Your group insurance plan

UNITY HEALTH TORONTO

Policy No. 541254

CUPE Clerical Full-time Permanent Employees of Unity Health

Desjardins Insurance
Life • Health • Retirement

Your Group Insurance Plan

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This document is an integral part of the Insurance certificate. It is a summary of your Group Insurance Policy effective July 1, 2021. Only the Group Insurance Policy may be used to settle legal matters.

This electronic version of the booklet has been updated on November 1, 2022. Please be advised that this electronic version is updated more frequently than the printed copy of your booklet. Therefore, there may be discrepancies between the paper and electronic copies.

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CONTACT US

HEALTH AND DENTAL INQUIRIES

There are 2 ways to reach us for any question about Eligible Expenses under the Extended Health Care Benefit or the Dental Care Benefit:

By e-mail at: Groupservice@dfs.ca

By phone at: 1 877 324-5041

For a better experience, it is important to have the policy number and the certificate number ready when an agent is available to take the call.

HEALTH ASSISTANCE

Health Assistance is a confidential telephone service that is available 24 hours a day. This enables the Covered Person to speak with experienced health care professionals and to obtain information immediately.

This telephone service provides the Covered Person with information on the following topics:

- health
- immunization
- nutrition
- lifestyle
- physical fitness
- child care
- availability of local resources

Health Assistance should be considered as a complement to medical consultations and emergency medical services (911 or other); it is not intended to replace the Covered Person's regular health care provider, nor the emergency medical services of a municipality.

This information service may be of use in improving the quality of life of the Participant and of his Dependents.

The Covered Person may contact HEALTH ASSISTANCE at any time.

Calls from	**Dial**
Anywhere in Canada	1 877 875-2632

TRAVEL ASSISTANCE SERVICE

"Travel Assistance" will take the necessary steps to provide the following services to any Covered Person who requires them:

1) 24 hour toll-free telephone assistance,

2) referral to Physicians or health-care facilities,

3) assistance for Hospital admission,

4) cash advances to the Hospital when required by the facility,

5) repatriation of the Covered Person to his home city, as soon as his state of health permits it,

6) establishing and staying in contact with DFS,

7) handling arrangements in the event of death,

8) repatriation of the Children of the Covered Person, if the Covered Person cannot be moved,

9) delivery of medical assistance and drugs to a Covered Person who is too far from health care facilities to be transported there,

10) arrangements to bring a member of the Immediate Family to the bedside of the Covered Person if he must be confined to Hospital for at least 7 days, provided that such visit is ordered by the attending Physician,

11) assistance in replacing lost or stolen travel documents so that the Covered Person can continue his trip,

12) referral to lawyers if legal problems arise,

13) translation services for emergency calls,

14) transmission of urgent messages to close friends or family in case of emergency, or

15) information prior to departure concerning passports, visas and vaccinations required in the country of destination.

In the event of a **MEDICAL EMERGENCY**, the Covered Person must contact the travel assistance firm immediately.

Calls from	**Dial**
Montreal area	(514) 875-9170
Canada and United States	1-800-465-6390 (toll-free)
Elsewhere (excluding North and South America)	overseas code + 800 29485399 (toll-free)
Collect call (Anywhere worldwide)	(514) 875-9170

GENERAL INQUIRIES

To obtain any other information, visit the “Contact us” section of DFS’s website at **www.desjardinslifeinsurance.com**.

YOU SHOULD KNOW

WHAT HAPPENS WITH THE DRUGS COVERAGE AT AGE 65?

At 65 years of age, the Participant is covered under the provincial health plan of his province of residence for drugs and other products included in this plan's list.

Where allowed by law, he may opt out of his provincial health plan and remain covered under the Extended Health Care benefit of the group benefit plan. If so, the Participant must notify DFS of his choice, in writing, within 31 days of his 65th birthday:

- continue coverage under the group benefit plan and the required premium will be determined by DFS,

  or

- choose his provincial health care plan. He will then no longer be covered for drugs and other products on his provincial health plan's list. This election is irrevocable.

IMPORTANT: Dependents cannot continue their coverage under the Extended Health Care Benefit unless the Participant remains covered.

TRAVELS ABROAD

The Participant must contact DFS if the duration of the trip is expected to be more than 180 days. Failing to do so can lead to the person travelling not being covered.

ACCESS TO THE POLICY

Upon request to DFS, the Participant may obtain a copy of the policy and, if applicable, his application and his insurability report.

HOW TO FILE A COMPLAINT

If a Participant is unhappy about something we've said or done, feels they've been wronged or wants us to take corrective action he can file a complaint with the Dispute Resolution Officer at DFS. The role of the Officer is to evaluate the merit of the decisions and practices of the company when one of its customers believes he has not received the service to which he was entitled.

There are 3 ways to reach the Dispute Resolution Officer

In writing, at the following address:

Dispute Resolution Officer

Desjardins Financial Security

200, rue des Commandeurs

Lévis (Québec) G6V 6R2

By e-mail at: disputeofficer@dfs.ca

By phone at: 1 877 838-8185

For further information on the procedure to follow in case of complaint, or to obtain the complaint form, visit the "Contact us" section of DFS's website at **www.desjardinslifeinsurance.com**.

DEFINITIONS

Wherever these terms are used in the policy, they are interpreted in agreement with the following. They apply to the entire policy unless otherwise specified.

Accident

A sudden and unexpected external event causing bodily injuries directly and independently of all other causes. An Accident does not include any form of disease, degenerative process, hernia (inguinal, femoral, umbilical or incisional) and any infection except when caused by a visible, external cut or wound accidentally sustained. A Physician must verify the bodily injuries.

