My group benefit plan

canada life™

Lethbridge College

CONTINUING FULL-TIME AND CONTINUING PART-TIME FACULTY EMPLOYEES AND TERM CERTAIN INSTRUCTORS

BENEFIT DETAILS

Canada Life is a leading Canadian life and health insurer. Canada Life's financial security advisors work with our clients from coast to coast to help them secure their financial future. We provide a wide range of retirement savings and income plans; as well as life, disability and critical illness insurance for individuals and families. As a leading provider of employee benefits in Canada, we offer effective benefit solutions for large and small employee groups.

Canada Life Online

Visit our website at www.canadalife.com for:

- information and details on Canada Life's corporate profile and our products and services
- investor information
- news releases
- contact information
- online claims submission

My Canada Life at Work

As a Canada Life plan member, you can register for My Canada Life at Work™ at www.mycanadalifeatwork.com. Make sure to have your plan and ID numbers available when registering.

With My Canada Life at Work you can:

- Submit claims quickly
- Review your coverage and balances
- Find healthcare providers like chiropractors and massage therapists near you
- Save your benefits cards to your payment service application or program
- Get notified when your claims have been processed

Canada Life's Toll-Free Number

To contact a customer service representative at Canada Life:

- for assistance with your medical and dental coverage, please call 1-800-957-9777.
- for assistance with your Health Care Spending Account, please call 1-877-883-7072.

Customer complaints

We are committed to addressing your concerns promptly, fairly and professionally. Here is how you may submit your complaint.

- Toll-free:
  - Phone: 1-866-292-7825
  - Fax: 1-855-317-9241
- Email: ombudsman@canadalife.com
- In writing:

The Canada Life Assurance Company
Ombudsman's Office T262
255 Dufferin Avenue
London, ON N6A 4K1

For additional information on how you may submit a complaint, please visit www.canadalife.com/complaints.

The information provided in the booklet is intended to summarize the provisions of Group Policy Nos. 335677 and 179640 issued by Canada Life and Group Policy No. 1HM90 issued to your employer by SSQ Insurance Company Inc.. If there are variations between the information in the booklet and the provisions of the policies, the policies will prevail to the extent permitted by law.

This booklet contains important information and should be kept in a safe place known to you and your family.

The Plan is underwritten by

and

SSQ Insurance Company Inc.

This booklet was prepared on: July 11, 2022

Access to Documents

You have the right, upon request, to obtain a copy of the policy, your application and any written statements or other records you have provided to Canada Life as evidence of insurability, subject to certain limitations.

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 (for actions or proceedings governed by the laws of Alberta and British Columbia), The Insurance Act (for actions or proceedings governed by the laws of Manitoba), the *Limitations Act, 2002* (for actions or proceedings governed by the laws of Ontario), or other applicable legislation. For those actions or proceedings governed by the laws of Quebec, the prescriptive period is set out in the Quebec Civil Code.

Appeals

You have the right to appeal a denial of all or part of the insurance or benefits described in the contract as long as you do so within one year of the initial denial of the insurance or a benefit. An appeal must be in writing and must include your reasons for believing the denial to be incorrect.

Benefit Limitation for Overpayment

If benefits are paid that were not payable under the policy, you are responsible for repayment within 30 days after Canada Life sends you a notice of the overpayment, or within a longer period if agreed to in writing by Canada Life. If you fail to fulfil this responsibility, no further benefits are payable under the policy until the overpayment is recovered. This does not limit Canada Life's right to use other legal means to recover the overpayment.

Quebec Time Limit for the Payment of Benefits

Where Quebec law applies, benefits will be paid in accordance with the terms of the plan within the following time period:

- for death benefits, 30 days following receipt of the required proof of claim.
- for disability income benefits for which there is no waiting period, 30 days following receipt of the required proof of claim.
- for disability income benefits for which there is a waiting period, 30 days from the expiry of the waiting period provided the required proof of claim has been received.
- for any other benefit, 60 days following receipt of the required proof of claim.

Employer Role

The employer's role is limited to providing employees with information and not advice.

Protecting Your Personal Information

At Canada Life, we recognize and respect the importance of privacy. Personal information about you is kept in a confidential file at the offices of Canada Life or the offices of an organization authorized by Canada Life. Canada Life may use service providers located within or outside Canada. We limit access to personal information in your file to Canada Life staff or persons authorized by Canada Life who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law. Your personal information may be subject to disclosure to those authorized under applicable law within or outside Canada.

We use the personal information to administer the group benefits plan under which you are covered. This includes many tasks, such as:

- determining your eligibility for coverage under the plan
- enrolling you for coverage
- investigating and assessing your claims and providing you with payment
- managing your claims
- verifying and auditing eligibility and claims
- creating and maintaining records concerning our relationship
- underwriting activities, such as determining the cost of the plan, and analyzing the design options of the plan
- Canada Life's and its affiliates' internal data management and analytics
- preparing regulatory reports, such as tax slips

We may exchange personal information with your health care providers, your plan administrator, any insurance or reinsurance companies, administrators of government benefits or other benefit programs, other organizations, or service providers working with us or the above when relevant and necessary to administer the plan.

As a plan member, you are responsible for the claims submitted. We may exchange personal information with you or a person acting on your behalf when relevant and necessary to confirm coverage and to manage the claims submitted.

You may request access or correction of the personal information in your file. A request for access or correction should be made in writing and may be sent to any of Canada Life's offices or to our head office.

For a copy of our Privacy Guidelines, or if you have questions about our personal information policies and practices (including with respect to service providers), write to Canada Life's Chief Compliance Officer or refer to www.canadalife.com.

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GROUP INSURANCE PLAN FOR EMPLOYEES OF

THE BOARD OF GOVERNORS OF LETHBRIDGE COLLEGE

Group Life & Health Insurance Policy GH. 335677

BENEFIT DESCRIPTION

Life Insurance

Class(es)	Amount of Insurance
Employees With Dependents	400% of annual earnings, to a maximum of $300,000.
Employees Without Dependents	200% of annual earnings, to a maximum of $300,000.

Any amount of Life Insurance which is not an integral multiple of $1,000 will be rounded to the next $1,000.

Reductions

Life Insurance will reduce 50% on your 65th birthday.

Optional Life Insurance

Employee and Spouse	Available in $10,000 units to a maximum of $500,000 for you or your spouse, subject to approval of evidence of insurability If you are covered under this plan as both an employee and a spouse, you are limited to the $500,000 maximum
Child	Available in $5,000 units to a maximum of $15,000, subject to approval of evidence of insurability after 31 days of becoming eligible
Optional Critical Illness Insurance	Available in $10,000 units to a maximum of $250,000 for you or your spouse, subject to approval of evidence of insurability If you apply for coverage within 31 days of becoming eligible, you may purchase up to $50,000 of Optional Critical Illness Insurance without providing evidence. If you are covered under this plan as both an employee and a spouse, you are limited to the $250,000 maximum

Long Term Disability

Class(es)	Amount of Insurance
Continuing Full-Time and Continuing Part-Time Faculty	66 2/3% of the first $2,600 of monthly earnings; 50% of the next $2,200 of monthly earnings and 45% of the balance of monthly earnings, to a maximum monthly benefit of $5,000.

Any amount which is not an integral multiple of $1.00 will be rounded to the next $1.00.

Benefit payments are non-taxable.

Benefits are paid monthly in arrears after an elimination period of 105 days and terminate on the earlier of your cessation of disability, death, or attainment of age 65, except if you were under age 65 when you became disabled you will receive at least 12 months of payment provided you remain disabled.

Pay Direct Drugs

Your deductible per prescription is nil.

Reimbursement is 80% of eligible charges.

Medi-Pack

Your deductible per calendar year is nil.

Reimbursement is 100% of eligible charges.

Dental

Canada Life will pay on the basis of each year's Dental Association Fee Guide for General Practitioners or Dental Hygienist Fee Guide, as of the 1st of the month following the month in which Canada Life receives the new Fee Guide.

Your deductible per calendar year is nil.

Dental 1 and 2 Charges
Reimbursement is 90% of eligible charges.

Maximum is unlimited.

Dental 3 Charges
Reimbursement is 50% of eligible charges.

Maximum is $1,000 per person in any calendar year.

Dental 4 Charges
Reimbursement is 50% of eligible charges.

Maximum is $2,000 in the lifetime per person.

Limitation

If you complete your application to become insured more than 30 days after your Eligibility Date, the maximum amount payable to you for charges incurred during the first twelve months of coverage under this Benefit provision will be $250. The full coverage offered under this Dental Care Benefit will begin after twelve months.

If you complete your application for Dependent’s insurance more than 30 days after your Eligibility Date or more than 30 days after first acquiring a dependent, the maximum amount payable for each dependent for charges incurred during the first twelve months of coverage under this Benefit provision will be $250. The full coverage offered under this Dental Care Benefit will begin after twelve months.

Survivor Extension

In the case of your death, Pay-Direct Drugs, Medi-Pack and Dental coverage, if applicable, will be extended to your eligible dependents until the earlier of the date your spouse remarries or the date of the second anniversary of your death.

Changes In Coverage

Changes in coverage due to reclassification, dependency status or gross salary will take effect on the date of the change. You must be actively at work in order for your insurance to increase. In order for the change in benefit to occur, Canada Life must also be properly notified by your Employer.

Termination of Benefits

Long Term Disability benefit terminates on your 65th birthday. All other benefits terminate on June 30th following your 70th birthday.

YOUR ELIGIBILITY

If you are under age 65 you are eligible to be insured from your date of employment. This is provided you work at least 30 hours per week on a regular basis if you are a Full-Time Continuing Faculty or more than half time for two semesters if you are a Part-Time Continuing Faculty or a Term Certain. You must also be a permanent employee in order to be eligible for Long Term Disability benefits.

Commencement of Your Coverage

The date you will become covered depends on the date your application is completed, and your eligibility date:

Application Completed	Commencement of Coverage
On or before your Eligibility Date.	Your Eligibility Date.
Within 30 days after your Eligibility Date.	Your Eligibility Date.
More than 30 days after your Eligibility Date.	The date Canada Life has in writing either approved evidence of your good health or waived such requirement.

If you are not Actively at Work on the date your coverage should commence, you will be covered when you return to work.

YOUR ELIGIBLE DEPENDENTS

Dependents eligible for benefits are either your spouse or common-law spouse and each unmarried child, step-child or common-law child who is under 21 years of age or under 25 years of age if attending an accredited educational institute, college or university on a full-time basis. Anyone who is in full-time service in any naval, military or air force will not be eligible as dependents.

The attainment of any maximum age specified above will not terminate the coverage on your dependent child if at the time your child is incapable of self-support due to a mental or physical handicap and relies upon you for support and maintenance.

A dependent who resides outside of Canada and the United States of America is not eligible for benefits.

Commencement of Your Dependent's Coverage

Your dependent coverage will commence on the same date as your coverage if you request dependent coverage on your application. If you complete your application more than 30 days after your eligibility date, evidence of your dependent's good health may also be required.

If you have no dependents when you become covered and later acquire a dependent, you must complete an application for coverage. The earliest date this coverage will commence depends on the date the application is completed:

Application Completed	Commencement of Coverage
Within 30 days after you acquire the dependent.	The date the dependent is acquired.
More than 30 days after you acquire the dependent.	The date Canada Life has in writing either approved evidence of their good health or waived such requirement.

Once you have dependent coverage, an additional child will automatically become insured on the date the child qualifies as your dependent. Notification is required if additional dependents are acquired.

If your dependent other than a new-born is confined in a hospital when coverage should commence, coverage will not begin until your dependent's discharge.

You must complete a new application if you wish to add or change a legally married or common-law spouse.

BENEFICIARY DESIGNATION

You may make, alter or revoke a designation of beneficiary as permitted by law. Any designation of beneficiary you made under your employer's previous policy prior to the effective date of this policy applies to this policy until you make a change to that designation. You should review your beneficiary designation made under this policy from time to time to ensure that it reflects your current intentions. You may change the designation by completing a form available from your employer.

GENERAL HEALTH EXCLUSIONS

No amount of benefit will be payable for any charge that resulted either directly or indirectly from, or was in any manner or degree associated with, or occasioned by, any one or more of the following:

a) war, insurrection or hostilities of any kind whether or not you or your dependent were a participant in such action,

b) participation in a riot or civil commotion,

c) committing or attempting to commit a criminal offence or provoking an assault.

Additional exclusions are found under the respective Benefit Descriptions in this booklet.

TERMINATION OF INSURANCE

You are no longer insured from the date your employment terminates or the policy terminates.

Insurance may terminate on the last day of the month that follows the month you began a lay-off.

Insurance terminates the day before you enter service in any naval, military or air force.

For benefits on termination see Conversion of Your Life Insurance under Your Life Insurance Benefit and Extension of Benefits following the health benefit description.

YOUR LIFE INSURANCE BENEFIT

Payment will be made in a lump sum amount to your named beneficiary in the case of your death. Your employer will explain the claim requirements to your beneficiary. Any amount of coverage for which there is no beneficiary will be payable to your estate.

Waiver of Premium

Coverage on your life will continue if you become totally disabled for at least 6 consecutive months or until your claim is admitted under a Group Long Term Disability Income Benefit with Canada Life. You must become disabled while covered before your 65th birthday. No premium payments will be required as of your date of disability.

"Totally Disabled" means your complete inability to engage in any gainful occupation for which you are reasonably fitted by education, training, experience or admittance under a Group Long Term Disability Income Benefit with Canada Life. Canada Life must receive initial proof that you are totally disabled no later than 12 months after your date of disability.

Extension of Benefits

The termination of the policy will not affect the continuation of your coverage under the Waiver of Premium provision.

