Employee Benefits Booklet

Burnaby Association for Community Inclusion

Employee Classification

BCGEU Childcare Employees

Group Number(s)

PBC 24162
DFS 647236
CHUBB CC50058301
Acclaim Ability 23654

Introduction

This booklet contains information about your Group Benefits. Please keep it in a safe place. It is intended to summarize the principal features of your plan. All rights to benefits are governed by the Group Contract/Policy.

The Group Policy contains a provision removing or restricting the right of the Member to designate persons to whom or for whose benefit insurance money is to be payable.

The Group Contract does not permit a Member or Dependent to designate a personal representative or a beneficiary to receive benefits, except for Life benefits.

Defined terms are capitalized (e.g. Dependent). Pacific Blue Cross (PBC), Desjardins Financial Security Life Assurance Company (DFS), Chubb Life Insurance Company of Canada (Chubb Life) ACCLAIM Ability Management Inc. (Acclaim) and Benefits by Design (BBD) is referred to as "we", "our", or "us" in this booklet. We will refer to you, the employee/member, as "you" or "your" in this booklet

Pacific Blue Cross, the registered trade-name of PBC Health Benefits Society, is an independent licensee of the Canadian Association of Blue Cross Plans.

Coverage is provided through:

Pacific Blue Cross
Extended Health Care (EHC)
Dental Care

DFS
Group Term Life

CHUBB
Basic Accidental Death & Dismemberment (AD&D)

ACCLAIM Ability Management Inc.
Early Intervention Program

Please refer to the Table of Contents to help you locate the appropriate section in this booklet. If you require additional information, please contact our office or your Plan Administrator.

Table of Contents

Our Commitment to Privacy

Our Privacy Code balances the privacy rights of our group and benefit plan participants, and our employees, with the legitimate information requirements to provide customer service and to meet our human resource requirements. It consists of the following key principles:

1) We ask for your personal information for the following purposes:
   - To establish your identification
   - To provide you and/or your dependents with the applicable benefit coverage
   - To protect you and us from error and fraud
   - To provide ongoing services

2) Consent
   When you enrolled in your group benefit plan as a plan participant, your personal information was obtained and used only with your consent. We obtained your consent before we:
   - Provided benefit coverage
   - Obtained, used or disclosed to other persons, information about you unless we were obliged to do so by law or to protect our interests
   - Used your personal information in any way we did not tell you about previously

   Your consent can be either express or implied. Express consent can be verbal or written. Consent can be implied or inferred from certain actions. For our existing group and benefit plan participants, we will continue to use and disclose your personal information previously collected in accordance with our current privacy code, unless you inform us otherwise and will infer that consent has been obtained by your continued use.

3) Withdrawal of Consent
   You can withdraw your consent any time after you've given it to us, provided there are no legal or regulatory requirements to prevent this. If you don't consent to certain uses of personal information, or if you withdraw your consent, we will no longer be able to administer your benefit coverage. If so, we will explain the situation to you to help you with your decision.

For further information on our privacy policies and procedures, please refer to the BBD web site at www.bbd.ca.

Schedule of Benefits

The Schedule of Benefits contains a brief summary of your benefits. Please refer to the appropriate page in this booklet for a more detailed benefit description.

Extended Health Care - *Underwritten by PBC*

Deductible	$25 per person or family each calendar year. If in any calendar year the Eligible expenses do not exceed the Deductible, the Eligible expenses incurred during the last 3 months of the calendar year may be applied against the Deductible for the next year.	
Reimbursement	**In-Province/Territory Eligible Expenses:**	
	Hospital Room Accommodation and Hearing Aids	100%
	All Other Eligible Expenses	80%
	Out-of-Province/Territory Eligible:	
	Emergency	100%
	Non-Emergency	Same as In-Province/ Territory
	After $1,000 has been paid for a person in a calendar year, further Eligible expenses for that person within that year will be reimbursed at 100%, subject to the Contract maximums for this benefit.	
Plan Maximum	The lifetime maximum amount of benefits payable for a Member or Dependent is unlimited, subject to the terms and conditions of the Group Contract.	
Termination	Age 85 or earlier retirement.	
Dependent Children	See definition of Dependent.	

Dental Care - *Underwritten by PBC*

Deductible	No Deductible		
	Plan A Basic Services	**Plan B** Major Restorative Services	**Plan C** Orthodontics
Reimbursement	100%	60%	60%
Frequency Plan Limits	**Each Calendar Year**	**Each Calendar Year**	**Lifetime**
Financial Limit Per Dependent Child	Not Applicable	Not Applicable	$2,750
Financial Limit Per Member or Spouse	Not Applicable	Not Applicable	$2,750
Financial Limit for Late Applicants	$250 per person for all dental services for first 12 months of coverage		
Termination	Age 85 or earlier retirement.		
Dependent Children	See definition of Dependent.		

Group Term Life – *Underwritten by DFS*

Benefit Amount	$50,000
Non Evidence Limit	$50,000
Benefit Reduction	Amount of insurance reduces by 50% at age 65
Termination	Age 70 or earlier retirement

Basic Accidental Death & Dismemberment (AD&D) - *Underwritten by Chubb Life*

Principal Sum	An amount equal to the amount payable under your current group term life insurance.
Aggregate Limit	$1,000,000
Benefit Reduction	Amount of insurance reduces by 50% at age 65
Termination	Age 70 or earlier retirement

PBC

This section includes a description of the benefits underwritten by PBC.

Group Number:

PBC 24162

General Information

Definitions

Coverage effective date
Means the date coverage becomes effective based on
1) your date of hire, and
2) the average number of hours you work each week or each year, and,
3) the waiting period selected by your employer, and
4) the Enrolment grace period.

Deductible
Means the initial portion of the Eligible expenses, which you must pay before we will reimburse charges for any Eligible expense.

Dentist
Means a doctor of dentistry who is duly qualified and licensed to practice dentistry in the area where the service is provided. For the purposes of this booklet, Dentist may also mean dental specialist, denturist, or dental hygienist, depending on the services each may provide.

Dependent
Means any of the following persons for whom coverage is provided under this Plan:
1) one Spouse of the Member
2) any unmarried child, stepchild, legally adopted child, or legal ward (but not a foster child) who is under age 19 and financially dependent on you or your Spouse, and
3) any age if the unmarried child is also in full-time attendance at a recognized educational institute, and
4) any unmarried disabled child of any age who is living with and is financially dependent on you and/or your Spouse and is incapable of self-sustaining employment. Disabled status is subject to approval by us. The Dependent must become disabled while covered as a Dependent under Clause 2 or 3 above.

You must be prepared to prove that an individual claimed as a Dependent falls within these requirements.

Enrolment grace period
Means within 4 months from the coverage effective date.

Fee guide
Means the Canadian provincial/territorial dental Fee guide that contains dental services and fees in effect on the date the dental services are performed. For Alberta, the Fee guide means the current Alberta Blue Cross Usual and Customary fee guide.

Fee schedule
Means Schedule 2 of the Pacific Blue Cross Fee schedule that contains eligible dental services, financial limits, treatment frequencies, and fees in effect on the date the dental services are performed.

Life event
Means a marriage, divorce, or legal separation, birth or adoption of a child, or a change in the eligibility of a Dependent.

Member
Means an employee or other person who has coverage under the Contract.

Non evidence limit
Means the maximum amount of insurance we will provide without evidence of insurability as indicated in the Schedule of Benefits.

Practitioner
Means a person currently licensed, certified, or registered to practice a profession by the appropriate licensing, certification, or registration authority in the jurisdiction where the care or services are provided, or where no such authority exists, has a certificate of competency form the professional body which establishes standards of competence and conduct for the profession, and is acting within the scope of that license. Services provided by a psychologist or counsellor employed by Burnaby Association for Community Inclusion are excluded.

Pacific Blue Cross reserves the right to refuse the service, medical supply or equipment from the provider based on ineligibility, or based on the provider's qualifications or conduct.

Provider
Means a person, group, or entity currently licensed, certified, or registered to provide an eligible service, medical supply or equipment by the appropriate licensing, certification, or registration authority in the jurisdiction where the services or equipment are provided or, where no such authority exists, has a certificate of profession, and is acting within the scope of that license. Pacific Blue Cross reserves the right to refuse

the service, medical supply or equipment from the Provider based on ineligibility, or based on the Provider's qualifications or conduct.

Spouse
Means your legal Spouse or a person who has been living with you in a common-law relationship for at least one full year and who is publicly represented as your Spouse.

Member Information/Access to Records

1) Each Member who becomes insured under the Group Contract/Policy must receive an ID card if covered for Extended Health Care and/or Dental Care, and for all benefits a booklet outlining the benefits, the circumstances under which the insurance terminates, and the rights of the Member upon termination of the insurance. We will not be liable or responsible for errors or omissions, which occur when; our booklet is altered in any way. A booklet issued to or held by a Member who, for any reason, is not entitled to insurance under the Group Contract/Policy, is not valid.
2) Only the Member and Dependent(s) are entitled to the benefits of this Contract/Policy. A Member's coverage may be suspended immediately, without notice, if that Member or a Member's Dependent assists an ineligible person to obtain, or attempt to obtain, benefits to which they are not entitled. The persons involved must repay any amounts obtained in this manner to us. Any other fraudulent action by a Member or Dependent to obtain or attempt to obtain benefits will have similar consequences.
3) Use of an ID card by a person who is not entitled to coverage may result in prosecution of that person.
4) The terms of the Group Contract/Policy govern if they conflict with the information in a booklet.
5) Upon request, and at no charge to the Member, we will provide the Member with one copy of:
   a) the Member's application for coverage
   b) the current Contract/Policy
   c) any written statement or other record provided to us as evidence of insurability of the Member.
6) A Member's access to the documents identified in clause 5 extends only to relevant information about a claim under the Group Contract/Policy or denial of such a claim.
7) A Member's access to the documents identified in clause 5 is subject to the *Personal Information Protection Act* and to the *Insurance Act* and their Regulations.

