

# Your Group Benefits Booklet

**NORDA STELO INC.**
**(Flexible Plan)**
**Regular Employees**
**Group no. 91318**

NORDA STELO

MEDAVIE BLUE CROSS

# LIST OF BENEFITS



## Updated Effective Date: August 1, 2021

# BENEFIT SUMMARY

**The benefit summary must be read together with the benefit provisions that are described in the different sections of the booklet.**

| | |
|---|---|
| **Plan waiting period** | Upon employment |

| **Covered employee's Basic Life Insurance** | |
|---|---|
| **Insurable amount** | 1 x the annual salary |
| **Rounding method** | To the next $1,000 |
| **Maximum without evidence of health** | $700,000 |
| **Maximum with evidence of health** | $1,000,000 |
| **Reduction at age 65** | 50% of the amount of insurance |
| **Terminal illness benefit** | Included |
| **Beneficiary designation transferred from previous policy** | Yes |
| **Termination** | Age 70 or retirement, if earlier |

| **Dependents' Basic Life Insurance** | | |
|---|---|---|
| **Amount of insurance** | | |
| | **Spouse** | $10,000 |
| | **Children** | $5,000 per child * |
| **Termination** | | Age 70 or retirement, if earlier (age of the covered employee) |

** a child is covered starting 24 hours after birth*

## Covered employee's and Dependent's Optional Life Insurance

**Insurable amount**

| | |
|---|---|
| • **Covered employee** | Units of $10,000 |
| **Maximum without evidence of health** | None |
| **Maximum with evidence of health** | $500,000* |
| • **Spouse** | Units of $10,000 |
| **Maximum without evidence of health** | None |
| **Maximum with evidence of health** | $500,000 |
| • **Child** | Units of $5,000 |
| **Maximum without evidence of health** | None |
| **Maximum with evidence of health** | $25,000 |

**Termination**

| | |
|---|---|
| **Covered employee and children** | Age 70 or retirement, if earlier (age of the covered employee) |
| **Spouse** | First of the following dates:<br>• Spouse's 70th birthday<br>• Covered employee's 70th birthday (or retirement, if earlier) |

* *the Basic Life Insurance and Optional Life Insurance combined maximum cannot exceed $1,300,000*

## Covered employee's and Dependent's Optional Accidental Death and Dismemberment Insurance (AD&D)

**Insurable amount**

| | |
|---|---|
| • **Covered employee** | Units of $10,000 |
| **Maximum without evidence of health** | $100,000 |
| **Maximum with evidence of health** | $100,000 |
| • **Spouse** | Units of $10,000 |
| **Maximum without evidence of health** | $100,000 |
| **Maximum with evidence of health** | $100,000 |
| • **Child** | Units of $5,000 |
| **Maximum without evidence of health** | $25,000 |
| **Maximum with evidence of health** | $25,000 |

**Termination**

| | |
|---|---|
| **Covered employee and children** | Age 65 or retirement, if earlier (age of the covered employee) |
| **Spouse** | First of the following dates:<br>• Spouse's 65th birthday<br>• Covered employee's 65th birthday (or retirement, if earlier) |

## Covered employee's and Dependent's Optional Enhanced Critical Illness Insurance

| | |
|---|---|
| **Insurable amount** | |
| **Full Benefit Payment** | |
| **Covered employee** | Units of $10,000, maximum of $250,000 |
| **Spouse** | Units of $10,000, maximum of $250,000 |
| **Child** | Units of $5,000, maximum of $25,000 |
| **Partial Benefit Payment** | 10% of the full benefit payment |
| **Maximum without evidence of health** | Proof of health is required for all amounts of coverage |
| **Maximum Conditions Payable** | Up to 2 Unrelated Covered Conditions eligible for full benefit payment/lifetime<br>1 per covered condition eligible for partial benefit payment/lifetime<br>1 covered childhood condition/lifetime |
| **Survival Period** | 30 consecutive days unless otherwise specified in the defined covered conditions |
| **Termination** | |
| • **Covered employee and children** | Age 65 or retirement, if earlier (age of the covered employee) |
| • **Spouse** | First of the following dates:<br>• Spouse's 65th birthday<br>• Covered employee's 65th birthday (or retirement, if earlier) |

| Short-term Disability Insurance | |
|---|---|
| **Insurable amount** | 70% of weekly salary, rounded to the next dollar |
| • **Maximum without evidence of health** | $3,000 |
| • **Maximum with evidence of health** | $3,000 |
| **Elimination period:** | |
| **Hospitalization or day surgery** | 7 days |
| **Accident** | 7 days |
| **Illness** | 7 days |
| **Maximum duration of benefits** | 17 weeks |
| **Taxability of benefits** | Taxable |
| **Integration with C.E.I.C.** | No |
| **Termination** | Retirement |

| Long-term Disability Insurance | |
|---|---|
| **Insurable amount** | 70% of monthly salary, rounded to the next dollar |
| • **Maximum without evidence of health** | $10,500 |
| • **Maximum with evidence of health** | $15,000 |
| **Elimination period** | End of Short-term benefits |
| **Maximum duration of benefits** | To age 65 |
| **Cost-of-Living Adjustment** | None |
| **Taxability of benefits** | Taxable |
| **Direct integration (CPP or QPP and other social programs)** | Yes |
| **Duration of own occupation** | 24 months following the end of the elimination period |
| **Co-ordination: Total benefits cannot exceed** | 85% of gross salary |
| **Termination** | Age 65 (or retirement, if earlier) |

# BRONZE PLAN

| Extended Health Benefit - Drug | |
|---|---|
| **GENERAL INFORMATION** | |
| **Deductible** | $5 per prescribed drug |
| **Percentage of reimbursement** | 70%* |
| **Payment type** | Direct payment card |
| **Supplemental coverage offered to Participants covered by RAMQ public plan** | Integration of RAMQ parameters to this plan's parameters |
| **Termination** | Covered employee's retirement |

| | **Maximum amount payable**** |
|---|---|
| **Regular list of drugs (including RAMQ's list of drugs for Quebec residents)** | Unlimited |
| **Preventive vaccines** | Not covered |

*The out-of-pocket maximum for Participants meets the requirements of the Régie de l'assurance maladie du Québec (RAMQ).

**Blue Cross will reimburse to the lowest ingredient cost Interchangeable Drug (generic drug).

The Participant may request a higher cost drug. However, they will be responsible for paying the difference in cost.

Regardless of whether the Participant's Physician indicates the prescribed drug cannot be substituted, Blue Cross will only reimburse to the lowest ingredient cost Interchangeable Drug (generic drug).

For Participants with an adverse reaction to the lowest cost interchangeable Drug (generic drug), Blue Cross will consider reimbursement of another Interchangeable Drug, on a case by case basis only through the Special Authorization process.

# SILVER PLAN

| Extended Health Benefit - Drug | |
|---|---|
| **GENERAL INFORMATION** | |
| **Deductible** | $5 per prescribed drug |
| **Percentage of reimbursement** | 80%* |
| **Payment type** | Direct payment card |
| **Supplemental coverage offered to Participants covered by RAMQ public plan** | Integration of RAMQ parameters to this plan's parameters |
| **Termination** | Covered employee's retirement |

| | **Maximum amount payable**** |
|---|---|
| **Regular list of drugs (including RAMQ's list of drugs for Quebec residents)** | Unlimited |
| **Preventive vaccines** | $400 / calendar year |

*The out-of-pocket maximum for Participants meets the requirements of the Régie de l'assurance maladie du Québec (RAMQ).

**Blue Cross will reimburse to the lowest ingredient cost Interchangeable Drug (generic drug).

The Participant may request a higher cost drug. However, they will be responsible for paying the difference in cost.

Regardless of whether the Participant's Physician indicates the prescribed drug cannot be substituted, Blue Cross will only reimburse to the lowest ingredient cost Interchangeable Drug (generic drug).

For Participants with an adverse reaction to the lowest cost interchangeable Drug (generic drug), Blue Cross will consider reimbursement of another Interchangeable Drug, on a case by case basis only through the Special Authorization process.

# GOLD PLAN

| Extended Health Benefit - Drug | |
|---|---|
| **GENERAL INFORMATION** | |
| **Deductible** | $5 per prescribed drug |
| **Percentage of reimbursement** | 90%* |
| **Payment type** | Direct payment card |
| **Supplemental coverage offered to Participants covered by RAMQ public plan** | Integration of RAMQ parameters to this plan's parameters |
| **Termination** | Covered employee's retirement |

| | **Maximum amount payable**** |
|---|---|
| **Regular list of drugs (including RAMQ's list of drugs for Quebec residents)** | Unlimited |
| **Preventive vaccines** | $400 / calendar year |

*The out-of-pocket maximum for Participants meets the requirements of the Régie de l'assurance maladie du Québec (RAMQ).

**Blue Cross will reimburse to the lowest ingredient cost Interchangeable Drug (generic drug).

The Participant may request a higher cost drug. However, they will be responsible for paying the difference in cost.

Regardless of whether the Participant's Physician indicates the prescribed drug cannot be substituted, Blue Cross will only reimburse to the lowest ingredient cost Interchangeable Drug (generic drug).

For Participants with an adverse reaction to the lowest cost interchangeable Drug (generic drug), Blue Cross will consider reimbursement of another Interchangeable Drug, on a case by case basis only through the Special Authorization process.

# BRONZE PLAN

## Extended Health Benefit - Accident /Sickness

### GENERAL INFORMATION

| | |
|---|---|
| **Deductible** | None |
| **Termination** | Retirement |

### HOSPITALIZATION

| | Percentage of reimbursement | Maximum amount payable | Maximum duration |
|---|---|---|---|
| **Active care** | 100% | Semi-private | Unlimited |
| **Convalescence or physical rehabilitation** | 100% | Semi-private | 180 days / period of hospitalization |

### VISION CARE

| | Percentage of reimbursement | Total maximum amount payable |
|---|---|---|
| **Eye examination** | n/a | n/a |
| **Eyeglasses, contact lenses and laser surgery** | n/a | n/a |

# BRONZE PLAN

**Extended Health Benefit - Accident /Sickness (cont'd)**

**PARAMEDICALS**

| | Percentage of reimbursement | Eligible maximum per visit | Eligible maximum per calendar year |
|---|---|---|---|
| **Acupuncturist** | 70% | $50 | $300* |
| **Audiologist** | 70% | $50 | $300* |
| **Chiropractor** | 70% | $50 | $300* |
| **X-Rays (chiropractor)** | 70% | n/a | $25 |
| **Dietician** | 70% | $50 | $300* |
| **Occupational therapist** | 70% | $50 | $300* |
| **Homeopath** | 70% | $50 | $300* |
| **Massage therapist** | 70% | $50 | $300* |
| **Naturopath** | 70% | $50 | $300* |
| **Speech therapist** | 70% | $50 | $300* |
| **Osteopath** | 70% | $50 | $300* |
| **Physiotherapist** | 70% | $50 | $300* |
| **Rehabilitation technician** | 70% | $50 | $300* |
| **Athletic therapist** | 70% | $50 | $300* |
| **Podiatrist (or chiropodist)** | 70% | $50 | $300* |
| **Psychologist / Social worker / Guidance counselor / psychotherapist (combined)** | 70% | $50 | $300 |

*Combined eligible maximum of $300 per calendar year

# BRONZE PLAN

## Extended Health Benefit - Accident /Sickness (cont'd)

**MEDICAL SUPPLIES AND SERVICES – NOT COVERED**

| | Percentage of reimbursement | Eligible maximum |
|---|---|---|
| **Nursing Care** | n/a | n/a |
| **Ambulance transportation** | n/a | n/a |
| **Orthopedic shoes** | n/a | n/a |
| **Moulded arch supports** | n/a | n/a |
| **Surgical stockings** | n/a | n/a |
| **Hearing aids** | n/a | n/a |
| **Intrauterine contraceptive device (I.U.D.)** | n/a | n/a |
| **TENS** | n/a | n/a |
| **Glucometer** | n/a | n/a |
| **Dental care due to an accident** | n/a | n/a |
| **Varicose vein injections** | n/a | n/a |
| **Prostheses** | n/a | n/a |
| **Mobility aids and orthopedic appliances** | n/a | n/a |
| **Major medical equipment** | n/a | n/a |
| **Diagnostic tests** | n/a | n/a |
| **Other medical supplies and services *** | n/a | n/a |

# SILVER PLAN

## Extended Health Benefit - Accident /Sickness

### GENERAL INFORMATION

| | |
|---|---|
| **Deductible** | None |
| **Termination** | Retirement |

### HOSPITALIZATION

| | Percentage of reimbursement | Maximum amount payable | Maximum duration |
|---|---|---|---|
| **Active care** | 100% | Semi-private | Unlimited |
| **Convalescence or physical rehabilitation** | 100% | Semi-private | 180 days / period of hospitalization |

### VISION CARE

| | Percentage of reimbursement | Total maximum amount payable |
|---|---|---|
| **Eye examination** | 100% | $50 / 24 consecutive months |
| **Eyeglasses, contact lenses and laser surgery** | 100% | $200 / 24 consecutive months |

# SILVER PLAN

## Extended Health Benefit - Accident /Sickness (cont'd)

**PARAMEDICALS**

| | Percentage of reimbursement | Eligible maximum per visit | Eligible maximum per calendar year |
|---|---|---|---|
| **Acupuncturist** | 80% | $60 | $600* |
| **Audiologist** | 80% | $60 | $600* |
| **Chiropractor** | 80% | $60 | $600* |
| **X-Rays (chiropractor)** | 80% | n/a | $25 |
| **Dietician** | 80% | $60 | $600* |
| **Occupational therapist** | 80% | $60 | $600* |
| **Homeopath** | 80% | $60 | $600* |
| **Massage therapist** | 80% | $60 | $600* |
| **Naturopath** | 80% | $60 | $600* |
| **Speech therapist** | 80% | $60 | $600* |
| **Osteopath** | 80% | $60 | $600* |
| **Physiotherapist** | 80% | $60 | $600* |
| **Rehabilitation technician** | 80% | $60 | $600* |
| **Athletic therapist** | 80% | $60 | $600* |
| **Podiatrist (or chiropodist)** | 80% | $60 | $600* |
| **Psychologist / Social worker / Guidance counselor / psychotherapist (combined)** | 80% | $60 | $600 |

*Combined eligible maximum of $600 per calendar year

# SILVER PLAN

## Extended Health Benefit - Accident /Sickness (cont'd)

| MEDICAL SUPPLIES AND SERVICES* | Percentage of reimbursement | Eligible maximum |
|---|---|---|
| **Nursing Care** | 80% | $15,000 / calendar year |
| **Ambulance transportation** | 80% | Unlimited |
| **Orthopedic shoes** | 80% | $300 / calendar year |
| **Moulded arch supports** | 80% | $300 / calendar year |
| **Surgical stockings** | 80% | 3 pairs / calendar year |
| **Hearing aids** | 80% | $500 / 36 consecutive months |
| **Intrauterine contraceptive device (I.U.D.)** | 80% | $500 / calendar year |
| **TENS** | 80% | $700 / lifetime |
| **Glucometer** | 80% | $200 1- appliance / 36 consecutive months |
| **Dental care due to an accident** | 80% | Unlimited |
| **Varicose vein injections** | 80% | $15 / visit and 10 visits / calendar year |
| **Prostheses** | | |
| • **artificial limbs and artificial eyes** | 80% | Unlimited |
| • **capillary prostheses after chemotherapy** | 80% | $300 / calendar year |
| • **external breast prostheses following a mastectomy** | 80% | $500 / calendar year |
| **Mobility aids and orthopedic appliances** | | |
| • **wheelchair** | 80% | $1,500 / lifetime |
| • **crutches, canes, walking aids, casts, trusses, orthopedic devices, cervical collars and ortheses** | 80% | Unlimited |
| **Major medical equipment** | | |
| • **hospital-type bed** | 80% | 1 / 5 calendar years |
| • **insulin pumps** | 80% | $1,750 / 60 consecutive months |
| • **compression pump and percussor** | 80% | 1 / 5 calendar years |
| • **apnea monitor** | 80% | 1 / 5 calendar years |
| • **therapeutic appliances** | 80% | $10,000 / lifetime |
| **Diagnostic tests** | | |
| • **Laboratory analyses, X-rays, electrocardiograms, scanners, ultrasounds and magnetic resonance imagery (MRI)** | 80% | $500 / calendar year |
| **Other medical supplies and services *** | | |
| • **oxygen** | 80% | Unlimited |
| • **appliances for the administration of oxygen** | 80% | 1 / 5 calendar years |

