guide:

Benefits are paid in accordance with the current Fee Guide for General Practitioners in effect in the province where the service is rendered on the date the charge is incurred.

The standard oral examination frequency limit is six months.

The maximum benefit per individual is as follows:

Basic and Major Restorative Services combined \$1,500 per person per calendar year.  
Orthodontics \$2,500 lifetime maximum for dependent children 18 years of age and under only.

Coverage terminates on the date you attain age 80 or retirement, whichever is earlier, and as outlined in the General Provisions section.

### **Important Information About Your Benefits**

The information provided here is an overview of the coverage and services your plan sponsor has chosen to offer as part of your group benefits program and every effort has been made to describe the program accurately.

Where required by law, you or any claimant under the policy have the right to request a copy of any or all of the following items:

- 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 policy.

The insurance providers reserve the right to charge you for such documentation after your first request.

## Basic Life Insurance

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Basic Life Insurance coverage provides for a benefit to be paid at the time of your death if you are insured under this plan at the time. The amount of benefit is according to your classification as described in the Schedule of Benefits.

### **Beneficiary**

The benefit is paid to the beneficiary designated on your enrollment form. Your beneficiary may have the benefits paid as a lump sum or in a series of monthly instalments with the approval of the insurance company.

You may designate a new beneficiary at any time, subject to the laws governing such changes, by completing a form available from your employer. If you do not name a beneficiary, benefits will be paid to your estate.

### **Compassionate Assistance Benefit**

If you have been diagnosed with a terminal illness, you may request advance payment of a portion of your life insurance that would be payable upon your death. Your request must be approved. To be eligible, you must provide proof that your life expectancy is 24 months or less and your Waiver of Premium benefits must be approved.

The prepayment amount is equal to 50% of the amount of your life insurance to a maximum of \$50,000. The prepaid amount is subject to any reduction in coverage scheduled to come into effect during the 24-month period following the date of your request. Upon your death, the amount payable to your designated beneficiary will be reduced by the amount of the Compassionate Assistance Loan.

### **Conversion Privilege**

During the 31-day period following either the termination of your employment, or your classification changing to one in which you are not insured, you may convert the amount of your Basic Life Insurance, provided you are under 65 years of age or on the day you reach age 65, to any individual whole life or convertible one-year term or term to age 65 plan without submitting evidence of health. To exercise your conversion privilege, you must apply in writing to the insurer no later than 31 days after your insurance under this benefit ends.

The amount of the individual policy shall not exceed the total amount of Basic plus Optional Insurance for which you were insured when coverage was discontinued, subject to a maximum of \$200,000 less any amount you become eligible for under a replacing contract of group life insurance.

The premium rate will be determined from your age, gender and smoking status at the time of conversion.

The conversion privilege does not apply for loss of insurance as a result of your reaching age 65.

**Waiver of Premium**

If you are under age 65 and become totally disabled while insured, in accordance with the definition of total disability included in the LTD section, and are so disabled for at least six consecutive months, your insurance will continue in force without premium payment. Initial proof must be filed within 12 months of total disability and annually thereafter. The benefit terminates on the earliest of the date you:

- are no longer totally disabled;
- fail to provide satisfactory proof of your continuing disability;
- fail to be examined by a qualified physician as required by the insurance company; or
- attain age 65.

## Optional Life Insurance

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You may apply for additional term life insurance for yourself and/or for your spouse. Monthly premium rates are calculated according to the applicant's age, gender and smoking status. The Waiver of Premium and Conversion Privilege provisions described under Basic Life Insurance are also included under Optional Life Insurance.

Evidence of insurability satisfactory to the insurer is required for the full amount of chosen coverage.

No benefit will be paid for death resulting from self-destruction, whether sane or insane, within two years of your insurance becoming effective. Misstatement of non-smoker status shall mean the insurer will not pay any part of your Optional Life Insurance or your spouse's Optional Life Insurance, regardless of the cause of death.

To qualify as a non-smoker, you must submit evidence of insurability satisfactory to the insurer which supports total abstinence from smoking any tobacco product and cannabis for a one year period preceding the date of application for non-smoker status.

## Dependent Life Insurance

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Your spouse and dependent children are insured for the amounts shown in the Schedule of Benefits.

If a dependent, other than a newborn child, is confined to hospital or home on the date on which his or her Life Insurance would ordinarily commence, insurance on that dependent will not become effective until the dependent is no longer confined. Confinement at home shall mean that the dependent is unable to carry on any substantial part of the regular and customary duties or activities of a person in good health and of the same age and gender.

### **Beneficiary**

You will be the beneficiary for the insurance provided for your dependents, unless otherwise directed. The benefit will be paid to your estate if you do not survive your dependent.

### **Conversion Privilege**

During the 31-day period following your death, your classification changing to one in which you are not insured or your termination of employment, your spouse's and child's amount of Dependent Life Insurance may be converted, provided your spouse is under 65 years of age or on the day your spouse reaches age 65, to any individual whole life or convertible one-year term or term to age 65 plan without submitting evidence of health. The premium rate will be determined from your spouse's or child's age, gender and smoking status at the time of conversion.

The amount of the individual policy shall not exceed the amount of Basic plus Optional Insurance for which your spouse was insured when coverage was discontinued or the amount of Basic Insurance for which your child was insured when coverage was discontinued, subject to a maximum of \$200,000 less any amount your spouse or child becomes eligible for under a replacing contract of group life insurance.

The conversion privilege does not apply for loss of insurance if insurance terminates when you (or your spouse) reach the age(s) specified in the Schedule of Benefits section.

### **Waiver of Premium**

Waiver of Premium coverage shall be the same as for Basic Life Insurance except that waiver of premium benefit ceases on the earlier of: a) the date the Waiver of Premium for Basic Life Insurance ceases, or b) the date the policy or coverage terminates.

## Basic Accidental Death & Dismemberment

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You, your eligible spouse and dependent children are covered for any accident resulting in death or dismemberment anywhere in the world - 24 hours per day - on or off the job. Benefits are payable in addition to any other insurance you may have.

Your Principal Sum will be equal to the approved Basic Life Insurance benefit coverage. If you are not approved for the full amount of Basic Life Insurance, your coverage will be limited to an amount equal to the non-evidence Life Insurance maximum. Your spouse and dependent children will automatically become insured for an amount of insurance as follows:

- Spouse:** 50% of the employee's Principal Sum if there are dependent children, 60% if there are no dependent children.
- Children:** 15% of the employee's Principal Sum (subject to a maximum of \$50,000) if there is a spouse, 20% of the employee's Principal Sum (subject to a maximum of \$75,000) if there is no spouse.

### Specific Loss Accident Indemnity

When injury results in any of the following losses within three hundred and sixty-five (365) days after the date of the accident, the insurer will pay for:

Brain Death	100%
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#### Loss of:

Life	100%
Entire Sight of Both Eyes	100%
Speech and Hearing in Both Ears	100%
Entire Sight of One Eye	75%
Speech	75%
Hearing in Both Ears	75%
Hearing in One Ear	33-1/3%
All Toes of One Foot	25%

#### Loss or Loss of Use of:

Both Arms or Both Legs	200%
Both Hands or Both Feet	200%
One Hand and One Foot	100%
One Hand and the Entire Sight of One Eye	100%
One Foot and the Entire Sight of One Eye	100%
One Arm or One Leg	75%
One Hand or One Foot	75%
Thumb and Index Finger or at Least Four Fingers of One Hand	33-1/3%



**Paralysis:**

Quadriplegia (both upper and lower limbs)	200%
Paraplegia (both lower limbs)	200%
Hemiplegia (upper and lower limbs of one side of body)	200%

"Loss" whenever used with reference to hand or foot means complete severance at or above the wrist or ankle joint but below the elbow or knee joint; as used with reference to arm or leg means complete severance at or above the elbow or knee joint; as used with reference to thumb and fingers means complete severance at or above the metacarpophalangeal joint; as used with reference to toes means complete severance at or above the metatarsophalangeal joint; as used with reference to eye means the irrecoverable loss of the entire sight thereof; as used with reference to speech means the total and irrecoverable loss thereof; as used with reference to hearing means the total and irrecoverable loss thereof; and as used with reference to Quadriplegia, Paraplegia and Hemiplegia means the permanent and irrecoverable paralysis of such limbs.

*"Loss of Use" means a loss which is permanent, total, irrecoverable and continuous for a period of 12 months from the date of the accident.*

Indemnity provided under this section for all losses sustained by any one insured person as the result of any one accident will not exceed the following:

- with the exception of quadriplegia, paraplegia and hemiplegia, the Principal Sum.
- with respect to quadriplegia, paraplegia and hemiplegia, Two Times the Principal Sum, or the Principal Sum if loss of life occurs within 90 days after the date of the accident.

In no event will indemnity payable for all losses under this section exceed, in the aggregate, Two Times the Principal Sum as the result of the same accident.

In addition to the Specific Loss Schedule, AD&D includes the following benefits:

**Cosmetic Disfigurement Benefit**

If an insured suffers a third degree burn, a percentage of the Principal Sum, depending on the area of the body which was burned according to the following table, will be paid:

Body Part	Area Classification (A)	Maximum Allowable Percentage for Area Burned (B)	Maximum Percentage of Principal Sum Payable (C)
		%	%
Face, Neck, Head	10	10	100
Hand and Forearm	5	5	25
Either Upper Arm	3	5	15
Torso (front or back)	2	18	36
Either Thigh	1	10	10
Either Lower Leg (below knee)	3	9	27

The maximum percentage of Principal Sum Payable (C) is determined by multiplying the Area Classification (A) by the maximum allowable percentage for Area Burned (B). In the event of a 50% surface burn, the maximum allowable percentage for Area Burned (B) is reduced by 50%. This table only represents the maximum percentage of the Principal Sum Payable for any one accident. If the insured suffers burns in more than one area, as a result of any one accident, benefits will not exceed a maximum of \$25,000.

### **Seat Belt Benefit**

If an insured is driving or riding in a vehicle and wearing a properly fastened seat belt at the time of the accident, and such insured sustains a specific loss for which an amount of Principal Sum becomes payable under the program, the amount payable for such specific loss is increased by 10%.

The driver of the vehicle must hold a current and valid driver's license of a rating authorizing him to operate such vehicle and neither be intoxicated nor under the influence of drugs, unless such drugs are taken as prescribed by a physician at the time of the accident.

### **Hospital Indemnity**

If any specific loss covered under the program confines you, your insured spouse or your insured dependent child to a hospital and such person is under the regular care and attendance of a physician, you will receive a daily benefit of 1/30th of 1% of your Principal Sum from the 1st day of hospitalization to a maximum of \$2,500 per month and for a maximum duration of 365 days per accident. Hospitalization must begin while the insurance is in force for you or your dependents.

Hospitalization for treatment of any injury other than for a specific loss will also be covered in accordance with the above, if hospitalized for at least 4 days.

### **Family Transportation Benefit**

If any specific loss covered under the program confines an insured to a hospital under the regular care and attendance of a physician, and such hospital is located at least 150 kilometres from the insured's residence, this benefit will pay the reasonable expenses actually incurred by a member of the insured's immediate family for accommodation and transportation via the most direct route to the insured's bedside, to a maximum of \$15,000. Private transportation expenses are limited to \$0.35 per kilometre travelled.

Room, board or other ordinary living, travelling or clothing expenses are not covered.

### **Parental Care Benefit**

If you sustain accidental loss of life for which an amount of Principal Sum becomes payable under the program, 5% of your Principal Sum to a maximum of \$5,000 will be paid to an eligible dependent parent who, at the time of the accident, is a resident in a licensed nursing care facility, or enrolled in a home health care program, or living in your residence, or receiving support and care provided by you.

### **Psychological Therapy Benefit**

If injury results in a loss payable to an insured under the "Specific Loss Accident Indemnity" section and results in the insured requiring psychological therapy, as prescribed by a physician, reasonable and necessary expenses actually incurred will be paid, to a maximum of \$5,000.

### **Child Enhancement Benefit**

With the exception of loss of life, the percentages indicated under the "Specific Loss Accident Indemnity" section are quadrupled with respect to your insured dependent children but in no event will exceed the maximum amount stated.

This provision does not apply if loss of life occurs within 90 days after the date of the accident.

### **Education Benefit**

If you sustain accidental loss of life for which an amount of Principal Sum becomes payable under the program, up to 5% of your Principal Sum, to a maximum of \$10,000, will be paid for reasonable and necessary expenses actually incurred for each of your dependent children who are already enrolled in an institution of higher learning above the secondary school level or who will do so within 365 days after your death.

The benefit is payable annually, for each year up to four consecutive years that the child continues school on a full-time basis beyond the secondary school level.

Room, board or other ordinary living, travelling or clothing expenses are not covered.

If none of your insured dependent children satisfy the above requirements, an amount of \$2,500 will be paid to your beneficiary.

### **Daycare Benefit**

If you sustain accidental loss of life for which an amount of Principal Sum becomes payable under the program, up to 5% of your Principal Sum, to a maximum of \$5,000, will be paid for reasonable and necessary expenses actually incurred for each of your dependent children under 13 years of age who are enrolled in a legally licensed daycare centre or who will do so within 365 days after your death. This includes a child who is born within nine months of your date of loss, provided the child was conceived prior to the date of loss.

The benefit is payable annually, for each year up to four consecutive years that the child remains enrolled in a legally licensed daycare centre.

Room, board or other ordinary living, travelling or clothing expenses are not covered.

If none of your insured dependent children satisfy the above requirements, an amount of \$2,500 will be paid to your beneficiary.

### **Spousal Retraining Benefit**

If you sustain accidental loss of life for which an amount of Principal Sum becomes payable under the program, and your spouse engages in a formal occupational training program in order to become qualified for active employment in an occupation otherwise not qualified, this benefit will refund expenses incurred within 3 years following the date of your death, to a maximum of \$15,000.

Room, board or other ordinary living, travelling or clothing expenses are not covered.

### **Rehabilitation Benefit**

If you sustain a specific loss for which an amount of Principal Sum becomes payable under the program and such injury requires your participation in a rehabilitation program in order to be qualified in a different occupation, this benefit will refund expenses actually incurred during the 3 year period following the loss, to a maximum of \$15,000.

Room, board or other ordinary living, travelling or clothing expenses are not covered.

### **Workplace Modification and Accommodation Benefit**

If injury requires special adaptive equipment and/or workplace modification for you to return to active full-time employment, the cost of these modifications will be paid, to a maximum of \$5,000, provided the employer agrees in writing to provide such modification and accommodation to the workplace for the purpose of making it accessible and adaptable to your needs and acknowledges in writing that the performance of the essential duties of your occupation may be altered.

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

If injury requires the use of a wheelchair to be ambulatory, the cost of alterations to the insured's principal residence and/or the cost of modification to one motor vehicle utilized by the insured will be paid, subject to a maximum amount of the greater of \$15,000 or 10% of the insured's Principal Sum amount to a maximum of \$50,000, as the result of any one accident, provided such injury results in a loss payable under the "Specific Loss Accident Indemnity" section.

### **Air Bag Benefit**

If, due to a vehicular accident, injury results in a loss payable under the "Specific Loss Accident Indemnity" section, the insured's amount of Principal Sum will be increased by 5%, provided that:

- a) such loss occurs while the insured is a passenger or driver of a private passenger type vehicle equipped with either a single air bag, air bags for both the driver and the front passenger seats, or air bags for the driver, front passenger and rear passenger seats; and
- b) the seat belt is in actual use and properly fastened at the time of the accident, and due proof of seat belt use must be provided as part of the written proof of loss.

### **Assault Benefit**

If injury results in a loss payable under the "Specific Loss Accident Indemnity" section, an additional indemnity equal to 10% of the applicable indemnity payable under that section will be paid, subject to a maximum of \$25,000, if the injury is caused by an assault on premises owned or rented by the employer, or if the assault occurred while the insured was travelling on company business.

No benefit will be payable under this section if the assault was the act of another employee or a member of the immediate family of the insured or a member of the insured's household.

### **Carjacking Benefit (\$10,000)**

If injury sustained by the insured results in a loss payable under the "Specific Loss Accident Indemnity" section, the insured's amount of Principal Sum will be increased by 10%, if the injury occurs during a carjacking of an automobile that the insured was operating, getting into or out of, or riding as a passenger.

### **Comatose Benefit**

If an injury does not cause loss of life, but results in a coma or comatose state, 1% of the Principal Sum (less any sum paid under the "Specific Loss Accident Indemnity" section) for each month the coma or comatose state continues will be paid, subject to an overall maximum of \$50,000. Payments commence at the end of the waiting period and are subject to a maximum of 100 consecutive months.

### **Permanent Total Disability**

If an injury totally and permanently disables an insured, under age 65, within 12 months of the date of the accident, preventing the insured from engaging in any and every occupation, the Principal Sum less any amounts paid or payable under the "Specific Loss Accident Indemnity" section as the result of the same accident will be paid, provided such disability has continued for a period of 12 consecutive months and is total, continuous and permanent at the end of this period.

### **Public Transportation Benefit**

If an injury results in loss of life and indemnity becomes payable under the "Specific Loss Accident Indemnity" section, an additional amount equal to 100% of the Principal Sum will be paid if, at the time of the accident, the insured was riding as a passenger in a regularly scheduled public land, air or water conveyance licensed to carry fare-paying passengers, including a train, bus, taxi, subway, tramway, boat or commercial airplane.