Integration with Government Plans

Extended health care benefits are intended to supplement and not overlap benefits under government plans such as the Medical Services Plan and Fair PharmaCare Program of British Columbia. You are required, as a condition of coverage, to take all reasonable steps to qualify and obtain the fullest extent of coverage, benefits, contribution, or reimbursement available under all applicable government plans. We will also make payment only where permitted by provincial/territorial legislation or other applicable law.

Effective Date of Coverage and Enrolment

If you are eligible for coverage, you must complete an application card within the Enrolment grace period to ensure that your coverage starts on the correct effective date.

You should apply for Dependent coverage (when applicable):
1) on the same date you apply for your own coverage, or
2) within the Enrolment grace period if you have a new Dependent.

Limitations:
1) If you are not actively at work on your coverage effective date, your coverage effective date will be delayed until you return to active full-time employment.
2) If we do not receive your application card within the required time limits, please refer to the Late Applicant section.

Provided you and your Plan Administrator have complied with our enrolment rules, your coverage effective date is shown on our website at www.pac.bluecross.ca/caresnet or from your Plan Administrator.

Should you require additional information about when your coverage starts, please contact your Plan Administrator.

Late Applicants

If you did not apply during the Enrolment grace period but request coverage later (for yourself and/or your Dependents), ask your Plan Administrator to explain the requirements for late enrolment in your Group Plan. Note: Different benefits may have different requirements – evidence of insurability or retroactive premium payment. In some instances, coverage may be denied.

Beneficiary

1) To the extent permitted by law, you have the right to name a personal representative or beneficiary for Life and Accidental Death and Dismemberment benefits or change this personal representative or beneficiary, by written request in a form satisfactory to us. If your designated personal representative or beneficiary does not survive you, any benefit amount due will be payable to your estate.
2) For all other benefits this plan does not permit you or your Dependents to designate a personal representative or a beneficiary to receive benefits.

Identification (ID) Cards

We will issue identification (ID) cards for distribution by your Plan Administrator.

You may be asked to substantiate that an individual you claim as a Dependent meets the definition of Dependent for your group.

Claims

1) All claims must be submitted to us in English.
2) We pay eligible claims when we receive all the required information within the required **time limits**. We encourage you to become familiar with the time periods allowed for claiming benefits. Under the Claims sections, we fully describe the claiming deadlines for each benefit. No payment will be made if we receive your claim after the time limits described in this booklet.
3) We may reject your claim if sufficient information is not provided to enable a full assessment of the claim, or if an attempt is made, except through unintentional error, to make an excessive claim, or if a claim is made for a person who is not entitled, or if any Group Contract/Policy exclusion applies.
4) The necessary claim forms are available from your Plan Administrator or on our website at www.pac.bluecross.ca/caresnet
5) The exchange rate on foreign currency is payable at the rate quoted by selected Canadian financial institutions for the date on which the expense was paid. Fluctuations in exchange rates are not our responsibility.

General Exclusions

1) We will not be liable for any portion of an expense for which you or your Dependent is entitled to reimbursement:
   a) under any other group or individual benefit plan or insurance policy, or
   b) due to the legal liability of any other party.
2) In no event will benefits be payable for expenses resulting directly or indirectly from, or in any manner or degree associated with, any of the following:
   a) war, whether declared or undeclared, or any act of war, or participation in a riot, insurrection, or civil commotion
   b) suicide or any self-inflicted injury, whether intentional or unintentional, sustained while travelling outside the normal province/territory of residence
   c) active duty in the military forces of any nation or international organization, or in any civilian noncombatant unit which serves with such forces in combat
   d) a direct or indirect attempt at, or commission of, an indictable offense under the Criminal Code of Canada or similar law of any other country

e) false pretences or fraudulent misrepresentation
f) any injury, illness, or condition for which care is provided or may be provided or available without cost by public authorities or by a tax-supported agency, including preventive treatment and services available under any Workers' Compensation Act or similar plan.

Legal Action

Every action or proceeding against us for the recovery of benefits payable under the Group Contract/Policy is absolutely barred unless commenced within the time set out in the *Insurance Act.*

Continuation of Coverage

Your coverage will continue if you are on maternity or parental leave (as defined by the Employment Standards Act). Coverage will also continue during an unpaid leave of absence or while you are receiving sick pay for the first 20 work shifts in any calendar year.

Coverage may continue beyond the first 20 work shifts if you pay 100% of the contributions during a leave of absence or while receiving sick pay.

Termination of Coverage

Generally, your coverage (and any Dependent coverage) terminates if you cease to be eligible due to change of group, leave of absence, age limitation or retirement, if you terminate your employment, or if the group plan terminates, etc. For further details on termination of coverage, please have your Plan Administrator refer to the Group Contract/Policy.

Right of Recovery

You are financially responsible for any claims paid by us on your or your Dependent's behalf after coverage is terminated from your employer's benefit plan. You agree to reimburse us for these payments upon receipt of our invoice.

Survivor Benefit

If you die while covered under this plan, coverage for your Dependents will continue until the earliest of the following occurs:

1) 24 months after your death
2) the date your Dependent ceases to be a Dependent other than as a result of your death
3) the date the Contract is terminated
4) the date your Dependent becomes eligible for coverage under a similar group plan.

Pre-existing condition

Means any illness or condition for which you receive medical attention, consultation, diagnosis, or treatment in the 12 month period before you apply for the individual plan.

Call our Individual Products Department at 604 419-2000 for an application form.

If you are converting to an individual plan offered by Blue Cross, contact your local Blue Cross organization for full details before your group coverage terminates.

Individual Travel Benefits

Individual coverage is also available from us. Call 604 419-2000 or 1 877 PAC-BLUE (722-2583) outside the Lower Mainland for information.

CARESnet

CARESnet is an online service from Pacific Blue Cross that offers you convenient and secure access to your benefit information 24 hours a day. Information about benefit coverage, claim status, and easy access to claim forms are the enhanced services CARESnet provides. To access CARESnet, visit our website: www.pac.bluecross.ca/caresnet/

Extended Health Care

The Extended Health Care (EHC) plan is designed to help you pay for specified services and supplies incurred by you and your Dependents, when not provided under a government health plan or by a tax- supported agency.

All dollar limits included in the benefit descriptions are **eligible** unless specifically shown as **payable**.

To determine the benefit amount **eligible**, PBC assesses the claim as follows:

- calculates the total Eligible expense
- applies the claimable limits
- subtracts the Deductible, when applicable
- applies the reimbursement percentage
- applies the EHC plan maximum.

To determine the benefit amount **payable**, PBC assesses the claim as follows:

- calculates the total Eligible expense
- subtracts the Deductible, when applicable
- applies the reimbursement percentage
- applies the payment limits
- applies the EHC plan maximum.

Definitions

Eligible expense
Means a charge for any service and/or supply included in this booklet as a benefit that:

1) in our assessment is a customary charge medically necessary for health care and maintenance, or to maintain or restore teeth, and
2) was ordered or referred by a Physician, Dentist, or a Primary healthcare nurse practitioner (PHCNP), unless otherwise specified in the benefit description, and
3) is not a cost normally paid (in whole or part) or provided by a government plan or any other Provider of health coverage, and
4) is incurred while your coverage is valid. An expense is "incurred" on the date the service is provided or the supply is received, and
5) is provided by a Practitioner or Provider approved by us.

It does not include any payment to a pharmacy or a Practitioner (demanded or received by balanced billing, extra billing, or extra charging), which represents an amount in excess of the schedule of costs prescribed by the government plan.

Provincial/territorial plans low cost alternative and reference drug programs will not be applied unless specified in this booklet.

Physician
Means an individual who is duly qualified and licensed to practice medicine or surgery, or both, in the area where the service is provided, but excludes a Physician residing with or related to you or your Dependent.

Primary healthcare nurse practitioner
Means a person duly qualified and licensed to deliver specific health care services in the jurisdiction where the services are provided and is acting within the scope of that license.

In-Province/Territory Eligible Expenses

Your EHC plan covers reasonable and customary charges for the following services and supplies when medically necessary, and prescribed, ordered, or referred by a Physician, Dentist, or Primary healthcare nurse practitioner. Unless otherwise indicated, the maximums included here are on a per person basis.

1) Hospital
   The additional charge for semi-private or private room accommodation in a hospital or the extended care unit of a hospital. Charges for rental of a telephone, television, or similar equipment are not covered.

2) Emergency ambulance
   a) charges for licensed ambulance service to and from the nearest Canadian hospital equipped to provide the type of care essential to the patient
   b) air transport will be covered when time is critical and the patient's physical condition prevents the use of another means of transport
   c) emergency transport from one hospital to another, only when the original hospital has inadequate facilities
   d) charges for an attendant when medically necessary.

3) Drugs
   Charges for drugs and medicines in a quantity we consider reasonable, and

   a) which are dispensed by a pharmacist, Physician, Dentist, or a Primary healthcare nurse practitioner including:
      i) life sustaining drugs

ii) insulin preparations, testing supplies, needles, and syringes for diabetics
iii) vitamin B12 for the treatment of pernicious anemia
iv) allergy serums when administered by a Physician, or Primary healthcare nurse practitioner, or

b) which legally require a prescription from a medical Provider legally authorized to do so, including:
i) contraceptives
ii) erectile dysfunction drugs to a calendar year maximum of $250.