***** *see text in Extended Health Benefit for the complete listing and details on coverage*

# GOLD PLAN

## Extended Health Benefit - Accident /Sickness

### GENERAL INFORMATION

| | |
|---|---|
| **Deductible** | None |
| **Termination** | Retirement |

### HOSPITALIZATION

| | Percentage of reimbursement | Maximum amount payable | Maximum duration |
|---|---|---|---|
| **Active care** | 100% | Semi-private | Unlimited |
| **Convalescence or physical rehabilitation** | 100% | Semi-private | 180 days / period of hospitalization |

### VISION CARE

| | Percentage of reimbursement | Total maximum amount payable |
|---|---|---|
| **Eye examination** | 100% | $75 / 24 consecutive months |
| **Eyeglasses, contact lenses and laser surgery** | 100% | $300 / 24 consecutive months |

# GOLD PLAN

## Extended Health Benefit - Accident /Sickness (cont'd)

**PARAMEDICALS**

| | Percentage of reimbursement | Eligible maximum per visit | Eligible maximum per calendar year |
|---|---|---|---|
| **Acupuncturist** | 90% | $70 | $900* |
| **Audiologist** | 90% | $70 | $900* |
| **Chiropractor** | 90% | $70 | $900* |
| **X-Rays (chiropractor)** | 90% | n/a | $25 |
| **Dietician** | 90% | $70 | $900* |
| **Occupational therapist** | 90% | $70 | $900* |
| **Homeopath** | 90% | $70 | $900* |
| **Massage therapist** | 90% | $70 | $900* |
| **Naturopath** | 90% | $70 | $900* |
| **Speech therapist** | 90% | $70 | $900* |
| **Osteopath** | 90% | $70 | $900* |
| **Physiotherapist** | 90% | $70 | $900* |
| **Rehabilitation technician** | 90% | $70 | $900* |
| **Athletic therapist** | 90% | $70 | $900* |
| **Podiatrist (or chiropodist)** | 90% | $70 | $900* |
| **Psychologist / Social worker / Guidance counselor / psychotherapist (combined)** | 90% | $70 | $900 |

*Combined eligible maximum of $900 per calendar year

# GOLD PLAN

## Extended Health Benefit - Accident /Sickness (cont'd)

**MEDICAL SUPPLIES AND SERVICES***

| | Percentage of reimbursement | Eligible maximum |
|---|---|---|
| **Nursing Care** | 90% | $15,000 / calendar year |
| **Ambulance transportation** | 90% | Unlimited |
| **Orthopedic shoes** | 90% | $300 / calendar year |
| **Moulded arch supports** | 90% | $300 / calendar year |
| **Surgical stockings** | 90% | 3 pairs / calendar year |
| **Hearing aids** | 90% | $500 / 36 consecutive months |
| **Intrauterine contraceptive device (I.U.D.)** | 90% | $500 / calendar year |
| **TENS** | 90% | $700 / lifetime |
| **Glucometer** | 90% | $200 1- appliance / 36 consecutive months |
| **Dental care due to an accident** | 90% | Unlimited |
| **Varicose vein injections** | 90% | $15 / visit and 10 visits / calendar year |
| **Prostheses** | | |
| • **artificial limbs and artificial eyes** | 90% | Unlimited |
| • **capillary prostheses after chemotherapy** | 90% | $300 / calendar year |
| • **external breast prostheses following a mastectomy** | 90% | $500 / calendar year |
| **Mobility aids and orthopedic appliances** | | |
| • **wheelchair** | 90% | $1,500 / lifetime |
| • **crutches, canes, walking aids, casts, trusses, orthopedic devices, cervical collars and ortheses** | 90% | Unlimited |
| **Major medical equipment** | | |
| • **hospital-type bed** | 90% | 1 / 5 calendar years |
| • **insulin pumps** | 90% | $1,750 / 60 consecutive months |
| • **compression pump and percussor** | 90% | 1 / 5 calendar years |
| • **apnea monitor** | 90% | 1 / 5 calendar years |
| • **therapeutic appliances** | 90% | $10,000 / lifetime |
| **Diagnostic tests** | | |
| • **Laboratory analyses, X-rays, electrocardiograms, scanners, ultrasounds and magnetic resonance imagery (MRI)** | 90% | $500 / calendar year |
| **Other medical supplies and services *** | | |
| • **oxygen** | 90% | Unlimited |
| • **appliances for the administration of oxygen** | 90% | 1 / 5 calendar years |

***** *see text in Extended Health Benefit for the complete listing and details on coverage*

# ALL PLANS

## Extended Health Benefit - Travel

### GENERAL INFORMATION

| | |
|---|---|
| **Deductible** | None |
| **Percentage of reimbursement** | 100% |
| **Waiver or premiums** | No |
| **Coverage duration*** | |
| • **under age 75** | First 180 days of Trip outside province of residence |
| • **age 75 and over** | First 60 days of Trip outside province of residence |
| **Termination** | Retirement |

### TRAVEL COVERAGE

| | **Maximum amount payable** |
|---|---|
| **Emergency Hospital and Medical Travel Coverage** | $2,000,000/Participant/Incident** |
| **Worldwide Travel Assistance** | Yes |
| **Referral Outside of Canada*** ** | $500,000/Participant/lifetime |

***Coverage duration will be determined based on the age of the Participant on their departure date.**
****Incident: An individual occurrence of Emergency illness or injury.**
*****Pre-authorization required.**

**Note: If the duration of your trip is to exceed the maximum number of days covered under this benefit, we strongly recommend that you take out an individual Travel insurance policy prior to your departure for the number of days that will not be covered under this benefit.**

# BRONZE PLAN

**Dental Care Coverage – Not covered**

**GENERAL INFORMATION**

| | |
|---|---|
| **Deductible** | n/a |
| **Fee Guide** | n/a |
| **Recall examination** | n/a |
| **Waiver of premiums** | n/a |
| **Termination** | n/a |

**DENTAL CATEGORIES**

| | **Percentage of reimbursement** | **Combined Maximum reimbursement** |
|---|---|---|
| **Preventive care and Basic care** | n/a | n/a |
| **Major Restoration** | n/a | n/a |
| **Orthodontic Services for dependent children (from age 6 to 18 inclusively)** | n/a | n/a |

# SILVER PLAN

## Dental Care Coverage

### GENERAL INFORMATION

| | |
|---|---|
| **Deductible*** | $50 per Participant, maximum of $100 per family, per calendar year |
| **Fee Guide** | Previous year |
| **Recall examination** | 1 per 9 consecutive months |
| **Waiver of premiums** | No |
| **Termination** | Retirement |

* *Eligible expenses incurred during the last three months of a calendar year and which have not been used because the deductible for that year had not been met, may be used to reduce the deductible for the following calendar year.*

### DENTAL CATEGORIES

| | Percentage of reimbursement | Combined Maximum reimbursement |
|---|---|---|
| **Preventive care and Basic care** | 80% | $1,250 / calendar year |
| **Major Restoration** | n/a | n/a |
| **Orthodontic Services for dependent children (from age 6 to 18 inclusively)** | n/a | n/a |

# GOLD PLAN

## Dental Care Coverage

### GENERAL INFORMATION

| | |
|---|---|
| **Deductible*** | $50 per Participant, maximum of $100 per family, per calendar year |
| **Fee Guide** | Previous year |
| **Recall examination** | 1 per 9 consecutive months |
| **Waiver of premiums** | No |
| **Termination** | Retirement |

* *Eligible expenses incurred during the last three months of a calendar year and which have not been used because the deductible for that year had not been met, may be used to reduce the deductible for the following calendar year.*

### DENTAL CATEGORIES

| | Percentage of reimbursement | Maximum reimbursement |
|---|---|---|
| **Preventive care and Basic care** | 90% | $2,000 / calendar year* |
| **Major Restoration** | 50% | $2,000 / calendar year* |
| **Orthodontic Services for dependent children (from age 6 to 18 inclusively)** | 50% | $2,000 / lifetime |

*Combined maximum reimbursement of $2,000 per calendar year.

# An overview of your group insurance plan

A group insurance program covering your medical and financial security has been made available to you by your employer. This program is offered to you through Medavie Inc. and Blue Cross Life Insurance Company of Canada, hereafter called the "Insurer".

The different sections of information summarize in a simplified form the provisions of the contract between your employer and the Insurer. In this section, you will find information dealing with eligibility and participation to the plan as well as pertinent information that you will require in order to use, in the best possible manner, the coverage that is offered for your well-being and that of your family.

This booklet together with your insurance certificate contains important information and must therefore be kept in a safe place.

Where legislated, you have the right to request a copy of the group policy details pertaining to your coverage, a copy of your application for benefits and any written statements or other record provided to the Company as evidence of your health. You may also request, with reasonable notice, a copy of the contract for insured benefits. The first copy will be provided at no cost to you. A fee may be charged for subsequent copies. All requests for copies of documents should be directed to Medavie Blue Cross.

Finally, please note that the masculine gender has been used indiscriminately throughout this document in order to facilitate its reading.

## *Is my enrolment in the group insurance plan mandatory?*

Yes, you must select all the benefits for which you are eligible under the employee category to which you belong, while taking into consideration your family status as well.

However, you may also exercise your right of **exemption** under the Extended Health Benefit and the Dental Care Benefit if you provide the Insurer with proof that you and your dependents are covered under your spouse's plan. Should this other coverage terminate **involuntarily**, you and your dependents shall again become eligible under your group plan. Your request must then be submitted within **31 days** following the termination of the other insurance.

## *When do I become eligible for group insurance?*

As a permanent employee, you become eligible for the group insurance coverage as soon as you have met the plan waiting period specified in the Benefit Summary. To participate in the plan, you must first complete the insurance forms that are provided to you upon your eligibility to the various plans.

Your dependents are insured on the date you become insured, or on the date they become your dependents.

## *Who are your eligible dependents?*

Your dependents are:

- Your **spouse**, who is the person to whom you are married, or the person that you introduce as your spouse and have been living with for at least one year, or regardless of the duration when a child is born of such union.

Your spouse, the one you have designated on your application, remains covered until there is annulment of marriage or divorce, or until such time that you and your common-law spouse have been living separately for at least **90 consecutive days** because of a breakdown of your conjugal relationship.

- Your unmarried **children** who are your financial dependents and

  - are under 21 years of age, or
  - are under 26 years of age if full-time students attending an institution providing instruction at a secondary, college or university level, as a duly registered student, or
  - regardless of their age, if they live with you and have become totally and permanently disabled before age 18 (or age 26 if a student) and who receive no allowance under the Act respecting income security.

  Note: For the **Dependents' Basic life Insurance Benefit**, a child is covered starting 24 hours after birth.

## *Is evidence of insurability required?*

You must submit evidence of insurability if:

- the amount of insurance exceeds the Non-evidence maximum specified in the Benefit Summary.
- you apply for any amount of Optional Life Insurance or increase thereof.
- your application for insurance for yourself or your dependents is presented to the Insurer more than 31 days after the eligibility date.

### *Is there a default level of coverage?*

If no choice of coverage is made within 31 days following the date you become eligible, Silver Plan you will be assigned as coverage by default, until the next annual enrolment period.

### *What are the rules regarding changes in coverage during the enrolment period?*

You may change your plan and status on January 1st, every two years, starting on January 1, 2022. Your request must be forwarded to the Insurer within 31 days following that date.

During the annual enrolment period, provided you are not totally disabled or receiving benefits from the salary continuance plan of your employer, you can modify your choice of coverage (plan and status), subject to certain restrictions that may apply. You must keep the chosen plan until the next enrolment period (or before that date when a life event occurs, as mentioned hereunder).

During a request, you will be authorized to modify your plan but by only one level at a time. The plan can be changed as follows:

| Benefit | Coverage in force | Coverage requested |
|---|---|---|
| **Extended Health Benefit - Drug Coverage** | Bronze Plan | Silver Plan |
| | Silver Plan | Bronze or Gold Plan |
| | Gold Plan | Silver Plan |
| **Extended Health Benefit - Accident/Sickness Coverage** | Bronze Plan | Silver Plan |
| | Silver Plan | Bronze or Gold Plan |
| | Gold Plan | Silver Plan |
| **Dental Care Coverage** | Bronze Plan | Silver Plan |
| | Silver Plan | Bronze or Gold Plan |
| | Gold Plan | Silver Plan |

**The Covered Employee may choose one of the following statuses:**

- Exempted (if the Covered Employee is covered under the Spouse's Group Plan)
- Individual
- Couple
- Single parent
- Family

You may choose the same coverage status for Extended Health Benefit (Drug, Accident/sickness and Travel coverage)

**Life event:** You can modify your choice of coverage (plan and status) before the two years period if one of the following life events occurs (the rules mentioned below are applicable):

- marriage or eligibility of your common-law spouse;
- separation, divorce or the end of your common-law union;
- birth or adoption of a first child;
- death of a Dependent;
- your last dependent child is no longer eligible or your child over the age of 21 (but less than 26) is going back to school full time when there were not any eligible children left;
- your spouse gains or loses access to coverage under his employer's group plan.

You have 31 days to modify your plan. Once the 31-day period has ended, you must wait for the next enrolment period to modify your choice of coverage (plan and status) and to cover a new dependent.

Past this 31 days delay, in Quebec, in accordance with the applicable legislation you and your dependents will be covered under the Health benefits, according to the policy's provisions.

If you are unfit to work on the date the change should take effect, such change will become effective on the date you are able to return to work.

**RETURN TO PARTICIPATION AT THE END OF AN EXEMPTION (EXTENDED HEALTH BENEFIT AND DENTAL CARE BENEFIT)**

If you were exempted from these benefits, you shall become eligible for either Bronze, Silver or Gold plan on the date that similar coverage which gave rise to the exemption terminates involuntarily on your part or on your spouse's part. You must enrol within 31 days following the termination date of that coverage.

## *How do I file a claim?*

Extended Health Benefit - Hospitalization
If you or one of your dependents are hospitalized, simply show your insurance certificate at the time you are being admitted. The claim will be forwarded to our office by the hospital.

Extended Health Benefit - Drug
The claim procedure includes direct payments through the BLUE CROSS card. Show your BLUE CROSS card to your pharmacist and you will then have to pay only $5 per prescribed drug, as well as your coinsurance.

You will have no claim to submit to your insurer.