Conversion of Your Life Insurance

You may convert your Group Life Coverage to an Individual Life Policy upon termination of your employment or termination of the policy. You must be under age 65 to convert but evidence of good health is not required. The individual policy will be one of the standard life insurance conversion forms available by Canada Life or any of its affiliates. For limits on the amount of coverage that may be selected please see your employer. It may not include any provision for disability, accidental death or other special benefit.

An application and the first premium due for the individual policy must be received by Canada Life within 31 days after the termination of your group coverage. In the case of your death during this 31 day period, the amount of coverage, subject to any limits, will be paid to your designated beneficiary.

LONG TERM DISABILITY BENEFIT

You will be paid a monthly amount based on your pre-disability monthly income after the elimination period of 105 days if you become disabled while insured.

Benefits are paid only if you are under the continuing care of a legally licensed physician or surgeon. For a disability arising from any medical condition, you must be receiving appropriate treatment as agreed upon by Canada Life and your treating physician. We reserve the right to seek and accept an independent medical opinion from a physician specialized in the treatment of the medical condition.

You must be disabled for a continuous period due to the same or related causes. A continuous period of disability includes all periods which are not separated by more than 30 days during the elimination period or six consecutive months after the elimination period.

Definition of Disability

"Disabled" and "Disability" means that due to injury, disease, illness, pregnancy or mental disorder you are not able to perform the essential duties of your regular occupation during the first 24 months of payment. Thereafter, it means that you are not able to earn at your own or any other occupation more than 75% of your pre-disability monthly earnings for which you are reasonably fitted by education, training or experience.

If you engage in any business or occupation except in a rehabilitation program approved by Canada Life, you will be deemed to no longer be disabled.

Waiver of Premium

Canada Life will waive the premium payments while you are receiving benefits from the date of disability.

Rehabilitation Provision

To help you recover while still receiving payments, you may engage in a Canada Life approved rehabilitation program. Training or work performed in such a program allows you to receive increased income.

Canada Life's monthly benefit will only be reduced when the total monthly income you receive from Canada Life, the sources described in the "Integration of Benefits" provision plus the net income from your rehabilitative program exceeds 100% of your net pre-disability monthly income. If your total monthly income exceeds 100% of your net pre-disability monthly income, your benefit will be reduced by the amount in excess of your net pre-disability monthly income. However, benefit payments will cease on the date when you cease to participate in the program.

Canada Life will pay expenses incurred by you, other than usual employment expenses, for services and equipment associated with an approved rehabilitation program. The expenses must be approved in advance by Canada Life in writing. The maximum lifetime amount payable for services and equipment will be $25,000.

Integration of Benefits

For the purpose of any calculation under this provision, we will consider the full amount of any benefits you are eligible to apply for and receive, before any income tax and/or any other deductions.

Benefits will be reduced by payments you are entitled to receive under the Workers' Compensation Act, and the Canada/Quebec Pension Plan, a plan in another country for which there is a reciprocal agreement with the Canada Pension Plan or Quebec Pension Plan (excluding child benefits to which any member of your family is entitled to apply for and receive as a result of your disability plus subsequent cost of living increases), or any other employment income other than described in the Rehabilitation Provision. If you have not applied or applied and have not received notice, Canada Life will estimate your benefits until they receive written notice that your application has been declined. If you notify us that an application or appeal has been declined and we determine that this decision should be subject to appeal, you must file an appeal and we may continue to reduce your payments until we are notified in writing that such appeal has been declined.

If necessary, benefits will be further reduced so that your total monthly gross income from all sources is not more than 85% of your net pre-disability monthly income. Income from all sources includes:

a) Canada Life's disability benefit.

b) Any indemnity payable to you under any Workers' Compensation Act or similar legislation.

c) Any benefits under the Canada/Quebec Pension plan or a plan in another country for which there is a reciprocal agreement, including child benefits to which any member of your family younger than 18 years of age is entitled to apply for and receive as a result of your disability plus subsequent cost of living increases.

d) Any indemnity payable to you under any Government legislated No-Fault Automobile Insurance plan.

e) Any indemnity for loss of time payable to you under an insured or uninsured plan which covers you on a group basis, other than a professional or other association type plan.

f) Any continuation of salary from your employer.

g) Any benefits received under any retirement or pension plan of your employer.

h) Any damages for loss of income recovered from a third party and arising out of the same circumstances that caused your disability.

If the amount of benefit, reduced as described above, plus the amount of benefit from a professional or association plan exceeds 100% of net pre-disability income, the benefit will be further reduced to the extent necessary so that the gross monthly income from all sources does not exceed 100% of net pre-disability income.

The benefit will not be reduced by amounts received under an individual policy.

Partial Disability

If after a period of total disability equal to the elimination period, you are able to return to your own occupation or any other occupation on a part-time basis, Canada Life will pay benefits provided that:

1. you are not able to return to your own occupation on a full-time basis, and

2. you are not able to earn more than 80% of your pre-disability monthly income.

The benefit amount will be reduced by whichever of the following two clauses will result in the smallest amount of benefit payable:

1. by 50% of the net income you received each month from employment.

2. to the extent necessary so that the total monthly income from Canada Life, the sources described in the "Integration of Benefits" provision plus the net income from your employment does not exceed 100% of your pre-disability net monthly income.

Exclusions

The following exclusions are in addition to those described in the "General Health Exclusions". No benefits will be paid with respect to the disability:

e) During the period which you are on leave of absence, including Pregnancy Leave of Absence. If you become disabled while on leave of absence, the leave of absence will be deemed to end on the day before the date on which you are scheduled to return to work.

f) During any period while you are permanently or temporarily outside of Canada or the United States. If you become disabled, your disability will be deemed to commence on the date you return to Canada or the United States.

g) During any period you refuse to participate in a rehabilitative program offered by us or you refuse a rehabilitative job offered to you for which you are reasonably suited unless your disability prevents you from participating in such program or from performing the duties of such job.

h) During any period that you have been paid (in a lump sum or otherwise) a severance allowance due to termination of employment, or for any period for which you have obtained through any legal proceeding damages or other payments representing wage loss or loss of income for the termination of the employment relationship. The period for which benefits will not be paid will be the number of months the severance allowance payments or damages award equates to your pre-disability monthly income, regardless of whether such payments or damages are payable in a lump sum or otherwise.

Extension of Benefits

If you are disabled at the time of termination of employment or cancellation of the plan, your payments will continue to be paid for that one period of disability, provided you are entitled to this benefit.

How to Submit a Claim

Claim forms are available from your employer. This form must be completed in full and submitted immediately but no later than 90 days after the elimination period. It is in your best interest to submit your claim as soon as possible since it helps to ensure prompt payment.

If the Group Insurance Policy terminates, no payment will be made for any claim unless proof is submitted within 90 days of the termination date.

PAY-DIRECT DRUG BENEFIT

The Drug Coverage on your group is being administered by the pharmacy benefits manager appointed by Canada Life.

Any eligible drug charge will be paid if:

1. it is medically necessary;

2. it is reasonable and customary;

3. it represents reasonable treatment;

4. payment is not prohibited by a Government Sponsored plan in your Province or Territory of residence.

Eligible Charges

Unless medical evidence of your good health is provided to Canada Life that indicates why a drug is not to be substituted, Canada Life can limit the eligible drug charge to the cost of the lowest priced interchangeable drug.

Drugs and drug supplies, prescribed in writing by a Physician or other person entitled by law to prescribe them, dispensed by a pharmacist or other person entitled by law to dispense them, bearing a Drug Identification Number on their labels, listed as prescription requiring in Federal or Provincial Drug Schedules and some other non-prescription requiring drugs are covered. Included are injectable drugs, injectable vitamins, insulins, allergy extracts, contraceptive drugs and products containing a contraceptive drug, extemporaneous preparations or compounds, disposable needles, disposable syringes, lancets, testing materials and sensors for flash glucose monitoring machines for monitoring diabetes and drugs in the following categories:

antimalarials
fibrinolytics
fluorides, single entity
iron salts, single entity
nitroglycerine
potassium replacements
thyroid agents
topical enzymatic debriding agents

Other Services and Supplies

Canada Life can, on such terms as it determines, cover services or supplies under this plan where the service or supply represents reasonable treatment.

Maintenance Drugs

Any single purchase of drugs or medicines which would be considered reasonable and customary to be consumed or used within a 34 day period or, with respect to maintenance drugs, a 100 day period.

antiasthmatics	cardiac agents
antibiotics for acne	estrogens
anticoagulants	glaucoma
anticonvulsants	hypoglycoemic
antihypertensives	antiparkinson
potassium replacements	antituberculosis
thyroid agents	oral contraceptives

Canada Life can limit an Eligible Charge for a service or supply to that of a lower cost alternative service or supply that represents reasonable treatment.

Canada Life can decline a claim for services or supplies that were purchased from a provider that is not approved by Canada Life.

Charges for the following are not covered whether or not they have been prescribed for medical reasons.

1. Atomizers, appliances, prosthetic devices, colostomy supplies, first aid kits or equipment, electronic diagnostic monitoring or testing equipment, non-disposable insulin delivery devices, delivery or extension devices for inhaled medications, spring loaded devices used to hold lancets, alcohol, alcohol swabs, disinfectants, cotton, bandages or supplies and accessories for the above.

2. Oral vitamins, minerals, dietary supplements, infant formulas or injectable total parenteral nutrition solutions whether or not prescribed for a medical reason, except where Federal or Provincial law requires a prescription for their sale.

3. Diaphragms, condoms, jellies/foams/sponges/ suppositories, intrauterine devices, contraceptive implants or appliances normally used for contraception, whether or not prescribed for a medical reason, unless such contraceptive products contain a contraceptive drug as provided under this provision.

4. Any drug which does not have a drug identification number as defined by the Food and Drugs Act, Canada.

5. Services or supplies associated with an eligible service or supply, unless specifically listed as an eligible service or supply or determined by Canada Life to be an eligible service or supply.

6. Drugs administered during treatment in an emergency room of a hospital, or as an in-patient in a hospital.

7. All preventative immunization vaccines and toxoids, other than Hepatitis B.

8. All homeopathic preparations.

9. Items deemed cosmetic (even if a prescription is legally required) e.g. topical minoxidil, sunscreens, etc.

10. Any portion of services or supplies which the insured is entitled to receive, or for which the insured is entitled to a benefit or reimbursement, by law or under a plan that is legislated, funded, or administered in whole or in part by a government ("government plan"), without regard to whether coverage would have otherwise been available under this plan. In this limitation, government plan does not include a group plan for government employees.

11. Smoking cessation products will be limited to a $500 lifetime maximum.

12. Supplies for recreation or sports, whether or not medically necessary.

13. Fertility drugs, after the lifetime maximum of $5,000 has been paid.

14. Anti-obesity treatments.

Erectile Dysfunction Drugs are included up to a maximum of $1,000 per calendar year per person.

Prior Authorization

In order to determine whether coverage is provided for certain services or supplies, Canada Life maintains a limited list of services and supplies that require prior authorization.

These services and supplies, including a listing of the prior authorization drugs, can be found on the GWL website as follows: www.canadalife.com/001/Client_Services/Group_Plan_Members/Forms/Prior_Authorizations_Forms/index.htm

Prior authorization is intended to help ensure that a service or supply represents a reasonable treatment.

If the use of a lower cost alternative service or supply represents reasonable treatment, Canada Life may require you or your dependent to provide medical evidence why the lower cost alternative service or supply cannot be used before coverage may be provided for the service or supply.

Health Case Management

If you or one of your dependents apply for prior authorization of certain supplies or services, Canada Life may contact you to participate in health case management. Health case management is a program recommended or approved by Canada Life that may include but is not limited to:

- consultation with you or your dependent and the attending physician to gain understanding of the treatment plan recommended by the attending physician;
- comparison with the attending physician, of the recommended treatment plan with alternatives, if any, that represent reasonable treatment;
- identification to the attending physician of opportunities for education and support; and
- monitoring your or your dependent's adherence to the treatment plan recommended by the attending physician.

In determining whether to implement health case management, Canada Life may assess such factors as the service or supply, the medical condition, and the existence of generally accepted medical guidelines for objectively measuring medical effectiveness of the treatment plan recommended by the attending physician.

Health Case Management Limitation

Canada Life can, on such terms as it determines, limit the payment of benefits for a service or supply where:

- Canada Life has implemented health case management and you or your dependent do not participate or cooperate; or
- you or your dependent have not adhered to the treatment plan recommended by the attending physician with respect to the use of the service or supply.

Health Case Management Expense Benefit

Expenses associated with health case management may be paid for by Canada Life at its discretion. Expenses claimed under this provision must be pre-authorized by Canada Life.

Designated Provider Limitation

For a service or supply to which prior authorization applies or where Canada Life has recommended or approved Health Case Management, Canada Life can require that a service or supply be purchased from or administered by a provider designated by Canada Life, and:

- limit the covered expense for a service or supply that was not purchased from or administered by a provider designated by Canada Life to the cost of the service or supply had it been purchased from or administered by the provider designated by Canada Life; or
- decline a claim for a service or supply that was not purchased from or administered by a provider designated by Canada Life.

Patient Assistance Program

A patient assistance program may provide financial, educational or other assistance to you or your dependents with respect to certain services or supplies.

If you or your dependents are eligible for a patient assistance program, Canada Life may require you or your dependents to apply to and participate in such a program. Where financial assistance is available from a patient assistance program that Canada Life requires participation in, Canada Life will reduce the amount of a covered expense for a service or supply by the amount of financial assistance you or your dependent are entitled to receive for that service or supply.