Reimbursement of eligible drugs will be subject to provincial/territorial plans low cost alternative and reference drug pricing programs.

Specific high-cost Pharmacare limited coverage drugs are identified on Pacific Blue Cross' Special Authority Enforcement list. We will reject claims for a drug on this list in British Columbia until we receive confirmation of BC Pharmacare's Special Authority decision for the drug. Once the PharmaCare decision (accepted or declined) is on file with us, we will accept claims for this high-cost drug.

4) Practitioners
Professional services of the following Practitioners to the maximum amounts indicated per calendar year, but excluding appliances and tray fees. *Only the services of a private duty nurse require referral by a Physician.* For certain Practitioners (chiropractor, massage Practitioner, naturopath, physiotherapist, and podiatrist), we will pay a visit fee to a maximum of $10 per visit per Practitioner for the first 12 visits (under age 65), first 15 visits (age 65 and over), subject to your plan's maximum benefit amount and reimbursement percentage.
We will pay the full amount of any further visits to these Practitioners, subject to the reimbursement percentage and any remaining benefit

a) acupuncturist.....$100
b) chiropractor.....$200
c) massage Practitioner $750
d) naturopath.....$200
e) physiotherapist.....$750
f) podiatrist $200
g) psychologist, social worker, and clinical counsellor combined $200
h) speech language pathologist $500
i) private duty care by a registered nurse for a person with an acute condition in the person's home.

Effective April 1, 2021

Professional services of the following Practitioners to the maximum amounts indicated per calendar year, but excluding appliances and tray fees. *Only the services of a private duty nurse require referral by a Physician or Nurse practitioner.*

a) acupuncturist.....$100
b) chiropractor $200
c) massage Practitioner $750
d) naturopath.....$200
e) physiotherapist.....$750
f) podiatrist $200
g) psychologist, social worker, and clinical counsellor combined $200
h) speech language pathologist $500
i) private duty care by a registered nurse for a person with an acute condition in the person's home.

5) Dental Accident
Dental treatment by a Dentist, which is required, performed, and completed within 52 weeks after an Accidental injury which occurred while covered under this EHC plan, for the repair or replacement of natural teeth or prosthetics. No payment will be made for temporary, duplicate, or incomplete procedures, or for correcting unsuccessful procedures.

Accidental

Means caused by a direct external blow to the mouth or face resulting in immediate damage to the natural teeth or prosthetics and not by an object intentionally or unintentionally being placed in the mouth.

We pay benefits based on eligible dental services and financial limits in our current Fee schedule, and we pay the fees in our current Fee schedule or, if applicable, the Fee guide in the province/territory of service.

6) Medical aids and supplies provided by a medical supplier (as approved by us)
Charges for the following services and supplies:

a) oxygen
b) ostomy and ileostomy supplies
c) intrauterine contraceptive devices (IUD's)
d) hyaluronic acid injections, when administered by a Physician or Practitioner healthcare nurse practitioner

e) walkers, canes and cane tips, crutches, casts, and trusses
f) splints and collars (but not elastic or foam supports), rigid support braces and permanent prostheses (artificial eyes, limbs, larynxes, and mastectomy forms), when prescribed by a Physician, physiotherapist, chiropractor, or a Primary healthcare nurse practitioner, as medically necessary after diagnosis of the patient. Myoelectrical limbs are excluded, but we will pay the equivalent of a standard prosthesis
g) mastectomy brassieres to a maximum of 1 brassiere per calendar year when required as a result of medical treatment for injury or illness
h) charges for the following items to the maximum amounts indicated per calendar year:
    i) stump socks ..... no maximum
    ii) surgical stocking ..... 2 pairs
i) wigs and hairpieces required as a result of medical treatment, injury, alopecia areata, alopecia universalis or alopecia totalis to a lifetime maximum of $500
j) orthopaedic shoes and orthotics
    i) when prescribed by a Physician, podiatrist, or chiropractor as medically necessary after diagnosis of the patient, custom made orthopaedic shoes (including repairs) and modifications to stock item footwear. A custom made orthopaedic shoe is one fabricated from raw materials and specifically designed for the patient, based on a three-dimensional volumetric model of the patient's foot and lower leg
    ii) when prescribed by a Physician, podiatrist, chiropractor, or physiotherapist as medically necessary after diagnosis (including an in person biomechanical assessment) of the patient, custom made orthotics. A custom made orthotic is one fabricated from raw materials using a three-dimensional volumetric model of the patient's feet

    to a combined maximum in a calendar year of $500 for adults and $300 for a Dependent child.
k) hearing aids and repairs to a maximum of
    i) $1,500 in a 12 month period for Dependent children, and
    ii) $1,500 in a 48 month period for adults.

    Batteries, recharging devices, and other such accessories are not covered. Replacement will be covered only when the hearing aid cannot be repaired satisfactorily.

7) Standard durable medical equipment
    a) Preauthorization is required from us for expenses in excess of $5,000
    b) Charges for standard durable medical equipment when rented from a medical supplier. If unavailable on a rental basis, or required for a long-term disability, purchase of these items from a Provider may be considered.

c) Repairs to purchased items. We will replace the item when it can no longer be made functional. We may request trade-in or return of replaced equipment.
d) Reimbursement on rental equipment will be made monthly and will in no case exceed the total purchase price of similar equipment.
e) Standard durable equipment includes:
    i) manual wheelchairs, manual type hospital beds, and necessary accessories – electric wheelchairs and hospital beds will be covered only when the patient is incapable of operating the manual equivalent, otherwise we will pay the manual equivalent
    ii) medical heart monitors and cardiac screeners
    iii) blood glucose monitors to a lifetime maximum of $200 and continuous glucose monitors and supplies
    iv) speech processors and headsets when prescribed for profound deafness subject to a 5 calendar year period
    v) bi-osteogen systems and growth guidance systems (when recommended by an orthopaedic surgeon)
    vi) breathing machines and appliances including respirators, compressors, percussors, suction pumps, oxygen cylinders, masks, and regulators
    vii) insulin infusion pumps for diabetics – when basic methods are not feasible
    viii) transcutaneous electric nerve stimulators (TENS) when prescribed for intractable pain
    ix) transcutaneous electric muscle stimulators (TEMS) required when, due to an injury or illness, all muscle tone has been lost.

8) Insulin Infusion Pump
When prescribed by a Physician and upon our approval, charges for the reasonable and customary cost of an insulin infusion pump. Charges for repairs or replacements for the insulin infusion pump, whichever is most appropriate, shall be considered after the warranty expiration date.

9) Vision Care and Laser Eye Surgery
Charges for the following when prescribed by a Physician or legally authorized optical Provider (as applicable)

a) purchase and/or repair of eyewear and charges for contact lens fittings, and
b) laser eye surgery

to a combined maximum of $350 in a 24 month period. Charges for non-prescription eyewear are not covered.

10) Eye Examinations
Charges for routine eye examinations every 24 months to a maximum of $100 when performed by a Physician or legally authorized optical Provider.

11) Medical Examinations
Charges of a Physician or Primary healthcare nurse practitioner, for medical examinations required by government statute or regulation for employment purposes provided such charges are not payable by your employer under a collective agreement.

Extended Health Benefit – Second Opinion™

This benefit offers you and your Dependents if faced with a serious medical condition, the opportunity to obtain a second medical opinion offered by one of North America's leading medical facilities.

Serious medical conditions, which qualify for Second Opinion are diagnoses of the following:

1. AIDS
2. ALS
3. Alzheimer's disease
4. Any amputation
5. Any life threatening illness
6. Benign brain tumor
7. Cancer
8. Cardiovascular conditions
9. Chronic pelvic pain
10. Coma
11. Deafness
12. Embolism/Thrombophlebitis
13. Emphysema
14. Hip/knee replacement
15. Kidney failure
16. Loss of speech
17. Major or severe burns
18. Major organ transplant
19. Major trauma
20. Multiple scerlosis
21. Neuro-degenerative diseases
22. Paralysis
23. Parkinson's disease
24. Rheumatoid arthritis

25. Stroke
26. Sudden blindness due to illness

A medical specialist reviews the patient's medical documentation and provides recommendations to the patient and their Physician. Treatment decisions are made between the patient and their Physician.

If you or your Dependents have been diagnosed with one of the conditions listed above, you can seek Second Opinion by calling 1-866-895-1371 (toll-free) between 5:00 am and 5:00 pm (Pacific time). You will be asked for your Pacific Blue Cross policy number, as shown on your ID card.

This benefit terminates:
1) for you and your Dependents when your employment is terminated, on your retirement, on termination of the EHC benefit, or when you reach age 85, whichever occurs first, and
2) for any Dependent who reaches age 85, provided your coverage has not terminated as indicated above.

Disease Support Programs

This benefit offers you and your Dependents faced with a cancer diagnosis the opportunity to obtain tools to improve recovery and survival during and after cancer treatment. A team of Physicians and health care practitioners work with the patient to assist in recovery, improve quality of life and help prevent cancer recurrence. The programs are supported by current research and are intended to integrate with conventional treatments.

Services available, including but not limited to:
1) Support groups.
2) Tools for patient to take charge of their health.
3) Natural approaches to prevention and treatment.
4) Multidisciplinary team of Physicians and health care practitioners.
5) Individualized cancer survivorship plan.

Conditions and Limitations:
1) Diagnosis of cancer by patient's Physician.
2) The cancer diagnosis must have occurred within 24 months of referral by the Physician to the program.
3) Any service covered by the Government plan is ineligible for reimbursement.
4) The lifetime maximum payable benefit is $300 per covered person.

For additional information visit the website at www.inspirehealth.ca or to arrange an appointment call 604 734-7125.