Extended Health Benefit – Accident/Sickness
Complete the Claim form, attach the original receipts and forward the whole to the Insurer.

The duly completed Claim form must be sent to the Insurer no later than 12 months after the date expenses were incurred.

To find out the local Blue Cross address your claim must be sent to, please refer to your claim form or contact our Customer Service 1 888 873-9200.

Extended Health Benefit - Travel
You must obtain detailed invoices for hospital, medical or other services and provide the Insurer with an attending physician's statement confirming that all services for which you submit a claim were rendered. The Insurer will see to it that the government plan's share is duly refunded.

**The duly completed Claim form must be filed with the Insurer no later than 4 months after the date expenses were incurred.**

**The Insurer will accept claims up to 12 months from the date the expense was incurred. However, in such circumstances, the claim may be subject to reductions for any amounts the Insurer would have been able to co-ordinate with the Participant's government health care coverage had the claim been submitted within the 4-month limitation period.**

Dental Care Insurance
Reimbursement is made electronically through the ACDQ network; you must present your insurance certificate to your dentist at every visit. Two reimbursement options are possible depending on your dentist's preference:

- you only pay your deductible and your coinsurance (if applicable), and excess expenses are paid directly to the dentist by the Insurer; or
- you pay the total amount requested by your dentist and you will receive in the next few days the portion of the expenses refundable by your plan.

If, however, your dentist cannot use the electronic transaction network, complete and submit a dental claim form to your Insurer. The duly completed claim form must be sent to the Insurer no later than 12 months after the date expenses were incurred.

To find out the local Blue Cross address your claim must be sent to, please refer to your claim form or contact our Customer Service at 1-888-873-9200**.**

**Mobile App**
Submit your claims through the Medavie Mobile app and have your reimbursement deposited directly to your bank account.

Visit www.medavie.bluecross.ca/app for more information or to download the app.

**FOR ADDITIONAL INFORMATION REGARDING YOUR INSURANCE PLAN, SIMPLY CALL THE MEDAVIE BLUE CROSS CUSTOMER SERVICE AT THE FOLLOWING NUMBER:**

**1-888-873-9200**

**A MEMBER PORTAL IS ALSO AVAILABLE FOR YOUR GROUP INSURANCE PLAN AT THE FOLLOWING ADDRESS:**

**www.medavie.bluecross.ca**

**SELECT "LOGIN" AND MAKE SURE YOU HAVE YOUR BLUE CROSS IDENTIFICATION CARD (DRUG CARD) ON HAND TO REGISTER FOR ACCESS TO THE PORTAL.**

Note: For insurance purposes, you and your dependents are deemed covered under the Hospital and Health Insurance acts in your province of residence, and under no circumstances will the amount paid by the Insurer to a Participant without such coverage ever exceed the amount that would have been paid had he been insured under such acts, unless specified otherwise.

## *Who has access to my confidential information?*

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

Upon a 30-day written notice, you will be entitled to access the information contained in your file and, if necessary, request that it be corrected, according to the provisions of the *Act respecting the protection of personal information in the private sector*.

# Life Insurance

The Life Insurance plan offers, at a reasonable cost, the amounts of Life Insurance protection required to meet your needs as well as those of your dependents.

## *Basic Life Insurance*

Your Basic Life insurable amount is as specified in the Benefit Summary.

The Basic Life Insurance coverage reductions are specified in the Benefit Summary. Coverage terminates when your employment terminates, at retirement or when you reach the Age specified in the Benefit Summary, if applicable, whichever occurs first.

## *Dependents' Basic Life Insurance*

Your dependents are also insured if you have chosen family coverage. Their amount of insurance is specified in the Benefit Summary.

The Dependents' Insurance terminates concurrently with your insurance termination, or when they are no longer eligible as dependents, whichever occurs first.

## *Optional Life Insurance*

You may subscribe to the Optional Life Insurance in $10,000 increments, as stipulated in the Benefit Summary.

For your spouse, the benefit amount is a multiple of $10,000, as stipulated in the Benefit Summary.

For your children, the benefit amount is a multiple of $5,000, as stipulated in the Benefit Summary.

Your Optional Life Insurance coverage and that of your dependents terminates when your employment terminates, at your retirement or when you reach **age 70**, whichever occurs first.

As well, your spouse's Optional Life Insurance coverage terminates when he himself reaches the age of **70**.

## *Terminal Illness*

If you are diagnosed with a terminal illness that is expected to result in your death within 24 months, a lump sum advance equivalent to **50%** of the amount of your Basic Life Insurance or $100,000, whichever is less, may be deducted from your death benefit and paid to you. This sum may be used at your discretion.

Satisfactory medical certification must be provided to the Insurer by the attending physician and you must meet the eligibility requirements regarding the waiver of premiums applicable to certain benefits of the contract. It is also understood that the special advance payment will be deducted from the Basic Life Insurance amount payable to your beneficiary upon your death.

## *Payment of benefits*

Upon your death, the Insurer will pay to your named beneficiary the amount of your Basic Life Insurance and of your Optional Life Insurance, if any. You are the beneficiary of the Dependents' Life Insurance.

Note: your beneficiary designation for the life benefit under the previous group insurance policy is continued under this plan.

## *Exclusion: suicide (applicable to Optional Life only)*

If you or one of your dependents die as a result of suicide or any attempt thereof in the **24 months** following the effective date of the **Optional Life Insurance or increase thereof**, the Optional Life Insurance or its increase is not payable. In this particular instance, the Insurer's obligation is limited to the refund of paid premiums.

## *Conversion privilege*

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

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

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

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

Life insurance amount that can be converted

1. If you reside in Quebec

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

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

b) $400,000.

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

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

2. If you reside outside Quebec

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

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

b) $200,000.

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

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

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

# Optional Accidental Death and Dismemberment Insurance (AD&D)

If, as a result of an Accident, the Covered Employee or Dependent dies, falls into a Coma or suffers a Loss defined in this benefit, the Insurer will pay a specified percentage of the amount of the optional accidental death and dismemberment in effect at the time of the Accident, subject to the conditions outlined below.

## *Additional Definitions*

**Coma or comatose**: State of unconsciousness with no reaction to external stimuli or response to internal needs that persists for a continuous period of at least 30 days.

**Hemiplegia**: Total and irrecoverable paralysis of the upper and lower limbs on one side of the body.

**Loss**: Any loss specified in the Table of Benefits.

**Loss of arm**: Complete severance at or above the elbow joint.

**Loss of finger**: Complete loss of two entire bones of a finger.

**Loss of foot**: Complete severance at or above the ankle joint but below the knee joint.

**Loss of hand**: Complete severance at or above the wrist joint but below the elbow joint.

**Loss of hearing**, sight or speech: Total and irrecoverable loss of hearing, sight or speech, certified by a physician.

**Loss of leg**: Complete severance at or above the knee joint.

**Loss of thumb**: Complete loss of one entire bone of a thumb.

**Loss of toe**: Complete loss of one entire bone of the big toe or of all bones of any other toe.

**Loss of use**: Complete and irreversible loss of use of a limb for at least 12 months.

**Quadriplegia**: Total and irrecoverable paralysis of both the upper and lower limbs.

**Paraplegia**: Total and irrecoverable paralysis of both lower limbs.

## *Coverage*

To be covered under this benefit, a Loss must:

- result from an Accident that occurs while the Covered Employee or Dependent is covered under this benefit; and
- occur within 365 days after the date of this Accident.

A Covered Employee or Dependent will be considered to have suffered loss of life as a result of an Accident if the Covered Employee's or Dependent's death is due to accidental drowning.

## *What the Insurer Will Pay*

**Table of benefits**

In the event of Loss, the Insurer will pay the following percentages of the coverage amount specified in the Benefit Summary:

| **Loss of** | **Amount of coverage** |
|---|---|
| Life | 100% |
| Both hands or both feet | 100% |
| Both arms or both legs | 100% |
| Speech and hearing in both ears | 100% |
| Sight in both eyes | 100% |
| Sight in one eye and one hand | 100% |
| Sight in one eye and one foot | 100% |
| One hand and one foot | 100% |
| One arm and one leg | 100% |
| One arm or one leg | 75% |
| One hand or one foot | 66 2/3% |
| Sight in one eye | 66 2/3% |
| Speech or hearing in both ears | 50% |
| Thumb and index finger of any one hand | 33 1/3% |
| At least four fingers of one hand | 33 1/3% |
| Hearing in one ear | 16 2/3% |
| All toes of one foot | 12 1/2% |

**Paralysis**

| | |
|---|---|
| Quadriplegia | 200% |
| Hemiplegia | 200% |
| Paraplegia | 200% |

**Loss of use of**

| | |
|---|---|
| Both arms or both legs | 100% |
| Both hands or both feet | 100% |
| One hand and one foot | 100% |
| One arm and one leg | 100% |
| One arm or one leg | 75% |
| One hand or one foot | 66 2/3% |

## *Additional Benefits*

The Insurer will also pay the following additional benefits, if applicable:

**Coma**

If the Covered Employee or Dependent falls into a Coma as a result of an Accident, the Insurer will pay a monthly benefit equal to 1% of the amount of coverage specified in the Benefit Summary.

For benefits to be payable, the Coma must occur within 30 days of the Accident and persist uninterrupted for at least 30 days. Benefits are then payable for the duration of the Coma or until the amount of coverage has been paid in full, whichever occurs first.

**Exposure and Disappearance**

If a Covered Employee or Dependent is unavoidably exposed to the elements and suffers a Loss as a result of and within 365 days of this exposure, the Loss will be deemed to be the result of an Accident.

A Covered Employee or Dependent will be deemed to have suffered loss of life as a result of an Accident if:

- the Covered Employee or Dependent disappears due to the accidental wrecking, sinking or disappearance of a vehicle; and
- their body is not found within 365 days (unless there is contrary evidence to suggest that the Covered Employee or Dependent is still alive).

**Repatriation**

If benefits are payable for loss of life that occurred at least 150 kilometres from the Covered Employee's or Dependent's place of residence, the Insurer will pay the expenses incurred to:

- prepare the body for burial or cremation; and
- ship the body to the place of burial or cremation or bury or cremate the body at the place of death.

The benefit maximum for all expenses under this benefit provision is $10,000. Amounts payable will be paid to any person who appears to the Insurer to be fairly entitled to the benefit as a result of having incurred any of the above mentioned expenses.

On receipt of written proof of anticipated expenses, the Insurer may make an advance payment, provided that the policyholder confirms to the Insurer:

- the name of the Covered Employee or Dependent and the date and cause of death; and
- that the Covered Employee or Dependent was eligible for this benefit on the date of death.

This coverage excludes the cost of a coffin.

**Rehabilitation**

If benefits are payable to a Covered Employee as a result of a Loss, the Insurer will pay reasonable and necessary expenses incurred by the Covered Employee for special training, provided that:

- these expenses are incurred within 3 years of the date of the Accident; and
- the training is needed:
  - as a result of the Loss; or
  - to enable the Covered Employee to work in an occupation for which they were not qualified before the Loss.

The amount payable under this benefit provision will not exceed $10,000.

This coverage excludes travel, clothing and ordinary living expenses.

**Occupation Training for the Spouse**

If benefits are payable for loss of life of a Covered Employee, the Insurer will pay the reasonable and necessary expenses incurred by their Spouse for a formal training program provided that:

- the Spouse is taking the program to gain active employment in any occupation for which they would not otherwise be qualified; and
- the expenses are incurred within 3 years of the Covered Employee's death.

The amount payable under this benefit provision will not exceed $10,000.

This coverage excludes travel, clothing and ordinary living expenses.

**Education for Children**

If benefits are payable for loss of life of a Covered Employee, the Insurer will pay tuition fees and other reasonable and necessary expenses incurred by each Child enrolled in a post-secondary education institution, provided that this enrolment is:

- on a full-time basis; and
- in effect at the time of the Covered Employee's death or occurs within 365 days of the Covered Employee's death.

The maximum amount payable per Child is the lesser of:

- 5% of the Covered Employee's coverage specified in the Benefit Summary;
- the actual eligible expenses incurred; or

- $5,000 for each year a Child continues their post-secondary education on a full-time basis to a maximum of 5 years or until the Child reaches age 25, whichever occurs first.

The amount payable will be paid in annual instalments to the Child (if age 18 and over) or to the surviving parent or legal guardian of the Child (if the Child is under age 18). Each payment instalment will be issued on receipt by the Insurer of written proof of enrolment and of expenses incurred.

This coverage excludes travel, clothing, room, board and ordinary living expenses.

**Family Travel**

If a Covered Employee or Dependent is confined to a hospital more than 150 kilometres from the Covered Employee's or Dependent's normal place of residence as a result of:

- a Loss or a Coma; or
- an illness or injury not specified in the Table of Benefits but which requires at least 4 days of hospital confinement.

The Insurer will pay the reasonable and necessary travel and accommodation expenses for 1 or more Family Covered Employees to travel to the Covered Employee's or Dependent's place of confinement.

The maximum amount payable under this benefit provision is the lesser of:

- hotel accommodation and transportation costs actually incurred; or
- $3,000.

If personal transportation is used instead of public transportation, a rate of $0.35 per kilometre applies.

**Common Disaster**

If the Covered Employee and their Spouse die as a result of, and within 90 days of, the same Accident, the amount payable for the loss of life of the Spouse will be increased to equal the amount payable for the loss of life of the Covered Employee.

**Extended Family Benefit**

If amounts are payable under this benefit due to the Covered Employee's loss of life, any coverage in effect for any of the Covered Employee's Dependents under this benefit will be automatically extended for 6 months without payment of premiums.

## *Payment of Claims*

**Beneficiary**

In the case of the Covered Employee's death, benefits will be paid directly to the Covered Employee's beneficiary, unless otherwise specified in this benefit. For any other Loss or Coma, benefits will be paid to the Covered Employee.

In the case of coverage for a Dependent, all benefits are payable to the Covered Employee.

**Maximum Amount Payable**

The total amount payable for one or more Losses or a Coma that results from the same Accident will not exceed 100% of the amount of coverage specified in the Benefit Summary, except for Quadriplegia, Paraplegia and Hemiplegia that are paid at 200%.

The Insurer will only pay one amount, the largest applicable, for injuries to the same limb that result from the same Accident.

In the event that the Covered Employee is also covered by the Covered Employee accidental death and dismemberment Insurance, the total maximum amount payable under this benefit and the Covered Employee accidental death and dismemberment Insurance is limited to the following amounts:

- Repatriation - total of $10,000;
- Rehabilitation - total of $10,000;
- Occupation Training for the Spouse - total of $10,000;
- Education for Children - total of $5,000 per year to a maximum of 5 years;
- Family Travel - total of $3,000.

**Time Limit to Submit a Claim**

The Insurer must receive proof of claim as soon as is reasonably possible and in no event later than 12 months following the date of the loss.

## *Exclusions and Limitations*

The Insurer will not pay any benefits for a Loss or a Coma that results directly or indirectly from the following causes:

a) any medical or surgical treatment or illness or disease of any kind, other than septic infection caused through a wound sustained as a result of an Accident;

b) suicide, attempted suicide or voluntary injury or illness;

c) voluntary ingestion of poison or drugs;

d) inhalation of fumes, unless an occupational health and safety board has deemed such inhalation to be an Accident;

e) any Accident or injury occurring while participating in a criminal act or attempting to commit a criminal act, regardless of whether charges are laid or a conviction is obtained;

f) insurrection, war (declared or not), the hostile action of the armed forces of any country or participation in any riot or civil commotion;

g) injuries sustained while flying or attempting to fly an airplane or other type of aircraft if the Covered Employee or Dependent is part of the crew or is performing any other flight duties; or

h) any Accident or injury that occurs while operating a vehicle under the influence of any intoxicant or with a blood alcohol level in excess of the legal limit in the jurisdiction in which the Accident occurred.