Pharmacy Benefits Manager

How Does the Pharmacy Benefits Manager Work?

Each time you use your pharmacy benefit manager drug card at a participating pharmacy, your drug claim will be checked for potential problems (such as harmful drug interactions, duplication of medicines, or age associated risks). If a problem is detected your pharmacist will be able to warn you of any dangers. In some cases, where taking the prescribed medicine would be very dangerous to your health, the claim may be declined for your safety. The pharmacy benefits manager's centralized claims data base is available at participating pharmacies across Canada.

Exclusion

This exclusion is in addition to those described under "General Health Exclusions":

e) Any cause which entitles you or your dependent to apply for and receive indemnity or compensation under any Workers' Compensation Act.

MEDI-PACK BENEFIT

You will be paid for any of the charges incurred by you or your dependent provided that the charge meets all of the following conditions.

1. It is medically necessary for the treatment of bodily injury, illness or disease.

2. It is reasonable and customary.

3. It is recommended and authorized by a physician or surgeon legally licensed to practise medicine.

4. It represents reasonable treatment.

5. Payment for services covered under this plan is not prohibited by the Provincial Government (plan) in your province of residence.

6. It is not more than the difference between the actual cost of the charge and the amount you are entitled to apply for and receive under any Government Sponsored plan in your province or territory of residence.

Services and supplies described under this Benefit provision are subject to the following provisions described under the Pay Direct Drug Benefit:

1. Prior Authorization

2. Health Case Management

3. Designated Provider Limitation

4. Patient Assistance Program

5. Other Services and Supplies

6. Lower Cost Alternative

7. Approved Provider

Nursing Care

The services of a Professional Nurse at your residence up to an individual maximum of $10,000 per calendar year; subject to prior approval by Canada Life.

From January 1st coincident with or next following your or your dependent's 65th birthday, the maximum payable is $25,000 lifetime.

Note: The services will not be considered as eligible expenses while you or your dependent are residing in a nursing home, home for the aged, rest home or any other facility providing similar care, or confined in a Licensed Hospital.

Payment will not be made for services which are for custodial care and do not require the skill of a Professional Nurse.

The services will not be considered as eligible expenses if the Professional Nurse is normally resident in your home.

Ambulance

Charges for a licensed ambulance or other emergency service, when medically necessary, to transport you or your dependent from the place where injury, disease, illness, pregnancy or mental disorder is suffered to the nearest hospital where adequate treatment can be rendered, from one hospital to another, and from a hospital to your residence.

Charges for the fare of one attendant to accompany you or your dependent if transportation is not provided by a licensed ambulance service.

Aids, Services & Supplies

Charges incurred in your province or territory of residence for (i) services furnished by a Licensed Hospital and (ii) supplies which are obtained from an out-patient department of a Licensed Hospital or a surgical supply company, while you or your dependent are not confined to the Hospital.

Purchase of braces, crutches, artificial limbs or eyes and prosthetic devices approved by Canada Life.

An initial pair of frames and one corrective prosthetic lens, for each eye, that is prescribed after cataract surgery.

An initial breast prosthesis following a mastectomy plus a replacement every two calendar years and two surgical brassieres per calendar year.

Rental of a wheelchair, hospital bed including mattresses or other approved durable equipment for temporary therapeutic use. This equipment may be purchased subject to Canada Life's approval prior to the purchase.

Oxygen.

Custom made Orthopaedic shoes prescribed by a podiatrist or physician up to a maximum of one pair per calendar year. Modifications to any shoes will not be payable.

Foot orthotics up to a maximum of $300 per calendar year. To be eligible for payment, the orthotic devices must be (i) prescribed by a physician, podiatrist or chiropodist, (ii) made from a plaster cast, (iii) diagnosed as being necessary by a biomechanical examination, (iv) made at a professional podiatry laboratory and (v) Medically Necessary for the Insured's regular daily living activities and not solely for recreation or sports.

Continuous glucose monitoring machines, including sensors and transmitters, up to an individual maximum of $4,000 per calendar year.

Two pairs of surgical stockings per calendar year.

Wigs and hairpieces purchased as a result of chemotherapy/radiation therapy up to a lifetime maximum of $100. We will also reimburse up to $250 lifetime for wigs purchased due to total hair loss from Alopecia Totalis.

The following are examples of items that are payable if they are recommended and authorized by a physician or surgeon legally licensed to practise medicine and approved by Canada Life:

> glucometers, tens machine (chronic pain), crutches, casts, mozes detectors, apnea monitor, diabetic supplies, flash glucose monitoring machines, canes, grab bars, walker, colostomy supplies, aerochambers, oxygen equipment, compressors and braces.

The following are examples of items that are not payable whether or not they have been recommended by a physician or surgeon:

> craftmatic or lifestyle beds, mattresses (except standard mattress with approved hospital bed), humidifiers, air conditioners or air purifiers, exercise machines or programs, home/automobile modifications (ex: ramps, lifts), breast pumps, contraceptive devices and spermicides/diaphragms/condoms, blood pressure kit, and obus forme/orthopaedic pillows.

Accidental Dental

Charges by a legally licensed dentist for dental treatment of injuries to natural teeth, or replacement of natural teeth, for accidents suffered by you or your dependent while insured under this benefit.

The charges will be subject to all of the following conditions:

- The treatment is necessitated by a direct accidental blow to the mouth and not by an object or food placed wittingly or unwittingly in the mouth.

- The accidental blow occurs while the person is insured.

- The treatment is received within twelve months after the accidental blow.

- The treatment is the least expensive that will provide a professionally adequate treatment.

- No payment will be made for any part of the charge which exceeds the amount shown for the treatment in the current Dental Association Schedule of Fees for General Practitioners in your province of residence.

- If treatment is to be received more than 90 days after the accidental blow, a treatment plan must be submitted to Canada Life within 90 days of the accident.

Emergency Treatment

The following Emergency treatment required by you or your dependent while temporarily absent from your province or territory of residence because of business or vacation and not for health reasons will be reimbursed at 100%. There is a maximum of $1,000,000 for an Emergency for you and each of your dependents under this Emergency Treatment section and the Travel Assistance Benefit. This limitation is not applicable to in-Canada emergency health care benefits. When emergency treatment for a condition is completed, any ongoing treatment related to that condition is not covered.

Room and board in a Licensed Hospital up to the hospital's standard ward rate for each day of confinement.

Hospital services and supplies furnished by a Licensed Hospital.

Diagnosis and treatment by a physician or surgeon legally licensed to practise medicine.

In the event of a medical emergency, you or someone acting on your behalf must contact the Travel Assistance Centre prior to seeking medical treatment. If it is not reasonably possible for you to contact the Travel Assistance Centre prior to seeking medical treatment due to the nature of the medical emergency, you must contact the Travel Assistance Centre as soon as possible. Failure to contact the Travel Assistance Centre as described will result in a reduction of benefits in the case of hospitalization of 40% of eligible costs. All costs for such emergency will be limited to your emergency out-of-country coverage and Travel Assistance coverage maximum or $25,000, whichever is less. This limitation is not applicable to in-Canada emergency health care benefits.

If a physician or the Travel Assistance provider recommends you or your dependents be moved to a different facility at the destination, and you choose not to go, eligible costs for emergency coverage and Travel Assistance coverage will in the case of hospitalization be reduced by 40% of eligible costs. All costs for such emergency will be limited to your emergency out-of-country coverage and Travel Assistance coverage maximum or $25,000, whichever is less. This limitation is not applicable to in-Canada emergency health care benefits.

If a physician or the Travel Assistance provider recommends you or your dependent return to your home province, and you choose not to go, emergency coverage and Travel Assistance coverage will end.

"Hospital" means an institution having diagnostic facilities that provides active, chronic care or emergency treatment with physicians and registered nurses in attendance 24 hours a day and is licensed by the appropriate governmental authority. It does not include an institution providing convalescent care, a nursing home for the aged, a rest home or any other facility providing similar care.

We will not pay for any costs resulting directly or indirectly:

(a) from an accident occurring while the insured person was operating a vehicle, vessel or aircraft, if the insured person:
    i) was impaired by drugs or alcohol, or
    ii) had a blood alcohol level higher than 80 milligrams of alcohol per 100 millilitres of blood.
(b) from the abuse of illegal substances.

Travelling outside Canada while pregnant: We will not cover any pregnancy related costs which are incurred outside of Canada within nine weeks of the expected delivery date. Costs associated with a child born outside Canada within nine weeks of the expected delivery date, or after the expected delivery date, are not covered.

Note: If you are travelling and require medical care, please contact the Assistance Centre using the telephone number on the Travel Assistance card. The Travel Assistance Centre number and services are available 24 hours a day.

Travel Assistance Benefit

The following services with respect to medical and personal emergencies required by you or your dependent while temporarily absent from your province or territory of residence because of business or vacation and not for health reasons will be reimbursed at 100% subject to the following conditions. When emergency treatment for a condition is completed, any ongoing treatment related to that condition is not covered.

- on the spot medical assistance
- emergency medical payments
- telephone interpretation service
- medical evacuation
- assistance with lost documents or luggage
- return of dependent children or a travelling companion
- visit of a family member
- transmission and retention of urgent messages
- help to locate Embassy or Consulate services
- assistance in the event of death to transport the remains
- return of a vehicle to your home or nearest rental agency

We will not pay for any costs resulting directly or indirectly:

(a) from an accident occurring while the insured person was operating a vehicle, vessel or aircraft, if the insured person:
    i) was impaired by drugs or alcohol, or
    ii) had a blood alcohol level higher than 80 milligrams of alcohol per 100 millilitres of blood.
(b) from the abuse of illegal substances.

Note: For specific details, please refer to your Canada Life Travel Assistance brochure which can be obtained through your employer.

Please contact the Travel Assistance Centre using the telephone number on the Travel Assistance card.

Travelling outside Canada while pregnant: We will not cover any pregnancy related costs which are incurred outside of Canada within nine weeks of the expected delivery date. Costs associated with a child born outside Canada within nine weeks of the expected delivery date, or after the expected delivery date, are not covered.

Referral Benefit

Charges for the following services provided in Canada and the United States but outside your province or territory of residence if they are not available in your province or territory of residence and are performed on the written referral of a physician or surgeon regularly attending you or your dependents in your province or territory of residence.

1. Room and board in a Licensed Hospital up to the hospital's standard ward rate for each day that you or your dependents are confined in the hospital.

2. Hospital services and supplies furnished by a Licensed Hospital.

3. Diagnosis and treatment by a physician or surgeon legally licensed to practise medicine.

Full details of the services to be provided must be submitted by the referring doctor to, and approved in advance by, Canada Life.

The maximum amount payable under this provision with respect to you or your dependents during your lifetime will be $10,000.

Diagnostic Test

Diagnostic tests, radium treatments and X-ray examinations, excluding dental X-rays, that are performed in your province or territory of residence when coverage is not available under the provincial government plan.

Speech Therapy, Clinical Psychology or Social Worker

The services, personally performed, by a registered clinical psychologist, registered speech therapist or qualified social worker, registered in the province or territory where the services are rendered, up to a combined maximum of $2,000 per calendar year.

These services will not be considered as eligible expenses if the registered clinical psychologist, registered speech therapist or qualified social worker is normally resident in your home.

Hearing Aids

The purchase of hearing aids and repairs, excluding batteries, up to an individual maximum of $500 in four consecutive years.

Hospital Accommodation

Hospital accommodation is the difference between the public ward allowance under the Provincial Hospital Plan and the private room rate in a Licensed Hospital. However for stays in a Convalescent Hospital, hospital accommodation is the difference between the public ward allowance under the Provincial Hospital Plan and the semi-private room rate in a Licensed Hospital.

Vision Care

Prescription eye glasses or contact lenses and the fittings of such eyewear for the purpose of correcting vision are subject to a combined maximum of $250 in any two consecutive calendar years for individuals age 18 and over and $250 in any calendar year for dependent children under 18 years.

An eye examination (including eye refractions) in two consecutive calendar years for each individual age 21 or over and in each calendar year for individuals under 21 years.

A pair of contact lenses up to a lifetime maximum of $200 if visual acuity is improved to at least a 20/40 level and this level of acuity is not possible through wearing eye glasses accompanied by a letter of verification. Otherwise, contact lenses are subject to the maximum as stated for eye glasses.

Note: All charges must be recommended or approved by a legally licensed physician, surgeon, optometrist or ophthalmologist.

Services received in Canada for visual training and remedial exercises subject to 50% reimbursement, regardless of the benefit maximum. Diagnosis and treatment received in Canada for accidental injury or disease to eyes.

All claims must be supported by an official receipt indicating name of patient and the date the eyewear was received.

Paramedical Services

The maximum amount payable per classification of practitioner is $500 in any calendar year, except for Massage Therapists and Physiotherapists where the maximum amount payable per classification of practitioner is $1,500 in any calendar year

Laboratory tests and X-ray examinations recommended or approved by a legally licensed chiropractor, osteopath or podiatrist.

The services of any of these legally licensed classification of practitioners:

- Chiropractors
- Osteopaths
- Podiatrist or Chiropodists
- Naturopaths
- Massage Therapists
- Physiotherapists
- Acupuncturists

Other Services and Supplies

Canada Life can, on such terms as it determines, cover services and supplies under this plan where the service or supply represents reasonable treatment.

Exclusions

These exclusions are in addition to those described under "General Health Exclusions":

e) Any cause which entitles you or your dependent to apply for and receive indemnity or compensation under the Workers' Compensation Act.

f) An examination by, or the services of, a physician or surgeon, if required solely for the use of a third party.

g) Any treatment to correct temporomandibular joint dysfunction.

h) Any treatment deemed cosmetic.

i) Any service incurred under this plan for which payment is prohibited by the Provincial Government plan in your province or territory of residence.

j) Drugs administered during treatment in an emergency room of a hospital, or as an in-patient in a hospital.