Actively at Work

The performance by the Employee of all the usual and customary duties of his occupation for the scheduled number of hours. An Employee is considered Actively at Work during a paid leave or a statutory holiday.

Child

A person residing in Canada who, at the time of the event that results in a claim, has no spouse and is dependent upon the Member or the Member's Spouse for financial support and maintenance. A Child must be the Member’s or the Spouse's natural or adopted child, and:

1) be under 21 years of age,

2) be under 25 years of age and a full-time student at an accredited educational institution, or

3) have reached the age of majority and be incapacitated due to a mental or physical disability on the date he was eligible as either 1) or 2) above.

The Child is considered incapacitated if he is incapable of engaging in any substantially gainful activity and is dependent upon the Member or the Member's Spouse for financial support and maintenance due to a mental or physical disability. In addition, he must be living with the Member or the Spouse who exercises parental authority or have legal guardianship as if the Child were a minor.

Chronic Care Establishment

An institution in Canada designated as such by law and recognized by DFS, and which:

1) provides care and treatment to the chronically ill under the supervision of a Physician,

2) provides the services of a registered nurse on-site and on duty 24 hours per day, and

3) maintains daily records of each patient under the care of a Physician.

Without limitation, this term does not include an active treatment Hospital as designated by law, rest home, Convalescent or Rehabilitation Centre, home for the aged, sanatorium or a place for the care and treatment of alcoholism, drug addiction or any other dependency.

Continuing Medical Care

The treatment a Member receives. It must be:

1) accepted by the medical profession as an effective, appropriate and essential treatment in the diagnosis or care of the specific Illness or injury,

2) reasonable, considered as standard practice, and

3) provided or prescribed by a Physician or, when DFS deems necessary, by a specialist in the appropriate field.

This is not limited to examinations and tests and must be provided at the frequency required for the specific Illness or injury.

Continuous Service

A period of unbroken employment with a Participating Employer from the date of employment plus any additional eligible service as a result of a transfer from another Participating Employer. This period includes:

1) vacation days and holidays granted by Participating Employers,

2) approved leaves of absence,

3) temporary lay-offs,

4) interruptions of service approved by DFS.

Convalescent/Rehabilitation Centre

An institution in Canada designated as such by law and recognized by DFS, and which:

1) provides care and treatment to patients under the supervision of a Physician or a registered nurse,

2) provides the services of a registered nurse on site and on duty 24 hours per day, and

3) maintains a daily record of each patient under the care of a Physician.

Without limitation, this term does not include a home for the aged, chronically ill, mentally ill, rest home or a place for the care and treatment of alcoholism, drug addiction or any other dependency.

Covered Person

The Member or their Dependent.

Day surgery

Outpatient surgery that allows an individual to return home on the same day as the surgical procedure is performed by a Physician. The procedure must require local or general anaesthesia. This does not include minor surgery performed in the office of a Physician.

Deductible

The amount of eligible expenses that a Covered Person must pay before reimbursement is made.

Dentist

A person licensed to practice dentistry by the appropriate authority in the jurisdiction where the services are provided.

Dependent

A Spouse or Child who resides in Canada. However, if a Dependent resides outside Canada he will be deemed to reside in Canada provided he is covered under a provincial medical plan and prior written approval is obtained from DFS.

Earnings

The regular rate of pay paid by the Participating Employer. Regular bonuses, regular overtime pay and regular incentive pay are excluded.

Elements (forces of nature)

Natural disasters such as an earthquake, storm, flood, landslide or any other disaster of a similar nature.

Employee

A person residing in Canada and employed by the Participating Employer on a full-time basis, as defined by the Participating Employer.

Equivalent Drug

A brand or generic drug, deemed interchangeable under the provincial law applicable where the drug is sold.

Evidence of Insurability

Any statement of an individual's physical health or other factual information that could have a bearing on the acceptance of the risk. Only Evidence of Insurability forms approved for use by DFS are acceptable.

Hemiplegia

The total and irrecoverable paralysis of upper and lower limbs on the same side of the body.

Hospital

Any institution designated as a Hospital by law, recognized by DFS and providing 24 hours per day:

1) medical and surgical treatment for sick or injured individuals, and

2) nursing care.

Without limitation, this term does not include a nursing home, home for the aged or chronically ill, a rest home, Convalescent/rehabilitation Centre or a place for the care and treatment of alcoholism, drug addiction or any other dependency.

Hospitalization

To be admitted to a Hospital as an inpatient, or any Hospital stay for Day Surgery.

Illness

Any health deterioration or bodily disorder verified by a Physician. Organ donations and related complications are also considered illnesses.

Immediate Family Member

Spouse, son, daughter, father, mother, brother, sister, step-father, step-mother, step-son, step-daughter, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, sister-in-law, of the Member.

Immediate Relative

The Covered Person's spouse, son, daughter, father, mother, brother or sister.

Insurer

Desjardins Financial Security Life Assurance Company, hereafter, DFS, with its head office at 200 rue des Commandeurs, Lévis (Quebec) G6V 6R2.

Irreversible

At the time of diagnosis, a medical condition that is considered unlikely to be improved by medical or surgical treatment that does not involve undue risk to the Covered Person's health.

Loss

1) For an arm, the complete severance through or above the elbow.

2) For a finger, the complete severance of 2 entire phalanges of one finger.

3) For a foot, the complete severance through or above the ankle joint but below the knee joint.

4) For a hand, the complete severance through or above the wrist but below the elbow joint.

5) For hearing, the complete and irrecoverable loss of hearing in one ear diagnosed by a duly qualified otolaryngologist and corresponding to an auditory threshold of greater than 90 decibels.

6) For a leg, the complete severance through or above the knee joint.