Out-of-Province/Territory Non-Emergency Eligible Expenses

We will reimburse you (and your Dependents) for non-emergency Eligible expenses incurred while travelling outside your province/territory of residence subject to the Deductible, in-province/territory reimbursement percentage, and maximums. We will not reimburse any expenses payable or provided under a government plan.

Out-of-Province/Territory Emergency Eligible Expenses

While travelling outside your province/territory of residence, benefits are payable for the following Eligible expenses incurred IN AN EMERGENCY ONLY and when ordered by the attending Physician. Non-emergency continuing care, testing, treatment, and surgery, and amounts covered by any government plan and/or any other Provider of health coverage are not eligible.

1) Local ambulance services when immediate transportation is required to the nearest hospital equipped to provide the treatment essential to the patient.
2) The hospital room charge and charges for services and supplies when confined as a patient or treated in a hospital, to a maximum of 90 days. If reasonably possible, we should be notified within 5 days of the patient's admission to hospital. When the patient's condition has stabilized, we have the right, with the approval of the attending Physician, to move the patient by licensed ambulance service to the hospital nearest the patient's home which is equipped and has space available to provide further medical treatment. Where transportation would endanger the patient's health, the 90 day limit may be extended with our expressed written consent.
3) Services of a Physician and laboratory and x-ray services.
4) Prescription drugs in sufficient quantity to alleviate an acute medical condition.
5) Other emergency services and/or supplies, if we would have covered them inside your province/territory of residence.
6) Charges, limited to the most economical means of transportation, for your Dependent child under 16 years of age to his or her place of residence in Canada in the event you and/or your Spouse is hospitalized and your child is left unattended. Arrangements for an escort to accompany your child will be made, if necessary.

7) Charges, limited to the most economical cost of one-way economy fare air transportation, less any amount reimbursed for unused return tickets, when the covered person's hospitalization delays the return trip. The coverage is for both your airfare and the airfare of your Spouse, if required.
8) Charges, limited to return economy fare air transportation, for one immediate family member to visit you or your Dependent if hospitalized. You or your Dependent must have been travelling alone and confined to a hospital for more than 7 days. An immediate family member is defined as a Spouse, child, parent, brother, sister, or a person with whom the insured person normally resides.
9) Charges relating to items 6), 7) and 8) are limited to a combined maximum expense of $5,000 per family per medical emergency.
10) Charges for accommodation for convalescence following hospitalization to a maximum of $75 per day per patient for a maximum of 5 days per medical emergency.
11) Charges for commercial accommodation and meals for an immediate family member while staying with a hospitalized Member or Dependent to a maximum of $100 per day up to 7 days per family per medical emergency. Limitation:

    Expenses only apply if the immediate family member had to travel to visit the patient, or if the immediate family member had to extend his or her stay beyond the scheduled date of his or her return trip.

12) Charges relating to the return of your vehicle (excluding commercial transport vehicles) to your place of residence or the nearest appropriate rental agency in the event you are unable to return it due to a medical emergency to a maximum of $500 per medical emergency.
13) Charges for the repatriation of a deceased Member and/or Dependent to their place of residence to a maximum of $5,000. In the event the deceased person is cremated outside their province/territory of residence, charges are limited to $1,500.

We will only cover Eligible expenses obtained within 60 days of the date you or your Dependent left the country of residence. If hospitalization occurs within the 60 day period, in-patient services are covered until the date of discharge up to a maximum of 90 days. You and your Dependents are required to provide proof of the date of departure and return date to your country of residence, when requested by us.

Emergency Travel Assistance

In emergencies which occur while you (and your Dependents) are travelling, during the first 60 days after you initially leave your country of residence, medi-assist will coordinate the following services:

1) locate the nearest appropriate medical care
2) obtain consultative and advisory services and supervision of medical care by qualified licensed Physicians
3) investigate, arrange and coordinate medical evacuations and related transportation needs
4) arrange and coordinate the repatriation of remains
5) replace lost or stolen passports, locate qualified legal assistance and local interpreters, and other incidental aid you and/or your Dependent may require when in distress.

Your Pacific Blue Cross worldwide emergency medi-assist card provides instant information on how to contact medi-assist. Call the nearest medi-assist emergency access number listed on your card. If necessary, call collect or contact the local telephone operator for help in placing your call to medi-assist. Have your Pacific Blue Cross Policy, ID, and provincial health care numbers ready for personal identification.

Exclusions

The following are not included as Eligible expenses under your EHC plan:

1) except as specifically included in this booklet: dentures or dental treatments, hearing aids, eyeglasses, contact lenses, surgical lens implants, or examinations for the prescription or fitting of any of these, x-rays, hospital coinsurance, vitamins and/or minerals, erectile dysfunction drugs, medications used to treat or replace an addiction or habituation, support stockings, orthotics, arch supports, continuous glucose monitors and supplies, transportation charges incurred for elective treatment and/or diagnostic procedures or for health or health examinations of any kind, and professional services of Physicians, Dentists, or Primary healthcare nurse practitioner, or any person who renders a professional health service in the patient's province/territory of residence
2) general anesthetic, medications used to prevent baldness or promote hair growth, food replacements or supplements, infant food, HCG injections, drugs not approved for sale and distribution in Canada, and medications available without a prescription

3) except as specifically included in this booklet: anti-obesity, sclerosing agents, contraceptives, drugs and supplies for smoking cessation, fertility drugs, and any drug, vaccine, item or service classified as preventive treatment or administered for preventive purposes, and which is not specifically required for treatment of an illness or injury
4) allergy testing unless rendered by a naturopath
5) personal comfort items, items purchased for athletic use, air humidifiers and purifiers, services of Victorian Order of Nurses or graduate or licensed practical nurses, services of religious or spiritual healers, occupational therapy, services and supplies for cosmetic, or experimental purposes, public ward accommodation, rest cures, and medical laboratory tests
6) charges for completion of forms or written reports, communication costs, delivery and mailing or handling charges, interest or late payment charges, non-sharable or capital costs levied by local hospitals, or charges for translating documents into English
7) any payment to a pharmacy, a Practitioner, Physician, Dentist, or Primary healthcare nurse practitioner (demanded or received by balanced billing, extra billing or extra charging) which represents an amount in excess of the schedule of costs prescribed by the government plan
8) that portion of a claim normally covered by the government plan which has been refused on the basis that the claim was not submitted within the government plan's time limits
9) expenses incurred, outside your province/territory of residence, due to elective treatment and/or diagnostic procedures, or complications related to such treatment
10) expenses incurred, outside your province/territory of residence, due to therapeutic abortion, childbirth, or complications of pregnancy occurring within 2 months of the expected delivery date
11) charges incurred outside your province/territory of residence for continuous or routine medical care normally covered by the government plan in your province/territory of residence
12) expenses of a Dependent hospitalized at the time of enrolment
13) services performed by a Physician, Dentist, or Primary healthcare nurse practitioner, who is related to or resides with you or your Spouse
14) services, medical supplies or equipment rendered by a Provider or Practitioner not approved by Pacific Blue Cross
15) fees for ambulance services when an ambulance is called but not used
16) ambulance charges for work related illness or injury assessed by the Workers' Compensation Board to be your employer’s responsibility
17) retroactive coverage and payment of any expense, including drugs that receive special authorization from provincial/territorial plans
18) any other item not specifically included as a benefit.

Claims

Electronic Claims

1) When submitting an electronic claim you must:
   a) complete the claim form online and submit it electronically to us
   b) keep original receipts and documentation to support the claim for 12 months from the date you submit the claim to us
   c) if the claim is selected for review by us, you must submit the original receipts and supporting documentation electronically or by mail to us within 21 calendar days. If we do not receive this information within this time, your claim will be refused and your ability to submit electronic claims will be removed.
2) We reserve the right to remove your ability to submit electronic claims if you provide false, incomplete or misleading claims information. In such circumstances you will have to submit paper claims with supporting receipts and documentation.
3) You must provide explanation or proof to support the claim or any other information we consider necessary.
4) We must receive an electronic claim by **June 30th** of the calendar year following the year in which the expense was incurred. If your electronic claim is selected for review by us, we will accept the original receipts and supporting documentation after the **June 30th** deadline, but within 21 calendar days (see 1c) above) from the date of electronic submission.
5) Payment of the claim will be directed to you, unless we agree to your request to assign payment directly to a third party.

Pay Direct

Provided your pharmacy is connected to our electronic processing system, we will pay them directly for prescription drugs and testing supplies for diabetics covered under your EHC plan. Simply show the pharmacist your EHC ID card.

The pharmacist will charge you only for amounts not covered by us. If you or the pharmacy do not have access to this system, or for other types of expenses, please follow the instructions below.

Paper Claims

1) Because we do not return receipts after the claim is processed, we suggest that you keep a photocopy of the receipts that you submit to us. We will send you a remittance statement for your records each time you submit a claim.

2) Certain medical expenses are covered under the provincial/territorial plans. If you submit your claim to us before you submit your claim to the provincial/territorial plans, we will deduct what the provincial/territorial plans would normally pay from your EHC claim. The balance of the EHC claim is then paid according to the plan design selected by your employer.
3) Accumulate receipts and when reasonable reimbursement is due, submit a claim as follows:
   a) Obtain a claim form from your Plan Administrator or on our website at www.pac.bluecross.ca/caresnet
   b) Follow the instructions on the claim form. To avoid delay in claims payment, please include original receipts and all other requested information with your claim. (Photocopies of receipts are acceptable only when accompanied by a claims payment statement from another carrier).
   c) We suggest you submit claims within **90 days** from the date the expense was incurred. However, we must receive your claim by **June 30th** of the calendar year following the year in which the expense being claimed was incurred. If not, your claim will not be paid under any circumstances.
      Example: **We must receive your receipts for 2019 before June 30, 2020.**
   d) We must receive the original claim form and original receipts. We will not accept a faxed or scanned claim form and/or receipts.