Canada Life can limit an Eligible Charge for a service or supply to that of a lower cost alternative service or supply that represents reasonable treatment.

Canada Life can decline a claim for services or supplies that were purchased from a provider that is not approved by Canada Life.

Extension of Benefits

If you or your dependent are disabled at the time of termination of your employment, Medi-Pack charges as a result of such disability will continue to be paid up to 90 days, provided the benefit remains in force.

How to Submit a Claim

You may submit all Medi-Pack claims online. To use the online service you will need to be registered for My Canada Life at Work and signed up for direct deposit of claim payments with eClaims. For online claim submissions, your Explanation of Benefits will only be available online.

Online claims must be submitted to Canada Life as soon as possible, but no later than 12 months after the claim was incurred.

You must retain your receipt for 12 months from the date you submit your claim to Canada Life as a record of the transaction, and you must submit it to Canada Life on request.

For claims not submitted online, access My Canada Life at Work to obtain a personalized claim form or obtain a claim form from your employer. This form must be completed in full and submitted with the original bills within 180 days after the end of the calendar year in which the claim was incurred.

Note: To ensure prompt claims service, any receipts should include:

- your name or your dependent's name receiving the service or treatment
- the date and the type of each service or treatment
- the charge for each date
- the prescription numbers for prescribed drugs and medicine
- the name of the drug or the medicine

How to make an out-of-province/country claim:

There are special rules for claiming the costs of emergency treatment outside of your province or territory of residence or Canada.

- For all medical expenses, you must contact the Travel Assistance provider at the time of the emergency. This will enable the Travel Assistance provider to co-ordinate payment directly with the hospital and/or medical provider involved. In addition, with your approval the Travel Assistance provider will co-ordinate payment with your Provincial Health Care plan.

- If a medical provider or hospital bills you directly, send the bill along with your claim form to the Travel Assistance provider.

Note: If your spouse has insurance with another carrier, please also refer to the "Coordination of Benefits" section for claim submission information.

If the Group Insurance Policy terminates, no payment will be made for any claim unless proof is submitted within 90 days of the termination date.

DENTAL BENEFIT

Fee guides, procedure codes, endodontics, scaling, root planing and occlusal equilibration.... It's easy to see why your company dental plan can be the most commonly used but least understood of the benefits your employer provides for you.

To get the most out of your dental plan, read this section of your booklet carefully, and take it with you when you visit the dentist. Discussing your coverage with your dentist and Canada Life before treatment begins is the best way to ensure that you get the care you need and minimize your out of pocket costs.

Your dental plan has been designed to help you and your dependents maintain a high standard of dental health. It includes these services:

Basic Services include the diagnostic, preventive and maintenance services required for regular dental care. Some of the insured charges include exams, x-rays, fluoride treatment, fillings, treatment of gum disease, root canal therapy and major surgical procedures.

Major Restorative Services cover dentures, crowns, bridgework and inlays/onlays.

Orthodontic Services provide coverage for orthodontics and all necessary dental treatment which has as its objective the correction of malocclusion of the teeth.

Assignment of Benefits

We reserve the right to refuse any assignment of benefit under this provision.

Important Note

A general overview of the services covered, along with the limitations that apply, can be found on the following pages. Your plan covers these treatments and services provided that the treatment is the least expensive that will produce a professionally adequate result (as determined by Canada Life). If the charge exceeds the cost of the least expensive service, Canada Life will pay the cost of the least expensive service.

In some cases, such as undergoing extensive treatment, Canada Life may require proof from your dentist that the services to be performed meet this criteria. This request is a normal cost control procedure and often just a copy of the x-rays taken is considered acceptable proof.

Pre-Authorization For Treatment Over $500

If dental expenses are estimated to be greater than $500, you must submit a "Pre-determination" to Canada Life. A Pre-determination is simply an outline of the proposed treatment which is prepared, by your dentist, prior to any work being performed. Canada Life will advise you of the portion that is covered by your company dental plan, enabling you to determine your costs.

Note: In order to determine benefits payable, Canada Life may require additional information such as:

1. A complete dental chart showing extractions, missing teeth, fillings, prostheses, periodontal pocket depths, and the date of any work previously done.

2. An itemized claim form for all dental care.

3. Pre-operative x-rays, study models, and laboratory reports.

Canada Life cannot pay the dental claim until the additional information requested is submitted to us.

Dental 1 Charges

A. <u>Diagnostic</u>

(1) Clinical (Complete) Examinations (not more than 1 examination per dentist):

01101, 01102, 01103, 01201, 01301, 01401, 01501, 01601, 01701, 01801 (other than in the Province of Quebec).

01110, 01115, 01120, 01125, 01130, 01135, 01500, 01605, 01717, 01805 (in the Province of Quebec).

(2) Recall Examinations (not more than 1 examination in any calendar year):

01202 (other than in the Province of Quebec).

01200 (in the Province of Quebec).

(3) Specific Examinations:

01203, 01204, 01302, 01402, 01502, 01602, 01702, 01703, 01802 (other than in the Province of Quebec).

01400 (in the Province of Quebec).

(4) Emergency Examination:

01205 (other than in the Province of Quebec).

01300 (in the Province of Quebec).

It is provided, however, that there will be no more than 4 examinations, of any kind, in any calendar year or more than 2 Clinical (Complete) Examinations and Recall Examinations in total in any calendar year.

B. **X-Rays**

(1) Full Mouth Series consisting of a minimum of 16 films including bitewings in any period of 36 consecutive months. (not applicable to the Dependent children of an Employee while they are under 12 years of age, other than for Orthodontia):

02102 (other than in the Province of Quebec).

The Quebec Dental Association Fee Guide does not list codes for this procedure.

(2) Panorex (not more than once in any period of 36 consecutive months):

02601 (other than in the Province of Quebec).

02600 (in the Province of Quebec).

(3) Periapical (not more than 16 films in any period of 36 consecutive months):

02111 to 02125 inclusive (other than in the Province of Quebec).

02111 to 02116 inclusive (in the Province of Quebec).

(4) Bitewing (not more than 4 films in any period of 12 consecutive months):

02141 to 02144 inclusive (in all Provinces).

(5) Occlusal (not more than 4 films in any period of 12 consecutive months):

02131 to 02134 inclusive (other than in the Province of Quebec).

02131, 02132 (in the Province of Quebec).

C. **Tests**

(1) Biopsy of Oral Tissue:

04311 to 04313 inclusive, 04321, 04322, 04323 (other than in the Province of Quebec).

04302, 04311, 04312 (in the Province of Quebec).

(2) Pulp Vitality Test (not in conjunction with Root Canal Therapy if rendered within 30 days):

04501, 04509 (other than in the Province of Quebec).

The Quebec Dental Association Fee Guide does not list codes for this procedure.

D. **Preventive**

(1) Prophylaxis (not more than 1 in any calendar year):

11101, 11102, 11107, 11109 (other than in the Province of Quebec).

11100, 11200, 11300 (in the Province of Quebec).

(2) Preventive Recall Package (not more than 1 in any calendar year period or more than 1 either Recall Examination or Preventative Recall Package in any calendar year):

11201 to 11203 inclusive, 11301 to 11303 inclusive (other than in the Province of Quebec). It is provided, however, that 11301 to 11303 inclusive will apply only to an Insured while they are under 19 years of age.

The Quebec Dental Association Fee Guide does not list codes for this procedure.

(3) Fluoride (not more than 1 in any calendar year):

12101 (other than in the Province of Quebec).

12400 (in the Province of Quebec).

(4) Oral Hygiene Instruction (No more than once in a lifetime period):

13211 (other than in the Province of Quebec).

13200 (in the Province of the Quebec).

(5) Pit and Fissure Sealants (This applies only to an Insured while they are under 19 years of age. Not more than once per posterior tooth in any period of 36 consecutive months):

13401, 13409 (in all Provinces).

(6) Space Maintainers (This applies only to the Dependent children of an Employee while they are under 15 years of age):

15101 to 15104 inclusive, 15201, 15202, 15301, 15302, 15401 to 15403 inclusive, 15501 (other than in the Province of Quebec).

15100, 15110, 15111, 15120, 15200, 15210, 15400 (in the Province of Quebec).

(7) Space Maintainers Maintenance (This applies only to the Dependent children of an Employee while they are under 15 years of age):

15601 to 15604 inclusive (other than in the Province of Quebec).

The Quebec Dental Association Fee Guide does not list codes for this procedure.

E. Minor Restorative

The fee for restorative procedures will include local anaesthesia, removal of decay, pulp protection, placement of a base and occlusal adjustment.

Charges for finishing or polishing are not an eligible expense.

Multiple restorations on a common surface placed on the same service date will be considered a single restoration.

The maximum Benefit payable will not exceed the fee for a 5 surface restoration regarding the same tooth during one sitting.

(1) Amalgam Restorations (Only if more than 24 consecutive months have elapsed since the last restoration):

21111 to 21115 inclusive, 21121 to 21125 inclusive, 21211 to 21215 inclusive, 21221 to 21225 inclusive, 21231 to 21235 inclusive (other than in the Province of Quebec).

21101 to 21105 inclusive, 21121 to 21125 inclusive, 21211 to 21215 inclusive, 21221 to 21225 inclusive, 21231 to 21235 inclusive, 21241 to 21245 inclusive (in the Province of Quebec)

(2) Tooth Coloured (Only if more than 24 consecutive months have elapsed since the last restoration):

23101 to 23105 inclusive, 23111 to 23115 inclusive, 23211 to 23215 inclusive, 23221 to 23225 inclusive, 23311 to 23315 inclusive, 23321 to 23325 inclusive, 23401 to 23405 inclusive, 23411 to 23415 inclusive, 23501 to 23505 inclusive, 23511 to 23515 inclusive (other than in the Province of Quebec).

23111 to 23115 inclusive, 23118, 23211 to 23215 inclusive, 23221 to 23225 inclusive, 23311 to 23315 inclusive, 23411 to 23415 inclusive (in the Province of Quebec).

(3) Retentive Pins:

21401 to 21405 inclusive (other than in the Province of Quebec).

21301 to 21304 inclusive (in the Province of Quebec).

(4) Caries, Trauma, Pain Control (Only when placed on a separate date from the final restoration):

20111, 20119, 20121, 20129 (in all Provinces).

(5) Veneer Applications, other than for cosmetic purposes (Only if more than 24 consecutive months have elapsed since the last restoration):

23121, 23122 (other than in the Province of Quebec).

23122 (in the Province of Quebec).

(6) Stainless Steel, Plastic and Polycarbonate full coverage restorations (This applies only to the Dependent children of an Employee while they are under 14 years of age. No more than once per tooth in any period of 36 consecutive months):

22201, 22202, 22211, 22212, 22301, 22302, 22311, 22312, 22401, 22411, 22501, 22511 (other than in the Province of Quebec).

27403, 27413, 27421 to 27424 inclusive (in the Province of Quebec).

F. <u>Minor Surgical</u>

(1) Extractions:

71101, 71109, 71201, 71209, 72111, 72119, 72211, 72219, 72221, 72229 (other than in the Province of Quebec, but the maximum Benefit payable for the extraction of maxillary (upper) third molars will not exceed the fee for procedure code 72211).

71101, 71111, 72100, 72210, 72220, 72230 (in the Province of Quebec, but the maximum Benefit payable for the extraction of maxillary (upper) third molars will not exceed the fee for procedure code 72220).

(2) Residual Root Removal:

72311, 72319, 72321, 72329, 72331, 72339 (other than in the Province of Quebec).

72300, 72310, 72320 (in the Province of Quebec).

G. <u>Major Surgical</u>

The fee for surgical procedures will include local anaesthesia, appropriate radiographs (x-rays), surgery, control of hemorrhage, sutures and routine post-surgical care.

Post-treatment evaluation is not an eligible expense.

(1) Alveoloplasty, Gingivoplasty, Stomatoplasty, Vestibuloplasty:

73111, 73121, 73151 to 73154 inclusive, 73161, 73171, 73172, 73181 to 73184 inclusive, 73211, 73411 (other than in the Province of Quebec).

73100, 73110, 73133 to 73135 inclusive, 73140, 73150, 73151, 73171 to 73176 inclusive, 73181 to 73186 inclusive, 73381 to 73384 inclusive, 73401 to 73404 inclusive (in the Province of Quebec).

(2) Surgical Excision:

74111 to 74118 inclusive, 74631 to 74638 inclusive (other than in the Province of Quebec).

74108, 74109, 74408, 74409, 74410 (in the Province of Quebec).

(3) Surgical Incision:

75111, 75112, 75121, 75122, 75301, 75302 (other than in the Province of Quebec).

75100, 75110 (in the Province of Quebec).

(4) Fractures:

76201 to 76204 inclusive, 76301 to 76305 inclusive, 76911 to 76913 inclusive, 76921 to 76924 inclusive, 76931 to 76934 inclusive, 76941, 76949, 76951, 76952, 76959, 76961, 76962 (other than in the Province of Quebec).

76210, 76310, 76910 to 76913 inclusive, 76950, 76951 (in the Province of Quebec).

(5) Frenectomy:

77801 to 77803 inclusive (in all Provinces).

(6) Miscellaneous:

79111 to 79113 inclusive, 79311 to 79314 inclusive, 79321, 79322, 79331, 79333, 79341, 79343, 79401, 79402, 79602 (other than in the Province of Quebec).