### **Identification Benefit**

If injury results in loss of life, and requires body identification, the expenses actually incurred by a member of the immediate family for lodging, board and transportation by the most direct route will be paid, provided the body is located at least 150 kilometres from the member of the immediate family's residence and the identification of the body is required by the police or a similar law enforcement agency having authority over such matters, to a maximum of \$15,000.

If transportation occurs in a vehicle or device other than one operated under the license for the conveyance of passengers for hire, then reimbursement of transportation expenses will be limited to a maximum of \$0.35 per kilometre travelled.

### **Repatriation Benefit**

If an insured sustains accidental loss of life for which an amount of Principal Sum becomes payable under the program, repatriation benefits up to \$15,000 will be paid for the reasonable and necessary expenses actually incurred for the transportation of the body to the city of residence, including the preparation of the body for transportation.

### **Funeral Expense Benefit**

If an injury sustained by an insured results in loss of life, an additional amount is payable for funeral expenses actually incurred, to a maximum of \$5,000.

### **Bereavement Benefit**

If you sustain an injury that results in loss of life, reasonable and necessary expenses actually incurred by your spouse and dependent children for up to six (6) sessions of grief counselling, by a professional counsellor will be paid, to a maximum of \$1,000.

### **Common Disaster Benefit**

If you and your insured spouse both sustain accidental loss of life as a result of a common accident or two separate accidents occurring within the same 24-hour period, and such losses become payable under the program, your spouse's amount of coverage will be increased to the same level as yours, subject to an overall total for you and your spouse of \$1,000,000.

### **Limited Air Travel Coverage**

An insured is covered only while flying as a passenger in any aircraft holding a current and valid certificate of airworthiness (other than an aircraft owned, operated or leased by or on behalf of your employer) and operated by a person holding a current and valid pilot's license with a rating authorizing him to pilot such aircraft. Coverage also applies while flying as a passenger in a military aircraft.

### **Exposure and Disappearance**

Unavoidable exposure to the elements will be covered under the program as any other loss, provided such exposure is sustained as the result of a covered accident and the loss for which indemnity would be payable occurs within 1 year of the accident.

An insured will be presumed to have suffered accidental loss of life if the insured's body is not found within 1 year after the disappearance, sinking or wrecking of the conveyance in which the insured was riding at the time of the accident.

### **Waiver of Premium**

If, as the result of total disability, you are approved for Waiver of Premium and remain eligible for such under the terms of your employer's Basic Life Insurance contract, you need not pay any further premiums under this program for yourself, your insured spouse and your insured dependent children.

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

- the date the program terminates;
- the date you reach age 65; or
- the date you cease to be totally disabled.

The insurer reserves the right to request proof of disability from time to time as may be reasonably required. Failure to provide proof satisfactory to the insurer may result in termination of the waiver of premium benefit.

All terms and provisions of the program will apply during the period your premiums are waived, including provisions relating to reductions in amounts of insurance.

### **Extended Family Coverage**

In the event of your death due to an injury for which benefits are payable, the coverage will be continued for your spouse and your insured dependent children for a period of six months, provided payment of premium is continued.

### **Continuation of Coverage**

Coverage will be continued for you, your insured spouse and your insured dependent children during your approved leave of absence, temporary layoff, maternity or parental leave, provided payment of premium is continued. Coverage will be continued for any approved disability leave until you reach 65 years of age, qualify for Waiver of Premium benefits or return to work in any capacity, whichever is earlier.

All terms and provisions of the program will apply during the period coverage is continued including provisions relating to reductions in amounts of insurance.

## **Conversion Privilege**

Upon termination of your insurance and provided the program is still in effect, you may convert your own insurance (but not your insured spouse's or your insured dependent children), without evidence of insurability to an individual accident insurance policy. You may elect an amount equal to or lower than the amount of the Principal Sum in force at the time of termination.

You must apply within 31 days of the termination of your coverage.

## **Co-ordination of Benefits**

The total maximum payable in combination with the similar benefit maximum provided under any other policy issued to you will not exceed the actual expenses incurred or the maximum amount of benefit provided, whichever is less: Repatriation Benefit, Daycare Benefit, Family Transportation Benefit, Spousal Retraining Benefit, Rehabilitation Benefit, Education Benefit, Identification Benefit, Workplace Modification and Accommodation Benefit, and Home Alteration and Vehicle Modification Benefit.

## **Aggregate Limit**

\$2,500,000 is the maximum payable to all insureds involved in any one accident.

## **Exclusions**

- Suicide or any attempt thereat or intentionally self-inflicted injury while sane or insane.
- Declared or undeclared war or any act thereof.
- Active full-time service in the armed forces of any country.
- Flying as a pilot or crew member of any aircraft.
- Flying as a passenger or otherwise in any aircraft owned, operated or leased by your employer.
- Flying in any vehicle or device for aerial navigation except as provided in the Limited Air Travel Coverage section.

## **Beneficiary**

Benefits payable in the event of loss of life are payable to the beneficiary or beneficiaries designated in writing by you and on file with your Plan Administrator. If there is no such beneficiary designation, such indemnity shall be payable to your estate. All other benefits payable, including those payable to your spouse or dependent children, are payable to you with the exception of indemnities payable under the Family Transportation, Parental Care, Education, Daycare, Spousal Retraining, Workplace Modification and Accommodation, Identification, Repatriation, Funeral Expense and Bereavement benefits.

In the situation where the policy replaces an existing policy issued to the employer, the beneficiary designation recorded under the replaced policy will be deemed to be valid and of full force and effect until changed in writing by the insured.

Every action or proceeding against an insurer for the recovery of insurance money payable under the policy is absolutely barred unless commenced within the time set out in the Insurance Act or other applicable legislation.



## Optional Accidental Death & Dismemberment

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Optional AD&D allows you to purchase additional accident coverage for yourself as well as for your spouse and dependent children. You will be covered for any accident resulting in death or dismemberment anywhere in the world - 24 hours per day - on or off the job. Benefits are payable in addition to any other insurance you may have.

### Amount of Insurance

You may select any amount of coverage for yourself from a minimum of \$25,000 to a maximum of \$250,000 in units of \$25,000.

You may also elect to insure your family. Your spouse will be insured for 60% of the benefit you have selected for yourself if there are no eligible children, and 50% if there are eligible children. Each dependent child will be insured for 15% of the benefit you have selected for yourself, subject to a maximum of \$25,000. If there is no eligible spouse, each eligible child is insured for 20% up to a maximum of \$37,500.

In the event that you and your spouse are both employed at the same company, you both may enroll in the benefit. However, one would select Single Coverage Only and the other may elect the Family Coverage. If only one of you elects to enroll in the plan, the other will be insured under the Family Plan as the spouse.

### Specific Loss Accident Indemnity

When injury results in any of the following losses within three hundred and sixty-five (365) days after the date of the accident, the insurer will pay for:

Brain Death	100%
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#### Loss of:

Life	100%
Entire Sight of Both Eyes	100%
Speech and Hearing in Both Ears	100%
Entire Sight of One Eye	75%
Speech	75%
Hearing in Both Ears	75%
Hearing in One Ear	33-1/3%
All Toes of One Foot	25%

**Loss or Loss of Use of:**

Both Arms or Both Legs	200%
Both Hands or Both Feet	200%
One Hand and One Foot	100%
One Hand and the Entire Sight of One Eye	100%
One Foot and the Entire Sight of One Eye	100%
One Arm or One Leg	75%
One Hand or One Foot	75%
Thumb and Index Finger or at Least Four Fingers of One Hand	33-1/3%

**Paralysis:**

Quadriplegia (both upper and lower limbs)	200%
Paraplegia (both lower limbs)	200%
Hemiplegia (upper and lower limbs of one side of body)	200%

"Loss" whenever used with reference to hand or foot means complete severance at or above the wrist or ankle joint but below the elbow or knee joint; as used with reference to arm or leg means complete severance at or above the elbow or knee joint; as used with reference to thumb and fingers means complete severance at or above the metacarpophalangeal joint; as used with reference to toes means complete severance at or above the metatarsophalangeal joint; as used with reference to eye means the irrecoverable loss of the entire sight thereof; as used with reference to speech means the total and irrecoverable loss thereof; as used with reference to hearing means the total and irrecoverable loss thereof; and as used with reference to Quadriplegia, Paraplegia and Hemiplegia means the permanent and irrecoverable paralysis of such limbs.

*"Loss of Use" means a loss which is permanent, total, irrecoverable and continuous for a period of 12 months from the date of the accident.*

Indemnity provided under this section for all losses sustained by any one insured person as the result of any one accident will not exceed the following:

- with the exception of quadriplegia, paraplegia and hemiplegia, the Principal Sum.
- with respect to quadriplegia, paraplegia and hemiplegia, Two Times the Principal Sum, or the Principal Sum if loss of life occurs within 90 days after the date of the accident.

In no event will indemnity payable for all losses under this section exceed, in the aggregate, Two Times the Principal Sum as the result of the same accident.

In addition to the Specific Loss Schedule, the following benefits are included:

### Cosmetic Disfigurement Benefit

If an insured suffers a third degree burn, a percentage of the Principal Sum, depending on the area of the body which was burned according to the following table, will be paid:

Body Part	Area Classification (A)	Maximum Allowable Percentage for Area Burned (B) %	Maximum Percentage of Principal Sum Payable (C) %
Face, Neck, Head	10	10	100
Hand and Forearm	5	5	25
Either Upper Arm	3	5	15
Torso (front or back)	2	18	36
Either Thigh	1	10	10
Either Lower Leg (below knee)	3	9	27

The maximum percentage of Principal Sum Payable (C) is determined by multiplying the Area Classification (A) by the maximum allowable percentage for Area Burned (B). In the event of a 50% surface burn, the maximum allowable percentage for Area Burned (B) is reduced by 50%. This table only represents the maximum percentage of the Principal Sum Payable for any one accident. If the insured suffers burns in more than one area, as a result of any one accident, benefits will not exceed a maximum of \$25,000.

### Seat Belt Benefit

If an insured is driving or riding in a vehicle and wearing a properly fastened seat belt at the time of the accident, and such insured sustains a specific loss for which an amount of Principal Sum becomes payable under the program, the amount payable for such specific loss is increased by 10%.

The driver of the vehicle must hold a current and valid driver's license of a rating authorizing him to operate such vehicle and neither be intoxicated nor under the influence of drugs, unless such drugs are taken as prescribed by a physician at the time of the accident.

### Hospital Indemnity

If any specific loss covered under the program confines you, your insured spouse or your insured dependent child to a hospital and such person is under the regular care and attendance of a physician, you will receive a daily benefit of 1/30th of 1% of your Principal Sum from the first day of hospitalization to a maximum of \$2,500 per month and for a maximum duration of 365 days per accident. Hospitalization must begin while the insurance is in force for you or your dependents.

Hospitalization for treatment of any injury other than for a specific loss will also be covered in accordance with the above, if hospitalized for at least four days.

### **Family Transportation Benefit**

If any specific loss covered under the program confines an insured to a hospital under the regular care and attendance of a physician, and such hospital is located at least 150 kilometres from the insured's residence, this benefit will pay the reasonable expenses actually incurred by a member of the insured's immediate family for accommodation and transportation via the most direct route to the insured's bedside, to a maximum of \$15,000. Private transportation expenses are limited to \$0.35 per kilometre travelled.

Room, board or other ordinary living, travelling or clothing expenses are not covered.

### **Parental Care Benefit**

If you sustain accidental loss of life for which an amount of Principal Sum becomes payable under the program, 5% of your Principal Sum to a maximum of \$5,000 will be paid to an eligible dependent parent who, at the time of the accident, is a resident in a licensed nursing care facility, or enrolled in a home health care program, or living in your residence, or receiving support and care provided by you.

### **Psychological Therapy Benefit**

If injury results in a loss payable to an insured under the "Specific Loss Accident Indemnity" section and results in the insured requiring psychological therapy, as prescribed by a physician, reasonable and necessary expenses actually incurred will be paid, to a maximum of \$5,000.

### **Child Enhancement Benefit**

With the exception of loss of life, the percentages indicated under the "Specific Loss Accident Indemnity" section are quadrupled with respect to your insured dependent children but in no event will exceed the maximum amount stated.

This provision does not apply if loss of life occurs within 90 days after the date of the accident.

### **Education Benefit**

If you sustain accidental loss of life for which an amount of Principal Sum becomes payable under the program, up to 5% of your Principal Sum, to a maximum of \$10,000, will be paid for reasonable and necessary expenses actually incurred for each of your dependent children who are already enrolled in an institution of higher learning above the secondary school level or who will do so within 365 days after your death.

The benefit is payable annually, for each year up to 4 consecutive years that the child continues school on a full-time basis beyond the secondary school level.

Room, board or other ordinary living, travelling or clothing expenses are not covered.

If none of your insured dependent children satisfy the above requirements, an amount of \$2,500 will be paid to your beneficiary.

### **Daycare Benefit**

If you sustain accidental loss of life for which an amount of Principal Sum becomes payable under the program, up to 5% of your Principal Sum, to a maximum of \$5,000, will be paid for reasonable and necessary expenses actually incurred for each of your dependent children under 13 years of age who are enrolled in a legally licensed daycare centre or who will do so within 365 days after your death. This includes a child who is born within nine months of your date of loss, provided the child was conceived prior to the date of loss.

The benefit is payable annually, for each year up to four consecutive years that the child remains enrolled in a legally licensed daycare centre.

Room, board or other ordinary living, travelling or clothing expenses are not covered.

If none of your insured dependent children satisfy the above requirements, an amount of \$2,500 will be paid to your beneficiary.

### **Spousal Retraining Benefit**

If you sustain accidental loss of life for which an amount of Principal Sum becomes payable under the program, and your spouse engages in a formal occupational training program in order to become qualified for active employment in an occupation otherwise not qualified, this benefit will refund expenses incurred within 3 years following the date of your death, to a maximum of \$15,000.

Room, board or other ordinary living, travelling or clothing expenses are not covered.

### **Rehabilitation Benefit**

If you sustain a specific loss for which an amount of Principal Sum becomes payable under the program and such injury requires your participation in a rehabilitation program in order to be qualified in a different occupation, this benefit will refund expenses actually incurred during the 3 year period following the loss, to a maximum of \$15,000.

Room, board or other ordinary living, travelling or clothing expenses are not covered.

### **Workplace Modification and Accommodation Benefit**

If injury requires special adaptive equipment and/or workplace modification for you to return to active full-time employment, the cost of these modifications will be paid, to a maximum of \$5,000, provided the employer agrees in writing to provide such modification and accommodation to the workplace for the purpose of making it accessible and adaptable to your needs and acknowledges in writing that the performance of the essential duties your occupation may be altered.

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

If injury requires the use of a wheelchair to be ambulatory, the cost of alterations to the insured's principal residence and/or the cost of modification to one motor vehicle utilized by the insured will be paid, subject to a maximum amount of the greater of \$15,000 or 10% of the insured's Principal Sum amount to a maximum of \$50,000, as the result of any one accident, provided such injury results in a loss payable under the "Specific Loss Accident Indemnity" section.

### **Air Bag Benefit**

If, due to a vehicular accident, injury results in a loss payable under the "Specific Loss Accident Indemnity" section, the insured's amount of Principal Sum will be increased by 5%, provided that:

- a) such loss occurs while the insured is a passenger or driver of a private passenger type vehicle equipped with either a single air bag, air bags for both the driver and the front passenger seats, or air bags for the driver, front passenger and rear passenger seats; and
- b) the seat belt is in actual use and properly fastened at the time of the accident, and due proof of seat belt use must be provided as part of the written proof of loss.

### **Assault Benefit**

If injury results in a loss payable under the "Specific Loss Accident Indemnity" section, an additional indemnity equal to 10% of the applicable indemnity payable under that section will be paid, subject to a maximum of \$25,000, if the injury is caused by an assault on premises owned or rented by the employer or if the assault occurred while the insured was travelling on company business.

No benefit will be payable under this section if the assault was the act of another employee or a member of the immediate family of the insured or a member of the insured's household.

### **Carjacking Benefit (\$10,000)**

If, injury sustained by the insured results in a loss payable under the "Specific Loss Accident Indemnity" section, the insured's amount of Principal Sum will be increased by 10%, if the injury occurs during a carjacking of an automobile that the insured was operating, getting into or out of, or riding as a passenger.

### **Comatose Benefit**

If an injury does not cause loss of life, but results in a coma or comatose state, 1% of the Principal Sum (less any sum paid under the "Specific Loss Accident Indemnity" section) for each month the coma or comatose state continues will be paid, subject to an overall maximum of \$50,000. Payments commence at the end of the waiting period and are subject to a maximum of 100 consecutive months.

### **Permanent Total Disability**

If an injury totally and permanently disables an insured, under age 65, within 12 months of the date of the accident, preventing the insured from engaging in any and every occupation, the Principal Sum less any amounts paid or payable under the "Specific Loss Accident Indemnity" section as the result of the same accident will be paid, provided such disability has continued for a period of 12 consecutive months and is total, continuous and permanent at the end of this period.