7) For sight, the total and irrecoverable loss of sight of one eye diagnosed by a duly qualified ophthalmologist, corresponding to a corrected visual acuity of 20/200 or less, or to a field of vision of less than 20 degrees.

8) For speech, the total, permanent and irreversible loss of the ability to speak due to injury or disease for a continuous period of 6 months. The diagnosis must be made by a licensed Physician.

9) For a thumb, the complete severance of one entire phalanx of the thumb.

10) For a toe, the complete severance of one entire phalanx of the big toe and all phalanges of the other toes.

Loss of Use

The total and irrecoverable loss of use of a limb that continues uninterrupted for at least 12 months.

Maternity Leave

Any leave of absence from work due to pregnancy:

1) as in agreement with any labour standards type legislation in effect in the Member's province of residence,

2) as in agreement between the Member and the Policyholder or Participating Employer,

3) during which Employment Insurance benefits are paid.

Maximum Benefit Period

The maximum period of time for which disability benefits are payable.

Medical Emergency

Any acute and unexpected Illness or injury requiring immediate medical treatment.

Member

An Employee covered under the policy.

Net Earnings

The gross weekly or monthly Earnings in effect immediately prior to the initial date of Total Disability, less the following deductions for:

1) income tax,

2) contributions to the Canada/Quebec Pension Plan,

3) contributions to the Employment Insurance, and

4) any other contribution to a public income replacement plan.

Orthosis

A rigid orthopaedic appliance or apparatus used to maintain a part of the body in the correct position.

Paraplegia

The total and irrecoverable paralysis of both lower limbs.

Parental Leave

Any leave of absence from work taken by a Member to take care of his newborn or adopted child, as in agreement with any labour standards type legislation, or other period agreed to by the Member and the Participating Employer.

Participating Employer

An employer that is a member of the Ontario Hospital Association and is participating in the policy.

Physician

A qualified medical practitioner who is legally licensed to practice medicine by the jurisdiction in which he operates.

Policyholder

1) The Ontario Hospital Association for the Member Custom Long Term Disability, Life Insurance and Accidental Death and Dismemberment benefits,

2) Unity Health Toronto, also referred to as the Participating Employer, for the Extended Health Care, Dental Care and Critical Illness benefits.

Quadriplegia

The total and irrecoverable paralysis of both upper and lower limbs.

Reasonable and Customary Charges

The charges generally paid for a like service or supply and limited to the lowest of:

1) the usual charge in the area where the services or supplies are provided, or

2) the suggested fee of the applicable governing body,

on the date the expenses were incurred. For expenses incurred outside Canada, Reasonable and Customary Charges are those applicable in the province where the Member resides.

Specialist

A Physician practicing in Canada certified as a specialist through the completion of certifying examinations in the applicable jurisdiction. The Specialist must be certified in the specific area of medicine relevant to the diagnosis for which a claim is made. In the absence or unavailability of a Specialist, the diagnosis or the necessity of a surgery may be established by a Physician practicing in Canada, as approved by DFS. The Specialist must not be the Covered Person, a business associate or a Family Member of the Covered Person.

Spouse

A person residing in Canada who, at the time of the event that results in a claim:

1) is legally married to or living in a civil union with the Member,

2) is living with the Member in a conjugal relationship for at least 12 months.

Stable

The health condition of a Covered Person who within 30 days prior to the Trip departure date is not affected by any medical condition or is affected by a medical condition:

1) that does not require a change or no change is recommended in the treatment or dosage of prescribed drugs,

2) that does not demonstrate any symptoms that indicate a deterioration of the medical condition during the duration of the Trip,

3) that does not require a Hospitalization or to consult a specialist,

4) that does not require any medical examination or test for investigative purposes awaiting results, and

5) for which no treatment is either planned, pending or not completed.

Survival Period

Except if otherwise indicated, the 30-day period immediately following diagnosis or surgery. At the end of 30 days, the Covered Person must be alive and not have experienced the complete and irreversible loss of brain function. Any days on life support are not included. Life support means the regular care of a physician for nutritional, respiratory and/or cardiovascular support, including without limitation cases of complete and irreversible loss of brain function.

Total Disability or Totally Disabled

1) During the first 2 years of disability,

   a) the Member is absent from work and not engaged in any gainful occupation, and

   b) a state of incapacity resulting from an Illness or Accident, which wholly prevents him from performing the regular duties of the occupation in which he participated immediately prior to the onset of Total Disability,

2) once the first 2 years of disability have elapsed,

   the Member continues to be in a state of incapacity, resulting from an Illness or Accident, which wholly prevents him from working in any gainful occupation for which he is or may become suited by education, Training and Experience.

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

If a Member is able to earn an income that is equal to or greater than the amount of monthly disability benefit payable under the Member Long Term Disability Benefit (adjusted annually by the Consumer Price Index), he is no longer considered to be Totally Disabled.

A Member who needs a government issued driver's license to perform the essential duties of his occupation is considered totally disabled for up to 12 months after the end of the Qualifying Period if his license has been revoked or not renewed solely for medical reasons.

Travelling Companion

A person age 18 or older who is not a Dependent Child and who is sharing travel arrangements with the Covered Person.

Travel Service Supplier

A travel agency, a travel wholesaler, a travel package organizer, a cruise operator or an airline that has a valid license and operating certificate issued by the appropriate Canadian or foreign authorities.

Trip

Any fixed period of time that:

1) arrangements have been made with any Travel Service Supplier, or

2) reservations have been made by the Covered Person for ground travel usually included in a travel package.

Vehicle
A car, a motor home or a van with a maximum load of 1,000 kilograms.