79104 to 79106 inclusive, 79301, 79303 to 79306 inclusive, 79308, 79400, 79401, 79601 (in the Province of Quebec).

H. <u>Additional Services</u>

(1) Anaesthesia, used in conjunction with an eligible dental procedure:

92212 to 92219 inclusive, 92301 to 92309 inclusive, 92411 to 92419 inclusive, 92421 to 92429 inclusive, 92431 to 92439 inclusive, 92441 to 92449 inclusive, 92451 to 92459 inclusive (other than in the Province of Quebec).

92201, 92310, 92311 (in the Province of Quebec).

Dental 2 Charges

A. <u>Endodontics</u>

The fee for the following procedures will include, where applicable, treatment plan, local anaesthesia, tooth isolation, clinical procedures, sutures, appropriate radiographs (x-rays) and follow-up care:

(1) Pulpotomy (Not in conjunction with restorations or Root Canal Therapy if rendered within 30 days):

32221, 32222, 32231, 32232 (other than in the Province of Quebec).

32201, 32202, 32210 (in the Province of Quebec).

(2) Root Canal Therapy:

33111, 33121, 33131, 33141, 33401 to 33403 inclusive (other than in the Province of Quebec)

33100, 33200, 33300, 33400 (in the Province of Quebec)

(3) Apexification:

33601 to 33604 inclusive (other than in the Province of Quebec)

33521 to 33523 inclusive (in the Province of Quebec)

(4) Periapical Services:

34111, 34121, 34122, 34131 to 34133 inclusive, 34141, 34151, 34161 to 34163 inclusive (other than in the Province of Quebec)

34101, 34111, 34201, 34203 (in the Province of Quebec).

(5) Root Amputation:

34411, 34412 (other than in the Province of Quebec)

34401, 34402 (in the Province of Quebec)

(6) Hemisection:

34421 to 34423 inclusive. (other than in the Province of Quebec)

39230. (in the Province of Quebec)

(7) Intentional Removal, Apical Filling and Reimplantation:

34451 to 34453 inclusive (in all Provinces)

B. <u>Periodontics</u>

The fee for surgical procedures will include local anaesthesia, surgical dressing, sutures and routine post-operative care for one month.

Charges for post-treatment evaluation are not an eligible expense.

The amount payable for any Quadrant, Sextant or Segment Surgical Procedure will be as follows:

(a) if the procedure requires treatment to 5, 6. 7 or 8 teeth, 100% of the fee for such procedure.

(b) if the procedure requires treatment to 3 or 4 teeth, 66 2/3% of the fee for such procedure.

(c) if the procedure requires treatment to 1 or 2 teeth, 33 1/3% of the fee for such procedure.

(1) Non-Surgical Procedures:

41101 to 41104 inclusive, 41109, 41221, 41222, 41301, 41302 (other than in the Province of Quebec).

41200, 41300 (in the Province of Quebec).

(2) Definitive Surgical Procedures:

42111, 42201, 42311, 42321, 42339, 42411, 42421, 42431, 42441, 42451, 42511, 42521, 42531 (other than in the Province of Quebec).

42001 to 42003 inclusive, 42010, 42100, 42101, 42200, 42300 (in the Province of Quebec).

(3) Adjunctive Surgical Procedures:

42821, 42822, 42831, 42832 (other than in the Province of Quebec).

42720 (in the Province of Quebec).

(4) Occlusal Equilibration:

43311 to 43314 inclusive, 43317, 43319, (Other than in the Province of Quebec, but no more than 4 units in any calendar year).

43300, 43310 (in the Province of Quebec but not more than 4 visits in a calendar year).

(5) Scaling and/or Root Planing:

11111 to 11117 inclusive, 11119, 43421 to 43427 inclusive, 43429 (other than in the Province of Quebec, but not more than 8 units in any calendar year).

43411 to 43414 inclusive, 43417, 43419, 42000, 42001 (in the Province of Quebec, but not more than 8 visits in any calendar year).

(6) Periodontal Appliances including impression and insertion (not more than 1 appliance per arch in any period of 24 consecutive months):

43611, 43612 (in all Provinces).

(7) Periodontal Appliance Repair, Maintenance and Adjustments:

43621 to 43623 inclusive, 43629 (other than in the Province of Quebec, but no more than 4 units in any calendar year).

43622 (in the Province of Quebec, but no more than 4 adjustments in any calendar year).

C. <u>Removable Prosthodontics-Related Treatment</u>

(1) Denture Adjustments (Only if more than 3 months have elapsed since the denture insertion):

54201, 54202, 54209 (other than in the Province of Quebec).

54250 (in the Province of Quebec).

(2) Denture Repairs:

55101, 55102, 55201 to 55203 inclusive, 55301, 55302, 55401 to 55403 inclusive (other than in the Province of Quebec).

55101 to 55104 inclusive, 55201 to 55204 inclusive, 55520, 55530 (in the Province of Quebec).

(3) Denture Rebasing and Relining including 3 months post-delivery adjustments (No more than one reline or rebase in any period of 36 consecutive months):

56211 to 56213 inclusive, 56221 to 56223 inclusive, 56231 to 56233 inclusive, 56241 to 56243 inclusive, 56311 to 56313 inclusive, 56321 to 56323 inclusive, (other than in the Province of Quebec).

56200 to 56202 inclusive, 56210 to 56212 inclusive, 56220 to 56222 inclusive, 56230 to 56232 inclusive, 56260 to 56263 inclusive, 56280, 56290 (in the Province of Quebec).

(4) Tissue Conditioning including 3 months post-delivery adjustments (No more than one in any period of 36 consecutive months):

56511 to 56513 inclusive, 56521 to 56523 inclusive (other than in the Province of Quebec).

56270 to 56273 inclusive (in the Province of Quebec).

Dental 2 Extension of Insurance

If an Insured's insurance under this provision terminates due to one of the reasons shown below and they had commenced root canal treatment prior to such termination, they will continue to be insured for any charges incurred for such treatment during the 30 days after such termination:

1. Termination of an Employee's employment.

2. The Employee ceases to qualify under the definition of Employee.

3. Termination of this policy, except when this policy is replaced by a policy issued by another insurer.

Dental 2 Extension of Insurance on Replacement of this Policy

If an Insured is undergoing root canal treatment, the insurer with the policy in force at the date the canal is closed will be responsible for the charges incurred.

Dental 3 Charges

A. Major Restorative

The fee for the following procedures will include, where applicable, treatment plan, occlusal records, local anaesthesia, subgingival preparation of the tooth and supporting structures, removal of decay and old restoration, tooth preparation, pulp protection, impressions, temporary coverage, insertion, occlusal adjustments and cementation:

(1) Inlay/Onlay Restorations (Only if more than 5 years have elapsed since the last placement):

25111 to 25114 inclusive, 25121 to 25124 inclusive, 25131 to 25134 inclusive, 25141 to 25143 inclusive, 25511, 25521, 25531 (other than in the Province of Quebec).

25121 to 25123 inclusive, 25521 (in the Province of Quebec).

(2) Retentive pins in Inlays, Onlays and Crowns (Only if more than 5 years have elapsed since the last placement):

25601 to 25605 inclusive (other than in the Province of Quebec).

25601 to 25604 inclusive (in the Province of Quebec).

(3) Crowns (Only if more than 5 years have elapsed since the last placement):

27111, 27131, 27151, 27201, 27211, 27221, 27301, 27311 (other than in the Province of Quebec).

27100, 27110, 27200, 27210, 27300, 27310 (in the Province of Quebec).

(4) Veneer Applications, other than for cosmetic purposes (Only if more than 5 years have elapsed since the last placement):

27601, 27602 (other than in the Province of Quebec).

23121 (in the Province of Quebec).

(5) Other Services (Only if more than 5 years have elapsed since the last placement):

21301, 21302, 23601, 23602, 25711 to 25713 inclusive, 25721 to 25723 inclusive, 25731 to 25733 inclusive, 25741 to 25743 inclusive, 25751 to 25756 inclusive, 25761 to 25766 inclusive, 27711, 27721, 29101, 29102, 29301, 29302 (other than in the Province of Quebec).

25751 to 25753 inclusive, 27700, 27701, 27710, 27711, 29100, 29300, 29501 to 29503 inclusive, 29600 (in the Province of Quebec).

B. <u>Removable Prosthodontics</u>

The fee for the following procedures will include, where applicable, treatment plan, impressions, jaw relation records, try-in, insertion, occlusal equilibration and 3 months post-insertion care:

(1) Complete Dentures (Only if more than 5 years have elapsed since the last placement):

51101 to 51103 inclusive, 51301 to 51303 inclusive (other than in the Province of Quebec).

51100, 51110, 51120, 51300, 51310, 51320 (in the Province of Quebec).

(2) Transitional Dentures:

51601 to 51603 inclusive, 52101 to 52103 inclusive (other than in the Province of Quebec).

51600, 51610, 51620, 52120, 52121 (in the Province of Quebec).

(3) Acrylic Dentures (Only if more than 5 years have elapsed since the last placement):

52111 to 52113 inclusive, 52201 to 52203 inclusive, 52211 to 52213 inclusive, 52301 to 52303 inclusive, 52311 to 52313 inclusive, 52401 to 52403 inclusive, 52411 to 52413 inclusive, 52501 to 52503 inclusive, 52511 to 52513 inclusive (other than in the Province of Quebec).

52120 to 52124 inclusive, 52230 to 52232 inclusive (in the Province of Quebec).

(4) Cast Partial Dentures (Only if more than 5 years have elapsed since the last placement):

53101 to 53103 inclusive, 53111 to 53113 inclusive, 53201 to 53203 inclusive, 53205, 53211 to 53213 inclusive, 53215, 53301, 53302, 53701 to 53703 inclusive, 53711 to 53713 inclusive (other than in the Province of Quebec).

52400, 52410, 52420, 52500, 52510, 52520, 52530 (in the Province of Quebec).

C. <u>Fixed Prosthodontics</u>

The fee for the following procedures will include, where applicable, treatment plan, occlusal records, local anaesthesia, subgingival preparation of the tooth and supporting structures, removal of decay and old restoration, tooth preparation, pulp protection, impressions, temporary coverage, splinting, intraoral indexing for soldering purposes, insertion, occlusal adjustments and cementation:

(1) Pontics (Only if more than 5 years have elapsed since the last placement):

62101, 62501, 62701, 62702 (other in the Province of Quebec).

62000, 62100, 62510, 62700, 62702 (in the Province of Quebec).

(2) Retainers and Abutments (Only if more than 5 years have elapsed since the last placement):

67101, 67102, 67111, 67121, 67129, 37131, 67161, 67171, 67181, 67201, 67202, 67211, 67221, 67231, 67241, 67251, 67301, 67311, 67321, 67322, 67331, 67341 (other than in the Province of Quebec).

65500, 65510, 67101, 67200, 67210, 67410, 67721 to 67723 inclusive (in the Province of Quebec).

(3) Repairs:

66211 to 66213 inclusive, 66221 to 66223 inclusive 66301, 66302, 66711, 66719 (other than in the Province of Quebec).

66600, 66610, 66620, 66710, 66720 (in the Province of Quebec).

(4) Retentive Pins in Retainers and Abutments (Only if more than 5 years have elapsed since the last placement):

69301 to 69305 inclusive (other than in the Province of Quebec).

69701 to 69704 inclusive (in the Province of Quebec).

Dental 3 Extension of Insurance

If an Insured's insurance under this provision terminates due to one of the reasons shown below and they had a tooth prepared for a crown, inlay, onlay, bridge or denture prior to such termination, they will continue to be insured for any charges incurred with respect to such crown, inlay, onlay, bridge or denture during the 90 days after such termination:

1. Termination of an Employee's employment.

2. The Employee ceases to qualify under the definition of Employee.

3. Termination of this policy, except when this policy is replaced by a policy issued by another insurer.

Dental 3 Extension of Insurance on Replacement of this Policy

If an Insured is undergoing crown, inlay, onlay, bridge or denture work, the insurer with the policy in force at the date the appliance is installed will be responsible for the charges incurred.

Dental 3 Limitations

Charges for replacing an existing crown, inlay, onlay, denture or bridgework will only be paid if it meets one of the conditions shown below:

1. The existing crown, inlay, onlay, denture or bridgework was installed at least 5 years prior to its replacement and cannot be made serviceable.

2. The denture or bridgework replacement is for an equivalent denture or bridgework.

3. The existing denture or bridgework is an immediate temporary denture or bridgework, for which impressions were taken while the Insured is covered under this provision. The permanent replacement denture or bridgework must be placed within 12 months from the date of installation of the immediate temporary denture or bridgework.

4. The existing denture or bridgework is replaced because additional teeth have been extracted after the denture or bridgework insertion, and while the Insured is covered under this provision.

Dental 4 Charges

Orthodontic Treatment

Charges incurred with respect to an Insured for all necessary dental services or treatment which has as its objective the correction of malocclusion of the teeth including but not limited to examinations, x-rays, models, photographs, reports and surgical exposure of teeth.

Payment of Orthodontic Claims

We will pay for the charges incurred based on one of the following:

(1) If an estimated cost of treatment is used in place of an itemized statement, benefits for the insured cost of the charge will be payable on a monthly or quarterly basis as billed by the dentist. The average monthly Benefit will be the total estimated cost of treatment, less the initial cost (case diagnosis, initial appliance cost, treatment plan) divided by the number of months in the treatment plan as specified by the dentist.

(2) If a separate estimate of the cost of the initial appliance is included, the first payment will be an amount equal to the insured cost of the appliance. The remainder of the payments will be as calculated in accordance with the terms of clause (1) above.

(3) If a statement is submitted for each treatment as the charge is incurred, payment for the insured cost of the charge will be made as such charge is incurred.