### **Public Transportation Benefit**

If an injury results in loss of life and indemnity becomes payable under the "Specific Loss Accident Indemnity" section, an additional amount equal to 100% of the Principal Sum will be paid if, at the time of the accident, the insured was riding as a passenger in a regularly scheduled public land, air or water conveyance licensed to carry fare-paying passengers, including a train, bus, taxi, subway, tramway, boat or commercial airplane.

### **Identification Benefit**

If injury results in loss of life, and requires body identification, the expenses actually incurred by a member of the immediate family for lodging, board and transportation by the most direct route will be paid, provided the body is located at least 150 kilometres from the member of the immediate family's residence and the identification of the body is required by the police or a similar law enforcement agency having authority over such matters, to a maximum of \$15,000.

If transportation occurs in a vehicle or device other than one operated under the license for the conveyance of passengers for hire, then reimbursement of transportation expenses will be limited to a maximum of \$0.35 per kilometre travelled.

### **Repatriation Benefit**

If an insured sustains accidental loss of life for which an amount of Principal Sum becomes payable under the program, repatriation benefits up to \$15,000 will be paid for the reasonable and necessary expenses actually incurred for the transportation of the body to the city of residence, including the preparation of the body for transportation.

### **Funeral Expense Benefit**

If an injury sustained by an insured results in loss of life, an additional amount is payable for funeral expenses actually incurred, to a maximum of \$5,000.

### **Bereavement Benefit**

If you sustain an injury that results in loss of life, reasonable and necessary expenses actually incurred by your spouse and dependent children for up to six (6) sessions of grief counselling, by a professional counsellor will be paid, to a maximum of \$1,000.

### **Common Disaster Benefit**

If you and your insured spouse both sustain accidental loss of life as a result of a common accident or two separate accidents occurring within the same 24-hour period, and such losses become payable under the program, your spouse's amount of coverage will be increased to the same level as yours, subject to an overall total for you and your spouse of \$500,000.

### **Limited Air Travel Coverage**

An insured is covered only while flying as a passenger in any aircraft holding a current and valid certificate of airworthiness (other than an aircraft owned, operated or leased by or on behalf of your employer) and operated by a person holding a current and valid pilot's license with a rating authorizing him to pilot such aircraft. Coverage also applies while flying as a passenger in a military aircraft.

### **Exposure and Disappearance**

Unavoidable exposure to the elements will be covered under the program as any other loss, provided such exposure is sustained as the result of a covered accident and the loss for which indemnity would be payable occurs within 1 year of the accident.

An insured will be presumed to have suffered accidental loss of life if the insured's body is not found within 1 year after the disappearance, sinking or wrecking of the conveyance in which the insured was riding at the time of the accident.

## **Waiver of Premium**

If, as the result of total disability, you are approved for Waiver of Premium and remain eligible for such under the terms of your employer's Basic Life Insurance contract, you need not pay any further premiums under this program for yourself, your insured spouse and your insured dependent children.

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

- the date the program terminates;
- the date you reach age 65; or
- the date you cease to be totally disabled.

The insurer reserves the right to request proof of disability from time to time as may be reasonably required. Failure to provide proof satisfactory to the insurer may result in termination of the waiver of premium benefit.

All terms and provisions of the program will apply during the period your premiums are waived, including provisions relating to reductions in amounts of insurance.

## **Extended Family Coverage**

In the event of your death due to an injury for which benefits are payable, the coverage will be continued for your spouse and your insured dependent children for a period of six months, provided payment of premium is continued.

## **Continuation of Coverage**

Coverage will be continued for you, your insured spouse and your insured dependent children during your approved leave of absence, temporary layoff, maternity or parental leave, provided payment of premium is continued. Coverage will be continued for any approved disability leave until you reach 65 years of age, qualify for Waiver of Premium benefits or return to work in any capacity, whichever is earlier.

All terms and provisions of the program will apply during the period coverage is continued including provisions relating to reductions in amounts of insurance.

## **Conversion Privilege**

Upon termination of your insurance and provided the program is still in effect, you may convert your own insurance (but not your insured spouse's or your insured dependent children), without evidence of insurability to an individual accident insurance policy. You may elect an amount equal to or lower than the amount of the Principal Sum in force at the time of termination.

You must apply within 31 days of the termination of your coverage.



## Co-ordination of Benefits

The total maximum payable in combination with the similar benefit maximum provided under any other policy issued to you will not exceed the actual expenses incurred or the maximum amount of benefit provided, whichever is less: Repatriation Benefit, Daycare Benefit, Family Transportation Benefit, Spousal Retraining Benefit, Rehabilitation Benefit, Education Benefit, Identification Benefit, Workplace Modification and Accommodation Benefit, and Home Alteration and Vehicle Modification Benefit.

## Aggregate Limit

\$2,500,000 is the maximum payable to all insureds involved in any one accident.

## Exclusions

- Suicide or any attempt thereat or intentionally self-inflicted injury while sane or insane.
- Declared or undeclared war or any act thereof.
- Active full-time service in the armed forces of any country.
- Flying as a pilot or crew member of any aircraft.
- Flying as a passenger or otherwise in any aircraft owned, operated or leased by your employer.
- Flying in any vehicle or device for aerial navigation except as provided in the Limited Air Travel Coverage section.

## Beneficiary

Benefits payable in the event of loss of life are payable to the beneficiary or beneficiaries designated in writing by you and on file with your Plan Administrator. If there is no such beneficiary designation, such indemnity shall be payable to your estate. All other benefits payable, including those payable to your spouse or dependent children, are payable to you with the exception of indemnities payable under the Family Transportation, Parental Care, Education, Daycare, Spousal Retraining, Workplace Modification and Accommodation, Identification, Repatriation, Funeral Expense and Bereavement benefits.

In the situation where the policy replaces an existing policy issued to the employer, the beneficiary designation recorded under the replaced policy will be deemed to be valid and of full force and effect until changed in writing by the insured.

Every action or proceeding against an insurer for the recovery of insurance money payable under the policy is absolutely barred unless commenced within the time set out in the Insurance Act or other applicable legislation.

## Weekly Indemnity

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In the event you become totally disabled due to an injury or sickness you will receive a disability benefit, provided you are under the continual treatment of a qualified and licensed physician. You must be receiving regular, ongoing care and treatment from a physician during the Elimination Period in order for benefits to be payable at the end of the Elimination Period. Otherwise, benefits are not payable until the date you are first treated by your physician.

The Elimination Period, weekly benefit and maximum disability period are shown in the Schedule of Benefits.

If following a period of disability, you return to active work for at least two weeks, a recurrence of this disability will be considered a new period of disability.

### Eligibility Criteria

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

- a) you must be continuously totally disabled throughout the Elimination Period;
- b) you must provide medical evidence documenting how your illness or injury causes you to be totally disabled. You will be considered totally disabled if a restriction or lack of ability due to an illness or injury prevents you from performing the essential duties of your own occupation;
- c) you must be receiving regular, ongoing care and treatment appropriate for your disabling condition from a physician, as determined by the insurer.

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

### Benefit Offsets

The amount payable to you under this benefit is calculated by deducting from your benefit other sources of income. These include the following:

- earnings received from your employer, including severance and vacation pay;
- income earned from an employer-sponsored salary continuance or wage loss replacement plan;
- benefits payable under any provincial Motor Vehicle Accident plan; and
- payments received from the Canada or Quebec retirement or disability pension plan.

### Rehabilitation

In the event you become totally disabled, you must agree to participate in good faith in any rehabilitation program approved and supervised by the insurer.

Your benefits will be reduced by any remuneration you receive during the rehabilitation period that, when combined with other income from the sources specified under the Benefit Offsets section with regard to reduction of benefits, exceeds 100% of your weekly salary prior to the start of your total disability.

## Exclusions

No benefits are payable for any disability related to:

- any illness or injury which arises out of or in the course of employment, unless your claim has been denied (because you are not insured) by workers' compensation;
- medical or surgical care which is performed solely for cosmetic purposes, except if due to an illness or injury;
- war, insurrection, the hostile actions of any armed forces or participation in a riot or civil commotion;
- abuse of addictive substances, including drugs and alcohol, unless you are participating in an in-patient medical treatment program for substance abuse;
- the committing of a criminal offence;
- injuries sustained while operating a motor vehicle while under the influence of any intoxicant, including alcohol; or
- self-inflicted injuries, unless medical evidence establishes that the injuries are related to a mental health illness.

## Extension of Benefits

If your employment terminates or the plan is cancelled, and you are disabled at that time, benefits will continue until the expiration of the maximum benefit duration in accordance with the terms of the plan provided you remain totally disabled.

## How to Make a Claim

Claim forms may be obtained from your employer. The claim form must be fully completed and submitted within six months of the commencement of disability.

## Subrogation

If you are entitled to recover compensation for loss of income from a third party as a result of the incident which caused or contributed to the disability, for which benefits are paid or payable, the insurer will be subrogated to all your rights of recovery for loss of income, to the extent of the sum of benefits paid or payable by the insurer. You shall execute such documents as required by the insurer.

In the event you provide proof to the insurer that you have not recovered full compensation for loss of income, the insurer shall determine the proportion of damages actually recovered and share pro rata in that amount.

Should you choose to settle the matter prior to judicial determination, it is understood that the sum reached in settlement will be deemed to be full compensation for loss of income, and the insurer's right of subrogation will apply.

The term compensation shall include any lump sum or periodic payments which you receive or are entitled to receive on account of past, present or future loss of income.

## Long Term Disability

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In the event you become totally disabled for the required period of time known as the Elimination Period and you are receiving regular, ongoing care and treatment from a legally qualified physician during the Elimination Period, you will receive a monthly income benefit.

The Elimination Period, monthly benefit and maximum disability period are shown in the Schedule of Benefits.

Benefits will not be payable beyond age 65, unless you satisfy the Elimination Period while age 64, in which case benefits will be payable for a maximum of 12 months.

### Eligibility Criteria

To be entitled to disability benefits, you must meet the criteria outlined below.

For the purposes of this coverage, you will be considered totally disabled if, solely as a result of a disease or injury:

- during the Elimination Period and for the next 24 months, you have a restriction or lack of ability due to an illness or injury which prevents you from performing the essential duties of your own occupation;
- you have a restriction or lack of ability due to an illness or injury which prevents you from performing the essential duties of any occupation for which you are qualified, or may reasonably become qualified, by training, education or experience; and
  - a) you are continuously totally disabled throughout the Elimination Period. If you cease to be totally disabled during this period and then become disabled again within 2 weeks due to the same or related illness or injury, your Elimination Period will be extended by the number of days during which you ceased to be totally disabled;
  - b) you provide medical evidence documenting how your illness or injury causes you to be totally disabled. You will be considered totally disabled if a restriction or lack of ability due to an illness or injury prevents you from performing the essential duties of your own occupation;
  - c) you are receiving from a physician, regular, ongoing care and treatment appropriate for your disabling condition, as determined by the insurer.

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

For purposes of this coverage, your own occupation refers to the nature of your work rather than your specific job with your employer at the time disability commenced.

The availability of employment will not be considered in the assessment of your claim under this coverage. Your failure to obtain or retain any license or certification required to practice your own occupation will not be considered in the assessment of a claim under this coverage.

## Recurrent Disability

If a disability recurs and it is due to the same or related causes, it will be considered as one continuous disability and will not be subject to the Elimination Period unless you have returned to active, full-time employment for a period of six consecutive months or longer.

If your new disability is due to causes unrelated to your prior disability you may be eligible for a new disability period, subject to the Elimination Period, if you have returned to active work for at least one full day.

## Benefit Offsets

The amount payable under this benefit for total disability is calculated by deducting from your benefit other sources of income you receive or are entitled to receive for the same or related disability. These include the following:

- Workers' Compensation or similar coverage;
- Canada or Quebec Pension Plans, excluding dependent benefits but including CPP/QPP Retirement benefits;
- any government motor vehicle automobile insurance plan or policy, unless prohibited by law;
- any group, association or franchise plan;
- earnings or payments from any employer, including severance payments and vacation pay; and
- disability benefits payable by government for victims of crime.

## All Source Maximum

Your total monthly income while disabled cannot exceed:

- a) 85% of your gross monthly earnings if your benefit payments are taxable; or
- b) 85% of your net monthly earnings if your benefit payments are not taxable;

as of the date your disability commenced.

If your total income exceeds 85%, your Long Term Disability benefit will be reduced accordingly. All sources include those stated above and any benefit you are entitled to receive from:

- any retirement or pension income;
- self-employment;
- any government plan, excluding Employment Insurance Benefits; and
- Canada or Quebec Pension Plans' dependent benefits.

The Schedule of Benefits confirms whether or not your benefit payments are taxable.

## **Disability Case Management Program**

The insurer has developed a disability case management program. The purpose of this program is to assist you, in the event you become totally disabled and qualify for benefits, to return to productive employment. A disability case management team will work with you, your employer and your physician to assist you to recover and return to the workplace.

## **Rehabilitative Employment**

In the event you become totally disabled, you must agree to participate in good faith in any rehabilitation program approved and supervised by the insurer.

Your benefits will be reduced by any remuneration you receive during the rehabilitation period that, when combined with other income from the sources specified under the Benefit Offsets section with regard to reduction of benefits, exceeds 100% of your monthly salary prior to the start of your total disability.

## **Exclusions and Limitations**

No benefits are payable for any disability directly or indirectly 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, either while under the influence of any intoxicant or if your blood contained more than 80 milligrams of alcohol per 100 millilitres of blood at the time of injury;
- 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; and
- a Pre-Existing Condition which causes disability within the first 12 months of insurance under this benefit. 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 date your insurance under this benefit became effective.

## **Waiver of Premium**

Premiums will be waived for any period during which you are receiving benefits.

## **Survivor Benefit**

In the event of your death before the end of a period during which you are entitled to benefits under this benefit, a lump sum payment equivalent to three full months of benefits will be made to your estate, or to your designated beneficiary, as applicable. The lump sum is calculated based on the amount of the last payment made.

## **How to Make a Claim**

Claim forms may be obtained from your employer. The claim form should be fully completed and submitted one month prior to the expiration of the Elimination Period but no later than six months after the commencement of disability.

## **Subrogation**

If you are entitled to recover compensation for loss of income from a third party as a result of the incident which caused or contributed to the disability, for which benefits are paid or payable, the insurer will be subrogated to all your rights of recovery for loss of income, to the extent of the sum of benefits paid or payable by the insurer. You shall execute such documents as required by the insurer.

In the event you provide proof to the Insurer that you have not recovered full compensation for loss of income, the insurer shall determine the proportion of damages actually recovered and share pro rata in that amount.

Should you choose to settle the matter prior to judicial determination, it is understood that the sum reached in settlement will be deemed to be full compensation for loss of income, and the insurer's right of subrogation will apply.

The term compensation shall include any lump sum or periodic payments which you receive or are entitled to receive on account of past, present or future loss of income.

# Critical Illness Insurance

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Critical Illness Insurance provides for a benefit to be paid in the event you are diagnosed with a Covered Condition or an AdvanceCare Benefit Condition while coverage is in force.

## Covered Condition Benefit

If an insured is diagnosed by a Specialist with a Covered Condition while coverage is in force and survives for 30 days following the Date of Diagnosis or such longer period as described in the "Definitions of Covered Conditions" section below, the insurer will pay the amount of Critical Illness Insurance in force (the "Covered Condition Benefit") subject to the limitations, exclusions and other terms and conditions described in this booklet. The Date of Diagnosis must be later than the effective date or latest reinstatement date of coverage.

## Multiple Event Coverage Benefit

This coverage allows you to claim more than once under Critical Illness Insurance, provided subsequent claims are for unrelated Covered Conditions, as illustrated in the Multiple Event Coverage (MEC) Grouping chart below.

If you receive a Covered Condition Benefit under this policy, and then are subsequently diagnosed with a different Covered Condition in a different MEC Grouping, you will be eligible for a benefit payment (the Multiple Event Coverage Benefit). You cannot claim more than once within each grouping. Please note that Stroke is included in both Group 2 and Group 3.

You must survive for 30 days following the Date of Diagnosis or such longer period as described in the Definitions of Covered Conditions to qualify for this Multiple Event Coverage Benefit.

<b>MEC Grouping</b>	<b>Covered Condition</b>
Group 1	Cancer (Life-Threatening)
Group 2	Aortic Surgery, Coronary Artery Bypass Surgery, Heart Attack, Heart Valve Replacement or Repair, Stroke
Group 3	Bacterial Meningitis, Benign Brain Tumour, Coma, Dementia including Alzheimer's Disease, Loss of Independent Existence, Loss of Speech, Motor Neuron Disease, Multiple Sclerosis, Paralysis, Parkinson's Disease and Specified Atypical Parkinsonian Disorders, Stroke
Group 4	Aplastic Anemia, Kidney Failure, Major Organ Failure on Waiting List, Major Organ Transplant
Group 5	Blindness
Group 6	Deafness
Group 7	Severe Burns
Group 8	Loss of Limbs
Group 9	Occupational HIV Infection



## AdvanceCare Benefit

If you are diagnosed by a Specialist with an AdvanceCare Benefit Condition, the insurer will pay a benefit equivalent to 10% of the Critical Illness Insurance coverage amount.