GENERAL PROVISIONS

APPLICABLE LAWS AND JURISDICTION

Any provision under the policy that is not compliant with applicable laws is presumed void. Even if a provision prohibited by law is included in the policy, all other provisions of the policy will still remain in force.

The policy, its interpretation, execution, application, validity and effects are subject to the applicable Canadian or provincial laws that govern, partially or totally, all of its provisions.

Any dispute resulting from its conclusion, interpretation or execution will be exclusively submitted to the competent court in the Canadian province agreed upon between the parties.

INCONTESTABILITY

If the coverage of a person is in force for a period of 2 years while that person is alive, DFS cannot contest the validity of this coverage based on any written statement given unless it refers to age or is fraudulent. However, if a disability occurs during the first 2 years of coverage, the foregoing does not apply and DFS can cancel or limit all related claims owed.

MISSTATEMENT OF AGE

If the age of any individual has been misstated, any benefits payable are based upon the actual age of the individual at the time of the event that results in a claim. Premium adjustments are made for the full time such coverage is in force.

CURRENCY

All payments under the policy, whether to or by DFS, are made in the lawful currency of Canada.

NUMBER AND GENDER

Where the context clearly requires, words in the singular include the plural and words referring to any one gender include any other gender.

ELIGIBILITY

EMPLOYEE ELIGIBILITY

An Employee is eligible for coverage on the date he meets the following requirements:

Number of hours worked per week	Waiting Period
37.5 hours	Member Long Term Disability Benefit: The first day of the month following 6 months of Continuous Service for the Participating Employer Other benefits: The first day of the month following 3 months of Continuous Service for the Participating Employer

DEPENDENT ELIGIBILITY

If an Employee already has a Dependent on the date he is eligible for coverage under the policy, that Dependent is also eligible for coverage on that date.

If an Employee does not have Dependents on the date he is eligible for coverage under the policy, Dependents are eligible for coverage on the date the Employee first acquires a Dependent.

APPLICATION

The policy contains a Beneficiary provision that removes or restricts the right of the Member to designate persons to whom or for whose amounts are to be payable for some benefits.

COVERAGE APPLICATION

Application for coverage is mandatory for any employee who meets the eligibility requirements.

1) Application within the time limit

An Employee must complete the required application form within 31 days of the date he is eligible.

2) Late application

a) All Benefits other than Dental Care Benefit

If application is not completed within the time limit specified above, the Employee may be required to submit Evidence of Insurability.

b) Dental Care Benefit

If the Employee applies for coverage for himself or his Dependents more than 31 days after the date he is eligible, DFS may limit the amount reimbursed for Eligible Expenses according to the EXCLUSIONS, RESTRICTIONS AND LIMITATIONS provision of the Dental Care Benefit.

Evidence of Insurability

Evidence of Insurability satisfactory to DFS is required for any amount exceeding the Maximum without Evidence of Insurability for these Benefits, if application for coverage is completed within the time limit:

1) Member Long Term Disability Benefit

2) Member Basic Life Insurance Benefit

3) Member Voluntary Life Insurance Benefit

4) Optional Critical Illness Benefit for the Member and the Spouse

Evidence of Insurability satisfactory to DFS is required for any amount of Spouse Voluntary Life Insurance Benefit. This applies whether the application for coverage is completed within the time limit or if it is a late application.

EXEMPTION PRIVILEGE

An Employee may decline to be covered under the Extended Health Care Benefit or Dental Care Benefit if that Employee is covered as a Dependent under the policy or another similar group insurance plan. However, if that other plan terminates or the Spouse is no longer a member of an eligible class, the Employee is eligible to apply for coverage. To become covered:

1) the Employee must previously have opted out of coverage,

2) the Spouse's coverage cannot have been terminated by personal choice, and

3) the Employee's written application must be made within 31 days of the date the Spouse loses coverage, otherwise, the Late Application provision applies.

COVERAGE TYPES

The coverage types available under the policy are:

Coverage Types	Covered Persons
Single	Member only
Family	Member, Spouse and Children

The Coverage Type does not have to be the same for all benefits.

The Coverage Type can be changed due to a life event. DFS must be notified within 31 days of the event.

A life event is defined as:

1) marriage, new common-law spouse, separation or divorce,

2) birth or adoption of a Child,

3) loss or gain of the Spouse's coverage, for a reason other than personal choice,

4) death of a Dependent,

5) termination of a Dependent's eligibility because of their age,

6) a Dependent Child returns to school, or

7) personal bankruptcy.

BENEFICIARY

DFS will recognize the beneficiary(ies) designated by the Member under the Participating Employer's group insurance plan immediately prior to the Effective Date of the policy, unless DFS requires beneficiary(ies) to be designated again.

Subject to applicable laws, the Member may designate or revoke, at any time, one or several beneficiaries. Only the benefits that include a benefit payment in the event of the Member's death are subject to the designation of beneficiary(ies), and the same designation applies to all these benefits. The rights of a beneficiary who dies before the Member revert to the latter. In the absence of a designated beneficiary, the amounts payable are paid according to applicable laws.

The amounts payable when a Dependent dies are paid to the Member, if alive. If the Member has died, the amounts are paid according to applicable laws.

DFS assumes no responsibility for the validity of any beneficiary designation or revocation.

COMMENCEMENT OF COVERAGE

COMMENCEMENT OF MEMBER COVERAGE

An Employee must be Actively at Work on the date his coverage becomes effective. If he is not Actively at Work on that date, his coverage will start on the first day he is next Actively at Work.

If an Employee is not Actively at Work due to Illness or injury on the date coverage would be effective, his coverage will start once he has been Actively at Work during 7 consecutive schedules working days following his return to work.