(4) Notwithstanding anything to the contrary in this provision, if an Insured described above incurs charges described in another section of this provision as part of a treatment described in this Dental 4 Charges section, then such charges will be deemed to have been incurred under this Dental 4 Charges section for the purpose of calculating Benefit Amounts and Maximum Benefit Amounts.

Exclusions

- war, insurrection or hostilities of any kind whether or not you or your dependent were a participant in such action.
- participation in a riot or civil commotion.
- committing or attempting to commit a criminal offence or provoking an assault.
- any cause for which you or your dependent may apply for and receive indemnity or compensation under any Workers' Compensation Act.
- any Group or Policyholder-Sponsored dental care or treatment.
- any dental care or treatment for which you are not legally obliged to pay.
- any dental care or treatment which is principally for cosmetic purposes.
- any appointments not kept or for the completion of claim forms.
- any dental treatment that has as its purpose the correction of temporomandibular joint dysfunction.
- any endodontic treatment commencing before you or your dependent became insured under this benefit.
- replacement of mislaid, lost or stolen appliances.
- any crowns placed on teeth that are not functionally impaired by incisal or cuspal damage.
- any crowns, bridges or dentures for which tooth preparations were made before you or your dependent became insured under this benefit.

- any charge for other than "metal" crowns or pontics, posterior to the second bicuspid tooth.

- any procedures, appliances or restorations used to increase vertical dimensions, or to repair or restore teeth damaged or worn due to attrition or vertical wear or to restore occlusion.

- any services or supplies for implantology, including tooth implantation and surgical insertion of fabricated implants.

- any orthodontic expenses which were incurred prior to the date on which you became insured.

How To Submit a Claim

For claims submitted online, access My Canada Life at Work to obtain a personalized claim form or obtain a copy of the claim form from your employer and have your dental service provider complete the form. The completed claim form will contain the information necessary to enter the claim online. To use the online service you will need to be registered for My Canada Life at Work and signed up for direct deposit of claim payments with eDetails. For online claim submissions, your Explanation of Benefits will only be available online.

Online claims must be submitted to Canada Life as soon as possible, but no later than 12 months after the claim was incurred.

You must retain your receipt for 12 months from the date you submit your claim to Canada Life as a record of the transaction, and you must submit it to Canada Life on request.

For claims not submitted online, access My Canada Life at Work to obtain a personalized claim form or obtain a copy of the claim form from your employer. This form must be completed in full and submitted with original bills within 180 days after the end of the calendar year in which the claim was incurred. If you anticipate a delay, please notify Canada Life in advance.

Since your dental service provider will be required to complete a section of the dental claim form, you should take it with you to your appointment.

If your company benefits plan terminates, you must submit your claim, for any charges already incurred, within 90 days of the termination of the plan.

COORDINATION OF BENEFITS

When payments for benefits provided under this plan are available to you or your dependent under any other insurance plan, benefits will be coordinated. The amount payable under this plan will be pro-rated and limited to the extent that the total amount available under all coverages will not exceed 100% of the allowable expenses.

Order of Benefit Determination

Payment of benefits will be decided in the following manner.

1. If another plan does not contain a Coordination of Benefits provision, the benefits of that plan will be deemed payable prior to the application of benefits under this plan.

2. If another plan does contain a Coordination of Benefits provision, the benefits of that plan will be coordinated with our benefits as follows:

    1. If your spouse has coverage under another insurance plan, their charges must first be submitted under that plan.

    2. Charges for dependent children should first be submitted to the plan of the parent whose month and date of birth comes earlier in the calendar year (excluding the year of birth).

If priority cannot be established in the above manner, the benefits shall be pro-rated.

DEFINITIONS

Actively at Work means that you are

(a) actually performing your normal duties, if it is a scheduled work day, or

(b) capable of performing your normal duties, if you were not at work due to a non-scheduled work day, holiday or vacation, at your normal place of employment or at some other location where your employer's business requires you to be.

Common-law Spouse means a person of the same or different gender whom you publicly represent as your spouse and have been living with for the past 12 months.

Common-law Child means a child of your common-law spouse from another relationship who resides with and is in the care and custody of you and your common-law spouse.

Earnings, if you are a Salaried Employee, means your annual gross base earnings from your employer, excluding any income you receive from your employer such as but not limited to commissions, bonuses, dividends, overtime and profit sharing. If you are an Hourly Employee, means your average monthly gross base earning (annualized) and subject to premium deductions in the preceding 12 month period (or period if employment if less than 12 months) as determined by your employer.

Licensed Hospital means a hospital that is licensed to provide active, convalescent or chronic care treatment by the government that is responsible for the issue of such licenses in the area that it is located. It does not include nursing homes, homes for the aged, rest homes or any other facility that provides similar care.

Emergency means any sudden, critical, unforeseen or unexpected occurrence requiring immediate medical attention and takes place outside your province or territory of residence while the coverage is in force.

Net Pre-disability Monthly Earnings means your monthly earnings immediately prior to becoming disabled after reduction by the amount of income tax prescribed by the Income Tax Act (Canada and/or Quebec) and Regulations.

Pregnancy includes childbirth or miscarriage and any disease or infirmity resulting from or aggravated by the pregnancy.

Pregnancy Leave of Absence means :

(a) any period of pregnancy leave taken by you pursuant to Provincial or Federal statute or pursuant to a mutual agreement between you and your employer, or

(b) any period of pregnancy leave which your employer requires you to take pursuant to Provincial or Federal statute.

Professional Nurse means a Registered Nurse or a Licensed Practical Nurse. If you live in Ontario, professional nurse means a Registered Nurse or a Registered Practical Nurse.

Reasonable Treatment means treatment that is considered reasonable if it is accepted by the Canadian medical profession, it is proven to be effective, and it is a form, intensity, frequency and duration essential to diagnosis or management of the injury, disease, illness, mental disorder or pregnancy.

THIRD PARTY LIABILITY

If you or your dependent have the right to recover damages from any person or organization with respect to which benefits are payable by Canada Life, you will be required to reimburse Canada Life in the amount of any benefits paid out of the damages recovered.

The term damages will include any lump sum or periodic payments received with respect to:

(1) past, present or future loss of income, and

(2) any other benefits, otherwise payable by Canada Life.

If you or your dependent receive a lump sum payment under judgement or settlement for benefits which would otherwise be payable by Canada Life, no further benefits will be paid by Canada Life until the benefits that would otherwise be payable equal the amount of the lump sum.

If a claim for damages is settled before trial, you will be required to reimburse Canada Life the amount that reasonably reflects the loss of benefits that would otherwise be payable by Canada Life.

You or your dependent must notify us of any action commenced against a third party and of any judgement or settlement in the circumstances described above.

PHYSICAL EXAMINATION AND AUTOPSY

A physician of Canada Life's choice may be required to examine anyone in respect to a claim. If required, payment will only be considered after the examination. Canada Life will pay all expenses of such examination. In the case of death, an autopsy may be performed.

PURPOSE OF THIS BOOKLET

These booklet pages are provided solely for the purpose of explaining the principal features of the Group Insurance Plan. All rights with respect to your benefits as a member of the plan will be governed by the Group Policy issued by The Canada Life Assurance Company.

OPTIONAL LIFE INSURANCE

Optional life insurance allows you to choose additional coverage for yourself and your dependents. Check the **Benefit Summary** for the amount of optional life insurance available.

When you apply for optional life insurance for yourself or your spouse, you must provide proof of insurability, and your application must be approved by Canada Life. When you apply for optional life insurance for your children, proof of insurability is required only if you apply more than 31 days after becoming eligible. Canada Life may void the optional insurance if any statement or answer in your application misrepresents or fails to disclose any fact material to the insurance.

On your death, Canada Life will pay your life insurance to your named beneficiary. If you have not named a beneficiary or there is no surviving beneficiary at the time of your death, payment will be made to your estate. Your employer will explain the claim requirements. If one of your dependents dies you will be paid the amount for which that person was insured.

- If you are approved for waiver of premium on your basic life insurance, any optional life insurance for yourself or your dependents will also continue without premium payment as long as your basic life insurance continues but not beyond the date your optional insurance would otherwise terminate.

- If your or your spouse's optional life insurance terminates, you or your spouse may be eligible for an individual conversion policy without providing proof of insurability. You must apply and pay the first premium no later than 31 days after the group insurance terminates. In the case of insurance for your spouse, you or your spouse may apply. See your employer for details.

- Your and your children’s optional life insurance will not continue past the end of the day before the date you reach age 65. Your spouse's coverage will not continue past the end of the day before the date you or your spouse reaches age 65, whichever comes first.

Limitation

No benefit is paid for suicide within the first two years of initial or increased optional life coverage. In such a situation, Canada Life refunds the premiums that have been received. This limitation does not apply to coverage for a dependent child.

OPTIONAL CRITICAL ILLNESS INSURANCE

If you or your spouse is diagnosed with one of the illnesses defined below while insured, Canada Life will pay you the optional critical illness insurance benefit. Check the **Benefit Summary** for the amount of insurance available. Where a survival period is specified for a condition below, Canada Life will not pay the benefit until the end of the survival period. In addition to this benefit, provided it is $10,000 or more, Canada Life will make a $500 donation in your name to a registered charitable organization of your choice.

If you apply for this optional benefit within 31 days of becoming eligible, you may elect up to $50,000 of coverage without providing proof of insurability. All amounts over $50,000 will require proof of insurability satisfactory to Canada Life. Only one critical illness benefit is payable in a person's lifetime. Once a benefit has been paid, no further critical illness insurance is available for that person.

Your optional critical illness insurance will not continue past the end of the day before the date you reach age 65. Spouse coverage will not continue past the end of the day before the date you or your spouse reaches age 65, whichever is earlier.

Covered Illnesses

Any of the following conditions is considered a critical illness if it meets the defined criteria and has been diagnosed by a specialist as defined by the policy. The specialist must not be the Group Policyholder, the insured, or a relative or business associate of the Group Policyholder or the insured.

Any tests or examinations that must be performed in order to satisfy the condition requirements must be conducted by a medical professional who is not the Group Policyholder, the insured, or a relative or business associate of the Group Policyholder or the insured.

The diagnosis must be supported by objective medical evidence.

Heart Attack

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

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

Limitations

No benefits will be paid under this condition for:

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

The benefit is payable after a survival period of 30 days following the date of diagnosis.

Stroke

"Stroke" means an acute cerebrovascular event caused by intra-cranial thrombosis or haemorrhage, or embolism from an extra-cranial source, with:

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

persisting for more than 30 days following the date of the condition. These new symptoms and deficits must be corroborated by diagnostic imaging testing.

Limitations

No benefits will be paid under this condition for:

- transient ischaemic attacks; or
- intracerebral vascular events due to trauma.

For greater certainty, lacunar infarcts which do not have the neurological symptoms and deficits set out above, persisting for more than 30 days, do not satisfy the definition of stroke.

The benefit is payable after a survival period of 30 days following the date of diagnosis.

Coronary Artery Bypass Surgery

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

Limitations

No benefits will be paid under this condition for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

The benefit is payable after a survival period of 30 days following the date of surgery.

Cancer (Life-Threatening)

"Cancer (Life-Threatening)" means a tumour, which must be characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue.

Types of cancer include carcinoma, melanoma, leukemia, lymphoma, and sarcoma.

Limitations

No benefits will be paid under this condition for the following:

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

The terms Tis, Ta, T1a, T1b, T1 and AJCC Stage 2 are as defined in the American Joint Committee on Cancer (AJCC) cancer staging manual, 8th Edition, 2018.

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

Cancer Exclusion Period

No benefits will be paid under this condition if, within the first 90 days following the later of the person's effective date of insurance or, for an increase, the effective date of the increase, the person has any of the following:

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

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

Kidney Failure

"Kidney Failure" means chronic irreversible failure of both kidneys to function, as a result of which regular haemodialysis, peritoneal dialysis or renal transplantation is initiated.

Blindness

"Blindness" means 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.

Major Organ Transplant

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

Dementia, Including Alzheimer's Disease

"Dementia, Including Alzheimer's Disease" means 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 (e.g. inability to think abstractly and to plan, initiate, sequence, monitor, and stop complex behaviour), which is affecting daily life.

The person must exhibit:

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

Limitations

No benefits will be paid under this condition for affective or schizophrenic disorders, or delirium.

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

Parkinson's Disease and Specified Atypical Parkinsonian Disorders

"Parkinson's Disease" means 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 person must exhibit objective signs of progressive deterioration in function for at least one year, for which the treating neurologist has recommended dopaminergic medication or other generally medically accepted equivalent treatment for Parkinson's Disease.

"Specified Atypical Parkinsonian Disorders" mean progressive supranuclear palsy, corticobasal degeneration, or multiple system atrophy.

Limitation

No benefits will be paid under this condition for any other type of parkinsonism.

Parkinson's Disease and Specified Atypical Parkinsonian Disorders exclusion period

No benefits will be paid under this condition if, within the first year following the later of the person's effective date of insurance or, for an increase, the effective date of the increase, the person has any of the following:

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

Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to Canada Life within six months of the date of the diagnosis. If this information is not provided within this period, Canada Life 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.

Paralysis

"Paralysis" means 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.

Multiple Sclerosis

"Multiple Sclerosis" means at least one of the following:

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

Deafness

"Deafness" means 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 3000 hertz.

Loss of Speech

"Loss of Speech" means the total and irreversible loss of the ability to speak as a result of physical injury or disease for a period of at least 180 days.

Limitation

No benefits will be paid under this condition for all psychiatric related causes.

Coma

"Coma" means 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 four or less.