The benefit is payable for only one AdvanceCare Benefit Condition, and payment of an AdvanceCare Benefit will not affect the payment of a subsequent Diagnosis of a Covered Condition.

## Limitations

a) An insured will not be entitled to a Covered Condition Benefit for Cancer (Life-Threatening) if within 90 days following the effective date of coverage, Cancer (Life-Threatening) is diagnosed, or such insured has any signs, symptoms or investigations leading to the diagnosis of Cancer (Life-Threatening), regardless of when the diagnosis is made.

In the event you receive any such Diagnosis of Cancer (Life-Threatening):

- the Covered Condition Benefit will not be payable.
- Cancer (Life-Threatening) will no longer be considered a Covered Condition.

b) An insured will not be entitled to a Covered Condition Benefit for Benign Brain Tumour if within 90 days following the effective date of coverage, Benign Brain Tumour is diagnosed, or the insured has any signs, symptoms or investigations leading to the diagnosis of Benign Brain Tumour, regardless of when the diagnosis is made.

In the event you receive any such Diagnosis of Benign Brain Tumour:

- the Covered Condition Benefit will not be payable.
- Benign Brain Tumour and all other MEC Group 3 Covered Conditions will no longer be considered a Covered Condition.

c) An insured will not be entitled to an AdvanceCare Benefit for Early Stage Cancer if within 90 days following the effective date of coverage, Early Stage Cancer is diagnosed, or such insured has any signs, symptoms or investigations leading to the diagnosis of Early Stage Cancer, regardless of when the diagnosis is made.

In the event of any such diagnosis,

- the AdvanceCare Benefit will not be payable.
- Critical Illness Insurance remains in force but Early Stage Cancer will be removed as an AdvanceCare Benefit Condition for such insured.

## Exclusions

In addition to the exclusions included within the definitions of certain Covered Conditions, no benefit will be paid if a Covered Condition or AdvanceCare Benefit Condition results directly or indirectly from any one or more of the following:

- a) Any illness, disease, mental, nervous or psychiatric condition or disorder for which any one of medical advice, treatment, service, prescribed medication, diagnosis or consultation, including consultation to investigate and/or diagnose (where diagnosis has not yet been made) was received by the insured or would have been received by a prudent individual within the 24 months immediately preceding the effective date of such insured's coverage. This exclusion applies for the 24 months

following the effective date of an insured's coverage;

b) Attempted suicide;

c) Taking poison or inhaling gas, whether voluntarily or involuntarily, not connected with the insured's employment;

d) Taking any drug other than as prescribed by a licensed physician;

e) Participation in a criminal act or any attempt to commit a criminal offense, including but not limited to, operating a motor vehicle while the concentration of alcohol in 100 millilitres of the insured's blood exceeds 80 milligrams;

f) Intentionally self-inflicted injury, while sane or insane; and/or

g) No benefit will be paid if the insured suffers Paralysis, Blindness, Deafness, Severe Burns, Stroke, Coma or Loss of Limbs, as a result, directly or indirectly, from amateur or professional boxing, bungee jumping, B.A.S.E. jumping, cliff diving, mountain climbing, motor vehicle racing or speed competition on land and/or water, parachuting or underwater activities, including scuba diving and snuba diving.

**Note 1:** If an insured's amount of coverage under critical illness is increased by two times or more, the 24/24 pre-existing condition exclusion in a) above will apply to all Covered Conditions on the increased portion only from the effective date of the increase.

**Note 2:** Exclusion a) above will not apply to an insured who is required to submit satisfactory evidence of insurability and is subsequently approved for critical illness coverage. For such an insured, the Covered Condition Benefit and the AdvanceCare Benefit will not be paid if a Covered Condition or AdvanceCare Benefit Condition results from any Covered Condition or AdvanceCare Benefit Condition diagnosed prior to the effective date of the insured's critical illness coverage.

## **Waiver of Premium Disability Benefit**

If you are under age 65 and become Totally Disabled while insured and are so disabled for at least six consecutive months, your critical illness insurance will continue in force and premiums will be waived retroactively subject to the terms and conditions described in this booklet. Initial proof must be filed within 12 months of Total Disability and as required thereafter. You will continue to satisfy the Pre-Existing Condition Timeframe if applicable, while premiums are waived and coverage is in force.

The Waiver of Premium Disability benefit terminates on the earlier of the following dates:

- the date you are no longer Totally Disabled;
- the date you fail to provide satisfactory proof of your continued disability;
- the date you fail to be examined by a qualified physician as required by the insurance company;
- if you are Totally Disabled prior to age 63, your Waiver of Premium Disability benefit will terminate at the end of the month coincident with or next following your 65th birthday; or
- if you are Totally Disabled at age 63 or older but under age 65, your Waiver of Premium Disability benefit will apply for a maximum of 24 consecutive months.

## **Continuation of Critical Illness Insurance During a Leave of Absence**

If you are not actively at work as a result of an employer-approved disability leave of absence, maternity/parental leave of absence or temporary layoff:

- Your Critical Illness Insurance will continue in force subject to the continued payment of premium.
- You will continue to satisfy the Pre-Existing Condition Timeframe, if applicable.

In the event you are subsequently approved for the Waiver of Premium Disability Benefit, premiums will be waived in accordance with the terms and conditions described in this booklet.

## **Termination of Critical Illness Insurance When on Disability**

If you are not actively at work as a result of a disability and were under age 63 when your disability commenced, your Critical Illness Insurance will terminate at the end of the month coincident with or next following the date you reach age 65, unless you return to full time active employment before the age of 65.

If you are not actively at work as a result of a disability and were age 63 or older but less than age 80 when your disability commenced, your Critical Illness Insurance will terminate at the earlier of your termination age or the end of the month coincident with or next following 24 consecutive months of disability-related absence from work.

## **Conversion Privilege**

If your employment terminates or changes so that you cease to be eligible under the plan, you may convert your Critical Illness Insurance, without evidence of insurability to a separate critical illness policy subject to the following:

- You are under age 65 and reside in Canada at the time you cease to be eligible;
- You have not received a Covered Condition Benefit or AdvanceCare Benefit under this plan or any other critical illness insurance benefit under any group policy issued by iA Financial Group;
- The maximum amount to be converted will be limited to the lesser of \$100,000 and the amount of coverage in force at the date of your termination;
- The insurer must be notified of the conversion request within 31 days of you ceasing to be eligible;
- Premiums will be charged based on your individual gender, smoker status and age at the time of conversion;
- The converted policy will be of a type then issued by the insurer providing term insurance to age 75 and will be issued without waiver of premium benefit, return of premium benefit, paid-up benefit or guaranteed increase benefit.
- If you have not been insured under the Critical Illness Insurance plan for at least 24 months when you cease to be eligible, any time remaining under the pre-existing condition exclusion will carry over to the separate policy.

## Claims at TuGo

Critical Illness Insurance also provides access to Claims at TuGo. If an insured chooses to obtain private treatment for a diagnosed condition, Claims at TuGo can help. The service provides assistance in obtaining specialized, private medical treatment at claim time. With access to treatment centres around the world, Claims at TuGo can provide:

- referral services to physicians at medical centres of excellence, most appropriate for his/her condition and course of treatment;
- co-ordination of surgery and pre- and post-operative visits;
- co-ordination of travel arrangements, including accommodations for the insured and his/her travelling companions;
- co-ordination of any other details connected to the insured's medical procedure; and
- access to discounted rates.

For assistance in accessing this service, please contact Claims at TuGo toll free at 1-800-663-0399 or via email at [claims@tugo.com](mailto:claims@tugo.com) or visit Claims at TuGo at: [www.tugo.com/tms](http://www.tugo.com/tms). Note that utilization fees may apply.

## Plan Definitions

**"Covered Conditions"** for which a benefit is paid with respect to an insured employee are Aortic Surgery, Aplastic Anemia, Bacterial Meningitis, Benign Brain Tumour, Blindness, Cancer (Life-Threatening), Coma, Coronary Artery Bypass Surgery, Deafness, Dementia including Alzheimer's Disease, Heart Attack, Heart Valve Replacement or Repair, Kidney Failure, Loss of Independent Existence, Loss of Limbs, Loss of Speech, Major Organ Failure on Waiting List, Major Organ Transplant, Motor Neuron Disease, Multiple Sclerosis, Occupational HIV Infection, Paralysis, Parkinson's Disease and Specified Atypical Parkinsonian Disorders, Severe Burns and Stroke. Each Covered Condition is defined below.

**"Date of Diagnosis"** means the date on which a Specialist diagnoses the insured with one of the Covered Conditions or one of the AdvanceCare Benefit Conditions.

**"Diagnosis"** means the certified diagnosis of the insured with a Covered Condition or one of the AdvanceCare Benefit Conditions by a Specialist.

**"Pre-Existing Condition Timeframe"** means a period of 24 months during which the Critical Illness Insurance is in force, commencing with the effective date of coverage.

**"Specialist"** means a licensed medical practitioner who

- has been trained in the specific area of medicine relevant to the Covered Condition or AdvanceCare Benefit Condition for which a benefit is being claimed;
- has been certified by a specialty examining board; and
- is currently practicing in their area of specialty in Canada or the United States of America.

Specialist includes but is not limited to: cardiologist, neurologist, nephrologist, oncologist, ophthalmologist, burn specialist and internist. The Specialist must not be the Insured Person, or a relative or business associate of the Insured Person.

In the absence or unavailability of a Specialist, and as approved by the insurer, a Covered Condition or AdvanceCare Benefit Condition may be diagnosed by a qualified medical practitioner practicing in Canada or the United States of America.

**"Total Disability" or "Totally Disabled"** means disability resulting from injury or sickness which requires the regular care and personal attendance of a registered physician and which totally and continuously disables and prevents an insured Employee from performing every duty pertaining to his regular occupation during the first 24 months of injury or sickness; and thereafter, totally and continuously disables and prevents an insured Employee from performing any gainful occupation for which he is or may become reasonably fitted by reason of his training, education or experience.

## Definitions of Covered Conditions

### Aortic Surgery

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

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

### Aplastic Anemia

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

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

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

### Bacterial Meningitis

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

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

### Benign Brain Tumour

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

**Exclusion:** No benefit will be payable under this Covered Condition if, within the first 90 days following the later of the effective date of an Insured Person's coverage, or the last reinstatement date of an Insured Person's coverage, such Insured Person has any of the following:

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

Medical Information about the Diagnosis and any signs, symptoms or investigations leading to the Diagnosis must be reported to the insurer within 6 months of the Date of Diagnosis. If this information is not provided within this period, the insurer has the right to deny any claim for Benign Brain Tumour or any Critical Illness caused by any Benign Brain Tumour or its treatment.

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

### **Blindness**

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

The Diagnosis of Blindness must be made by a Specialist.

### **Cancer (Life-Threatening)**

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

**Exclusion:** No benefit will be payable under this Covered Condition if, within the first 90 days following the later of the effective date of an Insured Person's coverage, or the last reinstatement date of an Insured Person's coverage, such Insured Person has any of the following:

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

Medical Information about the Diagnosis and any signs, symptoms or investigations leading to the Diagnosis must be reported to the insurer within 6 months of the Date of Diagnosis. If this information is not provided within this period, the insurer has the right to deny any claim for Cancer (Life Threatening) or any Critical Illness caused by any cancer or its treatment.

No benefit will be payable for the following:

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

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

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

### **Coma**

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

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

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

### **Coronary Artery Bypass Surgery**

Coronary Artery Bypass Surgery means the undergoing of heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass graft(s). The surgery must be determined to be medically necessary by a Specialist.

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

### **Deafness**

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

### **Dementia, Including Alzheimer's Disease**

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

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

The Insured Person must exhibit

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

The Diagnosis of Dementia, including Alzheimer's Disease must be made by a Specialist.

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

For purposes of the Policy, reference to the Mini Mental State Exam is to Folstein MF, Folstein SE, McHugh PR, J Psychiatr Res. 1975;12(3):189.

### **Heart Attack**

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

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

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

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

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

### **Heart Valve Replacement**

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

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

### **Kidney Failure**

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

### **Loss of Independent Existence**

Loss of Independent Existence means a definite Diagnosis of the total inability to perform, by oneself, at least two of the following six Activities of Daily Living or a continuous period of at least 90 days with no reasonable chance of recovery. The Diagnosis of Loss of Independent Existence must be made by a Specialist.

Activities of Daily Living are:

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



- Feeding - the ability to consume food or drink that already has been prepared and made available, with or without the use of adaptive utensils

### **Loss of Limbs**

Loss of Limbs means a definite Diagnosis of the complete severance of two or more limbs at or above the wrist or ankle joint as the result of an accident or medically required amputation. The Diagnosis of Loss of Limbs must be made by a Specialist.

### **Loss of Speech**

Loss of Speech means a definite Diagnosis of the total and irreversible loss of the ability to speak as a result of physical injury or disease, for a period of at least 180 days. The Diagnosis of Loss of Speech must be made by a Specialist.

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

### **Major Organ Failure on Waiting List**

Major Organ Failure on Waiting List means a definite Diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be medically necessary. To qualify under Major Organ Failure on Waiting List, the insured must become enrolled as the recipient in a recognized transplant center in Canada or the United States of America that performs the required form of transplant surgery. The date that the insured is enrolled in the transplant centre will be deemed the Date of Diagnosis for this Covered Condition. The Diagnosis of the major organ failure must be made by a Specialist.

### **Major Organ Transplant**

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

### **Motor Neuron Disease**

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

### **Multiple Sclerosis**

Multiple Sclerosis means a definite Diagnosis of at least one of the following:

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

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

### **Occupational HIV Infection**

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

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

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

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

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

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

### **Paralysis**

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

### **Parkinson's Disease and Specified Atypical Parkinsonian Disorders**

"Parkinson's Disease and Specified Atypical Parkinsonian Disorders" means a definite Diagnosis of either a) Parkinson's Disease or b) Specified Atypical Parkinsonian Disorders, as defined below.

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

b) "**Specified Atypical Parkinson's Disorders**" means a definite Diagnosis of progressive supranuclear palsy, corticobasal degeneration, or multiple system atrophy.

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

**Exclusions:** No benefit will be payable for Parkinson's Disease or Specified Atypical Parkinsonian Disorders if, within the first year following the later of the effective date or the latest reinstatement date of an Insured Person's coverage, such Insured Person has any of the following:

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

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

No benefit will be payable under Parkinson's Disease and Specified Atypical Parkinsonian Disorders for any other type of Parkinsonism.

### **Severe Burns**

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

### **Stroke (Cerebrovascular Accident)**

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

- acute onset of new neurological symptoms; and
- new objective neurological deficits on clinical examination,

persisting for more than 30 days following the Date of Diagnosis. These new symptoms and deficits must be corroborated by diagnostic imaging testing. The Diagnosis of Stroke must be made by a Specialist.

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

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

**Note:** Any illness or disorder not specifically defined as a Covered Condition will not be payable.

## **Definitions of AdvanceCare Benefit Conditions**

### **Coronary Angioplasty**

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

### **Early Stage Cancer**

Early Stage Cancer refers to the following conditions:

- malignant melanoma skin cancer that is less than or equal to 1.0 mm in thickness, unless it is ulcerated or is accompanied by lymph node or distant metastasis;
- any non-melanoma skin cancer, without lymph node or distant metastasis;
- prostate cancer classified as T1a or T1b, without lymph node or distant metastasis;

- papillary thyroid cancer or follicular thyroid cancer, or both, that is less than or equal to 2.0 cm in greatest diameter and classified as T1, without lymph node or distant metastasis;
- chronic lymphocytic leukemia classified less than Rai stage 1;
- malignant gastrointestinal stromal tumours (GIST) and malignant carcinoid tumours, classified less than AJCC Stage 2; or
- Ductal Carcinoma in situ of the Breast

The Diagnosis of Early Stage Cancer must be made by a Specialist.

# Extended Health Care

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## Employee and Dependent Coverage

Health benefits are designed to help meet the medical and hospital expenses incurred by you and your family. In the event you or an insured dependent incurs an eligible expense, as listed below and as shown in the Schedule of Benefits, you will be paid a percentage (coinsurance) of the expense, in excess of the deductible for that year.

## Lifetime Maximum Benefit

The total lifetime benefit payable in respect to you or your dependents is unlimited.

## Eligible Expenses - Hospital

### Preferred Accommodation in Canadian Hospitals

The difference between the charges made for ward and semi-private room and board in a licensed Canadian hospital. Such charges shall not be subject to the deductible.

## Eligible Expenses - Drugs

Reasonable and customary charges incurred for medically necessary generic drugs and medicines as specified in the Schedule of Benefits which:

- are dispensed by a licensed pharmacist or physician legally authorized to dispense such drugs and medicines, and
- are prescribed by a physician or other professional authorized by provincial legislation to prescribe medicines for the treatment of an illness or injury and are either:
  - a) drugs requiring the prescription of a physician or other health practitioner as permitted by law; or
  - b) other specified drugs and medicines which have been identified as covered expenses and are by convention usually not dispensed without a physician's prescription; or
  - c) injectable preparations identified as eligible and allergy serums; or
  - d) insulin preparations, test strips, diabetic needles and syringes.