.

Dental Care

Payment of Benefits

1) We pay benefits based on dental services, financial limits and treatment frequencies in the Fee schedule. We apply reasonable and customary limits to fee items as applicable.
2) We apply the reimbursement percentage shown in the *Schedule of Benefits* to the fees shown in the Fee schedule/Fee guide as follows:
   a) for services performed in British Columbia or outside Canada, if your province of residence is British Columbia — the fees in the Fee schedule
   b) for services performed in Canada but outside British Columbia —the fees in the Fee guide in the province/territory of service
   c) for services performed outside Canada if your province/territory of residence is not British Columbia—the fees in the Fee guide in your province/territory of residence.
3) Fees in excess of the amount shown in the applicable Fee schedule/Fee guide will be your responsibility.

Plan A – Basic Preventive & Restorative Services

Plan A covers services for the care and maintenance of teeth, including procedures to restore teeth to natural or normal function. Eligible expenses per person include, but are not limited to, the basic services shown below.

1) Diagnostic services
   a) examinations:
      i) complete – provided we have not paid for any other exam by the same Dentist in the past 6 months –1 per 3 year period
      ii) recall – 1 per 9 month period for adults and 2 per calendar year for Dependent children age 18 and under.
      iii) specific – 2 per calendar year
      iv) consultations (as a separate appointment)
   b) x-rays
      i) diagnostic
      ii) panoramic – 1 per 24 month period
      iii) complete mouth series – 1 per 36 month period

      All x-rays combined shall not exceed the dollar limit for a complete mouth series.

c) diagnostic models – 1 set per calendar year.

2) Preventive services
   a) scaling
   b) polishing – 1 per 9 month period for adults and 2 per calendar year for Dependent children age 18 and under
   c) topical application of fluoride – 1 per 9 month period for adults and 2 per calendar year for Dependent children age 18 and under
   d) fixed space maintainers
   e) preventive restorative resins and pit and fissure sealants – combined limit of 1 per tooth in a 2 year period. No age limit.

3) Restorative services
   a) fillings to restore tooth surfaces broken down as a result of decay – limited to a dollar amount equal to a 5 surface filling per tooth in a 2 year period:
      i) amalgam (silver coloured) fillings
      ii) composite (tooth coloured) fillings on permanent front (anterior and bicuspid) teeth only

   On permanent posterior (molar) teeth and all primary teeth, we pay the bonded amalgam rate for composite fillings.
   b) metal prefabricated restorations on primary and permanent teeth – once per tooth in a 2 year period.
   c) inlays or onlays – only 1 inlay or onlay on the same tooth will be covered in a 5 year period. Where other material would suffice, you will be responsible for the difference between the cost of the chosen material and the cost of alternative material.

4) Endodontics – for the treatment of diseases of the pulp chamber and pulp canal including, but not limited to root canals – 1 per tooth in a 5 year period.

5) Periodontics – for the treatment of diseases of the soft tissue (gum) and bone surrounding and supporting the teeth, excluding bone and tissue grafts, but including the following:
   a) occlusal adjustment and recontouring – a combined yearly limit shown in our Fee schedule
   b) root planing
   c) gingival curettage – 1 per sextant in a 5 year period
   d) osseous surgery – 1 per sextant in a 5 year period

6) Prosthetic repairs
   a) removal, repairs, and recementation of fixed appliances
   b) rebase and reline of removable appliances – a combined limit of 1 per upper and 1 per lower prosthesis in a 2 year period

c) tissue conditioning – 2 per upper and 2 per lower prosthesis in a 5 year period
d) gold foil – only when used to repair existing gold restorations.

7) Surgical services
   a) extractions
   b) other routine oral surgical procedures
   c) anesthesia in conjunction with surgery shall not exceed the dollar limit shown in our Fee schedule.

Plan B – Major Restorative Services

You are eligible for Plan B services when your Dentist recommends replacement of your missing teeth, or reconstruction of your teeth (where basic restorative methods cannot be used satisfactorily).

Mounted x-rays and/or diagnostic casts may be required for our approval.

Plan B services include, but are not limited to, the following:

1) Prosthodontic Services
   a) removable
      i) complete upper and lower dentures
      ii) partial upper and lower dentures
   b) fixed bridges.

2) Restorative Services
   a) inlays or onlays involved in bridgework
   b) veneers
   c) crowns and related services.

3) Periodontal Appliances
   bruxing guards – 2 appliances in a 5 year period (no benefit is payable for the replacement of lost, broken, or stolen bruxing guards).

Limitations
1) Only 1 major restorative service involving the same tooth will be covered in a 5 year period.
2) Crowns and fixed bridges on permanent posterior (molar) teeth are limited to the cost of the gold restoration.

3) Only 1 upper and 1 lower denture (complete or partial) is eligible in a 5 year period.
4) No benefit is payable for the replacement of lost, broken, or stolen dentures. Broken dentures may be repaired under Plan A.
5) Veneers, crowns, bridges, inlays, and onlays are subject to the conditions outlined in our Fee schedule. Where other material would suffice, you will be responsible for the difference between the cost of the chosen material and the cost of alternative material.

Plan C – Orthodontics

Benefits are payable for orthodontic services performed after you have been enrolled under this Dental Plan for a 12 consecutive month period. Plan C covers orthodontic services provided to maintain, restore, or establish a functional alignment of the upper and lower teeth.

Limitations
1) The lifetime benefit maximum under Plan C is shown in the Schedule of Benefits.
2) No benefit is payable for the replacement of appliances which are lost or stolen.
3) Services done for the correction of temporomandibular joint (TMJ) dysfunction are not covered.
4) Treatment performed solely for splinting is not covered.

Emergency Treatment Outside Your Province/Territory of Residence

You are entitled to the services of a Dentist if, while travelling or on vacation outside your province/territory of residence, you require emergency dental care. You will be reimbursed according to our Fee schedule. This will not apply to the services of a dental hygienist.

Exclusions

The following are not Eligible expenses under your dental plan:
1) items not listed in our Fee schedule and fees in excess of those listed in the Fee schedule

2) charges for broken appointments, oral hygiene or nutritional instruction, completion of forms, written reports, communication costs, or charges for translating documents into English
3) procedures performed for congenital malformations or for purely cosmetic reasons
4) charges for drugs, pantographic tracings, and grafts
5) charges for implants and/or services performed in conjunction with implants, except as indicated in our Fee schedule
6) anesthesia not done in conjunction with surgery, and charges for facilities, equipment and supplies
7) charges for services related to the functioning or structure of the jaw, jaw muscles, or temporomandibular joint
8) incomplete or temporary procedures
9) recent duplication of services by the same or different Dentist
10) any extra procedure which would normally be included in the basic service performed
11) services or items which would not normally be provided, or for which no charge would be made, in the absence of dental benefits
12) any item not specifically included as a benefit
13) travel expenses incurred to obtain dental treatment.

Claims

1) Present your ID card to your Dentist's office. It is important to ask if your dental benefits will cover the entire cost of your treatment. To avoid any misunderstanding, we suggest that your Dentist submit an outline of the proposed services to us **before you start treatment.** This is important especially when your Dentist is recommending extensive dental work. This will help you understand what portion of the Dentist's bill must be paid by you in the event that you wish to proceed with the treatment recommended by your Dentist.
2) We suggest that you submit claims within **90 days** of the completed date of services (earlier if possible). Failure to submit a claim within the 90 day limit will not invalidate the claim if it is submitted as soon as reasonably possible. However, in no event will we pay any claim or adjustment received later than **12 months** from the date the service is performed.
3) We require a separate claim form for each member of your family who has received dental services. Be sure to include the following information on the claim form:
   a) name of the Dentist
   b) name and birthdate of the person receiving the dental care
   c) your policy and ID numbers (this information is on your ID card)
   d) your home mailing address

e) whether you have coverage through another plan. Claims information regarding the other carrier is not retained on our files. If you or your Dependents are covered by two plans, your Dentist must complete two separate dental claim forms (one for each plan). Incomplete claims will be returned for clarification.

4) Before your Dentist starts treatment, please ask them how billing is made. We may pay in either of two ways:
   a) If you have paid your Dentist directly, we will reimburse you the benefit amount when we receive:
      i) a claim form signed by the patient that is either submitted with a receipt or is signed by the dental Provider showing the services performed and the fee charged, or
      ii) an electronic claim showing the services performed and the fee charged. The dental Provider must have the consent of the patient on file to permit the disclosure of the patient's personal information between the Provider and Pacific Blue Cross.
   b) For pay direct claims, we will pay the benefit amount to the Dentist directly for services provided under this benefit plan when we receive:
      i) a claim form showing the services performed and the fee charged, signed by the patient and the dental Provider, or
      ii) an electronic claim showing the services performed and the fee charged. The dental Provider must have the consent of the patient on file to permit the disclosure of the patient's personal information between the Provider and Pacific Blue Cross.