Limitation

No benefits will be paid under this condition for a medically induced coma.

Severe Burns

"Severe Burns" means third degree burns over at least 20% of the body surface.

Aortic Surgery

"Aortic Surgery" means the undergoing of 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.

Limitations

No benefits will be paid under this condition for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

The benefit is payable after a survival period of 30 days following the date of surgery.

Benign Brain Tumour

"Benign Brain Tumour" means a non-malignant tumour located in the cranial vault and limited to the brain, meninges, cranial nerves or pituitary gland. The tumour must require surgery or radiation treatment or cause irreversible objective neurological deficits.

Limitation

No benefits will be paid under this condition for pituitary adenomas less than 10 mm.

Benign brain tumour exclusion period

No benefits will be paid under this condition if, within the first 90 days following the later of the person's effective date of insurance or, for an increase, the effective date of the increase, the person has any of the following:

- signs, symptoms or investigations that lead to a diagnosis of benign brain tumour (covered or excluded under the policy), regardless of when the diagnosis is made; or
- a diagnosis of benign brain tumour (covered or excluded under the policy).

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

Heart Valve Replacement or Repair

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

Limitations

No benefits will be paid under this condition for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures

The benefit is payable after a survival period of 30 days following the date of surgery.

Loss of Independent Existence

"Loss of Independent Existence" means the total inability to perform, by oneself, at least two of the following six activities of daily living for a continuous period of at least 90 days with no reasonable chance of recovery.

Activities of daily living are:

- bathing – the ability to wash oneself in a bathtub, shower or by sponge bath, with or without the aid of assistive devices;
- dressing – the ability to put on and remove necessary clothing, braces, artificial limbs, or other surgical appliances with or without the aid of assistive devices;
- toileting – the ability to get on and off the toilet and maintain personal hygiene with or without the aid of assistive devices;
- bladder and bowel continence – the ability to manage bowel and bladder function with or without protective undergarments or surgical appliances so that a reasonable level of hygiene is maintained;
- transferring – the ability to move in and out of a bed, chair or wheelchair, with or without the aid of assistive devices; and
- feeding – the ability to consume food or drink that already has been prepared and made available, with or without the use of assistive devices.

Loss of Limbs

"Loss of Limbs" means 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.

Motor Neuron Disease

"Motor Neuron Disease" means 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.

Occupational HIV Infection

"Occupational HIV Infection" means infection with Human Immunodeficiency Virus (HIV) resulting from accidental injury during the course of the person's normal occupation, which exposed the person to HIV contaminated body fluids. The accidental injury leading to the infection must have occurred following the later of the person’s effective date of insurance or, for an increase, the effective date of the increase.

Payment under this condition requires satisfaction of all the following:

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

Limitations

No benefits will be paid under this condition if:

- the person has elected not to take any available licensed vaccine offering protection against HIV; or
- a licensed cure for HIV infection has become available prior to the accidental injury.

For greater certainty, non-accidental injury including, but not limited to, sexual transmission or intravenous (IV) drug use does not satisfy the definition of Occupational HIV Infection.

Bacterial Meningitis

"Bacterial Meningitis" means meningitis, confirmed by cerebrospinal fluid showing growth of pathogenic bacteria in culture, resulting in neurological deficit documented for at least 90 days from the date of diagnosis.

Limitation

No benefits will be paid under this condition for viral meningitis.

Aplastic Anaemia

"Aplastic Anaemia" – means chronic persistent bone marrow failure, confirmed by biopsy, which results in anaemia, 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.

General Limitations

No benefits are paid for:

- a critical illness that is directly or indirectly related to a condition for which you or your spouse received medical care within 24 months before your insurance started. This limitation does not apply:

    - if the illness is diagnosed after you or your spouse has been continuously insured for 24 months, or
    - to any amounts of insurance for which evidence of insurability is required.

- a critical illness resulting directly or indirectly from or associated with any of the following:

    - intentionally self-inflicted injury or attempt at suicide, regardless of the person's state of mind and whether or not they were able to understand the nature and consequences of their actions
    - war, insurrection or voluntary participation in a riot
    - participation in a criminal offence or provoking an assault
    - use of any drug, poisonous substance, intoxicant, or narcotic, unless prescribed for the person by a licensed physician and taken in accordance with directions given by the licensed physician
    - operating a motorized vehicle while the blood alcohol level is higher than 80 milligrams of alcohol per 100 millilitres of blood.

No benefits are paid if death or irreversible cessation of all functions of the brain occurs during the benefit payment waiting period.

How to Make a Claim

· To claim benefits, obtain a claim form at the Canada Life website **www.canadalife.com**. Complete it and return it to the address shown on the form.

· Claims should be submitted as soon as possible, but no later than 3 months after the earlier of:

    - the end of the critical illness survival period, where applicable; or
    - the date the plan terminates.

CONTACT – EMPLOYEE ASSISTANCE PROGRAM

The Contact employee assistance program provides you and your dependents with access to confidential counselling and information services.

The services provided under the Contact employee assistance program are available by dialing the toll-free number shown below. This toll-free number is staffed 24 hours a day, 7 days a week by intake counsellors who can provide immediate support and counselling, respond to crisis or emergency situations or schedule appointments.

For service in English or French:	1-866-289-6749
TTY:	1-877-338-0275

For more information on the services available under the Contact employee assistance program, please see the employee assistance program brochure provided by your plan administrator or visit the employee assistance program: www.login.lifeworks.com.

Survivor Benefits

If you die while your coverage is still in force, the Contact benefit for your dependents will be continued for a period of 2 years or until they no longer qualify, whichever happens first.

VIRTUAL HEALTH SERVICES

Virtual health services are available to you and your dependents by downloading the service provider's application specified by Canada Life from time to time. These services include the following:

- access to virtual health services 24 hours a day, 7 days a week
- unless prohibited by applicable laws, access to an unlimited number of consultations via telephone calls, text messaging and videoconferencing with medical professionals
- prescriptions and prescription renewals, when medically needed
- where diagnostic or laboratory tests are medically needed:
    - completion of necessary requisitions
    - results of the diagnostic or laboratory tests provided and accessible through the provider's application
- access to specialists such as psychologists, dieticians and work and life coaches for an additional fee
- access to self-guided internet-based cognitive behavioral therapy (iCBT)

HEALTH CARE SPENDING ACCOUNT BENEFITS (HCSA)

A Health Care Spending Account (HCSA) is like a bank account through which you may be reimbursed for health and dental expenses up to a predetermined annual credit amount. Your employer will establish the credits for your account prior to each plan year. These credits may be used to cover expenses not covered by group health plans or to top-up expenses not fully covered by group health plans, including deductibles and co-payment amounts. Also, since annual credits are in the form of before tax dollars, the HCSA is a tax-effective way of paying for your health-related expenses.

Eligibility

You and your dependents are eligible for HCSA credits through your employer if you are covered for basic health care benefits or basic dental care benefits under your or your spouse's group health plan. In addition to the dependents eligible for coverage under your group health plan, HCSA benefits are extended to any other person for whom you are entitled to claim a medical expense tax credit under the Income Tax Act (Canada).

Termination

Your HCSA coverage terminates when your group health plan coverage terminates or when your employer discontinues the plan.

Your dependents' HCSA coverage terminates when your coverage terminates or when they no longer qualify, whichever is earlier.

Covered Expenses

Coverage is provided for those expenses that qualify for a medical expense tax credit under the Income Tax Act (Canada), as may be amended from time to time.

Please refer to the Canada Revenue Agency website for information on medical expenses that qualify for the medical expense tax credit under the Income Tax Act (Canada). For additional information on covered expenses, contact a customer service representative at Canada Life toll-free at 1 877-883-7072.

Benefits will be paid for 100% of covered expenses that are incurred while you and your dependents are covered, up to a maximum annual payment equal to the credits in your HCSA. Dental expenses, other than orthodontic expenses, are considered to be incurred when treatment is completed. Orthodontic expenses are considered to be incurred on a periodic basis throughout the course of treatment. All other expenses are considered to be incurred when they are received.

Effective – July 1, 2020: Credits are available for covered expenses incurred in a plan year. Any remaining credits will be carried forward for covered expenses incurred in the following plan year. If they are not used for expenses incurred in that plan year, they are automatically forfeited.

Effective – July 1, 2020: The maximum annual payment available under your account will consist of the amount of the credit directed to it for the plan year plus any unused amount from the previous year.

Limitations

No benefits are paid for:

- Expenses that private benefit plans are not permitted to cover by law
- Services or supplies you are entitled to without charge by law or for which a charge is made only because you have coverage under a private benefit plan
- Any portion of the expense for services or supplies for which benefits are payable under your basic health plan, another group plan or a government plan

How to Make a Claim

The HCSA will reimburse you for the balance of the expense remaining after all other insurance plans have paid out. You must first submit all claims to any government and private insurance plans under which you or any eligible dependents are covered. Once you have received reimbursement for the expense from all other plans, you may submit a claim against the HCSA.

Claims against the HCSA may be submitted on a claim form. Claims for prescription drugs, paramedical services, visioncare and dentalcare expenses incurred in Canada may also be submitted online.

- To submit claims using a claim form, use form M445D (HCSA) for dental claims, and form M635D (HCSA) for all other claims

- To submit claims online, you will need to be registered for GroupNet for Plan Members and signed up for direct deposit of claim payments with eDetails. For online claim submissions, your Explanation of Benefits will only be available online

You must retain your receipt for 12 months from the date you submit your claim to Canada Life as a record of the transaction, and you must submit it to Canada Life on request.

Claims against the HCSA must be submitted to the Canada Life Benefit Payment Office before the earliest of the following:

- 15 days after the end of the plan year in which the expenses are incurred

- the date the HCSA contract terminates, if it terminates because your employer fails to make a required payment

- 31 days after the date the HCSA contract terminates, if it terminates for any other reason

POLICY # 1HM90

LETHBRIDGE COLLEGE

BASIC ACCIDENT INSURANCE
ACCIDENTAL DEATH & DISMEMBERMENT

(underwritten by SSQ Insurance Company Inc.)"

Definitions

Wherever used herein:

"You", "Your" and "Yourself" mean the person who is Insured herein.

"We", "Us" and "The Insurer" means SSQ Insurance Company Inc.

"Policy" means the Group Policy specified above, which is on file with the Policyholder.

"Spouse" means an individual

(a) to whom You are legally married,

(b) with whom You have continuously cohabited in a conjugal relationship for a minimum of one (1) year immediately before a Loss in incurred under the Policy.

Only 1 individual qualifies as a Spouse.

If You are legally married but are also cohabiting with an individual as described in (b) above, You may elect in writing which one of the individuals is insured as a Spouse. This election must be filed with the Employer. We are not bound by an election not filed before the event insured against. If an election is not filed, the Spouse is the individual to whom You are legally married.

“Dependent Child” means a natural child, adopted child, stepchild or a child who is in a parent-child relationship with You. The child is unmarried, under twenty five (25) years of age [twenty-six (26) in the province of Quebec] and dependent upon You for maintenance and support.

"Institution for higher learning" is limited to universities, colleges, CEGEPs and trade schools.

"Insured Person" means You.

"Injury" means bodily injury caused by an Accident occurring while an Insured Person's coverage is in force under the Policy, and resulting directly and independently of all other causes in loss covered by the Policy, 24 hours a day, anywhere in the world but in no event shall Injury mean Sickness or Disease howsoever caused unless caused by an Accident.

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

“Sickness” means an impairment of normal physiological function and includes illness and infections.

“Disease” means any unhealthy condition of the body or any part thereof.

"Principal Sum", when referring to You, means the amount of insurance under the Policyholder’s Basic Group Life Insurance program.

The male pronoun is construed as the feminine when the person is a female.

Specific Loss Schedule

When Injury results in any of the following losses within 365 days after the date of the Accident, SSQ Insurance Company Inc. pays:

For Loss of	Percentage of Principal Sum
Life	100%
Entire sight of both eyes	100%
Speech and hearing in both ears	100%
One hand and the entire sight of one eye	100%
One foot and the entire sight of one eye	100%
Entire sight of one eye	75%
Speech	75%
Hearing in both ears	75%
Hearing in one ear	40%
All toes of one foot	33 1/3%
For Loss or Loss of Use of	
Both hands	100%
Both feet	100%
One hand and one foot	100%
One arm	80%
One leg	80%
One hand	75%
One foot	75%
Thumb & index finger or at least four fingers of one hand	40%
For Paralysis of	
Both upper & lower limbs (Quadriplegia)	200%
Both lower limbs (Paraplegia)	200%
Upper & lower limbs of one side of body (Hemiplegia)	200%

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

"Loss" means, with reference to:

- Hand or foot, complete severance through or above the wrist or ankle joint, but below the elbow or knee joint.
- Arm or leg, complete severance through or above the elbow or knee joint.
- Thumb, the complete severance of 1 entire phalanx of the thumb.
- Finger, the complete severance of 2 entire phalanges of the finger.
- Toes, the complete severance of 1 entire phalanx of the big toe and all phalanges of the other toes.
- Eye, the irrecoverable loss of the entire sight thereof.
- Speech, complete and irrecoverable loss of the ability to utter intelligible sounds.
- Hearing, complete and irrecoverable loss of hearing.
- Loss of use, the total and irrecoverable loss of use, provided the loss is continuous for 12 consecutive months and such loss of use is determined to be permanent at the end of such period.

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

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

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

“Loss” as above used with reference to loss of use means the total and irrecoverable loss of use, provided the loss is continuous for twelve (12) consecutive months and such loss of use is determined to be permanent at the end of such period.