The coverage of any Employee is effective on the date he is eligible, provided application is made within the time limit. However, for late application or for benefits that require Evidence of Insurability, coverage is effective on the date the insurability of the Employee is approved by DFS.

COMMENCEMENT OF DEPENDENT COVERAGE

Coverage for a Dependent is effective on the date the Member is first eligible for Dependent coverage, provided application is made within the time limit. However, for late application or for benefits that require Evidence of Insurability, coverage is effective on the date the Dependent's insurability is approved by DFS.

If a Member already has Dependent coverage on the date he acquires a new Dependent, the coverage of that Dependent is effective on the date he becomes a Dependent, except for benefits requiring Evidence of Insurability. However, the Life and Accidental Death and Dismemberment Benefits for a newborn Child are effective from birth, if born alive, subject to all other terms and conditions of the policy provisions, including those above.

If a Dependent (other than a newborn Child) is confined to a Hospital on the date his coverage would otherwise become effective, his coverage begins on the day immediately following his discharge from the Hospital.

CHANGE IN AMOUNT OF COVERAGE AND BENEFIT

1) Change of option for Member Custom Basic Life Insurance Benefit

If a Member under age 65 elects to change from Option A to Option B, the Member must submit Evidence of Insurability, unless the change is made within 60 days after acquiring a Spouse or Child, through birth or adoption.

The change is effective:

a) on the first day of the month following the date the change is made, or

b) on the first day of the month following the date the insurability of the Member is approved by DFS.

2) Change of option for Custom Voluntary Life Insurance Benefit

If a Member requests an increase in his amount of insurance, he must submit Evidence of Insurability for himself and his Spouse, if his Spouse is covered. If DFS does not approve the Spouse's Evidence of Insurability, the amount of the Spouse Voluntary Life Insurance Benefit will not increase and may not be equal to 25% or 50% of the Member's amount of insurance.

If a Member requests an increase in any of his Children's amount of insurance, he must submit Evidence of Insurability for such Child.

However, a Member may elect to increase his amount of insurance to the next higher level, subject to a maximum of $150,000, within 60 days after acquiring a Spouse or Child, through birth or adoption. If the change is not made within this time limit, the Member must submit Evidence of Insurability.

The change is effective:

a) on the first day of the month following the date the change is made, or

b) on the first day of the month following the date the insurability of the Member, Spouse or Child is approved by DFS.

3) Change in Earnings

Any change in the amount of insurance of a Member due to a change in Earnings is effective on the first day of the month following the change of Earnings.

4) Changes to the Extended Health Care, Dental Care Benefits and Critical Illness Benefits

Any increase or decrease in the amount of coverage or any change in these Benefits is effective on the later of the following dates, provided the Member is Actively at Work on that date:

a) the date the Member is first eligible for the change provided written request is received by DFS on or before that date, or

b) the date the insurability of the Member is approved by DFS, if the request for change is received more than 31 days after the date of his eligibility for the change.

5) Any other change

Any increase or decrease in the amount of coverage or any change in Benefit is effective on the date the Member is first eligible for the change.

If a Member is not Actively at Work on the date his coverage should change, then the change is effective on the first day he is next Actively at Work.

CONTINUATION OF COVERAGE DURING ABSENCE FROM WORK

If a Member is not Actively at Work for any of the reasons described below, his coverage may be continued, according to the following provisions.

ILLNESS OR INJURY

The Policyholder, acting on a basis precluding individual selection, may continue all benefits that are in place immediately before the absence for a maximum of:

1) 24 months after disability benefit payments terminate, if the disability is recognized by DFS and as long as disability benefits are paid, or

2) 24 months after the last day the Member was Actively at Work, if the disability is not recognized by DFS.

Premiums must continue to be paid unless the Member is eligible for a premium waiver. If a Member is absent due to an illness or injury, he may:

1) keep all benefits

2) keep all benefits and:

   a) reduce the Coverage Type for the Extended Health Care Benefit, or

   b) reduce the Coverage Type for the Dental Care Benefit, or

3) discontinue the Extended Health Care Benefit, or

4) discontinue the Dental Care Benefit.

That choice must remain in force until the Member is again Actively at Work

TEMPORARY LAY-OFF

The Participating Employer or Policyholder, acting on a basis precluding individual selection, may continue coverage of the Member. Benefits can be continued for any predetermined period as long as premiums continue to be paid. However, the coverage can only be continued for a maximum of 3 months for the Member Long Term Disability Benefit and 12 months for all other benefits.

AUTHORIZED LEAVE OF ABSENCE

The Participating Employer or Policyholder, acting on a basis precluding individual selection, may continue coverage of the Member. All benefits except the Member Long Term Disability Benefit can be continued for any predetermined period as long as premiums continue to be paid. However, the coverage can only be continued for a maximum of 12 months.

MATERNITY, PARENTAL OR FAMILY RELATED ABSENCES AND LEAVES

For an absence or leave taken according to any applicable law, a Member may:

1) as long as premiums continue to be remitted, keep:

   a) all benefits, or

   b) all benefits except for the Member Long Term Disability Benefit,

2) discontinue all benefits.

Benefits may be continued for a maximum of 12 months or longer where required by law. DFS must be advised of the scheduled return to work date no later than 31 days following the start of the absence or leave.

DFS must be advised of the Member's choice prior to the start of the absence or leave. If benefits are discontinued, they are reinstated without Evidence of Insurability, on the date the Member is again Actively at Work. DFS must be advised within 31 days following the return to work otherwise, Evidence of Insurability is required.

STRIKE OR LOCK-OUT

Coverage terminates on the date the strike or lock-out begins.

TERMINATION OF BENEFITS AND COVERAGE

BENEFIT TERMINATION

Each Benefit terminates on the date specified below.