When there is more than one drug that is suitable to treat your condition, your plan allows for reimbursement based on the cost of the lowest priced equivalent drug. Should you decide to purchase a higher priced drug, you may pay the difference unless your medical or dental practitioner has written that there is to be no substitution of the prescribed drug or medicine.

**Note:** Drugs prescribed in connection with fertility treatment are covered to a lifetime maximum of \$2,400. Except for smoking cessation drugs, other lifestyle drugs are not covered. This includes, but is not limited to, anti-obesity drugs and drugs prescribed in connection with erectile dysfunction.

### **All provinces other than Quebec**

Maintenance drugs required to treat lifelong chronic conditions may be required to be purchased in a 90-day supply of a prescription at any one time. Non-maintenance drugs may be purchased in a supply not exceeding 3-months (90-day) supply of a prescription at any one time. However, for all drugs, 6 months for a vacation supply may be purchased and not more than a 13-month supply in any 12 consecutive months.

### **Quebec only**

In no event will the amount dispensed exceed a 3-month supply (6 months if a vacation supply is required) of a prescription at any one time and not more than a 13-month supply in any 12 consecutive months.

No benefit shall be payable for any single purchase of drugs which would not reasonably be used within 90 days from the date of purchase.

## **Drugs Covered Under the Quebec Universal Drug Plan Formulary**

Drugs not covered under the group plan but listed in the Quebec Universal Drug Plan formulary, will be reimbursed in accordance with the Quebec Universal Drug Plan.

A child age 22 to 25 inclusive will be considered a dependent if in full-time attendance at an accredited school, college or university.

Coverage will be maintained with payment of premium for a minimum period of 30 days in the event of strike, lock-out or any other organized work stoppage.

At age 65, you have the choice of being insured either by the Régie de l'assurance maladie du Québec (RAMQ) or under this policy. If you choose to be covered under this policy an annual premium will be charged. A decision to take coverage under the RAMQ plan is considered irrevocable and you cannot at a later date apply for drug coverage under the group plan.

## **Eligible Expenses - Vision Care**

Reasonable and customary charges for vision care as follows:

- a) lenses and frames for eyeglasses or contact lenses not covered in (b), or laser eye surgery, when prescribed by an ophthalmologist or optometrist, subject to the Vision Care Maximum shown in the Schedule of Benefits;
- b) contact lenses prescribed for severe corneal astigmatism, severe corneal scarring, Keratoconus (conical cornea) or Aphakia, provided visual acuity can be improved to at least the 20/40 level by contact lenses but cannot be improved to that level by spectacle lenses, subject to the Vision Care Maximum shown in the Schedule of Benefits.

## **Eligible Expenses - Supplementary Health Care**

Reasonable and customary charges for supplementary health care expenses as follows:

- licensed Convalescent Care Facility, subject to a daily maximum benefit equal to the charge made for semi-private accommodation for not more than 120 days of confinement per calendar year. Confinement must begin following a minimum of three consecutive days of hospital confinement and prior to the insured's 65th birthday;
- medical services (excluding custodial care, psychological or personal counselling) provided by a Registered Nurse (R.N.) or Registered Practical Nurse/Licensed Practical Nurse (R.P.N. / L.P.N.)

which are rendered while the insured is not confined to a hospital subject to an overall maximum benefit of \$10,000 in any calendar year provided such nurse is not a resident in your home or a relative of your family. These charges will be considered eligible expenses only if recommended by a physician and if medically necessary. For the purpose of this policy, custodial care is defined as assistance with daily living or tasks which a layperson could perform;

- professional ambulance service, other than airline, to and from the nearest hospital qualified to provide the necessary treatment.
- emergency transportation (except while travelling outside the insured's province of residence) by airline to and from the nearest hospital qualified to provide the necessary treatment. Such emergency transportation includes, if medically required, transportation costs for a medical attendant who is neither a resident in your home nor a relative of your family;
- diabetic equipment and supplies, such as:
  - blood glucose meters;
  - glucose monitoring system (GMS) such as continuous and flash type monitors subject to medical pre-authorization and reimbursed to the cost of a blood glucose meter. Disposable GMS supplies (used with the monitor), such as, but not limited to, sensors and transmitters, are included and subject to the overall annual maximum applicable to diabetic testing and monitoring equipment and supplies;
- rental (or, at GSC's option, purchase) of durable medical or surgical equipment required for therapeutic purposes and as approved by GSC;
- rental (or, at GSC's option, purchase) of crutches, custom-made braces and the purchase of prostheses;
- necessary dental treatment required as the result of an accidental injury to natural teeth when necessitated by a direct blow to the mouth and not by an object wittingly or unwittingly placed in the mouth, provided the accident occurred while insured under this coverage, subject to a maximum benefit of \$5,000 per accident. As determined by the benefit provider, only such charges directly related to such an accidental injury are considered a covered medical expense. The dental work must be completed within 12 months of the accident to be considered a covered medical expense;
- custom-made orthopedic shoes and orthotics which have been specially designed and molded for the insured individual and are required to correct a diagnosed physical impairment. The custom-made orthopedic shoes or orthotics must have been prescribed by a podiatrist, chiropodist, nurse practitioner or physician and dispensed by an orthotist, pedorthist, podiatrist, chiropodist or chiropractor. Such charges are limited to a maximum benefit of \$200 per orthopedic shoe up to a maximum of \$400 in any calendar year, or up to a maximum of \$400 in any calendar year for orthotics;
- laboratory tests and x-rays not covered by your provincial health care plan, subject to a maximum benefit of \$500 per calendar year per individual;
- purchase of hearing aids (excluding batteries) provided by a certified clinical audiologist, subject to a maximum benefit of \$500 per person in any three consecutive years;
- eye examinations performed by a qualified optometrist or ophthalmologist, once every 24 months, where provincial health care plan coverage of eye exams is not available.

## Paramedical Practitioners

Reasonable and customary charges for the services of the following paramedical practitioners, when operating within their field of expertise and when certified, registered or licensed by the appropriate provincial or federal body, are eligible for reimbursement subject to the conditions and calendar year maximums shown below:

Practitioner	Covered	Physician Referral Required	Annual Maximum
Speech Therapist	Yes	No	\$500
Clinical Psychologist	Yes	No	\$500
Osteopath	Yes	No	\$500
Chiropractor	Yes	No	\$500

Physiotherapist	Yes	No	\$500
Naturopath	Yes	No	\$500
Acupuncturist	Yes	No	\$500
Chiropodist/Podiatrist	Yes	No	\$500
Massage Therapist	Yes	No	\$500

Charges for x-rays are covered, subject to a maximum benefit of \$20 per calendar year for all specialties combined.

## Exclusions

The foregoing list of eligible expenses shall not include any of the following:

- charges which are considered an insured service of any provincial government plan;
- charges which were considered an insured service of any provincial government plan at the time this plan/benefit was issued and subsequently were modified, suspended or discontinued;
- charges for general health examinations, and examinations required for use of third party;
- charges for a surgical procedure or treatment performed primarily for beautification, or charges for hospital confinement for such surgical procedure or treatment;
- charges for medical treatment or surgical procedures by a physician;
- charges for transport or travel, other than as specifically provided under eligible expenses;
- charges not specified in the foregoing list of eligible medical expenses;
- charges for services or supplies which are furnished without the recommendation and approval of a physician acting within the scope of his license;
- charges which are not medically necessary to the care and treatment of any existing or suspected injury, disease or pregnancy;
- charges which are from an occupational injury or disease covered by any Workplace Safety and Insurance Board or similar legislation;
- charges which would not normally have been incurred but for the presence of this insurance or for which you are not legally obligated to pay;
- charges which GSC is not permitted, by any law or regulation, to cover;
- charges for dental work where a third party is responsible for payment for such charges;
- charges for bodily injury resulting directly or indirectly from war or act of war (whether declared or undeclared), insurrection or riot, or hostilities of any kind;
- charges for drugs, sera, injectable drugs or supplies which are not approved by Health Canada or are experimental or limited in use whether or not so approved;
- charges for any form of medical cannabis for the treatment of any medical condition, regardless of whether it is authorized by way of a medical document from a legally-authorized medical practitioner and obtained from a Health Canada-licensed producer pursuant to any federal or provincial legislation or regulation regarding access to and/or distribution of medical cannabis;
- charges for experimental medical procedures or treatment not approved by the Canadian Medical Association or the appropriate medical specialty society;
- charges made by a physician for travel, broken appointments, communication costs, filling in of forms, or physician's supplies.



## **Benefit Continuance for Surviving Dependents**

Extended Health Care coverage for dependents shall continue without premium payment following your death for up to a maximum of 24 months from the date of death or to the date the policy or benefit terminates, whichever is earlier.

Emergency Travel Assistance, Employee Assistance Program, Maple Virtual Care, WorldCare Ally Service and WorldCare Medical Second Opinion Service benefits continue throughout the survivor benefit period.

# Emergency Travel Assistance

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## Employee and Dependent Coverage

You are only eligible for the Emergency Travel Assistance benefit if you are covered for the Extended Health Care benefit. Refer to your Certificate of Insurance to determine if you are covered for these benefits.

Reimbursement of eligible benefits for emergency services will be made only if the services were required as a result of a medical emergency that occurred while you are temporarily outside of your regular province of residence for vacation or travelling for other than health reasons. Eligible travel benefits will be based on reasonable and customary charges in the area where they were received, less the amount payable by your provincial health care plan, if your province provides such coverage.

Upon notification of the necessity for treatment of an accidental injury or medical emergency, the patient must contact GSC Travel Assistance within 48 hours of commencement of treatment.

Emergency means a sudden, unexpected occurrence (acute episode of disease, illness or injury) that requires immediate medical attention and could not have been reasonably anticipated based upon the patient's prior medical condition. This includes treatment (non-elective) for immediate relief of severe pain, suffering or disease that cannot be delayed until you or your dependent is medically able to return to your province of residence. Any invasive or investigative procedures must be pre-approved by GSC Assistance Medical Team.

## Benefit Details

Eligible benefits are limited to the maximum days per trip shown in the Schedule of Benefits, commencing with the date of departure from your province of residence. If you are hospitalized on the last day shown in the Schedule of Benefits, benefits will be extended until the date of discharge.

## Hospital Services and Accommodation

Up to a standard ward rate in a public general hospital.

## Medical/Surgical Services

When rendered by a legally qualified physician or surgeon to relieve the symptoms of, or to cure, an unforeseen illness or injury.

## Emergency Transportation

- By land ambulance to the nearest qualified medical facility.
- By air ambulance - the cost of air evacuation (including a medical attendant when necessary) between hospitals and for hospital admission into Canada when approved in advance by your provincial health care plan or to the nearest qualified medical facility.

**Referral Services**

For hospital services and accommodation, up to a standard ward rate in a public general hospital, and/or medical surgical services rendered by a legally qualified physician or surgeon.

Prior to the commencement of any referral treatment, written pre-authorization from your provincial health care plan and GSC must be obtained. Your provincial health insurance plan may cover this referral benefit entirely. You must provide GSC with a letter from your attending physician stating the reason for the referral, and a letter from your provincial health care plan outlining their liability. Failure to comply in obtaining pre-authorization will result in non-payment.

**Services of a Registered Private Nurse**

Up to a maximum of \$5,000 per calendar year, at the reasonable and customary rate charged by a qualified nurse (R.N.) registered in the jurisdiction in which treatment is provided. You must contact GSC for pre-approval.

**Diagnostic Laboratory Tests and X-rays**

When prescribed by the attending physician. Except in emergency situations, GSC must pre-approve these services (i.e., cardiac catheterization or angiogram, angioplasty and bypass surgery).

**Reimbursement of Prescriptions**

Drugs, serums and injectables which require a prescription by law and are prescribed by a legally qualified medical practitioner (vitamins, patent and proprietary drugs are excluded).

**Medical Appliances**

Including casts, crutches, canes, slings, splints and/or the temporary rental of a wheelchair when deemed medically necessary and required due to an accident which occurs, and when the devices are obtained outside your province of residence.

**Treatment by a Dentist**

Only when required due to a direct accidental blow to the mouth up to a maximum of \$2,000. Treatments (prior to and after return) must be provided within 90 days of the accident.

**Coming Home**

When your emergency illness or injury is such that

- GSC Assistance Medical Team specifies in writing that you should immediately return to your province of residence for immediate medical attention, reimbursement will be made for the extra cost incurred for the purchase of a one-way economy airfare, plus the additional economy airfare if required to accommodate a stretcher, to return you by the most direct route to the major airport nearest the departure point in your province of residence.
- This benefit assumes that you are not holding a valid open-return air ticket. Charges for upgrading, departure taxes, cancellation penalties or airfares for accompanying family members or friends are not included.
- GSC Assistance Medical Team or commercial airline stipulates in writing that you must be accompanied by a qualified medical attendant, reimbursement will be made for the cost incurred for one round-trip economy airfare and the reasonable and customary fee charged by a medical attendant who is not your relative by birth, adoption or marriage and is registered in the jurisdiction in which treatment is provided, plus overnight hotel and meal expenses if required by the attendant.

### **Return Trip Delay - Transportation**

Charges incurred for delay of the return trip of a covered person due to the hospitalization of that person or another covered person with whom the individual is travelling, limited to the cost of one-way economy class transportation.

### **Return of Dependent Children**

Charges incurred for the return of dependent children to their residence in Canada in the event you or your spouse is hospitalized and the children are left unattended. The children must be under 16 years of age. Arrangements for an escort to accompany the children will be made if necessary.

### **Returning Your Personal Use Motor Vehicle**

The cost involved to your residence or nearest appropriate vehicle rental agency when you are unable to due to sickness, physical injury or death, up to a maximum of \$1,000 per trip.

### **Meals and Accommodation**

Up to \$1,500 (maximum of \$150 per day for up to 10 days) will be reimbursed for the extra costs of commercial hotel accommodation and meals incurred by you when you remain with a travelling companion or a person included in the "family" coverage, when the trip is delayed or interrupted due to an illness, accidental injury to or death of a travelling companion.

### **Transportation to the Bedside**

Round-trip economy airfare by the most direct route from your province of residence, for any one spouse, parent, child, brother or sister, and up to \$150 per day for a maximum of five days for meals and accommodation at a commercial establishment will be paid for that family member to:

- be with you or your covered dependent when confined in hospital. This benefit requires that the covered person must eventually be an inpatient for at least seven days outside your province of residence, plus the written verification of the attending physician that the situation was serious enough to have required the visit; and/or
- identify a deceased prior to release of the body.

### **Return Airfare**

If the personal use motor vehicle of you or your covered dependent is stolen or rendered inoperable due to an accident, reimbursement will be made for the cost of a one-way economy airfare to return you by the most direct route to the major airport nearest your departure point in your province of residence.

### **Return of Deceased**

Up to a maximum of \$5,000 toward the cost of embalming or cremation in preparation for homeward transportation in an appropriate container of yourself or your covered dependent when death is caused by illness or accident. The body will be returned to the major airport nearest the point of departure in your province of residence.

## **Travel Assistance Services**

The following services are available 24 hours per day, seven days per week through the international medical service organization. These services include:

- Access to Pre-trip Assistance (prior to departure), including Canada Direct Calling Codes, information about vaccinations, government-issued travel advisories, and visa/document requirements for entry into country of destination;
- Multilingual assistance;
- Assistance in locating the nearest, most appropriate medical care;
- International preferred provider networks;

- GSC Assistance Medical Team's consultative and advisory services, including second opinion and review of appropriateness and analysis of the quality of medical care;
- Assistance in establishing contact with family, personal physician and employer as appropriate;
- Monitoring of progress during treatment and recovery;
- Emergency message transmittal services;
- Translation services and referrals to local interpreters as necessary;
- Verification of coverage facilitating entry and admissions into hospitals and other medical care providers;
- Special assistance regarding the co-ordination of direct claims payment;
- Co-ordination of embassy and consular services;
- Management, arrangement and co-ordination of emergency medical transportation and evacuation as necessary;
- Management, arrangement and co-ordination of repatriation of remains;
- Special assistance in making arrangements for interrupted and disrupted travel plans resulting from emergency situations to include:
  - a) The return of unaccompanied travel companions
  - b) Travel to the bedside of a stranded person
  - c) Rearrangement of ticketing due to accident or illness and other travel-related emergencies
  - d) The return of a stranded personal use motor vehicle and related personal items
- Knowledgeable legal referral assistance;
- Co-ordination of securing bail bonds and other legal instruments;
- Special assistance in replacing lost or stolen travel documents including passports;
- Courtesy assistance in securing incidental aid and other travel-related services; and
- Emergency and payment assistance for major health expenses.

### **How Travel Assistance Works**

For assistance, dial 1-800-936-6226 within Canada and the United States or call collect 0-519-742-3556 when travelling outside Canada and the United States. These numbers appear on your Victor Benefits Card.

Quote the Emergency Travel Assistance Group Number and your Identification Number, found on your Victor Benefits Card, and explain your medical emergency. You must always be able to provide your Identification Number and your provincial health insurance plan number.

A multilingual Assistance Specialist will provide direction to the best available medical facility or legally qualified physician able to provide the appropriate care.