## *Right to Convert to Individual Coverage*

**Eligibility for Conversion**

The Covered Employee has the right to purchase an individual accidental death and dismemberment policy from the Insurer, if their optional accidental death and dismemberment benefit coverage terminates on or before their 65th birthday due to retirement, termination of employment or termination of coverage for the group or class of Employees to which the Covered Employee belongs.

On or before their 65th birthday, a Spouse has the right to purchase an individual accidental death and dismemberment policy from the Insurer if their optional accidental death and dismemberment insurance coverage terminates or reduces for any reason other than at the request of Covered Employee.

**Terms and Conditions of the Converted Policy**

Individual policies issued under this conversion option are subject to the following terms and conditions:

- You must, within 31 days of the date of termination of your group coverage:
  - submit the application form provided by the Insurer for the purpose of conversion to individual coverage; and
  - pay the entire amount of the first month's premium of the individual policy, in accordance with the method of payment stipulated by the Insurer;
- the individual policy will be issued without requiring proof of health;
- the premium for the individual policy is based upon the individual policy rates in effect on the date of application and the age and sex of the Participant on that date;
- the individual policy is subject to any maximum and minimum values or other additional terms and conditions that are outlined below.

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

- during the 31 day period that the conversion option may be exercised, the amount of coverage available through this conversion option is continued without charge;

- the effective date of coverage under the individual accidental death and dismemberment policy will be 31 days after the group coverage terminates;
- the individual accidental death and dismemberment policy will not include any disability or other supplementary benefits;
- the amount of coverage provided by the individual accidental death and dismemberment policy cannot be less than the minimum amount the Insurer will normally issue for the type of policy selected;
- the maximum amount of coverage provided by the individual accidental death and dismemberment policy is:
  - the lesser of $200,000 or the Covered Employee's combined accidental death and dismemberment insurance and optional accidental death and dismemberment insurance, in effect on the date of termination of the optional accidental death and dismemberment; and
  - the lesser of $200,000 or the Spouse's optional accidental death and dismemberment insurance, in effect on the date of the termination of the optional accidental death and dismemberment insurance benefit.

### *Termination of benefit*

Coverage for Optional Accidental Death and Dismemberment Insurance terminates for you and your dependents when your employment terminates, upon your retirement or when you reach the Age specified in the Benefit Summary, whichever occurs first.

Coverage for your spouse also terminates when he himself reaches the Age specified in the Benefit Summary.

# Optional Enhanced Critical Illness Insurance

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

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

For example, you may use the money to:

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

## *Amount of Coverage*

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

## *Additional Definitions*

**Activities of Daily Living:** The following 6 activities:

- Bathing: washing oneself in a bathtub, shower or by sponge bath;
- Dressing: putting on and removing necessary clothing, braces, artificial limbs or other surgical appliances;
- Toileting: getting on and off the toilet and maintaining personal hygiene;
- Bladder and bowel continence: managing bladder and bowel function with or without protective undergarments or surgical appliances so that hygiene is maintained;
- Transferring: moving in and out of a bed, chair or wheelchair; and
- Feeding: consuming food or drink that already have been prepared and made available.

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

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

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

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

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

- the Participant or the Participant's Family Covered Employee; or
- the Participant's employer or co-worker.

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

- the Participant or the Participant's Family Covered Employee; or
- the Participant's employer or co-worker.

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

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

## *Covered Conditions Eligible for Full Benefit Payment*

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

**Category 1:** Cancer

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

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

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

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

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

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

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

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

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

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

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

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

This coverage excludes viral meningitis.

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

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

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

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

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

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

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

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

**Blindness:** Definite diagnosis of the total and irreversible loss of vision in both eyes, evidenced by:

- the corrected visual acuity being 20/200 or less in both eyes; or
- the field of vision being less than 20 degrees in both eyes.

The diagnosis of Blindness must be made by a Specialist.

**Cancer:** Definite diagnosis of a malignant tumour. This tumour must be characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. Types of cancer include carcinoma, melanoma, leukemia, lymphoma, and sarcoma. The diagnosis of Cancer must be made by a Specialist and must be confirmed by a pathology report.

For purposes of this condition:

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

No benefit is payable under this condition for the following:

- lesions described as benign, non-invasive, pre-malignant, of low or uncertain malignant potential, borderline, carcinoma in situ or tumours classified as Tis or Ta;
- malignant melanoma of skin that is less than or equal to 1.0 mm in thickness, unless it is ulcerated or is accompanied by lymph node or distant metastasis;
- any non-melanoma skin cancer, without lymph node or distant metastasis. This includes but is not limited to, cutaneous T cell lymphoma, basal cell carcinoma, squamous cell carcinoma or Merkel cell carcinoma;
- prostate cancer classified as T1a or T1b, without lymph node or distant metastasis;
- papillary thyroid cancer or follicular thyroid cancer, or both, that is less than or equal to 2.0 cm in greatest dimension and classified as T1, without lymph node or distant metastasis;
- chronic lymphocytic leukemia classified as Rai stage 0 without enlargement of lymph nodes, spleen or liver and with normal red blood cell and platelet counts;

- gastro-intestinal stromal tumours classified as AJCC Stage 1;
- grade 1 neuroendocrine tumours (carcinoid) confined to the affected organ, treated with surgery alone and requiring no additional treatment, other than perioperative medication to oppose effects from hormonal oversecretion by the tumour; or
- thymomas (stage 1) confined to the thymus, without evidence of invasion into the capsule or spread beyond the thymus.

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

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

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

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

This coverage excludes:

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

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

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

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

The diagnosis of Deafness must be made by a Specialist.

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

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

The Participant must exhibit:

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

This coverage excludes affective or schizophrenic disorders or delirium.

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

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

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

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

No benefit is payable under this condition for:

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

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

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

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

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

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

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

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

**Loss of Limbs:** Definite diagnosis of the complete severance of two or more limbs at or above the wrist or ankle joint as the result of an accident or medically required amputation.

The diagnosis of Loss of Limbs must be made by a Specialist.

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

This coverage excludes all psychiatric related causes.

**Major Organ Failure on Waiting List:** Definite diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be Medically Necessary. To qualify under Major Organ Failure on Waiting List, the Participant must become enrolled as the recipient in a recognized transplant centre in Canada or the United States of America that performs the required form of transplant surgery. For the purposes of the Survival Period, the date of diagnosis is the date of the Participant's enrolment in the transplant centre. The diagnosis of the major organ failure must be made by a Specialist.

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

To qualify under Major Organ Transplant, the Participant must undergo a transplantation procedure as the recipient of a heart, lung, liver, kidney or bone marrow, and limited to these entities. The diagnosis of the major organ failure must be made by a Specialist.

**Motor Neuron Disease:** Definite diagnosis of one of the following: amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease), primary lateral sclerosis, progressive spinal muscular atrophy, progressive bulbar palsy, or pseudo bulbar palsy, and limited to these conditions.

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

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

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

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

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

No benefit is payable for the following:

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

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

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

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

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

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

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

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

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

No benefit is payable under this condition if:

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

**Paralysis:** Definite diagnosis of the total loss of muscle function of two or more limbs as a result of injury or disease to the nerve supply of those limbs, for a period of at least 90 days following the precipitating event.

The diagnosis of Paralysis must be made by a Specialist.

Parkinson's Disease and Specified Atypical Parkinsonian Disorders:

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

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

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

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

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

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

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

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

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

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

The diagnosis of Stroke must be made by a Specialist.

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

No benefit is payable under this condition for:

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

## *Covered Childhood Conditions*

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

Coverage includes the following childhood conditions:

- **Autism:** an organic defect in brain development characterized by failure to develop communicative language or other forms of social communication, with the diagnosis confirmed either by a pediatric psychiatrist or a pediatrician before the Child's third birthday.
- **Cerebral Palsy:** a definitive diagnosis of Cerebral Palsy, a non-progressive neurological defect characterized by spasticity and in coordination of movements.

- **Congenital Heart Disease:** any one or more diagnosis(es) from the following lists of heart conditions:

  **List A**

  a) Total Anomalous Pulmonary Venous Connection;

  b) Transposition of The Great Vessels;

  c) Atresia of any heart valve;

  d) Coarctation of the Aorta;

  e) Single Ventricle;

  f) Hypoplastic Left Heart Syndrome;

  g) Double Outlet Left Ventricle;

  h) Truncus Arteriosus;

  i) Tetralogy of Fallot;

  j) Eisenmenger Syndrome;

  k) Double Inlet Ventricle;

  l) Hypoplastic Right Ventricle; or

  m) Ebstein's Anomaly.

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

  **List B**

  a) Pulmonary Stenosis;

  b) Aortic Stenosis;

  c) Discrete Subvalvular Aortic Stenosis;

  d) Ventricular Septal Defect; or

  e) Atrial Septal Defect.

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

- **Cystic Fibrosis:** a definitive diagnosis of Cystic Fibrosis with evidence of chronic lung disease and pancreatic insufficiency.

- **Down Syndrome:** a definitive diagnosis of Down Syndrome by a qualified Specialist.
- **Muscular Dystrophy:** a definitive diagnosis of Muscular Dystrophy, characterized by well-defined neurological abnormalities, confirmed by electromyography and muscle biopsy.
- **Type 1 Diabetes Mellitus:** a diagnosis of Type 1 Diabetes Mellitus, characterized by absolute insulin deficiency and continuous dependence on exogenous insulin for survival. The diagnosis must be made by a qualified pediatrician or endocrinologist licensed and practicing in Canada, and there must be evidence of dependence on insulin for a minimum of 3 months.

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

## *Covered Conditions Eligible for Partial Benefit Payment*

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

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

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

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

**Coronary Angioplasty:** An interventional procedure to unblock or widen a coronary artery that supplies blood to the heart to allow an uninterrupted flow of blood. The procedure must be determined to be Medically Necessary by a Specialist.

**Ductal Carcinoma In Situ Of The Breast:** A non-invasive cancer that must be confirmed by biopsy. The diagnosis of ductal carcinoma in situ of the breast must be made by a Specialist.

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

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

- a diagnosis of Cancer.

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

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

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

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

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

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

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

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

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

## *Payment of Claims*

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

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

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

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

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

**Time Limit to Submit a Claim**

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

## *Exclusions and Limitations*

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

a) a Pre-Existing Condition, unless the covered condition occurs after 24 consecutive months of coverage;

b) an Accident, unless the covered condition is a Severe Burn;

c) attempted suicide or voluntary injury or Illness;

d) participation in a criminal act or an attempt to commit a criminal act, regardless of whether charges are laid or a conviction is obtained;

e) any Accident or injury occurring while operating a vehicle under the influence of any intoxicant or with a blood alcohol level in excess of the legal limit in the jurisdiction in which the Accident occurs; or

f) insurrection, war (declared or not), the hostile action of the armed forces of any country or participation in any riot or civil commotion.

## *Right to Convert to Individual Coverage*

**Eligibility for Conversion**

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

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

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

**Terms and Conditions of the Converted Policy**

Individual policies issued under this conversion option are subject to the following terms and conditions:

- You must, within 31 days of the date of termination of your group coverage:
  - submit the application form provided by the Insurer for the purpose of conversion to individual coverage; and
  - pay the entire amount of the first month's premium of the individual policy, in accordance with the method of payment stipulated by the Insurer;
- the individual policy will be issued without requiring proof of health;
- the premium for the individual policy is based upon the individual policy rates in effect on the date of application and the age and sex of the Participant on that date;
- the individual policy is subject to any maximum and minimum values or other additional terms and conditions that are outlined below.

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

- during the 31-day period that the conversion option may be exercised, the amount of coverage available through this conversion option is continued without charge;
- the effective date of coverage under the individual critical illness policy will be 31 days after the group coverage terminates;
- the individual critical illness policy will not include any disability or other supplementary benefits;

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

### *Termination of benefit*

Coverage for Optional Enhanced Critical Illness Insurance terminates for you and your dependents when your employment terminates, upon your retirement or when you reach the Age specified in the Benefit Summary, whichever occurs first.

Coverage for your spouse also terminates when he himself reaches the Age specified in the Benefit Summary.

# Short-term Disability Insurance

If you are absent from your work as the result of an accident or an illness, you are entitled to benefits for each day of total disability, up to the number of weeks specified in the Benefit Summary. Benefits are paid from the expiry date of the elimination period, which is the number of consecutive days at the start of disability and for which no benefits are payable under the contract. The elimination period is specified in the Benefit Summary.

Benefits are paid at weekly intervals. The elimination period is calculated in calendar days. However, because the total disability benefit is paid on a working day basis, benefits for each working day of total disability are equal to 1/5 of the weekly benefit.

## *Total disability*

For the purpose of the Short-term Disability Insurance, total disability means any state of incapacity resulting from an accident or illness, requiring continuous care and treatment from your physician from the beginning of the disability and wholly preventing you from performing the regular duties of your own occupation.

## *Maternity Leave*

For the purpose of the Short-term Disability Insurance, Maternity Leave shall mean any leave of absence from work due to pregnancy in accordance with any labour standards legislation that is applicable in your province of residence. Maternity Leave consists of a voluntary portion and a “health related portion”. The “health related portion” of the Maternity Leave commences on the date of the delivery and it lasts for at least 6 weeks (8 weeks for a caesarean birth). The rest of the Maternity Leave is the voluntary portion.

## *Recurrence*

Two successive periods of disability resulting from the same cause or from related causes separated by a period of **less than two consecutive weeks** of full-time work are considered as a same period of disability. Successive periods of disability due to totally different and unrelated causes are also considered as a same period of disability if at the beginning of the second disability you had not resumed the work you performed before the start of the first disability, for at least one entire day.

When successive periods of disability are considered to be the same period of disability, a second elimination period does not apply. Benefits continue for the remainder of the maximum period indicated in the Benefit Summary.

## *Reduction of benefits*

Weekly benefits are reduced by an amount equal to the benefits payable by the following:

- any Worker's Compensation Act or similar legislation;
- any provincial automobile insurance plan in which benefits payable under Employment insurance are not taken into account;
- any law or plan paying maternity benefits during the "health related portion" of the Maternity Leave, as defined in this Benefit;
- the Quebec Pension Plan or the Canada Pension Plan, excluding benefits paid for children and any increase in benefits due solely to the cost of living;
- any income replacement indemnity paid under any other federal or provincial legislation;
- any income or fringe benefits plan offered by the employer as defined by the Income Tax Act;
- any severance or wrongful dismissal payments.

The weekly benefits are reduced even if you fail or refuse to exercise your right to such benefits under the aforementioned acts and plans.

Furthermore, no weekly benefit is payable during any of the following periods:

- period during which you are on paid vacation;
- period during which you receive or are entitled to receive remuneration from your employer;
- period during which you receive maternity or parental benefits under any provincial or federal law, or when you take a Maternity, Parental or Family-related Leave under any provincial or federal law, or any agreement between you and your employer, subject to the following exception:
    - Short-term Disability benefits are paid during the "health related portion" of the Maternity Leave when required by the applicable legislation, whether the Participant's insurance was continued during the leave or not. The maternity benefits payable under any public or private plan are deducted from the benefits payable for this period, in accordance with the provisions of this contract.