5) Orthodontic Claims Procedures
   a) Receipts
      Please submit original receipts as photocopies are not accepted. Do not hold receipts until the completion of treatment.
   b) Claiming deadlines
      i) We suggest that you submit orthodontic claims within **90 days** of the date the payment was due to your orthodontist (the due date).
      ii) Reimbursement is made if the complete and correct claims information is received within 12 months of the due date. However, no benefit is payable for claims not received within **12 months** of the due date.
   c) Treatment plan
      i) Have your orthodontist complete the "Certified Specialist in Orthodontics Standard Information Form" (the treatment plan) before treatment starts. The treatment plan must include a brief description of treatment to be performed, a breakdown of the fees to be charged, and the estimated length of treatment.
      ii) If the payment schedule or treatment changes, we require a revised treatment plan for review.

iii) We will retain your treatment plan on file. If we do not have your treatment plan on file we are unable to pay:
- your initial fee/down payment
- your monthly/quarterly fees
- one time appliance fees

iv) Claims for consultations, exams and records (x-rays, study models, etc.) will be reimbursed without a treatment plan on file.

d) Monthly or quarterly fees

i) If you are paying in monthly or quarterly installments, submit receipts for the monthly or quarterly fees on a regular basis – as treatment progresses. Claims receipts received by us which are over 12 months old will not be reimbursed.

ii) If you paid any amount to the Dentist before treatment is complete, we will allow an initial payment amount and then prorate the balance into monthly payments to you throughout the treatment plan period.

iii) As long as your coverage is effective, monthly or quarterly reimbursements will be made to you until the dollar maximum is reached or the treatment is complete, whichever occurs first.

DFS

This section includes a description of the benefits underwritten by DFS.

Group Number:

DFS 647236

General Information

Definitions

Wherever used in this policy:

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

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

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

Child means a person who:

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

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

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

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

Earnings mean the regular rate of pay of an Employee paid by the Employer, including dividends. Additional income earned on a regular, formal basis from tips, bonuses and overtime will be included.

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

Employee means a person who is domiciled in Canada and who is employed by the Employer on a permanent full-time basis for not less than the number of hours specified in the Benefit Schedule. However, if an Employee is domiciled outside Canada, such Employee may be deemed to be domiciled in Canada provided prior written approval is obtained from the Insurer.

Employer means any companies listed on the application of the Policyholder for this policy or specified in the Benefit Schedule.

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

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

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

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

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

Insurer means Desjardins Financial Security Life Assurance Company.

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

Parental Leave means any leave of absence from work taken by a Participant to take care of his newborn or adopted child, in

accordance with such provincial or federal labour standards legislation, or an agreement between the Participant and the Employer.

Participant means an Employee who is insured under this policy.

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

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

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

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

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

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

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

Eligibility

Employee Eligibility

An Employee is eligible for insurance:

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

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

Insurance Application

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

Evidence of Insurability

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

Commencement of Insurance and Waiver of Premium

Commencement of Participant Insurance

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

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

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

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

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

Change of Insurance

Any increase or decrease in the amount of insurance or any change in Benefit will become effective on the later of the following dates, provided the Participant is Actively At Work on such date:

1) the date on which the Participant first becomes eligible for such change provided written request for change is received by the Insurer on or before that date,
2) the date on which the insurability of the Participant is approved by the Insurer,

a) if the increase in the amount of insurance requested exceeds the maximum amount that the Insurer will provide without evidence of insurability, as specified in the Benefit Schedule, or
b) if the request for change is received more than 31 days after the date of his eligibility for such change.

If a Participant is not Actively At Work on the date his insurance would have otherwise changed, such insurance will change on the first day he is subsequently Actively At Work.

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

Waiver of Premium

1) For the Benefits listed in the WAIVER OF PREMIUM provision in the BENEFIT SCHEDULE, as of the Beginning of Waiver of Premium mentioned in the WAIVER OF PREMIUM provision in the BENEFIT SCHEDULE, premiums will be waived for a Participant who becomes Totally Disabled while insured under this policy but prior to attaining Age 65, if he submits Proof of Claim satisfactory to the Insurer. Premiums will continue to be waived for as long as the Total Disability persists. For the purpose of this provision, premiums will cease to be waived on the earliest of the following dates:
   a) the date on which the Participant is unable or unwilling to provide satisfactory proof of Total Disability to the Insurer, if such proof is not provided within 3 months of the request,
   b) the date on which the Participant ceases to be Totally Disabled,
   c) for the Life Insurance Benefit, the date on which the Participant converts his insurance under the CONVERSION PRIVILEGE provision,
   d) the date on which the Participant attains Age 65 or retires, if earlier,
   e) in respect of each of the Benefits listed in the WAIVER OF PREMIUM provision in the BENEFIT SCHEDULE, the date on which each Benefit or this policy terminates except for the Basic Participant Life Insurance Benefit.
2) Under this policy, any provision for an increase in coverage is suspended during a Total Disability.
3) A recurrence of Total Disability within 6 months after the termination of a previous period of Total Disability for which premiums have been waived under this policy shall be deemed a continuation of the previous period if due to the same or related causes.

4) In the case of the Life Insurance Benefit, if a Totally Disabled Participant dies more than 31 days after his insurance terminates, prior to attaining Age 65, and written notice and proof of Total Disability has not been received by the Insurer, the amount of Life Insurance applicable to such Participant in accordance with the Benefit Schedule that was in effect at the time his insurance terminated will be payable provided that
   a) the Participant became Totally Disabled while insured under this Benefit,
   b) the Total Disability of the Participant was uninterrupted from the onset of his Total Disability to the date of his death,
   c) the Participant dies within 12 months from the onset of his Total Disability,
   d) the Participant did not convert any or all of his insurance under the CONVERSION PRIVILEGE provision at the time his insurance terminated, and
   e) satisfactory proof of the Total Disability and death of the Participant is received by the Insurer within 90 days of his death.

5) To be eligible for WAIVER OF PREMIUM, the Insurer must receive written notice of Total Disability within 12 months of the date the Participant becomes Totally Disabled, and proof satisfactory to the Insurer of Total Disability within 90 days following the date the Insurer received written notice.

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

Termination of Insurance

Termination of Participant Insurance

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

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

Continuation of Insurance

1) **Temporary Lay-Off or Leave of Absence**
   A Participant who ceases to be Actively At Work due to a temporary lay-off or leave of absence may remain insured for all benefits held immediately prior to the beginning of the lay-off or leave for any pre-determined period as long as premiums continue to be remitted. However, the insurance will not be continued beyond the period indicated in the Benefit Schedule. The Insurer must be informed of the scheduled date of return to work before the beginning of the leave.

   If the Participant decides not to continue his coverage during lay-off or leave, the benefits the Participant held immediately prior to the beginning of such lay-off or leave will be reinstated, without evidence of insurability, as of the date on which the Participant is once again Actively At Work, provided the Insurer is advised within 31 days following the return to work of the Participant; otherwise, evidence of insurability will be required.

2) **Maternity, Parental or Family-Related absences and leaves**
   A Participant who ceases to be Actively At Work due to a Maternity, Parental or Family-Related Leave, in accordance with provincial or federal legislation, may continue his coverage during the absence or leave for all benefits held immediately prior to the beginning of such

absence or leave. He must inform the Insurer of his choice before the beginning of the absence or leave. If the Participant decides to continue his coverage during the absence or leave, he must keep either all benefits, or all benefits with the exception of the Weekly Indemnity Benefit and Long Term Disability Benefit, if included in this policy, held immediately prior to the beginning of the absence or leave, for the entire duration of his absence or leave, as long as premiums continue to be remitted. The Insurer must be informed of the scheduled date of return to work before the beginning of the leave. The insurance may not be continued beyond a maximum 12 month period, unless provincial or federal legislation permits a longer period.

If the Participant decides not to continue his coverage during the absence or leave, the benefits the Participant held immediately prior to the beginning of such absence or leave will be reinstated, without evidence of insurability, as of the date on which the Participant is once again Actively At Work, provided the Insurer is advised within 31 days following the return to work of the Participant; otherwise, evidence of insurability will be required.

3) **Strike or Lock-out**
Insurance for a Participant who ceases to be Actively At Work due to a strike or lock-out terminates on the date the strike or lock-out begins.

Legal Obligation in the Event of Termination of Insurance

If federal or provincial legislation requires the Employer or the Policyholder to continue the insurance of a Participant beyond the date it would have otherwise terminated and the required premiums are paid, insurance will be continued to the end of the period required by law but not beyond the date this policy terminates.

.

Group Term Life

Definitions

As used in this Benefit

Total Disability or Totally Disabled means

1) during the Elimination Period provided for in the Long Term Disability Benefit and the succeeding 24 months

   a state of incapacity, resulting from an Illness or Accident, which wholly prevents the Participant from performing each and every essential duty of his regular occupation;

2) after the Elimination Period and the succeeding 24 months have elapsed

   a state of incapacity, resulting from an Illness or Accident, which wholly prevents the Participant from working in any occupation for which he is suited by education, Training and Experience.

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

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

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

Evidence of Insurability

Evidence of insurability satisfactory to the Insurer will be required of a Participant applying for any amount of Term Life Insurance in excess of the amount specified in the Benefit Schedule as the No Evidence Limit under the Term Life Insurance Benefit.

Payment of Benefit

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

Living Benefit

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

1) A Totally Disabled Participant may be required to be examined by a Physician designated by the Insurer;
2) A Totally Disabled Participant must qualify for approval for the Waiver of Premium under the Term Life Insurance Benefit of this policy;
3) Any individual having an interest in the insurance money must sign a consent to such payment on a form provided by the Insurer.