BENEFIT	TERMINATION DATE
Extended Health Care Benefit	The date of retirement
Dental Care Benefit	The date of retirement
Member Long Term Disability Benefit	The Member's 65th birthday or retirement, whichever comes first
Member Basic Life Insurance Benefit	The date of retirement
Member Voluntary Life Insurance Benefit	The Member's 65th birthday or retirement, whichever comes first
Dependent Voluntary Life Insurance Benefit	The Member or Spouse's 65th birthday or the Member's retirement, whichever comes first
Basic Accidental Death and Dismemberment Benefit	The Member's 65th birthday or retirement, whichever comes first
Voluntary Accidental Death and Dismemberment Benefit	The Member's 70th birthday or retirement, whichever comes first
Critical Illness Benefit	The Member's 70th birthday or retirement, whichever comes first

TERMINATION OF MEMBER COVERAGE

Except as specifically noted elsewhere in the policy, the coverage of the Member terminates on the earliest of:

1) the date he no longer qualifies as an Employee,

2) the date he no longer belongs to a class of Employees eligible for coverage,

3) the date his employment or contract with the Participating Employer is terminated,

4) the end of the period for which the premiums are paid on his behalf,

5) the date he retires,

6) the date he is no longer Actively at Work, or

7) the date the policy terminates.

TERMINATION OF DEPENDENT COVERAGE

Except as specifically noted elsewhere in the policy, the coverage for a Dependent terminates on the earliest of:

1) the date the Member's coverage terminates, unless the Dependent is eligible for survivor benefits,

2) the date the individual no longer qualifies as a Dependent, or

3) the date the premiums are not paid on behalf of the Member for Dependent coverage.

REINSTATEMENT OF COVERAGE

If an Employee's coverage terminates due to termination of employment and he is then rehired within 6 months by any Participating Employer, he is eligible for the reinstatement of his coverage on the date he resumes employment. Application for reinstatement must be made within 31 days of the rehire date.

The Employee must ask his new Participating Employer to arrange this transfer of coverage within one month of his first day of employment and inform his new Participating Employer of all prior service to be counted toward coverage. If the Employee fails to do so, he will have to provide Evidence of Insurability at his own expense to complete the transfer of coverage.

If an Employee does not qualify for reinstatement, he is considered a new Employee.

SURVIVOR BENEFIT

This provision applies to the following:

- Extended Health Care Benefit
- Dental Care Benefit

In the event of the Member's death and subject to policy provisions, coverage continues for his Dependents, until the earliest of:

1) 12 months from the date of death,

2) the date Dependent coverage normally terminates had the Member not died, or

3) the date the Benefit or policy terminates.

FRAUD

In case of fraud, DFS reserves the right to terminate the Member's coverage.

CLAIMS

NOTICE AND PROOF OF CLAIM

Notice and proof of any claim must be received by DFS within the time limit specified for each Benefit:

BENEFIT	TIME LIMIT
Extended Health Care Benefit	All claims, with receipts included, must be submitted to DFS within 90 days of the end of the year during which the expense is incurred or within 90 days of the termination of benefits, whichever is earlier.
Dental Care Benefit	All claims, with receipts included, must be submitted to DFS within 90 days of the end of the year during which date the expense is incurred or within 90 days of the termination of benefits, whichever is earlier.
Member Long Term Disability Benefit	• Initial written notice of a claim must be submitted to DFS within 31 days of the expiry of the Qualifying Period, and • initial written proof must be submitted to DFS within 180 days of the expiry of the Qualifying Period. • When Total Disability is recurrent, written notice of a claim must be submitted to DFS within 31 days of the date of recurrence, and • written proof must be submitted to DFS within 60 days of the date of the recurrence. • Subsequent written proof of continuing Total Disability satisfactory to DFS must be submitted to DFS upon request.
Life Insurance Benefit	Any claim must be submitted to DFS within 6 years of the date of death.

Accidental Death and Dismemberment Benefit	• Any death claim must be submitted to DFS within 6 years of the date of death. • Any other claim must be submitted to DFS within one year of the date of the loss.
Critical Illness Benefit	• Initial written notice of a claim must be submitted to DFS within 30 days of the date of the event. • For Cancer or Benign Brain Tumour, any medical information must be submitted to DFS within 6 months of the date of the diagnosis. • For HIV infection, a written notice of claim must be submitted to DFS within 14 days of the date of Accident or injury.

Failure to submit notice or proof of claim within the prescribed time limit does not invalidate the claim if the notice and proof of the claim are sent as soon as reasonably possible.

If the policy terminates, no payment will be made:

1) under the Extended Health Care and Dental Care benefits as of the date of termination of the policy, regardless of the date the expenses were incurred, and

2) unless the notice and proof of claim are submitted to DFS within 120 days of the date of termination of the policy, for all other benefits.

Every action or proceeding against DFS for the recovery of insurance money payable is barred absolutely unless commenced within the time set out in the Insurance Act or other legislation of the province where the Member resides.

SUBMISSION OF CLAIMS

Claims must be submitted to DFS on the appropriate form. When necessary, DFS may also require any other information it deems useful. All amounts are paid to the Member unless otherwise indicated in the policy.

Drugs and other Health Care Expenses

If the direct payment method is used for drug expenses, the Member is not required to submit a claim to DFS.

For all other medical expenses, the Member is not required to submit a claim to DFS if the professional or service provider uses the Electronic Data Interchange (EDI).

Dental Care

The Member is not required to submit a claim to DFS if the Dentist uses the Electronic Data Interchange (EDI).

DFS reserves the right to require radiographs and other types of diagnostics such as specialist reports, periodontal charts and study models.