Finally, no benefit is payable for any total disability resulting directly or indirectly from any one of the following causes:

- voluntary injury, whatever your state of mind at the time of the incident;
- injury sustained during active participation in a civil commotion, riot or an insurrection, unless while performing the duties of your occupation;
- injury sustained during a war, whether declared or not;
- cosmetic surgery or treatment, unless such surgery or treatment is required as a result of an accident that occurred while you were insured under this benefit;

- injury sustained when driving a motorized vehicle while impaired by drugs, or with an alcohol level that exceeds the limit set under the Criminal Code of Canada.

Generally, no Short-term Disability benefit is payable if the disability begins during a temporary lay-off, an authorized leave of absence without pay, a disciplinary suspension without pay, or imprisonment.

If disability occurs during the voluntary portion of a maternity leave, a parental leave or a family-related leave during which this benefit has remained in force and the Short-term disability insurance premiums have been paid, the elimination period begins on the first day of disability, but benefits will not be paid before the expiry date of the elimination period, nor before the expected date of return to work, as notified to the Insurer in writing before the beginning of the absence.

### *Rehabilitation program*

While receiving weekly benefits payable hereunder, you may be required by the Insurer to participate in a rehabilitation employment program:

a) Total disability will not be considered as having ended for the sole reason that you participate in the program.

b) If, while participating in such a rehabilitation program, you again become totally disabled, your benefits will revert back to the amount you were receiving before the start of the rehabilitation employment program.

c) During the rehabilitation program, the weekly benefits payable hereunder will be reduced as necessary so that the total income from all sources does not exceed 100% of your pre-disability earnings.

### *Loss of the right to benefits*

The right to receive benefits may be revoked upon the earliest of the following events:

- you refuse to undergo a medical examination requested by the Insurer;
- you fail to produce proof satisfying the Insurer of the persistence of disability;
- you engage in remunerative work (except for a rehabilitation employment program);
- the date you retire;
- attainment of the maximum duration of benefits, as specified in the Benefit Summary; or
- you refuse to take part in a rehabilitation program that is reasonably appropriate for you.

### *Termination of benefit*

The Short-term Disability Insurance Benefit ends upon termination of your employment or at retirement, whichever occurs first.

# Long-term Disability Insurance

If your total disability persists beyond the expiry of the elimination period specified in the Benefit Summary, you may become eligible for Long-term Disability Insurance benefits. The first payment is due at the end of the month during which the elimination period expires and on the last day of every month afterwards. The benefit is equal to 1/30 of the month for each day of total disability.

## *Total disability*

For the purpose of the Long-term Disability Insurance, **total disability** means:

- during the elimination period and the **24 months** immediately following the elimination period, a state of total and continuous incapacity, resulting from an illness or an accident, that wholly prevents you from performing, without exception, each and every regular duty of your main occupation; and
- subsequently, a state of total and continuous incapacity, resulting from an illness or an accident, that wholly prevents you from engaging in any work
  - that would enable you to earn at least 60% of your pre-disability gross earnings, and
  - for which you are reasonably qualified by training, education or experience.

Regular duties are defined as those work-related activities which are considered essential to the employee's performance in the occupation and which proportionately take the majority of time to complete.

The availability of such occupations, jobs or work will not be considered while assessing your disability.

The loss of a professional or occupation license or certification does not, in itself, constitute disability.

## *Maternity Leave*

For the purpose of the Long-term Disability Insurance, Maternity Leave shall mean any leave of absence from work due to pregnancy in accordance with any labour standards legislation that is applicable in your province of residence. Maternity Leave consists of a voluntary portion and a “health related portion”. The “health related portion” of the Maternity Leave commences on the date of the delivery and it lasts for at least 6 weeks (8 weeks for a caesarean birth). The rest of the Maternity Leave is the voluntary portion.

## *Recurrence*

Successive periods of total disability separated by less than three months of continuous active employment are considered one period of disability, unless the new disability is due to an illness or accident totally unrelated to the cause of the previous disability and commences only after your return to work.

When successive periods of disability are considered to be the same period of disability, a second elimination period does not apply. Benefits continue for the remainder of the maximum period indicated in the Benefit Summary.

## *Rehabilitation program*

While receiving Long-term Disability monthly benefits, you may be required by the Insurer to participate in a rehabilitation program:

a) The total disability will not be considered as having ended for the sole reason that you participate in such a program.

b) The monthly benefits payable hereunder will be reduced by 50% of the remuneration you receive from such a rehabilitation program.

c) If, while participating in such a rehabilitation program, you again become totally disabled, your benefits will revert back to the amount you were receiving before the start of the rehabilitation employment program.

d) During the rehabilitation program, the monthly benefits payable hereunder will be reduced as necessary so that the total income from all sources does not exceed 100% of your pre-disability earnings.

## *Pre-existing condition*

**(Applicable to all hiring as of July 1, 2017)**

This benefit does not apply when disability occurs during the first 12 months following the effective date of insurance and results from an illness or accident for which the Participant received **treatment** in the 3-month period immediately preceding such effective date, unless the Participant was insured under a similar benefit provided by a group insurance contract that expired within 31 days prior to the effective date of this benefit.

**Treatment** shall mean an Illness or Accident for which the Covered employee has had a medical consultation, or has received medical treatment, advice, care or services (including diagnostic measures) or has been prescribed medication.

## ***Exclusions and limitations***

### ***Reduction of benefits***

Monthly benefits are subject to two kinds of reductions: direct and indirect, as explained hereunder.

1. **Direct integration**

   Monthly benefits are reduced by an amount equal to the benefits you are entitled to receive for yourself (but not for your children) from

   - any disability benefit payable under the Quebec Pension Plan or the Canada Pension Plan,
   - any benefits paid under any Workers' Compensation Act or similar legislation;
   - any income payable under any legislation or plan paying maternity benefits during the "health related portion" of the Maternity Leave, as defined in this booklet;
   - any income replacement indemnity paid under any provincial automobile insurance plan, if applicable,
   - any disability benefits payable under any private pension plan;
   - any benefit paid under the Canada Employment Insurance Act,
   - any payable earnings under any other federal or provincial law.

2. **Indirect integration (co-ordination of benefits)**

   - If the amount of payable monthly benefits under this benefit, or
   - if the amount of monthly benefits payable by the Insurer after direct integration, if applicable, in accordance with point 1) above plus the following amounts:

     - income from a fringe-benefits plan offered by the employer
     - any disability benefits payable under any other group insurance plan by an employer or association;
     - any disability benefits payable under the Quebec Pension Plan or the Canada Pension Plan, excluding benefits paid for children;
     - income from a fringe-benefits plan set up according to any provincial or federal law, including the income sources mentioned in point 1) (excluding increase in benefits due solely to cost of living)
     - any disability benefits payable under any Workers' Compensation Act or any other similar legislation or any other government plan, excluding benefits paid under the Employment Insurance Act;

- any income replacement indemnity payable under any provincial automobile insurance plan , if applicable;
- any disability benefits payable under any private pension plan, excluding any increase in benefits after benefits commence due solely to cost of living

exceed **85%** of your salary before the start of your disability, the monthly benefits payable under this coverage shall be reduced as necessary so that such sum does not exceed this percentage.

However, reductions will be made without taking into account subsequent increases, by way of adjustments to the cost of living, in the benefits granted under the above mentioned acts and plans.

The monthly benefits are reduced even if you, who must submit the required claim, neglect or refuse to exercise your rights under the aforementioned acts and plans.

### *Limitations to the payment of benefits*

If the total disability results directly from alcoholism or drug addiction, benefits are paid only if you enter an in-house detoxification program, under the supervision of a physician.

In addition, no benefit is payable during a period during which you receive maternity or parental benefits under any provincial or federal law or when you are on a maternity or parental or family-related leave taken in accordance with any provincial or federal law or any agreement between you and your employer, subject to the following exception:

- Long-term Disability benefits are paid during the “health related portion” of the Maternity Leave when required by the applicable legislation, whether the Participant’s insurance was continued during the leave or not. The maternity benefits payable under any public or private plan are deducted from the benefits payable for this period, in accordance with the provisions of this contract.

If disability occurs during the voluntary portion of a maternity leave, a parental leave or a family-related leave during which this benefit has remained in force and the Long-term disability insurance premiums have been paid, the elimination period begins on the first day of disability, but benefits will not be paid before the expiry date of the elimination period, nor before the expected date of return to work, as notified to the Insurer in writing before the beginning of the absence.

Finally, no benefit is payable for any disability which results directly or indirectly from one of the following causes:

- voluntary injury, whatever your state of mind at the time of the incident;

- injury sustained during active participation in a civil commotion, riot or an insurrection, unless while performing the duties of your occupation;
- injury sustained during a war;
- cosmetic surgery or treatment, unless such surgery or treatment is required as a result of an accident that occurred while you were insured under this benefit;
- injury sustained when driving a motorized vehicle while impaired by drugs, or with an alcohol level that exceeds the limit set under the Criminal Code of Canada.

### *Loss of the right to benefits*

Even when totally disabled, the right to receive benefits may be revoked, if:

- you refuse to undergo a medical examination requested by the Insurer;
- you refuse to participate in a medical or rehabilitation employment program judged reasonable and appropriate by both the Insurer and your attending physician;
- your disability no longer meets the contract definition;
- you fail to produce proof satisfying the Insurer of the persistence of disability;
- you engage in remunerative work, unless it is part of a rehabilitation employment program;
- you move or live temporarily outside Canada, unless you have notified the Insurer in writing and he has given his prior approval.

In any event, benefits terminate at your retirement, when you reach age 65 or when the maximum duration of payment specified in the Benefit Summary expires.

### *Termination of benefit*

The Long-term Disability Insurance benefit ends upon termination of your employment, at retirement or when you reach age 65, whichever occurs first.

# Extended Health Benefit - Drug Coverage

This insurance benefit covers drug expenses incurred by you or your dependents as the result of an illness, a pregnancy or an accident, subject to the deductible and percentage of reimbursement specified in the Benefit Summary. These drug expenses must be incurred in Canada.

**Applicable to all Participants**

If, in any calendar year, a Covered employee spends more than the maximum contribution amount established by the RAMQ for RAMQ drug Expenses for themselves or their Dependent children, the amounts in excess of the maximum contribution amount will be reimbursed by Blue Cross at a rate of 100% until the end of that calendar year. The contribution amount includes the Deductible, amounts in excess of the reimbursement level or co-payment, if applicable, for themselves or their Dependent children.

If, in addition, in any calendar year, a Covered employee's Spouse spends more than the maximum contribution amount established by the RAMQ for RAMQ drug Expenses for himself, the amounts in excess of the maximum contribution amount will be reimbursed by Blue Cross at a rate of 100% until the end of that calendar year. The contribution amount includes the Deductible, amounts in excess of the reimbursement level or co-payment, if applicable, for the Covered employee's Spouse.

## *Deductible*

The deductible is the portion of eligible expenses that you must pay for you or your dependents before the Insurer begins to reimburse expenses eligible under this contract. The deductible is applied per prescribed drug.

## *Eligible expenses*

1. The Insurer's **regular list** of drugs consists of usual, customary and reasonable expenses for drugs or products available in Canada and dispensed by a pharmacist (or a duly authorized physician or dentist in areas where there is no pharmacist) that can only be obtained on the written prescription of a physician, a dentist or a podiatrist, for use in respect of a pregnancy, an illness or injury and that do not exceed a 100-day supply.

   The prescribed drugs and products must be sold in accordance with the Regulations to the Foods and Drugs Act of Canada, they must bear a Drug Identification Number (DIN), they must be used in accordance with the official indications for which the drug or product has been authorized.

Also included are:

- Injections and serums prescribed by a physician to treat an illness.
- Preventive vaccines, subject to the maximum eligible amount mentioned in the Benefit Summary.
- Growth hormones (for Participants under 18 years old).
- Anaesthetic administered during surgery that is not performed in a hospital.
- Syringes, needles, lancet devices, pen needles, urine testing supplies, alcohol swabs, test strips for the control of diabetes, as well as an aerochamber and spinhaler.

2. Drugs that are necessary for survival, or for the treatment of a clearly diagnosed chronic illness, notably in case of heart disease, pulmonary disease, diabetes, arthritis, Parkinson's disease, epilepsy, cystic fibrosis and glaucoma. The claim must then include, as corroboration, the physician's prescription and written statement giving his diagnosis and the period for which the drugs were prescribed.

**Important notice**

***For Quebec residents*****,** this benefit must always include the drugs and products that appear on the List provided by the Régie de l'assurance-maladie du Québec (RAMQ) and dispensed by a pharmacist on the written prescription of a physician, a resident physician, a dentist or a podiatrist.

Some of these drugs are covered only in the cases, on the conditions and for the therapeutic indications specified in the regulation, namely exception drugs.

Furthermore, the drugs covered under the Insurer's list, as described above, must appear on the list of drugs made and updated by the Quebec Association of Pharmacy Owners (AQPP).

## *Expenses not reimbursable by the plan*

Incurred expenses for the following products or drugs are excluded:

- products for the care of contact lenses;
- contraceptives (other than oral);
- proteins or dietary supplements, amino acids;
- processed food for infants;
- hygiene products, including soaps and emollients;
- softeners and protective substances for the skin;
- smoking cessation aids (for Quebec residents: only the excess of eligible expenses payable under the Act respecting prescription drug insurance is excluded);
- minerals;

- homeopathic products;
- hair growth stimulants;
- fertility drugs (for Quebec residents: only the excess of eligible expenses payable under the Act respecting prescription drug insurance is excluded);
- sexual stimulants, as well as drugs used to treat erectile dysfunction;
- anabolic steroids;
- drugs and injections for weight loss;
- drugs administered for experimental purposes;
- drugs and material used in surgery (except for anaesthetic mentioned in the **Eligible Expenses** section of this benefit);
- drugs and all forms of drugs without therapeutic indication and intended exclusively to improve the quality of life;
- mouthwashes, dressings, syrups and cough drops ∗;
- shampoos, oils, creams ∗;
- vitamins and multivitamins ∗;
- prenatal supplements or vitamins ∗.

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

Furthermore, the following services are not covered.

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

## *Provisions applicable to Quebec residents*

When you reach the **age of 65**, you and your Spouse have a decision to make regarding your drug coverage.

Decision to join the RAMQ plan at age 65

When you or your Spouse reach the age of 65, you may choose to be insured under the basic prescription drug insurance plan provided by the Act respecting prescription drug insurance (RAMQ's plan) rather than to maintain the full drug coverage under the group insurance plan. **Such choice is then irrevocable**.

If, at age 65, you choose to be insured under the RAMQ's plan, you and your dependents, regardless of their age, will no longer be eligible for coverage under the group insurance plan for drugs covered under the RAMQ's plan.

If, at age 65, your Spouse chooses to be covered under the RAMQ's plan, then he will no longer be eligible for coverage under the group insurance plan for drugs covered under the RAMQ's plan.

However, if you and your dependents are covered under the RAMQ's basic plan, you remain covered for supplementary coverage under the complementary group insurance plan as described below, subject to the deductible and the percentage of reimbursement mentioned in the Benefit Summary for drug coverage:

1. deductible and coinsurance paid by the Participant under the RAMQ's plan; and
2. any prescription drug which does not appear on the list provided by the RAMQ, but which is covered under the Insurer's list of drugs.