Upon admission to a hospital or when consulting a legally qualified physician or surgeon for major emergency treatment, GSC will guarantee the provider (hospital, clinic or physician), that you have both the required provincial health insurance plan coverage and travel benefits as detailed above. The provider may then bill GSC directly for these approved services.

GSC Assistance Medical Team will follow your progress to ensure that you are receiving the best available medical treatment. These physicians also keep in constant communication with your family physician and your family, depending on the severity of your condition.

When calling collect while travelling outside Canada and the United States, you may require a Canada Direct Calling Code. In the event that a collect call is not possible, keep your receipts for phone calls made to GSC Travel Assistance and submit them for reimbursement upon your return to Canada.

## Travel Limitations

- Coverage becomes effective at the time you or your dependent crosses the provincial border departing from your province of residence and terminates upon crossing the border returning to your province of residence on the return home. If travelling by air, coverage becomes effective at the time the aircraft takes off in the province of residence and terminates when the aircraft lands in the province of residence on the return home.
- Upon notification of the necessity for treatment of an accidental injury or medical emergency, GSC Assistance Medical Team reserves the right to determine whether repatriation is appropriate if the patient's medical condition will require immediate or scheduled care. Such repatriation is mandatory, where GSC Assistance Medical Team determines that the patient is medically fit to travel and appropriate arrangements have been made to admit the patient into the provincial government health care system of their province of residence. Repatriation will ensure continued coverage under the plan. Should the patient opt not to be repatriated or elects to have such treatment or surgery outside their province of residence, the expense of such continuing treatment will not be an eligible benefit.
- The patient must contact GSC Travel Assistance within 48 hours of commencement of treatment. Failure to notify them within 48 hours may result in benefits being limited to only those expenses incurred within the first 48 hours of any and each treatment/incident or the plan maximum, whichever is the lesser of the two.
- Air ambulance services will only be eligible if:
  - a) they are pre-approved by GSC Travel Assistance;
  - b) there is a medical need for you or your dependent to be confined to a stretcher or for a medical attendant to accompany you during the journey;
  - c) you or your dependent are admitted directly to a hospital in your province of residence;
  - d) medical reports or certificates from the dispatching and receiving legally qualified physicians are submitted to GSC Travel Assistance; and
  - e) proof of payment (including air ticket vouchers or air carrier invoices) is submitted to GSC Travel Assistance.
- If planning to travel in areas of political or civil unrest, or in areas where Global Affairs Canada (GAC) has issued a formal travel warning regarding non-essential travel, contact the Travel Assistance for pre-travel advice, as they may be unable to guarantee assistance services.
- GSC reserves the right, without notice, to suspend, curtail or limit its services in any area in the event of political or civil unrest, including rebellion, riot, military uprising, labour disturbance or strike, act of God, or refusal of authorities in a foreign country to permit GSC to provide service. This includes travel in any area if at the time of booking the trip (including delay of travel), or before your departure date, Global Affairs Canada (GAC) issued a formal travel warning advising Canadians to avoid all or non-essential travel to that specific country, region or city due to a likely or actual epidemic or pandemic (non-essential travel will be deemed as anything other than a significant medical or family emergency, such as the death of a family member).

## Travel Exclusions

Eligible Benefits do not include and reimbursement will not be made for:

- any expenses incurred for the treatment related directly or indirectly to a pre-existing or pre-diagnosed medical condition that, at the time of your departure from your province of residence, was not completely stable (in the assessment of GSC Assistance Medical Team) and where medical evidence suggested a reasonable expectation that treatment or hospitalization could be required while traveling. GSC reserves the right to review your medical information at the time of claim.

**Stable** means that during the 90 days immediately preceding your departure:

- a) your pre-existing/pre-diagnosed medical condition:
    - i) has been controlled by the consistent use of the same medications and dosages (excluding changes in medication that regularly occur as part of your ongoing treatment, or decreases in dosage resulting from an improvement in your pre-existing or pre-diagnosed medical condition) prescribed by a legally qualified medical professional;
    - ii) has not, in the reasonable opinion of a legally qualified medical professional, required additional treatment for a recurrence, complication or any other reason related either directly or indirectly to your pre-existing or pre-diagnosed medical condition;
  - b) you have not consulted a legally qualified medical professional for, or had investigated or diagnosed, a new medical condition for which you have not received medical treatment;
  - c) you have not scheduled/are not awaiting any future appointments for non-routine examinations, consultation, tests or investigations (including results) for an undiagnosed medical condition;
  - d) you have not scheduled/are not awaiting any exploratory surgical procedures for an undiagnosed medical condition or surgical procedures for a diagnosed medical condition.
- any expenses incurred for treatment or surgery that is not required for the immediate relief of acute pain or suffering as recommended by a legally qualified physician or surgeon. Eligible benefits will not be reimbursed for treatment or surgery that could reasonably be delayed until you return to your province of residence;
  - any expenses incurred for treatment or surgery not covered under your provincial health insurance plan;
  - any expenses incurred for treatment or surgery normally covered under the out-of-Canada benefits of your provincial health insurance plan's out-of-Canada coverage (where applicable), when the provincial plan has declined payment;
  - any claims arising directly or indirectly from any medical condition you suffer or contract in a specific country, region or city due to an epidemic or pandemic, if at the time of booking the trip (including delay of travel), or before your departure date, Global Affairs Canada (GAC) issued a formal travel warning advising Canadians to avoid all or non-essential travel to that specific country, region or city. In this exclusion, a medical condition is limited to the reason for which the formal travel warning was issued and includes complications arising from such medical condition;
  - treatment or services required for ongoing care, rest cures, health spas, elective surgery, check-ups or travel for health purposes, even if the trip is on the recommendation of a physician;
  - treatment or service that you elect to have performed outside Canada when the medical condition would not prevent your return to Canada for such treatment;
  - amounts paid or payable under any Workplace Safety and Insurance Board or similar plan;
  - hospital and medical care for childbirth occurring within eight weeks of the expected delivery date from the date of departure or deliberate termination of pregnancy;
  - treatment or service provided in a chronic care or psychiatric hospital, chronic unit of a general hospital, Long Term Care facility, health spa or nursing home;
  - services received from a chiropractor, chiropodist, podiatrist or for osteopathic manipulation;
  - cataract surgery or the purchase of eyeglasses or hearing aids; and/or
  - any expenses incurred during any trip taken for the purpose of seeking medical treatment or advice that have not been previously authorized as outlined in Referral Services.

**GSC does not assume responsibility for nor will it be liable for any medical advice given, but not limited to a physician, pharmacist or other health care provider or facility recommended by GSC Travel Assistance.**

# Employee Assistance Program

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## Life happens. Let us help.

Your Employee Assistance Program (EAP) can offer you help when you need it most - from everyday challenges to complex issues, and everything in-between. Your EAP is a confidential and voluntary support service that can help you take the first step towards change. The EAP is completely confidential within the limits of the law and there is no cost to use the program.

## Access Support Services

You and your eligible dependents can receive support over the telephone, in person, online and through a variety of issue-based health and wellness resources. For each concern you are experiencing, you can receive a series of sessions. You can also take advantage of online tools to help manage personal well-being.

You'll get practical, relevant support, fast and in a way that is most suited to your preferences, learning approach and lifestyle. Caring professionals are available 24 hours a day to help you select a support option that works best for you.

## What can the EAP help me with?

The EAP offers solutions for a wide range of life's challenges, which may include:

- Family issues and parenting
- Nutrition questions
- Child- and eldercare resources
- Drugs, alcohol, gambling and smoking concerns
- Workplace challenges
- Financial concerns
- Relationship issues
- Legal worries
- Physical health concerns
- Crisis situations
- Depression, grief and stress

## Professional Counselling

The EAP counsellor network is a multi-disciplinary team of professionals who have master's degrees or PhDs in the fields of psychology, clinical social work or educational psychology. Counselling is accessed voluntarily by employees and is strictly confidential. As always, a thorough assessment of employee concerns, needs and preferences will first be conducted to determine the best suited mode of treatment.

Modes of counselling include:

### In-Person Counselling

- Counselling sessions are held in an office at a pre-determined appointment time

### Telephonic Counselling

- Works well for individuals reluctant to access face-to-face services
- Also good for those living in remote, rural and northern locations



## E-Counselling

- Professional counselling service delivered via written email exchange
- Counselling without the rigidity of appointments; access anytime from anywhere!
- SSL-secure website maintains the highest level of security for all correspondence
- You can access E-Counselling via Morneau Shepell's Members Only website at [www.workhealthlife.com](http://www.workhealthlife.com) and via My EAP, Morneau Shepell's mobile device application

## Online Program and Self-Help Counselling

- Access to a collection of clinician-complied comprehensive text-based, solution-focused resources and information
- Convenient self-directed counselling provides ultimate flexibility and privacy

## Video Counselling

- Real-time, professional counselling delivered via the Internet using a webcam and Internet software
- A solution for those living in remote, rural and northern locations
- Video Counselling software ensures absolute security and confidentiality

## First Chat

- Instant connection to a professional counsellor for immediate issue exploration
- Provides ultimate convenience ideal for those most comfortable with real-time online communication
- First Chat software provides the utmost security and confidentiality
- You can access First Chat via Morneau Shepell's Members Only website at [www.workhealthlife.com](http://www.workhealthlife.com)

## Online Group Counselling

Attend scheduled group counselling online where multiple participants discuss their similar issue(s) with a counsellor in a private and secure online setting. Group interactions allow you to build relationships, receive feedback on how to meet your goals and overcome challenges, and gain encouragement from others.

## My Migo

A mobile program designed for you to create your personal counselling plan and engage in ongoing support and check-ins to keep you on track to achieve your goal.

## WorkLife Solutions

WorkLife Solutions is a confidential, advisory service that is available through your EAP to assist you and your family in balancing work/life issues. Morneau Shepell's professional WorkLife Specialists provide telephone assessment, consultation, support information and resource referrals. This service is available 24 hours a day, seven days a week. WorkLife Solutions services include:

### Expectant and New Parents

Morneau Shepell's Parenting Specialists will address any questions you might have about imminent parenthood or a new baby.

### Childcare

Childcare Specialists provide access to a wide range of information and resources to address your childcare needs or concerns.

### **Children and Adults with Special Needs**

Provides information and resources on issues such as attention deficit disorder, parent support groups and newly diagnosed conditions.

### **School Age Decisions**

WorkLife Specialists provide you with customized packages of resources and educational materials on schools, tutors, special needs schools, after-school programs and more. Assistance is also provided in researching universities and colleges, scholarship opportunities, etc.

### **Practical Parenting**

Addresses issues that range from toilet training and sleeping through the night, to setting limits with your teenagers.

### **Youthline**

Offers teens and their parents an opportunity to talk to someone outside the family to gain information, support and an objective point of view. Offered to children ages 12-19 and young adults ages 20-25.

### **Home Care**

Home Care Specialists consult with those who need information and support around caring for partners or older relatives. Provides you information on, and access to, free, subsidized and private community services.

### **Eldercare Services**

Eldercare Specialists can assist you with practical resources, support and strategies for those who are caregivers of a sick or frail family member.

### **Relationship Information**

Combines support and information when seeking strategies and resources for making your relationship work.

### **Resiliency Coaching**

The Resiliency Coaching program is specifically designed to help you find a point of focus in life, reduce overall stress and remove irritants. It can also provide a helping hand to those who want to change direction in some area of life.

### **Legal Advisory**

Morneau Shepell can also assist you with professional legal consultation or provide a referral to a local lawyer if required. Can include issues such as family law, buying and selling a home, tenant rights, small claims court, equal rights, financial planning, etc. Some exceptions may apply.

### **Financial Advisory**

Offers advice, support, debt counselling and referrals to community resources to assist in taking control over your finances. Information encompasses debt management, pension/severance packages, RRSP/RESP, budgeting, financial aspects of divorce, etc.

### **Career Advisory**

Helps you identify career direction and choices, assess interests and skill-sets, and develop strategies to enhance work satisfaction and performance. Career Specialists can also assist you with stress or work/life issues, retirement and lifestyle issues.

### **Nutritional Counselling**

Registered Dietitians provide you with a nutritional assessment and consultation to help individuals achieve their nutritional goals and improve overall health and well-being.

## Smoking Cessation

Support to help you become a 'life-long quitter' includes educational materials, clinical assessment, self-analysis, customized smoking cessation strategies and relapse prevention techniques.

## Naturopathic Wellness Services

Telephonic consultation will provide information about naturopathic medicine and how it works in context with the body. You will receive health and wellness information on choices related to physiology, diet, lifestyle and mental-emotional well-being, including preventative strategies. Naturopathic wellness services cover these important areas:

- Sleeping Healthy
- Aging Well (includes 'The Menopausal Years' and 'Entering Andropause')
- Stress-free Living
- Workplace Wellness (includes shift work related issues)

## LIFT session

An online wellness platform offering fitness solutions to accommodate the fitness needs of everyone, specifically working professionals who don't have the time to plan their day around fitness or go to the gym. LIFT session virtual fitness programs are available on your mobile device, so you can stay active anytime, anywhere. Chat live online with fitness coaches who can help with fitness, nutrition, and recovery questions you have. Each session lasts 30 minutes, and the typical journey is three sessions per week for a total duration of six weeks. No equipment required!

## Health & Wellness Resource Packages

The Health and Wellness Resource Package, a solution-focused collection of resources and information, is currently available for the following topics:

- Parenting: School-age to Teenager
- Enhancing Relationships
- Separation & Divorce
- Enriching your Career
- Eating for Health
- Managing Stress
- Retirement ready
- Job Loss & Transition

The Health and Wellness Resource Package contains articles, videos, activities and other engaging resources. You can access the interactive regularly updated resources the same way you do our other online programs through Morneau Shepell's Members Only website at [www.workhealthlife.com](http://www.workhealthlife.com) or by calling Morneau Shepell's at 1-800-238-8663.

## WorkHealthLife Online

This website is also available to you through your EAP, and addresses work, health and life related questions and issues that you may be experiencing through unlimited online access to an extensive collection of expert health and wellness information and related links. This is your go-to EAP resource! Visit [www.workhealthlife.com](http://www.workhealthlife.com) to get started.

You can also register for members-only services at [www.workhealthlife.com](http://www.workhealthlife.com).

The landing page will be displayed and you should type in and select Victor Canada EAP Program in the search box. Click on Register on the top of the screen and proceed to complete the registration process.

## **My EAP Mobile Device Application**

Discover information, support and practical solutions for issues that impact your work, health and life directly on your mobile device. **My EAP** is the world's first and only mobile device application providing fast and easy self-service access to expert information.

Using materials from [www.workhealthlife.com](http://www.workhealthlife.com), My EAP features robust, high quality resources including:

- Expert health and wellness articles
- LifeSpeak expert videos on demand
- Secure and confidential E-Counselling

My EAP is free to download on your mobile device. Visit [www.workhealthlife.com](http://www.workhealthlife.com).

## **Connect with the EAP Service**

Connect to people and resources that can make a difference in your life. Your call will be answered by a professional Client Care Representative who will ask for some basic information, listen to and discuss your concerns, and help you select a support option that works best for you.

You may access your EAP at the following numbers:

Canada-wide English.....	1-800-238-8663
Canada-wide French.....	1-800-363-3872
Telephone Device for the Deaf (TDD) English.....	1-800-363-6270
Telephone Device for the Deaf (TDD) French.....	1-800-263-8035

# Maple Virtual Care

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## Feel Better Sooner

Maple is a technology platform that tackles some of the world's most meaningful issues in health care, starting with timely and convenient access to General Practitioners and other health care providers. It allows you to connect directly with doctors for medical care in minutes from your smartphone or computer 24/7. Maple guarantees a connection with a doctor on every visit, enabling an issue resolution rate of 91% across all of their patient visits.

## Co-payments

You and your eligible dependents have access to the following preferred rates for General Practitioner consultations. Per-visit fees are based on the time of day the service is engaged:

- \$10 for a weekday daytime visit (7 a.m. to midnight)
- \$15 for a weekend or holiday daytime visit (7 a.m. to midnight)
- \$25 for an overnight visit (midnight to 7 a.m.)

## How to Access Services

Maple is accessible via any modern browser or through the Maple mobile application (iOS and Android). To access the service, please follow the following steps:

- Navigate your browser to [www.getmaple.ca/victor](http://www.getmaple.ca/victor)
- Enter your certificate number and date of birth to validate your coverage
- Complete registration by entering the required information
- To see a doctor, click "See the Doctor" and select General Practitioner

## 24/7 Availability

Maple offers real-time, 24/7 instant access to General Practitioners across Canada. Their General Practitioners provide round-the-clock support to patients, with an average wait time of less than 2 minutes, regardless of where a patient is located in Canada and what time of day the request comes in.

## Highly Skilled General Practitioners

Maple has over 300 skilled physicians providing care on the Maple platform across Canada. Each doctor goes through a comprehensive screening and onboarding process to ensure top quality physicians and care interactions.