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

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

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

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

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

Living Benefit Exclusion

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

Benefit Termination

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

Conversion Privilege

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

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

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

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

1) The Participant must submit written application for conversion to the Insurer and must pay the first premium within 31 days of the termination of his insurance under this Benefit;
2) The individual policy may be insurance for a non-convertible Term to Age 65, insurance for a non-renewable 1-Year Convertible Term or any regular permanent plan issued by the Insurer at the date of conversion, excluding special permanent plans as may be designated by the Insurer from time to time. The individual policy will not include any special

benefit provisions for which an extra premium is charged and will not be a plan under which the amount of insurance may or will increase in the future; at least one permanent plan will be available for conversion at all times. A Dividend Option under which dividends are used to obtain additional insurance may be elected at the time of conversion, if permitted by the Insurer;

3) In the event the individual policy selected is insurance for a non-renewable 1-Year Convertible Term, the Participant may elect to pay a single premium or quarterly premiums. This policy can be converted to one of the plans described above, but cannot be converted to insurance for another 1-Year Convertible Term;
4) The individual policy issued will conform to the conditions, terms, and amounts of individual insurance plans regularly used by the Insurer at the date of conversion;
5) The individual policy premium will be based on the rate used by the Insurer on the effective date of that policy and that is applicable to the plan and the amount of the policy issued, the Age of the Participant at nearest birthday and the class of risk to which he belongs;
6) If the amount of Life Insurance that may be converted is less than the minimum amount for which the Insurer will then normally issue the selected plan, the individual policy must be for the full amount that the Participant may convert;
7) The individual policy will not take effect prior to the end of the 31 day period immediately following the date of termination of insurance of the Participant under this Benefit.

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

Extension of Benefit After Termination

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

Notice and Proof of Claim

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

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

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

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

Chubb Life

This section includes a description of the benefits underwritten by Chubb Life Insurance Company of Canada.

Group Number:

Chubb Life.....CC50058301

Basic Accidental Death & Dismemberment

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

Eligibility

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

Benefit Amount

An amount equal to the amount payable under your current group term life insurance.
Benefit reduces at 50% at age 65 and terminates at age 70 or earlier retirement.
In the event of your death, the benefit amount is payable to the beneficiary you have named under your Group Life Insurance Plan or in the absence of such designation, to your Estate.

Benefits payable under the following section will be limited to only one (1) policy in the event the benefits are contained in two (2) or more policies issued to the Policyholder by CHUBB *(not applicable to the Schedule of Losses, Exposure and Disappearance and Conversion).*

Schedule of Losses

Accidental Death & Dismemberment
If such injuries shall result in any one of the following specific losses within 1 year from the date of the accident, CHUBB will pay the percentage of the benefit amount, based on the amount stated under the benefit amount section, however, that not more than one (the largest) of such benefits shall be paid with respect to injuries resulting from one accident.

	Percentage of Benefit Amount
Loss of Life	100%
Loss of Entire Sight of Both Eyes	100%
Loss of One Hand and One Foot	100%
Loss of Use of One Hand and One Foot	100%
Loss of One Hand and Entire Sight of One Eye	100%
Loss of One Foot and Entire Sight of One Eye	100%
Loss of Speech and Hearing in Both Ears	100%
Brain Death	100%
Loss of Both Arms, Both Hands, Both Legs or Both Feet	200%
Loss of Use of Both Arms, Both Hands, Both Legs or Both Feet	200%
Quadriplegia	200%
Paraplegia	200%
Hemiplegia	200%
Loss of One Arm or One Leg	75%
Loss of Use of One Arm or One Leg	75%
Loss of One Hand or One Foot	75%
Loss of Use of One Hand or One Foot	75%
Loss of Entire Sight of One Eye	75%
Loss of Speech or Hearing in Both Ears	75%
Loss of Thumb and Index Finger of Same Hand	33 1/3%
Loss of Use of Thumb and Index Finger of Same Hand	33 1/3%
Loss of Four Fingers of Same Hand	33 1/3%
Loss of Hearing in One Ear	33 1/3%
Loss of All Toes of Same Foot	25%

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

CHUBB will pay the amount specified in the Schedule of Losses even if the severed limb is surgically reattached, whether successful or not.

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

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

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

Quadriplegia, Paraplegia, Hemiplegia and Loss of Use losses are subject to an all policies combined maximum Benefit Amount of $1,000,000.

Repatriation Benefit

When injuries result in loss of life of an Insured Person outside 150 kilometers from their city of permanent residence or outside Canada and the loss of life occurs within 365 days from the date of the accident, CHUBB will pay the actual expense incurred for preparing the deceased for burial and shipment of the body to the city of residence of the deceased, but not to exceed $15,000.

Rehabilitation Benefit

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

a. such training is required because of such injuries and in order for an Insured Employee to become qualified to engage in an occupation in which he or she would not have been engaged except for such injuries;
b. expenses are to be incurred within 2 years from the date of the accident;
c. no payment will be made for ordinary living, travelling, or clothing expenses.

Family Transportation Benefit

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

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

Spousal Occupational Training Benefit

When injuries result in a payment being made by CHUBB under the Loss of Life Benefit, CHUBB will pay in addition the expenses actually incurred, within 365 days from the date of the accident, by the spouse of an Insured Employee for a formal occupation training program for the purpose of specifically qualifying such spouse to gain active employment in an occupation for which the spouse would otherwise not have sufficient qualifications. The maximum payable hereunder is $15,000.

Home Alteration and Vehicle Modification Benefit

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

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

Benefit payments herein will not be paid unless:

(i) home alterations are made by a person or persons experienced in such alterations and recommended by a recognized organization, providing support and assistance to wheelchair users; and

(ii) vehicle modifications are carried out by a person or persons with experience in such matters and modifications are approved by the Provincial vehicle licensing authorities.

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

Day Care Benefit

If an Insured Person suffers a loss of life in a covered accident while the policy is in force, CHUBB will pay, in addition to all other benefits payable under the policy a Day Care Benefit equal to the reasonable and necessary expenses actually incurred, subject to the lesser of 5% of an Insured Person's Principal Sum amount or a maximum of $5,000 per year, on behalf of any dependent child who is enrolled in a legally licensed day care centre on the date of the accident or who enrolls in a legally licensed day care centre within 365 days following the date of the accident.

The "Day Care Benefit" will be paid each year for 4 consecutive years, but only upon receipt of satisfactory proof that a child is enrolled in a legally licensed day care centre.

"Dependent Child" means the Employee's eligible unmarried natural, legitimate, illegitimate, adopted, step child or common law child who is principally dependent on the Employee or the Employee's spouse for financial support

Special Education Benefit

If an Insured Person suffers a loss of life in a covered accident while the policy is in force, CHUBB will pay, in addition to all other benefits payable under the policy, a Special Education Benefit up to 5% of an Insured Person's Principal Sum amount, (subject to a maximum of $5,000 per year), on behalf of any dependent child who, on the date of the accident, is enrolled as a full-time student in any post-secondary institution of higher learning or was at the 12th grade level and subsequently enrolls as a full-time student in any post-secondary institution of higher learning within 365 days following the date of the accident.

The "Special Education Benefit" is payable annually for a maximum of 4 consecutive annual payments but only if the dependent child continues his or her education as a full-time student in an institution of higher learning.

Bereavement Benefit

When injuries covered by the policy result in loss of life of an Insured Person within 365 days from the date of the accident, CHUBB will pay the reasonable and necessary expenses actually incurred by the spouse and dependent children of an Insured Person for up to 6 sessions of grief counseling, by a "Professional Counsellor", subject to a maximum of $1,000.
"Professional Counsellor" means a therapist or counsellor who is licensed, registered or certified to provide such treatment.

In-Hospital Confinement Monthly Income Benefit

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

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

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

Cosmetic Disfigurement Benefit

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

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

In the event of a 50% surface burn, the % of benefit is reduced by 50%. This table only represents the maximum percent of the Principal Sum payable for any one accident. If the Insured suffers burns in more than one area as a result of any one accident, benefits will not exceed a maximum of $25,000.

Seat Belt Benefit

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

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

Identification Benefit

In the event accidental loss of life is sustained by an Insured Person not less than 150 kilometers from an Insured Person's normal place of residence and identification of the body by an "Immediate Family Member" has been requested by the police or a similar governmental authority, CHUBB will reimburse the reasonable expenses actually incurred by such member for:

a) transportation by the most direct route to the city or town where the body is located; and
b) hotel accommodation in such city or town, subject to a maximum duration of 3 days.

The reimbursement of such expenses incurred is subject to the accidental Loss of Life benefit being subsequently payable in accordance with the terms of the policy following the identification of the body as an Insured Person. The maximum amount payable will not exceed $15,000 for all such expenses.

Payment will not be made for board or other ordinary living, travelling or clothing expenses, and transportation must occur in a vehicle or device operated under a license for the conveyance of passengers for hire.

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

Critical Disease Benefit

If an Insured Person, prior to age 65, is diagnosed by a Specialist with a Covered Disease while the policy is in force and is Totally Disabled from the Covered Disease for at least nine months following the Date of Diagnosis, CHUBB will pay 10% of the Principal Sum up to a maximum of $40,000. This benefit is payable only if investigations leading to the diagnosis of a Covered Disease is initiated more than 90 days following the effective date of insurance with respect to an Insured Person. Payment of the Critical Disease Benefit is limited to only the first Covered Disease to occur.

Covered Disease
Whenever used in the policy means Poliomyelitis, Parkinson's Disease, Huntington's Chorea, Multiple Sclerosis, Alzheimer's Disease, Type 1 Diabetes (Insulin Dependent), Amyotrophic Lateral Sclerosis (ALS), Peripheral Vascular Disease and Necrotizing Fasciitis.

Conversion Privilege

On the date of termination of employment or during the 31-day period following termination of employment, an Insured Person may convert his or her insurance to an individual ACCIDENTAL DEATH and DISMEMBERMENT only insurance policy (excluding the Critical Illness Rider) of CHUBB. The individual policy will be effective either as of the date that the application is received by CHUBB or on the date that coverage under the group policy ceases, whichever occurs later. The premium will be the same, as a person would ordinarily pay when applying for an individual policy at that time. Application for an individual policy may be made at any office of CHUBB. The amount of insurance benefit converted shall not exceed that amount issued during employment up to an all policies combined maximum of $200,000. The individual policy will cover ACCIDENTAL DEATH and DISMEMBERMENT only.