Decision to cancel registration with the RAMQ at Age 65

When you or your Spouse reach the age of 65, you are automatically registered by the RAMQ as a beneficiary of its prescription drug coverage. When you and your Spouse reach the age of 65, **you must therefore cancel your automatic registration** with the RAMQ plan in order to continue the full drug coverage under the group insurance plan.

Terms and conditions relating to premiums, if applicable, are mentioned in the Premium rate schedule given to the policyholder or, after the effective date of the contract, in the rate renewal conditions issued by the Insurer.

## *Termination of coverage*

The Drug coverage ends at your retirement or termination of employment whichever occurs first. The coverage for eligible dependents ends when your Drug Insurance benefit terminates or on the date they no longer meet the definition of dependent, whichever occurs first.

# Extended Health Benefit - Accident/Sickness Coverage

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

## *Deductible*

No deductible applies to the Extended Health Benefit – Accident/Sickness Coverage.

## *Eligible expenses*

The expenses must be:

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

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

**HOSPITALIZATION**

- Short stay
  Hospitalization charges for a Participant admitted as an inpatient in a hospital for **active care** after the effective date of his insurance and for as long as he is entitled to insured services under the medical program in his province of residence, subject to the maximum amount payable specified in the Benefit Summary.

- Convalescent care and physical rehabilitation
  Charges for convalescent care and physical rehabilitation, if the Participant is admitted less than **14 days** after obtaining his discharge from a hospital where he has been receiving active treatment, subject to the maximums specified in the Benefit Summary.

**MEDICAL SUPPLIES AND SERVICES *(if covered in the coverage, as per the chosen plan)***

- **Nursing care**
  Services of a registered nurse (or registered nursing assistant when a registered nurse is not available), who is not a member of the Participant's family, nor resides with him, provided such services are rendered at the Participant's home and are not primarily for custodial care, subject to the overall maximum amount payable specified in the Benefit Summary.

- **Ambulance transportation**
  Charges for transportation by ambulance, including air or rail transport in Canada, when it is necessary to transport the Participant to or from the nearest hospital equipped to provide the emergency care required. The claim must indicate the medical reason for ambulance transportation and may stand in lieu of the prior recommendation from a physician that could not be obtained due to the emergency situation.

- **Orthopedic shoes**
  Charges for the purchase and repair of made-to-measure orthopedic shoes and Denis Browne splints, subject to the eligible maximum amount specified in the Benefit Summary. Purchases must be made from a known orthopedic supplier authorized under the provincial health and welfare ministry. Pre-fabricated shoes with modifications or adjustments are also eligible.

  Specific exclusion
  Charges for the purchase of off-the-shelf shoes that are regular stock, as well as extra-depth shoes are not covered.

- **Moulded arch supports**
  Charges for the purchase of moulded arch supports to accommodate, relieve or remedy some mechanical foot defect or abnormality, subject to the eligible maximum amount specified in the Benefit Summary. Purchases must be made from a known orthopedic supplier authorized under the provincial health and welfare ministry.

- **Surgical stockings**
  The purchase of medical elastic stockings, subject to the maximum number of pairs specified in the Benefit Summary.

- **Prostheses**
  - The purchase and repair of artificial limbs (including the myoelectric arm) and artificial eyes.
  - The purchase of capillary prostheses required after chemotherapy, subject to the eligible maximum amount specified in the Benefit Summary.
  - The purchase of external breast prostheses when required because of a total or radical mastectomy, including the purchase of two surgical brassieres, subject to the overall eligible maximum amount specified in the Benefit Summary.

- **Hearing aids**
  Charges for the purchase and repair of hearing aids, subject to the eligible maximum amount specified in the Benefit Summary.

- **Intrauterine contraceptive device (IUD)**
  Charges for the purchase of an intrauterine contraceptive device (iud), subject to the eligible maximum amount specified in the Benefit Summary.

- **TENS**
  Charges for the purchase or rental, at the Insurer's option, of a transcutaneous electrical nerve stimulator (TENS), subject to the eligible maximum amount specified in the Benefit Summary.

- **Glucometer**
  Charges for the purchase of a glucometer, subject to the eligible maximum amount specified in the Benefit Summary.

- **Varicose vein injections for medical purposes**
  Only the cost of the injected drugs is covered. The eligible maximum amount per visit and the maximum number of visits per calendar year are specified in the Benefit Summary.

- **Mobility aids and orthopedic appliances**
  - Charges for the purchase or rental, at the Insurer's option, of a wheelchair (with cushions and inserts), as well as the purchase of an adjustable axle plate and repairs of the axle plate, subject to the eligible maximum amount specified in the Benefit Summary. **The Participant must obtain the Insurer's approval before any purchase or rental, otherwise the claim may be rejected.**
  - Charges for the purchase or rental of crutches, canes and walking aids, as well as charges for casts, trusses, orthopedic devices, cervical collars and ortheses. Ortheses and orthopedic devices must be purchased through a known orthopedic supplier authorized under the provincial health and welfare ministry.

- **Diagnostic tests**
  Charges for the following diagnostic tests, when deemed required for the treatment of an illness or following an accident, or for a check-up (if applicable), subject to the overall eligible maximum amount specified in the Benefit Summary:
  - laboratory analyses, X-rays, Electrocardiograms, Computer-assisted tomography (CT Scan), Ultrasounds and Magnetic Resonance Imaging (MRI);
  - radiotherapy or radium therapy.

- **Major medical equipment**
  **For all the following eligible items, the Participant must obtain the Insurer's approval before any purchase or rental, otherwise the claim may be rejected.**
  - Charges for the purchase or rental, at the Insurer's option, of a standard manual hospital-type bed for bedridden patients, up to the usual cost of a standard manual bed, subject to the limit and frequency specified in the Benefit Summary.
  - Charges for the purchase of insulin pumps, subject to the eligible maximum amount specified in the Benefit Summary.
  - Charges for the purchase of compression pumps and percussors, subject to the eligible maximum amount specified in the Benefit Summary.
  - Charges for the purchase or rental of an apnea monitor for respiratory dysrhythmia, subject to the limit and frequency specified in the Benefit Summary.
  - Charges for the purchase or rental, at the Insurer's option, of therapeutic equipment currently used according to the manufacturer's standards and specifically recognized for the immediate treatment of a pathological condition following an illness or accident, subject to the eligible overall maximum amount specified in the Benefit Summary. This category of equipment includes, for example: non-union bone stimulators, aerosol therapy equipment, feeding pump and intermittent positive pressure breathing machines.
- **Other medical services and supplies**
  - Charges for the purchase of oxygen and the purchase or rental of appliances for the administration thereof, subject to the limit and frequency specified in the Benefit Summary. The Participant must obtain the Insurer's approval before any purchase or rental, otherwise the claim may be rejected.
  - Charges for ostomy supplies and artificial larynx.
  - Charges for the purchase of burn pressure garments.
  - Charges for medicated dressings.
  - Charges for supplies for paraplegics, provided such supplies are required for the treatment and the care of a paraplegic Participant.
  - Charges for medical supplies for gavage.
  - Charges for an opaque glass required during radiotherapy or psoriasis treatments.

- **Dental care following an accident**
  Services of a dentist when required to repair or replace sound natural teeth following an accidental blow to the mouth received while the person is insured hereunder, but not due to an object or food being wittingly or unwittingly placed in the mouth, provided that treatments begin or a satisfactory treatment plan is submitted to the Insurer within 12 months following the date of the accident. There will be no reimbursement for treatments performed more than two years after the date of the accident.

  The eligible amounts are determined according to the suggested *Fee Guide for Dental Services* approved by the *Dental Surgeons' Association* of the Participant's province of residence. The maximum amount payable per accident is specified in the Benefit Summary.

**VISION CARE *(if covered in the coverage, as per the chosen plan)***

- **Eye examination**
  Charges for an eye examination by an ophthalmologist or optometrist, subject to the eligible maximum amount specified in the Benefit Summary.

- **Eyeglasses, contact lenses and laser surgery**
  The cost of eyeglasses (frames and lenses) and contact lenses, when prescribed by an ophthalmologist or optometrist. As well as the cost of laser surgery to correct myopia, hypermetropia or astigmatism, subject to the overall eligible maximum amount mentioned in the Benefit Summary.

  Specific exclusion
  Expenses incurred for non-corrective sunglasses and safety glasses are excluded.

**PARAMEDICALS**

Care or treatments rendered by the following practitioners do not require prior medical recommendation:

- subject to the eligible maximum amount per visit and per calendar year specified in the Benefit Summary, for each type of practitioner or all of them together, as indicated in the Benefit Summary. The health professional may not be a member of your family, nor reside with you:

  acupuncturist, audiologist , chiropractor, dietician, occupational therapist, homeopath, massage therapist, naturopath, speech therapist, osteopath, physiotherapist (or a rehabilitation technician or athletic therapist), podiatrist (or chiropodist) and psychologist (or social worker or guidance counsellor or psychotherapist).

- Charges for X-rays taken by a chiropractor, subject to the eligible maximum amount mentioned in the Benefit Summary.

### *General exclusions*

The following expenses are not reimbursed under the plan:

- medical care to which the Participant is entitled under any federal or provincial government legislation or that is covered under such legislation, including charges payable under any occupational health and safety board, or any automobile insurance plan, or any other similar law or public plan, if applicable;
- medical care that was covered under the above mentioned legislation or plans at the time this benefit was issued and subsequently was modified, suspended or discontinued;
- services, treatments or supplies received free of charge;
- services, treatments or supplies that are experimental in nature;
- preventive care;
- cosmetic treatment or prostheses;
- services of a nurse, at home, when acting as a midwife or psychotherapist, or when services other than nursing care are provided;
- dental services, with the exception of treatment rendered after an accident;
- with the exception of intrauterine contraceptive devices (IUD), all processes relating to family planning, including artificial insemination and laboratory, or any other charges incurred in any infertility treatment, regardless as to whether infertility is considered to be an illness or not;
- with regards to therapeutic equipment:
  - items which are not mainly medical in nature or which are intended for comfort and commodity (e.g. domestic appliances such as whirlpools, air purifiers, humidifiers, air conditioners and other similar equipment);
  - monitoring and diagnostic devices (e.g. stethoscopes, sphygmomanometer and similar equipment);
- all charges, services, articles or supplies that do not appear on the above Eligible Expenses list;
- all charges that would not have been made if no insurance coverage had existed;
- charges for any care, treatment, services or supplies other than those declared necessary for the treatment of an injury or illness;
- charges incurred outside Canada;
- charges for services eligible under the Travel benefit;
- eligible charges incurred directly or indirectly because of
  - intentionally self-inflicted injuries, whether the Participant is sane or not;
  - active participation in a civil commotion, riot or insurrection, except while the Participant was performing the duties of his occupation, or injury sustained during war;
  - perpetration or attempt to perpetrate a criminal act.

## *Termination of Benefit*

The Accident/Sickness coverage ends at your retirement or the termination of your employment, whichever occurs first. The dependent's coverage ends either on the date you cease to be covered or on the date they no longer meet the definition of dependent, whichever occurs first.

## *Conversion privilege*

If you cease to be eligible for Accident/Sickness coverage, you may convert your insurance to an individual insurance policy without submitting evidence of insurability by completing the form provided for this purpose within 31 days of the end of your coverage. However, the entire amount of the first premium, in accordance with the chosen method of payment accepted by the Insurer, must be included with the conversion request.

This conversion privilege also applies to your dependents

# Extended Health Benefit - Travel Coverage

## *Purpose of Travel Insurance*

The Insurer will pay the Eligible Expenses described in this benefit, subject to the conditions outlined below.

## *Specific definition*

The following definitions apply to this benefit, in addition to those found in this booklet.

**Emergency:** a sudden and unexpected illness or injury that requires immediate medical Treatment due to:

- an injury resulting from an accident;
- a new medical condition which begins during the trip; or
- a medical condition that existed prior to a Trip (or prior to booking a Trip) provided that it is not part of an established treatment program.

**Hospital:** A facility that:

- is licensed as an accredited hospital outside of the Participant's province of residence;
- offers care and treatment to either inpatients or outpatients;
- has a registered nurse on duty 24 hours a day;
- has a laboratory; and
- has an operating room where surgical operations are performed by a legally qualified surgeon.

Coverage excludes any facility used primarily as a clinic, continued or extended care facility, convalescent home, rest home, health spa or drug addiction or alcohol treatment centre unless specifically authorized by the Insurer.

**Immediate Family Member:** A Participant's parents, spouse, child, brother or sister.

**Incident:** An individual occurrence of Emergency illness or injury.

**Travel Companion:** Persons who are sharing prepaid travel arrangements with the Participant. No more than 3 persons can qualify as a Travel Companion for any given trip.

**Trip:** Travel outside of the Participant's province of residence.

## *Eligible expenses*

The Insurer will pay for the expenses explicitly listed in the categories below, subject to the following terms and conditions:

- payment is limited to the reimbursement level, benefit maximums and coverage duration specified below and/or in the Summary of Benefits;
- prior approval of the Insurer must be obtained before the Eligible Expense is incurred;
- the charges must be usual, customary and reasonable, meaning that:
  - the amount charged is consistent with the amount typically charged by health practitioners for similar products or services in the geographical area in which the service or supply is being purchased; and
  - the frequency and quantity in which services or supplies are purchased by the Participant are, in the opinion of the Insurer in consultation with its health care consultants, consistent with the frequency and quantity that would usually be prescribed or needed for the Participant's condition;
- payment is limited in accordance with the Exclusions and Limitations provision of this benefit; and
- payment of this benefit is limited to amounts that are in excess of coverage provided by any other plan (where a court determines that this policy and any other plans provide primary coverage, this benefit will be co-ordinated with the other plan); and
- payment is subject to post-payment audit.

## *A) Hospital and Medical Travel Coverage*

Make sure to bring your Blue Cross identification card with you when you travel.

The Insurer will pay the Eligible Expenses listed in this section if:

- they are incurred as a result of an Emergency;
- the Participant is covered by government health care coverage when the Emergency occurs; and
- the Insurer is satisfied the expense is necessary to stabilize the Participant's medical condition.

### *Eligible expenses*

**Hospitalization:** Charges for Hospital room accommodation (not a suite of rooms) and for Medically Necessary inpatient and outpatient services.

**Physician Fees:** Fees charged for physician or surgeon services.

**Medical Appliances:** The cost of casts, crutches, canes, slings, splints, trusses, braces or the temporary rental of a wheelchair or scooter, when prescribed by the attending physician.

**Nursing Care:** Fees for private duty nursing performed by a professional nurse or nursing assistant when prescribed by the attending physician. The nurse providing the service must not be a family member of the Participant or an employee of the Hospital.

This coverage excludes nursing fees for custodial care.

**Diagnostic Services:** Charges for laboratory tests, X-rays and diagnostic imaging, when prescribed by the attending physician.

**Drugs:** The cost of drugs prescribed by a physician, but only in a quantity sufficient to treat the condition for the duration of the Trip. The Participant must provide satisfactory proof of purchase of this medication that includes:

- the name of the Participant;
- the date of purchase;
- the name of the medication;
- the Drug Identification Number, if available;
- the quantity and strength of the drug; and
- the total cost.

**Paramedical Services:** The cost of services rendered by chiropractors, osteopaths, chiropodists/podiatrists and physiotherapists. This coverage excludes charges for X-rays.

**Accidental Dental and Other Dental Emergencies:** Fees of a dental practitioner for Treatment:

a) of damage to natural teeth that occurs as a result of a direct accidental blow to the mouth;

b) that is necessary to repair a fracture or reposition a dislocation of the jaw resulting from an accident; or

c) that is needed to relieve pain caused by an Emergency other than those listed in (a) or (b).