Death

Before settling any claim, DFS requires satisfactory written proof of:

1) death, including a medical report or death certificate, the cause and circumstances of the death,

2) eligibility of the deceased at the time of death,

3) date of birth of the deceased, and

4) right of the claimant to receive the proceeds.

DFS may also require any other information it deems useful.

In the case of a disappearance, DFS will pay the claim on presentation of a declaratory judgment of death.

Critical Illness

Before settling any claim, DFS requires satisfactory written proof of:

1) the existence of an Eligible Illness, and

2) the Covered Person's eligibility for benefits at the time the diagnosis was made.

DFS reserves the right to verify the diagnosis with the attending Physician(s) and to require any Member or Dependent that submitted a claim be examined at DFS's expense.

CO-ORDINATION OF BENEFITS

If an individual covered under the Extended Health Care and Dental Care benefits, is also covered under another Plan that provides similar benefits, total reimbursements made by all plans in any year are co-ordinated.

Co-ordination of benefits is calculated as specified in the guidelines of the Canadian Life and Health Insurance Association. Total amounts paid under all plans cannot exceed 100% of the individual's incurred Eligible Expenses.

Travel Insurance Expenses

If an individual covered under Travel Insurance is also covered under any other plan or insurance policy that provides similar benefits, Travel Insurance only covers Eligible Expenses in excess of the amounts payable by the other plans or insurance policies.

If the other plans or insurance policies include a similar clause or Co-ordination of Benefits provision, benefits are co-ordinated between all plans or insurance policies so that the total amounts paid do not exceed 100% of the individual's incurred Eligible Expenses.

MEDICAL EXAMINATIONS

From time to time, DFS is entitled to have a claimant examined by a health professional of its choice.

SUBROGATION

When reimbursement for expenses incurred for which another party is or may be liable, DFS is subrogated to the same rights of recovery available to the Member. DFS may bring action in the name of the Member to enforce these rights.

When a Member is paid disability benefits for loss of income for a cause that another party is or may be liable, DFS is subrogated to the same rights of recovery available to the Member. The amount subject to subrogation is limited to the amount of salary loss benefits paid or payable to the Member by DFS.

RIGHT OF RECOVERY

Payments made by DFS in excess of the maximum amount that should have been paid are recoverable by DFS, limited to that excess amount. It will be recovered from any individuals or entity to or for whom the payments were made.

WAIVER OF PREMIUM

This provision applies to the following Benefits:

- Member Long Term Disability Benefit
- Basic Life Insurance Benefit
- Voluntary Life Insurance Benefit
- Basic Accidental Death and Dismemberment Benefit
- Voluntary Accidental Death and Dismemberment Benefit
- Optional Critical Illness Benefit

1) Beginning of the Waiver of Premium

A Member under age 65 who becomes Totally Disabled while covered under the policy may be entitled to have his premiums waived the first day of the month coincident with or next following the date Member Long Term Disability Benefits are expected to commence. The Member must submit proof of Total Disability satisfactory to DFS.

2) Termination of the Waiver of Premium

Premiums are no longer waived on the earliest of the following dates:

a) the date the Member is unable or unwilling to provide satisfactory proof of Total Disability to DFS, if such proof is not provided within 3 months of DFS's request,

b) the date the Member ceases to be Totally Disabled,

c) the date the Member is engaged in any occupation or employment for remuneration or profit. This does not include a rehabilitative program approved by DFS,

d) the date of the Member's 65th birthday,

e) the date the Member retires,

f) the date the coverage of the Member terminates, or

g) the date the Benefit is cancelled or the policy terminates, except for the Life Insurance Benefit, the Accidental Death and Dismemberment Benefit and the Member Long Term Disability Benefit.

3) Recurrent Total Disability

A Total Disability that recurs within 6 months after the end of a previous period of Total Disability for which premiums were waived is deemed a continuation of the previous period if for the same or related causes.

4) Notice and Proof of Total Disability

For the Member to be eligible for Waiver of Premium, DFS must receive:

a) written notice of Total Disability within 12 months of the date the Member is Totally Disabled, and

b) satisfactory proof of Total Disability within 90 days following the date DFS received written notice.

For recurrent Total Disability, DFS must receive written notice and proof of claim within 30 days of the recurrence.

EXTENDED HEALTH CARE BENEFIT

This benefit is not insured by DFS. It is administered by DFS on behalf of the Policyholder.

SUMMARY OF BENEFITS

When DFS receives satisfactory Proof of Claim that a Covered Person incurred Eligible Expenses while covered under this Benefit, DFS will reimburse those expenses according to policy provisions.

Deductible	
Eligible Expenses	**Amount**
Hospitalization	Hospital: • Semi-private room - None • Private room - Combined with the deductible for all other expenses Convalescent/Rehabilitation Centre and Chronic Care Establishment: Combined with the deductible for all other expenses
Dental Treatment due to an accident	None
Detoxification	None
Referral Treatment	None
Travel Insurance	None
All other expenses	$22.50 per single coverage or $35 per family coverage, per calendar year

Percentage of Reimbursement	
Eligible Expenses	**Percentage**
Drugs	1) Generic drugs: 100% of the lowest priced Equivalent Drug available on the market 2) Brand name drugs: 100% of the brand name drug if no Equivalent Drug is available on the market or 100% of the lowest priced Equivalent Drug available on the market
Referral Treatment	80%
All other expenses	100%

BENEFIT PAYMENT

For all Eligible Expenses, DFS will reimburse the portion of the Reasonable and Customary Charges in excess of the Deductible, subject to the Percentage of Reimbursement.