Indemnity provided under this section for all losses sustained by any 1 Insured Person as the result of any 1 Accident cannot exceed:

(a) with the exception of quadriplegia, paraplegia and hemiplegia, the Principal Sum.

(b) with respect to quadriplegia, paraplegia and hemiplegia, 200% of the Principal Sum, or 100% if Loss of Life occurs within 90 days after the date of the Accident.

In no event will indemnity payable for all losses exceed, in the aggregate, 200% of the Principal Sum as the result of the same Accident.

Repatriation *

If You sustain a Loss of Life caused by an Accident for which an amount of Principal Sum becomes payable under the Policy, We will pay up to $15,000 for reasonable and necessary expenses actually incurred for the return home of Your body (including preparation charges for transportation). Such Loss must occur more than 50 kilometres from Your residence.

Education **

If You sustain a Loss of Life caused by an Accident for which an amount of Principal Sum becomes payable under the Policy, up to 5% of your Principal Sum or $5,000 is payable for each of Your Dependent Children under 25 years of age already enrolled full-time:

- in an Institution for Higher Learning.

The benefit is payable annually for each year (up to 4 consecutive years) that the Dependent Child continues his education in an Institution for Higher Learning.

Day-Care **

If You sustain a Loss of Life caused by an Accident for which an amount of Principal Sum becomes payable under the Policy, up to 5% of your Principal Sum or $5,000 is payable for each of Your Dependent Children under 13 years of age, who

- are enrolled in a legally licensed Day-Care Centre on the date of Your death; or
- will enroll in a legally licensed Day-Care Centre within 365 days after Your death.

The benefit is payable annually for each year (up to 4 consecutive years) that the Insured Dependent Child is enrolled in a legally licensed Day-Care Centre. If none of Your Dependent Children satisfy either the above requirements or the requirements as shown under the section entitled "Education", then an amount equal to 5% of Your Principal Sum or $2,500, whichever is less, is payable to Your beneficiary.

"Day-Care Centre" means a facility, which is run according to the law, including laws and regulations applicable to day-care facilities and which provides care and supervision for children in a group setting on a regular basis. Day-Care Centre will not include a hospital, the child's home or care provided during normal school hours while the Dependent Child is attending grades one (1) through twelve (12).

Rehabilitation *

If You suffer a Loss covered under the "Specific Loss Schedule" section of the Policy and as a result, must participate in a rehabilitation program in order to be qualified to engage in a different employment, We will refund the reasonable and necessary expenses actually incurred during the 3 year period following the date of the Accident, to a maximum of $15,000. Payment is not made for room, board or other ordinary living, travelling or clothing expenses.

Workplace Modification and Accommodation *

If You sustain an Injury which results in a loss payable under the “Specific Loss Schedule” and You require special adaptive equipment and/or workplace modifications in order to accommodate your active full-time work with the Policyholder, this benefit will reimburse the Policyholder for the expenses incurred up to $5,000.

Occupational Training *

If You sustain Loss of Life caused by an Accident for which an amount of Principal Sum becomes payable under the Policy, and Your Spouse must engage in a formal occupational training program in order to upgrade employment qualifications, We will refund the reasonable and necessary expenses actually incurred during the 3 year period following Your death, to a maximum of $15,000. Payment is not made for room, board or other ordinary living, travelling or clothing expenses. In the event Your Spouse satisfies the requirements indicated above, such spouse will be deemed the beneficiary with respect to the benefits payable under this provision.

Family Transportation *

If following an Injury which results in a Loss covered under the "Specific Loss Schedule" section of the Policy, You are confined as an inpatient to a Hospital located more than 150 kilometres from Your residence, We will refund the reasonable and necessary expenses actually incurred by any Immediate Family Member(s) or a family representative for Accommodation and transportation by the most direct route from the normal place of residence of such Immediate Family Member(s) or family representative to You and return to the normal place of residence of such Immediate Family Member(s) or family representative up to a maximum of $15,000. Private transportation expenses are limited to $0.35 per kilometre travelled.

Payment is not made for board or other ordinary living, travelling or clothing expenses.

Identification *

If You sustain Loss of Life resulting from an Injury and the police or similar governmental authority require the identification of Your body by a Immediate Family Member or family representative, and indemnity for such Loss subsequently becomes payable under the Policy, We Will refund the reasonable and necessary expenses actually incurred by Immediate Family Member or family representative for:

- transportation to the location of Your body by the most direct route and,
- for lodging and board,

provided the body is located more than 150 kilometres from the Immediate Family Member's residence.

Private transportation expenses are limited to $0.35 per kilometre travelled and the total maximum amount refundable for all expenses is limited to $10,000.

Home Alteration and/or Vehicle Modification

If You sustain the Loss of or Loss of Use of Both Feet or Legs or become a Quadriplegic, Paraplegic or Hemiplegic, for which indemnity becomes payable under the Policy, and You subsequently require the use of a wheelchair to be ambulatory, We will refund the reasonable and necessary expenses actually incurred during the 3 year period following the Accident, for the cost of alterations to Your principal residence for making it accessible and/or the cost of modifications to 1 motor vehicle utilized by You, when such modifications are approved by licensing authorities where required, for the purpose of adapting it to the needs of You.

Payment by Us for the total of all expenses incurred by or for You will not exceed a maximum of fifteen thousand dollars ($15,000) as the result of any one Accident. The amount payable under this section will be coordinated with any amount paid or payable under any other insurance plan providing the same or similar benefit.

Note

Benefits marked with an asterisk (*) are only payable under 1 of the policies issued to the Employer by SSQ Insurance Company Inc.

Benefits marked with 2 asterisks (**) are payable up to the percentage of Principal Sum as stated in the policy subject to one combined maximum for similar benefits provided under any other policy issued to your Employer by SSQ Insurance Company Inc.

Aircraft Coverage

You are covered only while flying as a passenger in any aircraft holding a current and valid certificate of airworthiness (other than an aircraft owned, operated, leased or chartered by or on behalf of the Employer) and flown by a licensed pilot. Coverage also applies while flying as a passenger in a military aircraft.

Exposure and Disappearance

Unavoidable exposure to the elements is covered under the Policy as any other Loss, provided such exposure is sustained as the result of a covered Accident. You are presumed to have suffered Loss of Life caused by an Accident if his body is not found within 1 year after the disappearance, sinking or wrecking of the conveyance in which You were riding at the time of the Accident.

Aggregate Limit

A maximum limit of $6,000,000 is imposed on the total of all losses arising out of any one Accident covered under the program. This means that if you and any other persons insured under the program suffer losses occurring from the same Accident, and the total of all benefits (the benefit you are entitled to added to those which the others are entitled to) is greater than the aggregate limit of indemnity amount, then the amount payable to each individual will be proportionately reduced so that the total amount of all benefits payable equals $6,000,000.

The aggregate limit of indemnity only applies to losses payable under the following section of the Policy:

Specific Loss Schedule

To Whom Are Benefits Paid

The Accidental Death benefit will be paid to the beneficiary designated on your Basic Group Life Insurance application, otherwise to Your Estate. With the exception of the sections entitled “Repatriation Benefit”, “Education Benefit”, “Day-Care Benefit”, “Workplace Modification and Accommodation Benefit“, “Occupational Training Benefit”, “Family Transportation Benefit” and “Identification Benefit”, all other indemnities payable will be paid to You.

Effective Date of Coverage

Coverage commences on the date insurance under the Policyholder’s Basic Group Life Insurance contract becomes effective with respect to an Employee who becomes insured under such program after the Effective Date of the Policy.

When Insurance Coverage Stops

Your insurance coverage stops on the earliest of the following dates:

- on the date the Policy is terminated;
- on the premium due date if the Policyholder fails to pay Us Your premium;
- on the date Your Group Life Insurance ceases;
- on the date You cease to be associated with the Policyholder in a capacity making such person eligible for insurance hereunder;
- on the date You cease to be an active employee on account of leave of absence, lay-off, maternity leave, disability, resignation, dismissal, pension or retirement, except as provided under:

Waiver of Premium
Continuation of Coverage
During Approved Leaves
Extension of Coverage
Retirement

Waiver of Premium

Provided You have been approved for Waiver of Premium and remain eligible for such under the terms and conditions of the Policyholder's Basic Group Life Insurance policy, You need not pay any further premiums under the Policy for Yourself, while You remain disabled, until the earliest of the following dates:

- the Policy terminates;

- You reach age 65;

- You cease to be totally disabled.

All terms and provisions of the Policy in affect as of the date of commencement of disability will apply during the period premiums are waived, including provisions relating to reductions in amount of insurance. Notwithstanding anything contained to the contrary in the Policy, benefits payable for any Loss which occurs while this clause is in effect cannot exceed the amount of insurance payable on the commencement date of disability.

Continuation of Coverage

Your coverage under this benefit will be continued, if coverage is continued under your Policyholder's Basic Group Life Insurance contract during any approved leave of absence, temporary layoff, maternity leave or disability leave, provided payment of premium is continued.

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

Extension of Coverage

Coverage under this policy may be continued for a period of up to twelve (12) months when Your employment has been terminated by the Policyholder, provided such continuation of coverage is required by the Employment Standards Act or by a severance package agreement received by You from the Policyholder and payment of premium is continued.

This extension of coverage will terminate at 12:01 a.m., Standard Time, on the first (1st) day of the month following either the completion of the twelve (12) month period or the date You return to work in any capacity, whichever is earlier.

The coverage which is continued under this clause will be subject to the terms and provisions of this policy in effect as of the date of termination of employment, including any provision providing for reductions in amounts of insurance.

Notwithstanding anything contained to the contrary in this policy, in no event will benefits payable for any Loss which occurs while coverage is being continued under this clause exceed the amount of insurance that would have been payable to You at the date of termination of employment.

Retirement

If You retire prior to age 65, coverage may be continued for You until you reach age 65, provided payment of premium is continued.

Coverage may be continued after age 65, subject to the following:

(1) Your Principal Sum will be limited to $100,000;
(2) Paralysis benefits will not exceed 100% of the Principal Sum; and
(3) Your coverage will terminate at age 70.

Note: You cannot increase your amount of insurance after you retire.

What We Will Not Pay For

You are not covered for Loss, fatal or non-fatal caused or contributed to by:

- suicide or intentionally self-inflicted Injury;
- war, whether declared or not;
- participation in a riot, insurrection, civil commotion or disturbance;
- active full-time, part-time or temporary service in the armed forces of any country;
- riding as a passenger or otherwise in any vehicle or device for aerial navigation, other than as provided in the section entitled “Aircraft Coverage”.
- medical treatment or surgery, except if the medical treatment or surgery was needed because of an Accident.

In the Event of a Claim

If a person insured under the Policy is injured and the Injury may lead to a claim under the Policy, We must be notified in writing within 30 days of the Accident causing the Injury. You or Your representative may notify our Head Office in Montreal, any of our Regional Offices in Canada or our authorized agent. Whomever You contact should be advised of Your name and the policy number under which You are insured. If You or Your representative do not contact Us within 30 days, but can show that it was not reasonably possible to contact Us within the 30 day period, Your claim will not be invalidated solely because of failure to contact Us within the 30 day period, but in no event later than 1 year after the date of the Accident.

Upon receipt of Your notice of claim, We will supply You or Your representative with any form or forms necessary to show proof of loss. If We have not supplied the form or forms within 15 days of the date notice of claim was received, You or Your representative may satisfy Your obligation under this section by submitting a letter describing the Accident or occurrence causing the loss, the nature of the loss and the extent of the loss for which Your claim is made.
Written proof of loss that You have suffered must be provided to Us within 90 days of the loss. If it is shown that it was not reasonably possible to provide proof within this time, and if proof is supplied as soon as reasonably possible, the claim will not be invalidated solely because of failure to provide proof of loss within the 90 day period, but in no event later than 1 year after the date of the Accident.

While Your claim is pending, We will have the right and the opportunity to examine the person suffering the loss as often as necessary. If the claim is for loss of life, We will also have the right and opportunity to require an autopsy where it is not forbidden by law.

We will pay all amounts payable under the Policy immediately after We have received satisfactory proof of loss.

We will pay all claims under the Policy in Canadian Currency.

Limits Of The Policy

Any changes to the Policy which have been approved by Us will become part of the Policy. No change will be valid unless approved by an officer of SSQ Insurance Company Inc., with such approval set out in an endorsement attached to the Policy. No one else, including any agent, has the authority to change any part of the Policy. If the Policy is amended, the provisions of this certificate will automatically be amended to conform to the amended provisions of the Policy.

If You or Your representative believe there is cause to bring legal action against Us, action may be brought not sooner than 60 days after providing Us with proof of loss according to the terms of the Policy. No such action may be brought unless brought within 1 year (3 years in the province of Quebec) of the expiration of the time within which proof of loss is required by the Policy.

If any time limits which We have prescribed in the Policy are less than those permitted by the law of the province in which the claimant is residing at the time of claim, then it is understood that such limits are extended to agree with the minimum period permitted by law.

The Policy may be cancelled by the Employer by mailing to SSQ Insurance Company Inc. written notice stating when cancellation is to be effective. The date of cancellation will not precede the date of written notice.

The Policy may be cancelled by SSQ Insurance Company Inc. by mailing to the Employer written notice stating when, not less than 30 days prior to the Policy anniversary date, cancellation is to be effective. The mailing of such notice will be sufficient proof of notice and the effective date of cancellation stated in the notice will become the end of the Policy period. Delivery of such notice by SSQ Insurance Company Inc. or by the Employer will be considered the same as mailing.

We will be permitted to examine the Policyholder’s records relating to the Policy at any reasonable time up to 2 years after the Policy has expired or been cancelled, or until all claims under the Policy have been settled, whichever is later.