With respect to Treatment under categories (a) or (b):

- treatment must begin while the Participant is covered by this benefit and end within 6 months of the accident, unless deferred Treatment is approved by the Insurer due to the age of the Participant; and
- the maximum reimbursement per Participant per Incident is $2,000.

With respect to Treatment under category (c), the maximum reimbursement per Participant per Incident is $200.

**Ambulance Service:** The cost of ground or air ambulance for transportation of a stretcher patient to the nearest qualified medical facility. This includes the cost of an inter-Hospital transfer if the attending physician and the Insurer determine that existing facilities are inadequate for Treatment or stabilization.

**Repatriation to the Province of Residence:** The cost of repatriating the Participant to their province of residence to receive immediate medical attention, along with the cost of simultaneously returning a Travel Companion or any Immediate Family Members covered by the policy. If Medically Necessary, this cost may include an accompanying medical attendant.

If returning on a commercial aircraft, coverage includes:

- economy fare to the Participant's home city in Canada; and
- in the case of a medical attendant, round-trip economy fare.

Unless the repatriation or transfer of the Participant is not possible for medical reasons considered acceptable by the Insurer, the Insurer may require repatriation of any Participant or transfer to other medical facilities. If the Participant refuses repatriation or transfer, all rights to benefits in relation to the Incident are terminated.

**Transportation to Visit the Participant:** The cost of round-trip economy fare (by airline, bus or train) for an Immediate Family Member to the Hospital where the Participant has been confined for 7 or more days if the attending physician provides written acknowledgement that this attendance is required. The Insurer may waive the 7 day waiting period if the Insurer is satisfied that this waiver is required.

The cost of round-trip economy fare (by airline, bus or train) for an Immediate Family Member to identify the body of the Participant, if deceased.

**Vehicle Return:** The fees charged by a commercial agency to return the Participant's vehicle, whether private or rental, to the Participant's residence or to the nearest appropriate vehicle-rental agency, when the Participant is unable to drive as a result of an Emergency illness or injury. A medical certificate from the attending physician confirming the Participant's medical incapacity to operate the vehicle is required. This benefit is subject to a maximum of $1,000 per Trip.

**Return of the Deceased:** The cost of preparing and transporting the remains of the deceased Participant to their province of residence to a maximum of $5,000.

**Meals and Accommodation:** The cost of commercial accommodation and meals when the Participant's travel is delayed due to an Emergency illness or injury of the Participant or Travel Companion. The medical reason for the delay must be verified by the attending physician. The maximum reimbursement is $150 per Participant per day for a maximum of 20 days (up to a total maximum of $3,000 per Incident).

All costs must be supported by receipts from commercial organizations.

## *B) Worldwide Travel Assistance*

The Insurer through its travel assistance provider, will provide an emergency toll-free line available 24 hours a day, 7 days a week, for Participants who need medical assistance or general assistance while travelling.

**Medical Assistance**

If the Participant requires hospitalization or a consultation with a physician as a result of an Emergency, the travel assistance provider appointed by the Insurer will provide the following support services:

- direct the Participant to an appropriate clinic or Hospital;
- confirm with the service provider that the Participant is covered;
- ensure a follow-up of the medical file and communicate with the Participant's family physician;
- co-ordinate the return home of a Child if the Participant is hospitalized;
- repatriation of the Participant to the province of residence if the Participant meets the eligibility requirements of this expense;
- arrange for the transportation of an Immediate Family Member to the Participant's bedside if the Participant meets the eligibility requirements of this expense; and
- co-ordinate the return of the Participant's vehicle if the Participant meets the eligibility requirements of this expense.

**General Assistance**

In Emergency situations, the travel assistance provider appointed by the Insurer will also provide the Participant with the following services:

- transmittal of urgent messages;
- co-ordination of claims;
- services of an interpreter for Emergency calls;
- referral to legal counsel in the event of a serious accident;
- settlement of formalities in the event of death;
- assistance with the loss or theft of identity papers; and
- information regarding embassies and consulates.

In addition, pre-travel advice regarding visas and vaccines is available.

The Insurer and its travel assistance provider are not responsible for the quality of medical and Hospital care provided to the Participant or for the availability of such care.

## *C) Referral Outside of Canada*

When an attending physician refers a Participant outside of Canada for medical services not available in Canada, the Insurer will cover the portion of expenses listed below which exceed those covered by the Participant's government health care coverage.

**Hospital Services:** Charges for:

- hospital room accommodation;
- intensive care room accommodation;
- nursing services;
- operating and recovery room services;
- diagnostic and laboratory services, including X-rays;
- oxygen and blood;
- prescription drugs including intravenous solutions; and
- physiotherapy.

**Physicians and Surgeons:** Charges for services rendered by a physician or surgeon.

**Ambulance Transportation and Attendant:** Charges for licensed ambulance services needed to transport a stretcher patient to and from the nearest hospital able to provide acute care, including any charges for travel expenses of an accompanying registered nurse or qualified medical attendant, other than a relative.

To be eligible for coverage under this category, all expenses must be pre-approved by the Insurer and the Participant's government health care coverage must agree to cover a portion of the expenses.

## *D) Payment of Claims*

### How Payments are Made

The Insurer may approve payment directly to the service provider. In certain circumstances, the Participant will pay the full cost of any Eligible Expense at the time of purchase. The Insurer will then reimburse any Eligible Expenses on receipt of proof of payment from the Participant.

## *E) General Exclusions and Limitations*

No payment will be made (or payment may be reduced) if:

a) the Participant fails to communicate with the Insurer in the event of medical consultation or hospitalization following an injury or illness;

b) expenses are incurred beyond the coverage duration period specified in the Summary of Benefits;

c) the purpose of the Trip is primarily or incidentally to seek medical advice or treatment, even if this Trip is on the recommendation of a physician, with the exception of Referral Outside of Canada;

d) expenses have already been paid or are eligible for refund from a third party;

e) expenses are incurred while travelling in a country (or a specific region of a country) for which there is a Government of Canada travel warning, to avoid all travel or avoid non-essential travel, when such travel warning was issued before the departure date and the loss or expense is related to the reason for which the travel warning was issued; or

f) expenses are incurred as a result of:

i. participation in a criminal act or attempt to commit a criminal act, regardless of whether charges are laid or a conviction is obtained;

ii. an illness or injury that occurred while operating a vehicle under the influence of any intoxicant or with a blood alcohol level that was proven to be in excess of the legal limit in the jurisdiction in which the accident occurred;

iii. an injury or illness resulting from intentional non-compliance with the medical treatment or therapy that has been prescribed;

iv. suicide, attempted suicide or voluntary injury or illness, or

v. insurrection, war (declared or not), the hostile action of the armed forces of any country or participation in any riot or civil commotion.

## F) Specific Exclusions and Limitations

**Emergency Hospital and Medical Travel Coverage**

No payment will be made for:

a) expenses for any care, treatment, surgery, products or services that:

i. are not incurred as a result of an Emergency;

ii. are not Medically Necessary;

iii. are performed for cosmetic purposes only;

iv. are not required for the immediate relief of acute pain and suffering; or

v. could be delayed until the Participant's return to Canada;

b) expenses incurred due to pregnancy or pregnancy complications that occur within 8 weeks of the expected date of delivery; or

c) expenses incurred due to an Emergency that occurs while participating in:

i. a sport for remuneration;

ii. a motor vehicle or speed contest of any kind; or

iii. any Extreme Sport, defined as an activity with a high level of inherent danger and which often involves speed, height, a high level of physical exertion, highly specialized gear or spectacular stunts.

**Referral Outside of Canada**

No payment will be made for:

a) services available in Canada;

b) health care services or treatments unavailable in Canada due to waiting lists;

c) health care services or treatments that physicians in Canada have refused to perform;

d) services, treatment or supplies that are experimental or investigative;

e) services provided while the Participant is not under the Treatment of a physician; and

f) any expenses relating to any Pre-Existing Condition, as defined below.

Pre-Existing Condition means an illness:

- that begins within 12 months of the date the Participant obtained coverage under this benefit; and
- for which, in the 12 month before the date the Participant obtained coverage under this benefit, the Participant has:
  - had a medical consultation;
  - been prescribed or taken medication; or
  - received treatment, including diagnostic services.

## *Termination of Travel Coverage*

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

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

Termination of benefit while travelling

Travel coverage during a trip ceases on the earliest of the following dates:

- The date the Participant ceases to be covered under his government health program in his province of residence, or

- On the 181st day of any trip for Participants under 75 years of Age, or on the 61st day of any trip for Participants 75 of age and older.

# Dental Care Coverage

This benefit covers eligible expenses incurred by you and your dependents for dental services recommended by a dentist and performed by

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

Expenses are subject to the deductible, percentages of reimbursement and maximums specified in the Benefit Summary.

However, if you or your dependents become insured more than 31 days after your date of eligibility, the maximum amount reimbursed under this benefit for all eligible services is limited to $250 during the first 12 months of insurance.

## *Calculation of eligible expenses*

The eligible amount for insured services is the amount indicated in the *Suggested Fee Guide for Dental Services* approved by the *Dental Surgeons' Association* or the *Denturists' Fee Guide* of your province of residence, as per the edition year mentioned in the Benefit Summary.

## *Deductible*

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

The eligible expenses incurred during the last three months of a calendar year and which totally or partially met the deductible for that year may be used to reduce the deductible for the following calendar year.

## *Eligible expenses*

Preventive care

- Oral examination and diagnostic
  - complete oral examination (one per 24-month period)
  - recall oral examination (one per 9-month period)
  - emergency oral examination
  - specific oral examination (once every 6 months)

- X-rays
  - intra-oral films - periapical
  - intra-oral films - occlusal
  - intra-oral films - bitewings
  - complete series and panoramic film (one per 24-month period combined)
  - extra-oral films
  - sialography
  - radiopaque dyes
  - photograph, diagnostic

- Laboratory tests and examinations
  - bacteriologic culture
  - vitality test
  - biopsy of soft oral tissue
  - biopsy of hard oral tissue
  - diagnostic cast unmounted
  - cytological examination
- Preventive treatment
  - polishing of coronal portion of teeth (once per 9-month period)
  - topical application of fluoride (once per 9-month period)
  - pit and fissure sealants (for Participants under age 16)
  - scaling (14 units per calendar year)
- Space maintainers (for Participants under age 16).

Basic care

- Restorations
  - amalgam, acrylic, silicate or composite on posterior and anterior teeth
  - retentive pins
  - pre-formed steel or plastic crowns (for Participants under age 16)
- Removable denture adjustments
  - minor adjustments (once per 6-month period)
  - rebasing and relining
  - prophylaxis and polishing
  - repairs
- Oral surgery
  - removal of erupted tooth (uncomplicated)
  - complicated surgical removal
  - surgical excision of cysts and neoplasms
  - remodelling and recontouring of oral tissue
  - surgical incision and drainage
  - oro-dental trauma
  - other oral surgery
- General adjunctive services
  - General anaesthesia and conscious sedation (related to surgery)
- Temporary dressing for the emergency relief of pain
- Finishing restorations

Endodontics

- pulp capping
- pulpotomy
- emergency pulpotomy
- endodontic traumatism
- root-canal therapy
- endodontic surgery
- bleaching (endodontically treated teeth)
- apexification

Periodontics
- periodontal surgery
- provisional splinting
- management of acute infections
- desensitization (maximum of 3 teeth per 12-month period)
- other adjunctive periodontal services (post-operative visits are limited to 4 visits per calendar year)
- curetage including root planning (one per 60-month period)
- periodontal appliances (bruxism) ( adjustments are limited to one per calendar year)

Major restoration *(if covered in the coverage, as per the chosen plan)*

- Restorations
  - Inlays (once per 60 consecutive months, per teeth)
  - porcelain inlays (if no other material can be used) (once per 60 consecutive months, per teeth)
  - veneer (once per 60 consecutive months, per teeth)
- Other restorative services
  - cast post
  - prefabricated metal post
  - recementation of inlay or crown
  - removal of crown or inlay
- Crowns (single restorations only), other than pre-formed stainless steel and plastic crowns, for teeth broken due to caries or traumatic injury, which cannot be filled by amalgam or composite. Replacement of an existing crown if such crown is at least **sixty months old**.
- Prosthodontic appliances (e.g. fixed bridgework and permanent removable partial or complete dentures) other than dentures with precision or stress-breaker attachments or precision attachments and telescoping crown units for fixed bridgework, as follows:
  - if such appliance was necessary because of the extraction of at least one natural tooth while insured under this benefit,
  - if the existing appliance is at least **five** years old, or
  - if the existing appliance is temporary and is replaced by a permanent appliance within **12** months of the installation date of the temporary one.
- Denture repairs
  - Fixed prosthodontic repairs
  - Partial dentures remake

Orthodontics *(if covered in the coverage, as per the chosen plan*)

The plan reimburses reasonable charges for orthodontic treatment when incurred to correct dental irregularities of a **dependent child who is at least six years old but under age 19 when the treatment begins.**

Eligible expenses cover the following:

- oral examination
- removable active appliances for tooth guidance
- fixed or cemented appliances
- appliances to control harmful oral habits
- retention appliances
- comprehensive treatment

## *Proposed dental treatment in excess of $500*

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

## *Expenses not covered by the plan*

The following expenses are not covered:

- treatment or appliance, related directly or indirectly to full mouth reconstruction, or to correct vertical dimension and temporomandibular joint dysfunction;
- services rendered by a dental hygienist but not administered under the supervision of a dentist, except in those provinces where it is no longer a legal requirement;
- dental services eligible under the Accident/Sickness coverage;
- services and supplies relating to any appliance worn in the practice of a sport;
- expenses that are paid under a public plan or that would normally be so if a claim had been submitted;
- charges eligible under an occupational health and safety board or by an automobile insurance bureau, or any other similar law or public plan, if applicable;
- expenses resulting from any suicide attempt or self-inflicted injury, whether the Participant was sane or not;
- expenses due to any injury resulting from any active participation in civil unrest, riot, insurrection, unless while performing work-related functions, or injury sustained in a war;
- services that are not medically required, that are given for cosmetic purposes (this exclusion does not apply to composite restoration);

- services that exceed the ordinary services given in accordance with current therapeutic practice;
- care or services rendered free of charge, or that would be if the Participant had no coverage;
- expenses incurred for implants;
- precision attachment, stress-breaker, telescoping crown and transfer coping;
- splinting for periodontal reasons, where cast crowns or inlays are used for this purpose, with or without onlays;
- all charges, services, articles or items that are not included on the list of Eligible Expenses described in this benefit.

**Restriction**

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

Reimbursement of laboratory fees will be limited to the usual, customary and reasonable charges for such services in the area where the services are provided. However, in no event will the total reimbursement of laboratory fees exceed 50% of the suggested fee in the appropriate fee guide for the particular dental treatment requiring laboratory services.

## *Termination of Benefit*

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

CHUBB

# Basic Accidental Dismemberment Insurance

For the Employees of:
**Norda Stelo Inc. and the members of its group**

Policy Number:
AB30085101

Underwritten by:
Chubb Life Insurance Company of Canada

Effective Date:
01/01/20

This brochure has been prepared in connection with a group plan underwritten by Chubb Life Insurance Company of Canada ("Chubb Life"). For ease of reference it contains a brief description only and does not mention every provision of the contract issued. Please remember that rights and obligations are determined in accordance with the contract and not this brochure. For the exact provisions applicable, please consult your Employer.