Waiver of Premium

If an Insured Employee, under age 65, becomes totally disabled for 6 consecutive months and an Insured Employee provides evidence of total disability satisfactory to CHUBB, CHUBB will then waive the payment of each premium which falls due with respect to an Insured Employee and any Insured Dependents. Subject to all the terms and conditions of the policy, waiver of any premium as herein provided will continue with respect to an Insured Employee until age 65 or earlier termination of the policy. If an Insured Employee ceases to be disabled and an Insured Employee returns to employment with the Policyholder and is a member of an eligible class, insurance with respect to an Insured Employee may be continued upon resumption of premium payments by an Insured Employee or the Policyholder.

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

Recurrent Disabilities
When an Insured Employee becomes totally disabled again from the same or related causes within 6 months of cessation of the Waiver of Premiums, then all such recurrences will be considered a continuation of the same disability and CHUBB will waive the 6 month qualification period.

If the same disability recurs more than 6 months after cessation of the Waiver of Premiums, such disability will be considered a separate disability. Two disabilities which are due to unrelated causes are considered separate disabilities if they were separated by a return to work of at least one 1 day.

Termination of Waiver of Premium
Waiver of Premiums will cease on the earliest of:

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

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

"Totally Disabled or Total Disability" with respect to Waiver of Premium means disability resulting from injury or sickness which prevents engagement in an Insured Person's regular occupation for 6 consecutive months.

Continuance of Coverage

If an Insured Employee is: (1) laid off on a temporary basis; (2) temporarily absent from work due to short-term disability; (3) on leave of absence; or (4) on maternity leave, coverage shall be extended for 12 months, subject to the payment of premiums. If an Insured Employee assumes other occupational duties during the leave or lay-off period, no benefits shall be payable for a loss occurring during the performance of such other occupation.

Exposure and Disappearance

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

If the body of an Insured Person has not been found within 1 year of disappearance, stranding, sinking or wrecking of the conveyance in which an Insured Person was riding at the time of the accident, it shall be presumed, subject to all other conditions of the policy, that an Insured Person suffered a loss of life resulting from bodily injuries sustained in the accident covered under the policy.

Exclusions

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

1. intentionally self-inflicted injuries, suicide or any attempt thereat, while sane or insane;
2. declared or undeclared war or any act thereof;
3. travel or flying in an aircraft owned or leased by the Policyholder, an Insured Person or a member of an Insured Person's household, or

aircraft being used for any test or experimental purpose, firefighting, power line inspection, pipeline inspection, aerial photography or exploration;

4. losses occurring while an Insured Person is serving on full-time active duty in the Armed Forces of any country or international authority (any premium paid to be returned by CHUBB pro-rata for any such period of full-time active duty);
5. travel or flight in any vehicle or device for aerial navigation; except to the extent such travel or flight is provided in the "Hazards Insured Against" section of the Accidental Death & Dismemberment portion of the policy.

Cancer Critical Illness Benefit

If, while coverage is in effect but only after coverage has been in effect on an Insured Person for a period of 90 days, an Insured Person is then diagnosed with Cancer and an Insured person survives for a period of 30 days thereafter and is under age 65, CHUBB will pay 5% of the Principal Sum up to a maximum of $10,000.
CHUBB shall only be obligated to pay the Cancer Critical Illness Benefit once.

30 Day Survival
If, while coverage is in effect, an Insured Person suffers a Cancer and an Insured Person survives for a period of 30 days thereafter, CHUBB will pay the benefit amount as outlined above.

Pre-Existing Medical Conditions Provision: means a sickness suffered from or injury sustained by an Insured Person for which he or she sought or received medical advice, consultation, investigation, diagnosis, or for which treatment was required or recommended by a physician during the 24 months immediately prior to the Insured Person's effective date of insurance or any increased amount of insurance, in which directly or indirectly causes the condition to occur within the first 24 months from the Insured Person's effective date of insurance or any increased amount of insurance. (Except for increases caused by annual salary changes.)

Definition
Cancer: means a malignant tumor characterized by the uncontrolled growth and spread of malignant cells and invasion of tissue. This includes Leukemia, Hodgkin's Disease and invasive melanoma but does not include:

- Carcinoma in situ
- Kaposi's Sarcoma or other AIDS related cancers and cancer in the presence of Human Immunodeficiency Virus (HIV)

- Skin cancer or melanoma that is not invasive and has not exceeded .75 millimeters in depth
- Prostate cancer diagnosed as TI N0 M0 or equivalent staging
- a recurrence or metastasis of a cancer which was originally diagnosed prior to the effective date of coverage

A Physician certified as an Oncologist must confirm diagnosis in writing.

90 Day Cancer Exclusion

The Cancer exclusion period is 90 days from the later of:

a) the Effective Date, or;
b) the date of the last reinstatement of the policy.

Within this exclusion period, there shall be no coverage for cancer if a diagnosis of any type of cancer, whether included or excluded under the policy, is made or if any symptoms or medical problems manifest themselves which, or the persistence or recurrence of which, subsequently results in an investigation leading to the diagnosis of cancer. In the event of any such diagnosis the policy will remain in force but cancer will no longer be considered an Insured Condition, except for a subsequent diagnosis of an unrelated cancer.

Cancer Critical Illness Benefit Exclusions

1. for injury or sickness, other than the covered illness;
2. a complication of Human Immunodeficiency Virus (HIV) infection or any variance thereof including AIDS and AIDS Related Complex;
3. the use, existence or escape of nuclear weapons, material or ionizing radiation from or contamination by radioactivity from any nuclear fuel or waste from the combustion of nuclear fuel;
4. intentionally self-inflicted injury, suicide or any attempt thereat, while sane or insane;
5. declared or undeclared war or any act thereof;
6. the commission or attempted commission by an Insured Person of any act which if adjudicated by a court would be an illegal act under the laws of the jurisdiction where the act was committed;
7. misuse of medication or the abuse of drugs or intoxicants;
8. any Pre-Existing Medical Condition, except where coverage has been in effect for a period of 24 consecutive months following an Insured Person's effective date of coverage.

How To Claim

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

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

Failure to give notice of claim or furnish proof of claim within the time prescribed in the policy condition will not invalidate the claim if the notice or proof is given or furnished as soon as reasonably possible and if it is shown that it was not reasonably possible to give notice or furnish proof within the time so prescribed. In no event, will CHUBB accept notice of claim beyond one (1) year.

General Provisions

Beneficiary
An employee or any spouse has the right to name a beneficiary when he applies for insurance.

It is understood that the beneficiary designation made under the Policyholder's Group Life Insurance Policy shall be recognized as the beneficiary under the policy, unless a further designation has been made that specifically identifies the policy. Failing such designation, all benefits will be paid to the estate of the insured person.

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

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

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

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

Legal Actions
No action at law or in equity shall be brought to recover on the policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with requirements of the policy. For residents of Alberta and British Columbia: 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 residents of Manitoba: 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 residents of Ontario: 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 Limitations Act, 2002. Otherwise, every action must be brought within one year from the date of loss or such longer period as may be required under the law applicable in the insured person's province of residence.

Change of Insurer
An insured person under a former policy may not be excluded from the new policy or be denied benefits solely because of a pre-existing condition limitation that was not applicable or that did not exist in the former policy, or because the person is not at work on the date of coming into force of the new policy.

The insured person and any claimant under the policy has the right, as determined by law applicable in the insured person's province of residence, to obtain a copy of his/her application, any written evidence of insurability (as applicable) and the Policy, on request, subject to certain access limitations.

Effective Date: July 2014

ACCLAIM Ability Management Inc.

This section includes a description of the benefits underwritten by ACCLAIM.

Group Number:
ACCLAIM 23654

Early Intervention Program

The Early Intervention Program (EIP) is a collaborative and consensus-based program that is included in collective agreements to assist employees who are ill or injured return to work in an early and safe manner.

The Early Intervention Program (EIP) will help assist employees off work due to work related injuries (WCB) and non-related work injuries.

Once a referral is received by the independent service provider, ACCLAIM Ability Management Inc., ACCLAIM's Early Intervention Coordinator (EIC) will contact the employee to discuss the EIP and determine how the program can help. After receiving medical documentation, the EIC will review the information and consult with the members of the employee's EIP team who include the employee and their employer, union, physician and/or health care team, and the EIC. This team works together collaboratively to design a customized and individualized return to work plan for the employee based on their medical condition, the requirements of their job, abilities and employer's ability to accommodate any applicable limitations. Only capabilities and limitations with respect to performing the employee's job tasks or alternative work is shared.

Once the return to work plan is implemented, the EIC will monitor the progress and make adjustments to the plan as needed to ensure that the employee's return to work is successful.

ACCLAIM
Ability Management Inc.

Federation Association Benefit Plan Broker

Schmunk, Gatt, Smith & Associates

Suite 204 - 20334, 56th Ave., Langley, BC V3A 3Y7
Phone: (604) 533-9813 Fax: (604) 533-9814

www.schmunkgattsmith.com

Federation Association Benefit Plan Administrator

Benefit by Design (BBD) Inc.

#500 - 2755 Lougheed Highway, Port Coquitlam, BC, V3B 5Y9
Phone: (604) 464-0313 Fax: (604) 464-7997
Toll Free Service
Phone: 1-800-668-2295 Fax: 1-800-667-1336

www.bbd.ca

Notes