## What Can Maple General Practitioners Help You With?

Maple can help prevent the need to go to a walk-in clinic or the hospital's emergency room. Maple doctors are safely and accurately able to diagnose and address the majority of common illnesses and medical issues including, but not limited to, the following:

- Abrasions
- Allergies
- Bacterial vaginosis
- Bites and stings
- Body aches
- Bronchitis
- Bruises
- Cough

- Dehydration
- Diarrhea
- Earache
- Fever
- Flu
- Frostbite
- Headaches and migraines
- Hives
- Insomnia
- Itchy eyes
- Lice
- Mild lacerations
- Mental health
- Nasal congestion
- Nausea
- Pinkeye
- Respiratory infections
- Sexually transmitted infections
- Sinus infections
- Skin infections
- Sore throats
- Sprains and strains
- Urinary tract infections
- Vomiting
- Yeast infections

Find out more at [getmaple.ca/for-you-family/conditions/](https://getmaple.ca/for-you-family/conditions/).

### **Multiple Options for Consulting with Health Care Providers**

You have the option to choose whichever communication medium is most convenient and comfortable for you. Options include secure instant messaging, video chat and phone.

### **Prescriptions, Renewals and Free Delivery**

If you are issued a digital prescription during your consultation, you have the option to send it directly to a local pharmacy for pickup, or have it delivered anywhere in Canada through Alliance Pharmacy, free of charge. For pickup, the prescription is sent directly to your pharmacy via electronic fax. Each prescription has the physician's electronic signature along with the physician's practicing address and contact details.

### **Lab Requisitions**

If you are issued a lab requisition during your consultation, you can download and print the completed form and take it to any lab in the province. You will be notified via email when your lab results are ready, and they will be uploaded to your Maple virtual care record. You will also be notified if a follow-up with a doctor is required to review the results. For this follow-up, you can request another visit with a Maple doctor or make an appointment with a doctor in the community.

### **Fully Bilingual Service**

Maple's in-app experience, communications, onboarding and physician consultations are all available in both English and French. You can easily switch your language preference in the account setting tab.

### **Robust Virtual Medical Record**

On Maple, you will have a personal virtual health record. This is owned by you, is securely stored on the platform and is accessible at any time. The virtual health record captures data from each of your interactions with providers on Maple. At the click of a button, consultation summaries can be shared with an in-person care provider, such as your family doctor. You can also add existing medical records through Maple's integration with Dot Health, a comprehensive medical record retrieval system. This integration enables you to have access to all of your community and hospital medical records at your fingertips, directly on Maple. Dot Health offers various levels of plans, including a free option. You can also add to your virtual record by uploading previous medical data, outlining pre-existing conditions, surgeries, immunization records, medication lists, etc.

## Privacy by Design

In order to maintain medical records, great care has been taken to ensure that how Maple collects, stores, shares and discloses personal health information is Canadian privacy legislation compliant. All your records are encrypted, and only visible to the treating physician and yourself. You are able to 'hide' records from certain interactions on the platform if you do not want this visible to other doctors you visit on Maple. All sharing of your health records with other providers or programs is only performed at your direction and with your express consent.

## Access to Maple While Travelling

While Maple does not replace travel insurance coverage, you can use Maple when travelling internationally, and speak with Canadian doctors anywhere in the world for medical advice, 24/7. This can help provide you with peace of mind while travelling to the United States and beyond.

## Other Health Care Providers

In addition to General Practitioners, Maple also provides access to other specialty doctors and health care providers. These providers are available to you for an additional charge, directly on Maple. Visit [www.getmaple.ca](http://www.getmaple.ca) for specialties available in each province (e.g. psychotherapy, dermatology, naturopathy, etc.).

## Connect With Customer Support

If you have any issues or questions, you can speak to a Maple representative by clicking the chat icon on the bottom corner of the Maple app or website ([www.getmaple.ca](http://www.getmaple.ca)) or by sending an email to [hello@getmaple.ca](mailto:hello@getmaple.ca). Maple has a dedicated team to provide full-service customer support from 7 a.m. to 10 p.m. on weekdays and from 7 a.m. to 9 p.m. on weekends (Eastern Time).

## WorldCare ALLY Service

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The WorldCare ALLY service helps you actively participate in decisions regarding your medical care. The service assists you in understanding and interpreting complex medical information so you can make informed decisions about your health. It helps you make sense out of your health care needs by increasing your understanding and helping you focus on the real decision-making questions.

This service is available to you and your family provided you are covered for Extended Health Care benefits. Health care coverage must be in force at the time the WorldCare ALLY service is requested. No pre-existing condition limitation applies.

### **WorldCare International, Inc.**

Founded in Boston, Massachusetts in 1992, WorldCare is a pioneer and leader in providing global e-health services and solutions. Committed to medical excellence, WorldCare has partnered with some of the top academic medical centres in the United States, which comprise The WorldCare Consortium™ to provide access to over 20,000 specialist and subspecialists for remote medical second opinions and other medical consultation services. WorldCare aims to complement and support local physician-patient relationships and medical institutions by bringing them access to these multi-disciplinary teams of acclaimed specialists and subspecialists at The WorldCare Consortium™ hospitals, which have access to over \$4 billion in annual biomedical research funding.

The WorldCare Consortium™ includes the following top-ranked medical institutions in the United States:

- Boston Children's Hospital
- Children's Mercy Kansas City
- Jefferson University Hospitals
- Mayo Clinic
- Northwestern Medicine
- Partners HealthCare, which includes:
  - Brigham and Women's Hospital
  - Dana-Farber Cancer Institute
  - Massachusetts General Hospital
  - McLean Hospital
  - Spaulding Rehabilitation Hospital
- UCLA Health

### **Access the WorldCare ALLY Service**

A simple process is in place:

- You contact WorldCare online, by phone, email, fax or mail to initiate the WorldCare ALLY service.
- A WorldCare Ally (a nurse or physician) works with you to gather relevant medical records and helps you understand what your doctor(s) has written about your condition, care and existing treatment plan.
- WorldCare will then provide you a WorldCare ALLY Report containing helpful information and guidelines.

### **The WorldCare ALLY Report**

When the WorldCare ALLY service is provided, you will have access to a customized detailed research report. This report can be a valuable long-term resource and can include:

- A clear easy-to-understand overview of the medical condition;
- Answers to specific research questions you may have posed;



- Various treatments and therapies available based on the latest clinical research;
- Suggested questions to discuss with a doctor before starting treatment;
- Possible side-effects and complications;
- Available clinical trials and options for participation, if desired;
- Reference sources, such as medical societies, associations, support organizations, discussion boards, etc.

### **How to Obtain WorldCare ALLY Service**

If you would like to utilize the WorldCare ALLY service, your first step is to contact WorldCare. Submit an online request, call toll free or send your request via fax, mail or email to:

WorldCare  
7 Bulfinch Place  
Suite 301  
Boston, MA 02114  
[www.worldcare.com](http://www.worldcare.com)

Toll Free: 1-877-676-6439  
Fax: 1-877-266-1150  
Email: [MemberCare@worldcare.com](mailto:MemberCare@worldcare.com)  
Online form: [www.worldcare.com/contact](http://www.worldcare.com/contact)

## WorldCare Medical Second Opinion Service

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Your WorldCare Medical Second Opinion service provides independent medical second from the top-ranked academic and research hospitals in the United States through The WorldCare Consortium™. Through the WorldCare Medical Second Opinion service, members and their physicians have immediate access to leading edge medical expertise from world-renowned research and academic hospitals. You and your attending physician are provided with confirmation or modification of your original diagnosis and treatment recommendations, including alternative treatments and/or therapies.

This service is available to you and your family provided you are covered for Extended Health Care benefits. You are eligible to receive two medical second opinions per family per year, up to a lifetime maximum of six. Health care coverage must be in force at the time the medical second opinion is requested. No pre-existing condition limitation applies.

### **WorldCare International, Inc.**

Founded in Boston, Massachusetts in 1992, WorldCare is a pioneer and leader in providing global e-health services and solutions. Committed to medical excellence, WorldCare has partnered with some of the top academic medical centres in the United States, which comprise The WorldCare Consortium™, to provide access to over 20,000 specialists and subspecialists for remote medical second opinions and other medical consultation services. WorldCare aims to complement and support local physician-patient relationships and medical institutions by bringing them access to these multi-disciplinary teams of acclaimed specialists and subspecialists at The WorldCare Consortium™ hospitals, which have access to over \$4 billion in annual biomedical research funding.

The WorldCare Consortium™ includes the following top-ranked medical institutions in the United States:

- Boston Children's Hospital
- Children's Mercy Kansas City
- Jefferson University Hospitals
- Mayo Clinic
- Northwestern Medicine
- Partners HealthCare, which includes:
  - Brigham and Women's Hospital
  - Dana-Farber Cancer Institute
  - Massachusetts General Hospital
  - McLean Hospital
  - Spaulding Rehabilitation Hospital
- UCLA Health

### **Access the WorldCare Medical Second Opinion (MSO) Service**

A simple three-step process is in place:

- You contact WorldCare online, by phone, email, fax or mail to request a second medical opinion.
- WorldCare works with your physician to gather your medical records and determines the medical institution(s) best suited to address your medical condition.
- The designated physician team reviews your records and provides an independent medical second opinion to you and your doctor. If necessary, WorldCare can co-ordinate a call between your physician and the lead physician on the team that supplied the medical second opinion to discuss

outstanding questions on your case.

There is an average turnaround time of four working days once the complete medical information is received and pathology, if any, is reviewed, while emergency cases can be completed within hours.

### The WorldCare MSO Booklet

When a medical second opinion is provided, you and your physician will receive a comprehensive, multi-disciplinary report, known as the WorldCare MSO Booklet. The WorldCare MSO Booklet includes:

- The medical second opinion report, including confirmation of your diagnosis and treatment plan recommendations;
- Background information on the physician(s) and medical institutions(s) rendering the medical second opinion;
- Educational material about your illness;
- Local and online support services;
- The original medical records upon which the medical second opinion was based.

WorldCare has rigorous procedures in place to ensure quality and to safeguard privacy. Electronic transfer of records is done using FDA-cleared compression and encryption technology and handling of all information is consistent with HIPAA guidelines and the Canadian Personal Information Protection and Electronic Documents Act (PIPEDA).

Medical records and opinions are permanently stored in WorldCare's secure database to facilitate follow-up or future second opinions.

### Right of Refusal

The WorldCare Consortium™ physicians make every effort to provide a medical second opinion based upon the information provided. In certain cases, the medical information submitted may not be sufficient, or of adequate quality, to render a medical second opinion (e.g. if the quality of the submitted imaging is substandard for interpretation and you do not provide optimal imaging, the radiologist will maintain the right to refuse delivery of a diagnostic report). In such cases, WorldCare will inform you of the reasons for the inability to deliver a report within 24 hours. You will have the opportunity to deliver additional or alternative material to WorldCare.

### Covered Conditions

You are entitled to receive medical second opinions for the following conditions:

AIDS	Hip/Knee Replacement
ALS	Kidney Failure
Alzheimer's Disease	Loss of Speech
Any Amputation	Major or Severe Burns
Any Life Threatening Illness	Major Organ Transplant
Benign Brain Tumor	Major Trauma
Cancer	Multiple Sclerosis
Cardiovascular Conditions	Neuro-degenerative Disease
Chronic Pelvic Pain	Paralysis
Coma	Parkinson's Disease
Deafness	Rheumatoid Arthritis
Embolism & Thrombophlebitis	Stroke
Emphysema	Sudden Blindness Due to Illness

## Exclusions

Conditions resulting from the following are excluded from coverage:

- attempted suicide, self-inflicted injuries or injuries caused by a third person with the patient's knowledge;
- alcohol or drug abuse;
- radioactive contamination;
- war or warlike operations (whether war is declared or not), riot, civil commotion, revolution, insurrections, conspiracy, or any events or causes which determine the proclamation or maintenance of martial law or state of siege;
- natural disasters such as fire, flood, earthquake, tornado, hurricane and other Acts of God; or
- poisoning or poisonous gas inhalation.

## How to Obtain a WorldCare Medical Second Opinion

If you would like to request a WorldCare Medical Second Opinion for one of the covered conditions, your first step is to contact WorldCare. Submit an online request, call toll free or send your request via fax, mail or email to:

WorldCare  
7 Bulfinch Place  
Suite 301  
Boston, MA 02114  
[www.worldcare.com](http://www.worldcare.com)

Toll Free: 1-877-676-6439  
Fax: 1-877-266-1150  
Email: [MemberCare@worldcare.com](mailto:MemberCare@worldcare.com)  
Online form: [www.worldcare.com/contact](http://www.worldcare.com/contact)

Consult the WorldCare Second Medical Opinion Service Guide for complete details about the process. Log in at [www.victorinsurance.ca/gbconnect](http://www.victorinsurance.ca/gbconnect) to download the guide (located under My Benefits), or contact your plan administrator.

# Dental Care

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## Employee and Dependent Coverage

As the wording of this dental coverage is technically oriented, you may wish to take this booklet with you when you visit your dentist.

In the event you incur in a calendar year any of the eligible expenses listed below, and also listed in the Schedule of Benefits, you will be paid a percentage (coinsurance) of such expenses in excess of the deductible for that year. The percentage (coinsurance) and deductible are specified in the Schedule of Benefits.

## Maximum Benefit

The total benefits payable are subject to the maximums specified in the Schedule of Benefits.

## Extension of Benefits

No benefits for Eligible Expenses will be paid for claims incurred after the termination of the group benefits program or after your insurance under this coverage ceases.

## Alternate Benefits and Submission of Treatment Plan

Where there exists more than one customarily employed and professionally adequate method of treating injury or disease to the teeth, GSC reserves the right to determine eligible expenses on the basis of an alternate benefit.

As a service to you, GSC will advise you in advance of the amount of its liability when a proposed course of treatment is expected to exceed \$500. To use this service, simply have your dentist submit a treatment plan, including pre-treatment x-rays if the proposed treatment involves crowns, bridgework or implants.

## Eligible Expenses

Charges for the following supplies and services are considered Eligible Expenses if they do not exceed the reasonable and customary charges in accordance with the Fee Guide and the maximum shown in the Schedule of Benefits.

## Eligible Expenses - Basic Services

### Basic Restorative Dentistry

The basic procedures used to restore the natural teeth to their normal functions by the use of silver amalgam, silicate, synthetic or inlay restorations (fillings), including white fillings on molar teeth. In addition, sedative dressings are covered.

### **Oral Surgery**

Routine oral surgical procedures as follows: surgical removal of impacted teeth, residual roots and associated post-operative care.

### **Anaesthesia**

General anaesthesia, deep sedation and intravenous sedation where reasonably and customarily required in conjunction with extractions or eligible oral surgery.

### **Diagnostics**

Procedures required to assist the dentist in evaluating existing conditions and determining any further dental care which may be required subject to the following limitations:

- oral examinations: standard oral examinations as shown in the Schedule of Benefits;
- x-rays: single diagnostic x-rays; complete series or equivalent once every two years;
- study casts: once per year;
- consultations.

### **Preventive Therapy**

Procedures intended to eliminate or reduce the need for future dental treatment subject to the following limitations:

- preventive visits for scaling (where one unit of time = 15 minutes): limited to one unit of time every six consecutive months;
- polishing: limited to one unit of time every six consecutive months;
- topical fluoride: once every six consecutive months.

### **Extractions**

Removal of teeth.

### **Endodontics**

Endodontic procedures including root canal therapy.

### **Periodontics**

- Adjunctive Services as follows: Periodontal scaling, Root planing (up to 10 time units per calendar year), Acute infections, Occlusal Adjustment, Provisional splinting;
- Surgical Services as follows: gingival curettage, gingivoplasty, gingivectomy or osseous surgery;
- Special Periodontal Appliances.

### **Basic Restorative Dentistry**

The basic procedures used to restore the natural teeth to their normal functions by the use of silver amalgam, silicate, synthetic or inlay restorations (fillings), including white fillings on molar teeth. In addition, sedative dressings are covered.

### **Oral Surgery**

Routine oral surgical procedures as follows: surgical removal of impacted teeth, residual roots and associated post-operative care.

### **Anaesthesia**

General anaesthesia, deep sedation and intravenous sedation where reasonably and customarily required in conjunction with extractions or eligible oral surgery.

### **Repairs, Relining and Rebasing of Dentures**

Repair or relining and rebasing of dentures, including addition of new teeth, but not including the cost of dentures, their replacement or duplication.

## **Eligible Expenses - Major Restorative Services**

### **Dentures**

The initial installation of dentures and replacement of existing dentures is covered if:

- It is required because of extraction or loss of one or more teeth after the individual became insured under this plan; or
- The existing dentures are at least five years old and no longer serviceable.

Replacement of lost or stolen dentures, the duplication of dentures and personalization or characterization of dentures is not covered.

### **Extensive Restorative Dentistry**

Those procedures, including onlays and crowns, used to restore the natural teeth to their normal functions where the tooth, as a result of extensive caries or fracture, cannot be restored with a filling. When a tooth can be restored with amalgam or composite restorations, benefits will be determined based on the usual costs of such a restoration. Existing onlays and crowns must be at least five years old and no longer serviceable.

### **Bridgework**

Recementing and replacement of the facing or veneer of the bridge.

The initial installation of bridgework and replacement of existing bridgework is only covered if:

- It is required because of extraction or loss of one or more teeth after the individual became insured under this plan, or
- The existing bridge is at least five years old and no longer serviceable.

### **Implant Treatment**

Implantology including tooth implantation and surgical insertion of fabricated implants, limited to one attempt per tooth (frequency once per lifetime).