## COVERAGE

The plan offers you full 24-hour protection against accidents, on or off the job, on business, on vacation, at home, regardless of your health history.

## ELIGIBILITY

All active, permanent full-time employees of the policyholder, under age 70.

## BENEFIT AMOUNT

You are covered for a Principal Sum that is equal to one times your annual earnings* rounded to the next $1,000 (if not already a multiple thereof) to a maximum of $1,000,000.

*The term "annual earnings" as used herein shall mean an Insured Person's basic annual salary excluding overtime, bonus or commission.

Benefit reduces by 50% at age 65 and terminates at age 70.

In the event of your death, the benefit amount is payable to the beneficiary you have named under your Group Life Insurance Plan or in the absence of such designation, to your Estate.

**Benefits payable under the following section will be limited to only one policy in the event the benefits are contained in two or more policies issued to the Policyholder by Chubb Life** (not applicable to the Schedule of Losses, Exposure and Disappearance, and Conversion).

## SCHEDULE OF LOSSES

### Accidental Dismemberment

If such injuries shall result in any one of the following specific losses within one year from the date of the accident, Chubb Life will pay the percentage of the benefit amount, based on the amount stated under the Benefit Amount section, however, that not more than one (the largest) of such benefits shall be paid with respect to injuries resulting from one accident.

| | **Percentage of Benefit Amount** |
|---|---|
| Loss of Entire Sight of Both Eyes | 100% |
| Loss of One Hand and One Foot | 100% |
| Loss of Use of One Hand and One Foot | 100% |
| Loss of One Hand and Entire Sight of One Eye | 100% |
| Loss of One Foot and Entire Sight of One Eye | 100% |
| Loss of Speech and Hearing in Both Ears | 100% |
| Brain Death | 100% |
| Loss of Both Arms, Both Hands, Both Legs or Both Feet | 200% |
| Loss of Use of Both Arms, Both Hands, Both Legs or Both Feet | 200% |

| | |
|---|---|
| Quadriplegia | 200% |
| Paraplegia | 200% |
| Hemiplegia | 200% |
| Loss of One Arm or One Leg | 75% |
| Loss of Use of One Arm or One Leg | 75% |
| Loss of One Hand or One Foot | 75% |
| Loss of Use of one Hand or One Foot | 75% |
| Loss of Entire Sight of One Eye | 75% |
| Loss of Speech or Hearing in Both Ears | 75% |
| Loss of Thumb and Index Finger of Same Hand | 33 1/3% |
| Loss of Use of Thumb and Index Finger of Same Hand | 33 1/3% |
| Loss of Four Fingers of Same Hand | 33 1/3% |
| Loss of Hearing One Ear | 33 1/3% |
| Loss of All Toes of Same Foot | 25% |

**"Loss"** shall mean with respect to hand or foot, the actual severance through or above the wrist or ankle joint; with respect to arm or leg, the actual severance through or above the elbow or knee joint; with respect to eye, the total and irrecoverable loss of sight; with respect to speech, the total and irrecoverable loss of speech which does not allow audible communication in any degree; with respect to hearing, the total and irrecoverable loss of hearing which cannot be corrected by any hearing aid or device; with respect to thumb and index finger or four fingers, the actual severance through or above the metacarpophalangeal joints of the same hand (the joints between the fingers and the hand); with regard to toes, the actual severance through or above the metatarsophalangeal joints (the joints between the toes and the foot) of the same foot. If an Insured Person suffers complete severance of a hand, foot, arm or leg as described above, then Chubb Life will pay the amount specified in the Schedule of Losses even if the severed limb is surgically reattached, whether successful or not.

**"Loss"** as used with reference to quadriplegia (paralysis of both upper and lower limbs), paraplegia (paralysis of both lower limbs), and hemiplegia (total paralysis of upper and lower limbs of one side of the body), means the complete and irrecoverable paralysis of such limbs, provided such loss of function is continuous for 180 consecutive days and such loss of function is thereafter determined on evidence satisfactory to Chubb Life to be permanent.

**"Loss of Use"** shall mean the total and irrecoverable loss of function of an arm, hand, foot, leg or thumb and index finger of the same hand provided such loss of function is continuous for 12 consecutive months and such loss of function is thereafter determined on evidence satisfactory to Chubb Life to be permanent.

**"Brain Death"** means irreversible unconsciousness with total loss of brain function; and complete absence of electrical activity of the brain, even though the heart is still beating.

All benefits that are payable at 200% of the Principal Sum are subject to an all policies combined maximum benefit amount of $1,000,000.

## Rehabilitation Benefit

When injuries result in a payment being made by Chubb Life under any benefit, Chubb Life will also pay the reasonable and necessary expenses actually incurred up to a limit of $15,000 for special training of an Insured Employee provided:

a. such training is required because of such injuries and in order for an Insured Employee to become qualified to engage in an occupation in which he or she would not have been engaged except for such injuries;
b. expenses are to be incurred within two years from the date of the accident;
c. no payment will be made for ordinary living, travelling, or clothing expenses.

## Family Transportation Benefit

When injuries result in an Insured Person confinement as an in-patient in a hospital outside 150 km from an Insured Person's city of permanent residence or outside Canada and requires personal attendance of a "Family Member" as recommended by the attending physician, in writing, Chubb Life will pay for the expense incurred by the member of the family, for the transportation by the most direct route by a licensed common carrier to an Insured Person, while confined, but not to exceed $15,000.

**"Family Member"** means spouse, parent or stepparent, child or stepchild or brother or sister, stepbrother or stepsister, brother-in-law or sister-in-law, mother-in-law or father-in-law, and son-in-law or daughter-in-law.

## Home Alteration and Vehicle Modification Benefit

In the event an Insured Person sustains an injury which results in a payment being made under the Schedule of Losses, and such injury subsequently requires the use of a wheelchair to be ambulatory, Chubb Life will pay the reasonable and necessary expenses actually incurred within 365 days from the date of the accident for:

1. the one-time cost of alterations to an Insured Person's principal residence to make it wheelchair accessible and habitable; and
2. the one-time cost of modifications necessary to a motor vehicle utilized by an Insured Person to make the vehicle accessible or operable for an Insured Person.

Benefit payments herein will not be paid unless:

i. home alterations are made by a person or persons experienced in such alterations and recommended by a recognized organization, providing support and assistance to wheelchair users; and
ii. vehicle modifications are carried out by a person or persons with experience in such matters and modifications are approved by the Provincial vehicle licensing authorities.

The maximum payable under both items 1 and 2 shall be 10% of an Insured Person's Principal Sum amount to a maximum of $50,000.

## In-Hospital Confinement Monthly Income

In the event an Insured Person sustains an injury which results in a payment being made under the Schedule of Losses, and an Insured Person is hospital confined as an in-patient and is under the care of a legally qualified and registered physician or surgeon other than himself or herself, Chubb Life will pay for each full month, 1% of an Insured Person's Principal Sum amount, subject to a maximum amount of $2,500, or 1/30 of such monthly benefit for each day of partial month, retroactive to the 1st full day of such confinement but not to exceed 365 days in the aggregate for each period of hospital confinement.

**"Hospital"** as used herein means a legally constituted establishment which meets all of the following requirements: (1) operates primarily for the reception, care and treatment of sick, ailing or injured persons as in-patients; (2) provides 24 hour a day nursing service by registered or graduate nurses; (3) has a staff of one or more licensed physicians available at all times; (4) provides organized facilities for diagnosis and surgical facilities; and (5) is not primarily a clinic, nursing home or convalescent home or similar establishment nor, other than incidentally, a place for alcoholics or drug addicts.

**"In-Patient"** means a person admitted to a hospital as a resident or bed-patient and who is provided at least one day's room and board by the hospital.

## Cosmetic Disfigurement

If an Insured Person suffers a third degree burn due to an accident, Chubb Life will pay a percentage of the Principal Sum depending on the area of the body which was burned according to the following table, subject to a maximum benefit payable of $25,000:

| **Body Part** | **% of Principal Sum Payable** |
|---|---|
| Face, Neck, Head | 100% |
| Hand & Forearm | 25% |
| Either Upper Arm | 15% |
| Torso (Front or Back) | 35% |
| Either Thigh | 10% |
| Either Lower Leg (below knee) | 25% |

In the event of a 50% surface burn, the % of benefit is reduced by 50%. This table only represents the maximum percent 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

In the event an Insured Person sustains an injury which results in a payment being made under the Schedule of Losses, an Insured Person Principal Sum amount will be increased by 10% to a maximum of $25,000 if, at the time of the accident, an Insured Person was driving or riding in a vehicle and wearing a properly fastened seat belt. Due proof of seat belt use must be provided as part of the written proof of loss.

**"Vehicle"** means a private passenger car, station wagon, van, or jeep-type automobile. **"Seat Belt"** means those belts that form a restraint system.

## Conversion Privilege

On the date of termination of employment or during the 31-day period following termination of employment, an Insured Person may convert his or her insurance to an individual ACCIDENTAL DISMEMBERMENT only insurance policy of Chubb Life. The individual policy will be effective either as of the date that the application is received by Chubb Life or on the date that coverage under the group policy ceases, whichever occurs later. The premium will be the same, as a person would ordinarily pay when applying for an individual policy at that time.

## Exposure and Disappearance

Loss resulting from unavoidable exposure to the elements shall be covered to the extent of the benefits afforded an Insured Person.

## Waiver of Premium

If an Insured Employee, under age 65, becomes totally disabled for six consecutive months and an Insured Employee provides evidence of total disability satisfactory to Chubb Life Insurance, Chubb Life Insurance will then waive the payment of each premium which falls due with respect to an Insured Employee and any Insured Dependents. Subject to all the terms and conditions of the policy, waiver of any premium as herein provided will continue with respect to an Insured Employee until age 65 or earlier termination of the policy. If an Insured Employee ceases to be disabled and an Insured Employee returns to employment with the Policyholder and is a member of an eligible class, insurance with respect to an Insured Employee may be continued upon resumption of premium payments by an Insured Employee or the Policyholder.

If after 120 days, an Insured Employee receives approval of any long term disability claim provided under a policy of group insurance through the Policyholder, Chubb Life will then waive the payment of each Accidental Dismemberment insurance premium subject to the terms stated above.

## Recurrent Disabilities

When an Insured Employee becomes totally disabled again from the same or related causes within six months of cessation of the Waiver of Premiums, then all such recurrences will be considered a continuation of the same disability and Chubb Life will waive the six month qualification period.

If the same disability recurs more than six months after cessation of the Waiver of Premiums, such disability will be considered a separate disability. Two disabilities which are due to unrelated causes are considered separate disabilities if they were separated by a return to work of at least one day.

**Termination of Waiver of Premium**

Waiver of Premiums will cease on the earliest of:

a. the date an Insured Employee ceases to meet the policy's definition of totally disabled;
b. the date an Insured Employee does not supply Chubb Life with appropriate medical evidence as deemed necessary by Chubb Life;
c. the date an Insured Employee is no longer receiving regular, ongoing care and treatment of a Physician appropriate for the disabling condition, as determined by Chubb Life;
d. the date an Insured Employee does not attend a medical, psychiatric, psychological, functional, educational and/or vocational examination evaluation by an examiner selected by Chubb Life;
e. the date the policy terminates;
f. the date an Insured Employee turns 65; or
g. the date an Insured Employee dies.

**Coverage During Waiver of Premium**

While premiums are being waived, Basic Accidental Dismemberment Insurance under the policy on an Insured Employee will continue to be in force. The amount of such insurance will be the amount of insurance that was in effect on the date of commencement of the disability, subject to any age reduction or termination shown in the policy.

**"Totally Disabled or Total Disability"** with respect to Waiver of Premium means disability resulting from injury or sickness which prevents engagement in an Insured Person's regular occupation for six consecutive months.

**Continuance of Coverage**

In the case of a Primary Insured who is (1) laid-off on a temporary basis, (2) temporarily absent from work due to short-term disability, or (3) on leave of absence, coverage shall be extended for a period of 12 months following the beginning of any such event subject to payment of premiums.

In the case of a Primary Insured who is on maternity or parental leave coverage shall be extended for a period of up to 18 months following the beginning of any such event subject to payment of premiums.

If an Insured assumes other occupational duties during the leave or lay-off

period, no benefits shall be payable for a loss occurring during the performance of such other occupation.

Exclusions

The plan does not cover any loss, which is the result of:

a. Intentionally self-inflicted injury, suicide or any attempt thereat;
b. Declared or undeclared war, or any act thereof; except to the extent as provided by War Risk coverage (please refer to Human Resources for further details);
c. Travel or flying in an aircraft owned or leased by the Policyholder, an Insured or a member of an Insured's household, or aircraft being used for any test or experimental purpose, firefighting, power line inspection, pipeline inspection, aerial photography or exploration;
d. Losses occurring while the Insured is serving on full-time active duty in the Armed Forces of any country or international authority (any premium paid to be returned by the Company pro-rata for any such period of full-time active duty;
e. Travel or flight in any vehicle or device for aerial navigation; except to the extent such travel or flight is provided in the "Hazards Insured Against" section of this policy, if applicable).

General Provisions

**Beneficiary**

An employee or any spouse has the right to name a beneficiary when he applies for insurance. It is understood that the beneficiary designation made under the Policyholder's Group Life Insurance Policy shall be recognized as the beneficiary under the policy, unless a further designation has been made that specifically identifies the policy. Failing such designation, all benefits will be paid to the estate of the insured person.

All other indemnities of the policy will be payable to the insured person.

An insured person can change his beneficiary at any time, where permitted by law. The Company assumes no responsibility for the validity of such designation or change of beneficiary.

The beneficiary designation made by the insured person (if any) under the replaced policy has been retained. The insured person should review the existing designation to ensure it reflects his/her current intention.

**The policy contains a provision removing or restricting the right of the insured person to designate persons to whom or for whose benefit insurance money is to be payable.**

## Legal Actions

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the Insurance Act, Limitations Act, 2002 or other applicable legislation in the Insured's province of residence.

## Change of Insurer

An insured person under a former policy may not be excluded from the new policy or be denied benefits solely because of a pre-existing condition limitation that was not applicable or that did not exist in the former policy, or because the person is not at work on the date of coming into force of the new policy.
The insured person and any claimant under the policy has the right, as determined by law applicable in the insured person's province of residence, to obtain a copy of his/her application, any written evidence of insurability (as applicable) and the Policy, on request, subject to certain access limitations.

How to Claim

In the event of a claim, claim forms can be obtained from the Plan Administrator.

Notice of claim must be given to Chubb Life within 30 days from the date of the accident, the beginning of the disability or after the survival period, and subsequent proof of claim must be submitted to Chubb Life within 90 days from the date of the accident or after survival period.

Failure to give notice of claim or furnish proof of claim within the time prescribed in the policy condition will not invalidate the claim if the notice or proof is given or furnished as soon as reasonably possible and if it is shown that it was not reasonably possible to give notice or furnish proof within the time so prescribed.

In no event, will Chubb Life accept notice of claim beyond one year.

10/19

Chubb Life is part of the Chubb group of insurance companies, with operations in 54 countries, Chubb provides commercial and personal property and casualty insurance, personal accident and supplemental health insurance, reinsurance and life insurance to a diverse group of clients.

Chubb Limited, the parent company of Chubb Life, is listed on the New York Stock Exchange (NYSE: CB) and is a component of the S&P 500 index.