## Eligible Expenses - Orthodontics

The diagnosis or correction of teeth irregularities and malocclusion of jaws, by wire appliances, braces or other mechanical aids, commonly known as "straightening of the teeth", when the treatment is performed in an office in person, and monitored on an ongoing basis by an eligible provider. These include active space retainers or orthodontic appliances, for the purpose of repositioning or moving of the teeth.

When a lump sum fee has been paid toward orthodontic treatment, the total amount of the claim will be split into separate portions to allow for payment of an initial fee (approximately one-third of the total lump sum). The balance of the claim will be divided into monthly fees of equal amounts to be reimbursed over the duration of the treatment. Receipts for payment must be received by GSC no later than 180 days following the end of the calendar year in which the expense was incurred while treatment is in progress, not at the end of the treatment.

If orthodontic treatment is terminated for any reason before completion, the obligation to pay benefits will cease with payment to the date of termination. If such services are resumed, benefit for the remaining services, will be resumed. The benefit payment for orthodontic services will be only for the months that coverage is in force.

## Exclusions and Limitations

For dentures, bridges and implants:

- payments will not be made for any dental procedure in respect of teeth extracted or missing before the employee or dependent became insured for that procedure except for appliance replacement as specifically stated under Eligible Expenses.
- no benefit will be payable for the initial installation (or addition) of prosthetic devices unless such installation (or addition) is required primarily due to teeth that were missing or extracted after becoming insured under this plan for prosthetic devices.

Payments for crowns on implants will be limited to once every 10 years. Payments will not be made for implants on the second molar or wisdom teeth.

No benefit is payable for the following:

- services or supplies that are primarily for cosmetic dentistry;
- charges which were considered an insured service of any provincial government plan at the time this plan/benefit was issued and subsequently were modified, suspended or discontinued;
- services or supplies which are not furnished by a legally qualified dentist or denturist acting within the scope of his license;
- any charge for an injury resulting from war, riot, insurrection or participation in a criminal act;
- any miscellaneous charges such as counselling or instruction, travel, broken appointments, communication costs or filling in of forms;
- any services covered in whole or in part by any government plan, services for which no charge is made, or services which GSC is not permitted by law to cover;
- any charge for services which would not normally have been incurred, but for the presence of this insurance, or for which you are not required to pay;
- any hospital charges for board and room and related services and supplies;
- any dental examinations required by a third party;
- services or supplies which are not medically necessary to the care and treatment of any existing or suspected injury, or disease; or



- diagnostic procedures in connection with any benefit categories excluded as eligible expenses.

### **Benefit Continuance for Surviving Dependents**

Dental Care coverage for dependents shall continue without premium payment following your death for up to a maximum of 24 months from the date of death or to the date the policy or benefit terminates, whichever is earlier.

# General Provisions

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## When Your Insurance Starts

Your insurance comes into effect on the latest of the following dates if you are actively at work on that date:

- the date you become eligible;
- the date you apply; or
- if Evidence of Insurability is required, the date it is approved.

If you contribute to the cost of the benefits, an enrollment form must be completed within 31 days of your eligibility date. Otherwise, evidence of health satisfactory to the insurance company must be submitted and approved before you will be eligible for benefits.

If you are not actively at work on the date your insurance would normally be effective or change, then the date on which commencement or change will take place will be the first day on which you are again actively at work.

## Commencement of Dependent Coverage

Coverage for your dependent(s) commences on the date you become eligible. Health evidence is not required provided application is made within 31 days after the date of eligibility.

If you are initially enrolled for single coverage and later acquire a dependent, you must apply for dependent coverage. Coverage will be effective from the date of application provided the request is made within 31 days of acquiring dependents. If application is made after 31 days, evidence of good health will be required for each dependent.

When dependent coverage is in effect, notification of a new dependent is still required or claims service will be affected.

## Evidence of Insurability

Evidence of Insurability is required if:

- you apply for insurance more than 31 days after becoming eligible to apply;
- the amount of insurance you are eligible for exceeds or increases beyond the Non-Evidence Maximum;
- you reapply after your insurance has terminated due to non-payment of premium.

## When Your Insurance Terminates

Your insurance terminates on the earliest of the following:

- non-payment of premium;
- a change in your classification to one not insured;
- termination of your coverage;

- termination or amendment of the Policy;
- your commencing active duty in any armed forces;
- the date outlined in the Schedule of Benefits.

Insurance for your dependents terminates on the earliest of the following:

- termination of your coverage;
- the date your dependent is no longer an eligible dependent;
- the date your dependent attains the specified age limit;
- non-payment of premium;
- termination or amendment of the Policy.

**Note:** In the event you are absent from work due to sickness, injury, layoff or leave of absence, your group benefits may continue if the required premiums are paid. Continued coverage may be subject to pre-approval.

## Eligible Dependents

The following are considered eligible dependents:

- Unmarried children who are under age 22, or under age 25 if attending an accredited school, college, or university as a full-time student. Dependent children must be dependent on you for support and not employed at a regular full-time job.
- Functionally impaired children who are totally dependent upon you for support. For the purposes of this plan, functionally impaired shall mean an unmarried person who was insured as a dependent prior to becoming functionally impaired who is wholly dependent upon you for support and maintenance within the terms of the Income Tax Act.
- A child of your spouse provided:
  - a) he/she is also your biological child; or
  - b) your spouse is living with you and has custody of the child.
- Your spouse as the result of a valid civil or religious ceremony, or a person with whom you have cohabited for a minimum of 6 consecutive months and who has been publicly represented as your spouse.

**Note:** Divorced or separated spouses (with or without a court order or separation agreement) are not eligible for coverage.

## Change in Amounts of Insurance

A change in the amount of your insurance shall become effective on the date of change, if you are actively at work for that full scheduled working day, otherwise on the first day thereafter on which you are actively at work.

## **Naming a Beneficiary**

This Plan contains a provision removing or restricting the right of the group life insured to designate persons to whom or for whose benefit insurance money is to be payable.

The insurers do not accept beneficiary designations for any benefits other than Employee Life Insurance and Accidental Death & Dismemberment.

You have the right to designate and/or change a beneficiary, subject to governing law. The necessary forms are available online at [victorinsurance.ca/gbconnect](http://victorinsurance.ca/gbconnect) or from your plan administrator.

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

## **Change in Government-sponsored Programs**

The medical, dental and hospital benefits under this group insurance plan are provided in conjunction with government-sponsored provincial programs. In the event coverage under any provincial program is modified, suspended or discontinued, the group insurance plan will not automatically assume responsibility for any services or products previously covered under the provincial programs.

## **MIB, Inc., formerly known as Medical Information Bureau**

MIB, Inc. is a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members.

The insurers or their reinsurers may periodically report information to MIB, Inc. If you apply to receive life or health insurance coverage from another MIB member company or submit a claim for benefits to such a company, the MIB upon request will supply the other insurer with the information on file.

The insurers or their reinsurers may also release information in its file to other life and health insurance companies to whom you may apply for insurance or submit a claim for benefits. All information obtained will be treated as confidential.

Upon your request, the MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the MIB's file, you may contact the MIB and seek a correction. Their address is:

MIB, Inc.  
330 University Avenue, Suite 501, Toronto, Ontario M5G 1R7  
[www.mib.com](http://www.mib.com)

## **Co-ordination of Benefits**

Payment of Extended Health Care, Emergency Travel Assistance and Dental Care benefits shall be co-ordinated so that benefits from all plans do not exceed 100% of the eligible claim. For this purpose, GSC has a right to receive and release information on benefits and if necessary, collect any overpayments made by it.

## Time Limitations

A claim for Life Insurance benefits must be submitted within six months of the date of death.

A claim for Long Term Disability benefits must be submitted within six months of the end of the Elimination Period.

A claim for Weekly Indemnity benefits must be submitted within six months from the date of disability.

A claim for Waiver of Premium benefits must be submitted within 12 months of the date of disability.

A claim for Accidental Death & Dismemberment must be submitted within 90 days of the accident as is reasonably possible, but in no event later than 12 months following the date of the accident.

A claim for Critical Illness, either a Covered Condition benefit or an AdvanceCare benefit, must be submitted within 90 days of the date of diagnosis.

Health and dental claims must be received within 180 days following the end of the calendar year in which the expense was incurred.

Health Care Spending Account claims must be received within 180 days following the end of the calendar year in which the expense was incurred.

However, in the event of termination of insurance, all claims must be received within 90 days following the date of termination of your insurance or the date following termination of a coverage or the policy.

# Submitting Claims

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## How to Submit a Claim

If you have Extended Health, ETA and/or Dental benefits, you will receive a Victor Benefits Card. Please refer to your Certificate of Insurance to confirm your benefit coverage.

## Prescription Drug Claims

Pay Direct Plan - Show your Benefits Card to your pharmacist, who will submit claims directly to GSC. You will only pay the amount not covered by your plan.

Reimbursement Plan - Show your Benefits Card to your pharmacist, who will submit claims electronically to GSC. You will pay the full amount at the time of sale and eligible expenses will be reimbursed.

Prescription drug claim questions should be directed to GSC at 1-888-711-1119.

## Other Medical Claims

The Benefits Card can also be used for other types of claims, such as vision and paramedical claims. Service providers will require the name of the carrier and your Identification Number. Show your service provider your Benefits Card in case the claim may be submitted electronically.

Medical claim questions should be directed to GSC at 1-888-711-1119.

## Emergency Travel Assistance Claims

The ETA policy and phone numbers are listed on your Benefits Card. If you require emergency medical assistance while travelling, you should contact GSC Travel Assistance immediately. This multilingual call centre, which operates 24 hours a day, 365 days a year, will ensure you get the care you need without incurring unnecessary expenses.

GSC Travel Assistance

Within Canada and the United States .....1-800-936-6226

International Collect .....0-519-742-3556

If you pay out-of-pocket for any medical expenses, keep the receipts and make sure you tell GSC Travel Assistance about all the travel coverage you have when submitting claims. Your provincial health plan and GSC will reimburse you for those approved eligible expenses from all sources (e.g., provincial plans that provide out-of-Canada coverage, a spousal plan, travel coverage provided through your credit card, etc.) upon your return. Claims should be submitted to:

Allianz Global Assistance  
4273 King Street East  
Kitchener, Ontario  
N2P 2E9

## Dental Claims

Your dental services provider can now submit both pre-determination requests and dental claims electronically. Show your card to your provider, who will submit the request or claim electronically. You will only pay the amount not covered by your plan.

Dental claim questions should be directed to GSC at 1-888-711-1119.

## Other Claims

For Life, Long Term Disability, Weekly Indemnity, AD&D and/or Critical Illness insurance questions, please contact your Plan Administrator for details.

## Time Limit on Legal Action

If an appealed claim is subsequently denied, then you may not commence legal action against the insurance provider less than 60 days after the proof has been filed as outlined under Submitting Claims. Every action or proceeding against the insurance provider for the recovery of insurance money payable under the plan is absolutely barred unless commenced within the time set out in the:

*Insurance Act* (AB, BC, MB, NS, NT, NU, PE and YT)

*Limitations Act, 2002* (ON)

*Limitations Act* (NL and SK)

*Limitations of Actions Act* (NB)

*Civil Code of Quebec* (QC)

## Common Insurance Terms

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### **Actively at Work**

An employee shall be considered actively at work for the purposes of insurance if on the date in question the employee reports for work at the usual place of employment with the employer, which is outside of the employee's home, and is able to perform all of the usual and customary duties of his/her occupation on a regular full-time basis. If an employee does not customarily so report, or if the usual place of employment with the employer is not outside the home, an employee shall be considered actively at work if at any time on the date in question the employee is neither (i) hospital confined, nor (ii) disabled to a degree that the employee could not have then reported to a place of employment outside the home and performed all the usual and customary duties of his/her occupation on a regular and full-time basis.

An employee who is not disabled is also deemed to be actively at work if his/her absence is due only to a period of leave or a non-working day.

### **Beneficiary**

The beneficiary is a person designated by the insured to receive the benefit proceeds when the insured dies.

### **Claim**

A claim is a notification to the insurance company that details an insured person's loss and request for payment of benefits under the policy.

### **Class**

A class is a group of employees as defined in your Group Insurance Application (e.g., "salaried employees" or "Alberta staff").

### **Client Number**

Your organization has been assigned an eight-digit Client Number, which is your Victor file number. The Client Number is not used by other companies or individuals, or in the claims process.

### **Coinsurance**

Coinsurance percentage is the amount that an employee will be reimbursed for a claimed eligible expense, in excess of any applicable deductible.

### **Deductible**

The portion of eligible expenses that the insured must pay before a benefits provider will pay any claim. The deductible may be a per claim or annual amount.

### **Earnings**

Earnings are defined as follows:

For self-employed, partners, sole proprietors or contract workers, eligible earnings are based on the average of the person's net self-employment income or net partnership income as reported for federal tax purposes in the last two calendar years.

For an owner of an incorporated company, eligible earnings are based on the average of the owner's earnings including salary, bonuses, overtime, commissions and dividends received from their incorporated company as reported for federal tax purposes in the last two calendar years, less taxable benefits included in the earnings.



For salaried employees, eligible earnings are based on the employee's earnings including salary, regular bonuses, regular overtime, profit sharing plans and shift differentials. Earnings do not include sporadic bonus, sporadic overtime, incentive pay and automobile allowances.

For commission salespersons, eligible earnings are based on the average of the person's earnings including salary, commissions and bonuses as reported for federal tax purposes in the last two calendar years, less taxable benefits included in earnings. If employed less than two calendar years, earnings will be averaged over the length of service with the employer.

If there is a difference between the actual annual earnings and those reported by the employer for premium purposes, the lesser of the two amounts will be considered the annual earnings amount under this policy.

### **Elimination Period**

With respect to disability insurance, the Elimination Period is the period of time that must elapse after the onset of illness or disability before the insured person is eligible for benefits.

### **Emergency**

Means a sudden, unexpected occurrence (disease or injury) that requires immediate medical attention.

### **Evidence of Insurability**

Evidence of insurability is any statement or proof of a person's physical condition, medical history, occupation, leisure activities or other factors which may affect his/her acceptance for insurance. This evidence is usually requested to supplement information provided on an application form and is required so that the insurer can accurately assess the risk for insurance.

### **Insured**

Means a plan member and any eligible dependents.

### **Late Applicant**

An enrollment or a change in coverage request is considered to be late if it is submitted more than 31 days after the employee's eligibility date for coverage or more than 31 days after the occurrence that prompted the change in coverage. Late applicants are required to submit evidence of insurability in order to obtain group insurance coverage.

### **Leave of Absence**

This means a period of time away from work mutually agreed to by you and your employer. In the case of maternity leave of absence, the leave shall begin and finish on dates agreed to by you and your employer or as required by Provincial or Federal Law.

### **Misrepresentation**

A misstatement, falsehood or omission which may influence an insurer's approval or rejection of the risk (i.e., the person to be insured). Misrepresentation is grounds for employee coverage and/or policy termination.

### **Medical Underwriting**

The process of assessing whether a person can be insured based on his/her medical history. An insurance company will review the medical history of the applicant and, based on the health of the applicant, determine if coverage can be made available.

The process of being medically underwritten can take anywhere from four to eight weeks, depending on the amount of coverage requested, the type of additional medical information required and how quickly the medical information is provided.

### **Non-Evidence Maximum (NEM)**

A non-evidence maximum is the maximum amount of coverage an employee can receive without providing evidence of insurability. Non-evidence maximums will usually apply to life and disability benefits. This is sometimes referred to as a non-evidence limit or NEL.

### **Non-Smoker**

A person who has totally abstained from smoking all tobacco products and cannabis for a one year period immediately preceding the date of his/her application for Non-Smoker Status.

### **Non-Taxable Benefits**

When an employee pays for full premium cost of Weekly Indemnity and/or Long Term Disability benefits, benefits that are received are not taxable.

### **Overage Children**

These are children of covered employees who are older than the usual maximum age for benefit coverage but may qualify for continued coverage because they are full-time students or because they are functionally impaired and dependent on the employee for support.

### **Plan Effective Date**

Coverage for your employer's company first becomes effective on a specific day, known as the plan effective date. This is the earliest date you may join the plan.

### **Pre-existing Condition**

A sickness or injury for which the insured received medical treatment, consultation, care or services including diagnostic measures, or had taken prescribed drugs or medicines for a specific period prior to the insured's effective date.

### **Reasonable and Customary**

The usual fee charged in a geographic area by a health or dental provider for a specific medical procedure or service.

These reasonable and customary amounts are established by a benefits provider using a combination of their own claims data, the published fee schedules from provincial/territorial associations, typical reasonable and customary fees for provincial/territorial associations without published fee schedules and surveyed responses from practitioners within specific provinces/territories when information from associations is not available.

### **Taxable Benefits**

When an employer pays any portion of the premium for Weekly Indemnity and/or Long Term Disability benefits, the benefits an employee will receive are taxable.

### **Waiting Period**

The waiting period is the period of time each new employee must work for your organization before becoming eligible to join your plan. The employee's "eligibility date" is the day following the end of the waiting period.



Log in to [victorinsurance.ca/gbconnect](https://victorinsurance.ca/gbconnect) for more information.