To be eligible, the expenses must be medically necessary for the treatment of the Covered Person and incurred as a result of an Illness, a pregnancy or an Accident, and cover care that:

1) is prescribed by a Physician or other health professional as authorized by law, before the expense is incurred,

2) is recognized throughout the medical field as appropriate and consistent with the diagnosis, and

3) cannot be omitted without endangering the person's health or the quality of medical care.

The incurred date for any Eligible Expense is the date the service is provided or the item is supplied.

ELIGIBLE EXPENSES

IN CANADA

Eligible Expenses are those listed below and incurred:

1) in the Member's province of residence, and

2) within Canada, but outside the Member's province of residence, if not related to a Medical Emergency.

MARK-UP AND DISPENSING FEE	
Limits for Eligible Drug Expenses	
Mark-up	Reasonable and Customary Charges
Dispensing fee	Reasonable and Customary Charges

DRUGS

1) Drugs with a DIN (Drug Identification Number) when dispensed by a pharmacist, and

   a) by law require a prescription, or

   b) do not require a prescription, but are categorized as life sustaining, including without limitation:

      - malarials
      - fibrinolytics
      - nitroglycerin
      - single entity iron salts
      - thyroid agents
      - topical enzymatic debriding agents

   Compounded preparations dispensed by a pharmacist where the principal active ingredient in the compound is an eligible drug.

2) Insulins, lancets, syringes and test strips for diabetics.

3) Expenses used to cover the provincial drug insurance plan deductible and co-insurance amount for persons covered under their provincial plan.

4) Prior Authorization Drugs

Prior authorization by DFS is required for certain drugs listed on DFS's website. A prior authorization form completed by the Physician must be submitted to DFS in order to determine whether the prescribed drug meets the prior authorization criteria established by DFS. The criteria are based, in particular, on clinical practice guidelines and recommendations issued by health technology assessment agencies and they include verification that:

a) the drug is prescribed for an approved therapeutic indication approved by Health Canada, and

b) the drug's effectiveness is satisfactory compared to its associated cost.

Proof of the effectiveness of the approved drug, including medical results, may be requested during the course of treatment to determine if the drug is having the desired effect so that it may remain eligible for reimbursement.

DFS reserves the right to reimburse an Equivalent Drug when a less expensive equivalent or biosimilar drug is available on the market.

Other Eligible Drug Expenses	**Maximum Payable Amount per Covered Person**
Preventive vaccines	Reasonable and Customary Charges
Sclerotherapy products to treat varicose veins	Reasonable and Customary Charges
Smoking cessation aids (products only)	$500 lifetime
Fertility treatment	Drugs only, $2,500 per calendar year
Drugs used for the treatment of obesity, provided the Covered Person's body-mass index (BMI) equals 30 or more or equals 27 or more if other risk factors are present	$1,800 per calendar year

HOSPITALIZATION	
Eligible Expenses	**Maximum Payable Amount per Covered Person**
Hospital Charges for confinement in a Hospital for each day of acute care Hospitalization	The difference between the cost of a ward and a private room
Convalescent/Rehabilitation Centre Charges for confinement in a Convalescent or Rehabilitation Centre Successive periods of confinement are considered the same period of confinement if they: • result from the same Illness or Accident, and • are separated by less than 60 consecutive days during which the Covered Person is not hospitalized.	$3 per day up to 120 days per period of confinement
Chronic Care Establishment Charges for confinement in a Chronic Care Establishment	$20 per day up to of 120 days per period of confinement

HEALTH PROFESSIONALS	
Eligible Expenses	**Maximum Payable Amount per Covered Person**
Paramedical Services Services of the following professionals if they are practicing within their recognized field and are members in good standing of their professional governing body that is recognized by DFS. Medical recommendation is not required unless specified.	For each type of professional, the maximum is limited to one visit per day
• acupuncturist • audiologist • chiropractor • dietician or nutritionist • massage therapist, orthotherapist or kinesiotherapist • naturopath • occupational therapist • osteopath • physiotherapist or physical rehabilitation therapist • podiatrist or chiropodist • psychologist, social worker, psychotherapist, registered clinical counsellor, psychoanalyst or marital/couple/family therapist • speech therapist	Combined amount of $1,000 per calendar year, including x-rays ordered by a podiatrist. In addition, one x-ray per calendar year is covered for each of the following practitioner: chiropractor and osteopath

Home Nursing Care Nursing services given at home by a registered nurse or a licensed practical nurse, provided the services are within the competence of that nurse. The nurse must not be related to the Member or to any of his Dependents by birth or marriage and must not ordinarily reside in his or his Dependent's home.	$30,000 or the equivalent of 90 eight-hour shifts per calendar year

AMBULANCE
Transporting the Covered Person by a licensed ground ambulance: 1) in the event of a Medical Emergency, from the place of the Accident or Illness to the nearest Hospital where adequate treatment is available, and 2) from the Hospital to the place of residence of the Covered Person, when his health condition does not allow any other means of transportation. Also eligible is transportation of the Covered Person by a licensed air ambulance to the nearest Hospital where adequate treatment is available when required due to a Medical Emergency.

MEDICAL EQUIPMENT OR SUPPLIES	
MOBILITY AIDS	
Eligible Expenses	**Limitations and/or Maximum Payable Amount per Covered Person**
Walkers, canes or crutches	Purchase or rental, at the option of DFS Reasonable and Customary Charges
Wheelchairs	Purchase and repair, or rental, at the option of DFS, up to the cost of a non-motorized wheelchair, unless the Covered Person's health condition requires a motorized wheelchair One in any 60-month period, plus initial batteries for an eligible motorized wheelchair

ORTHOPAEDIC SUPPLIES	
Eligible Expenses	**Limitations and/or Maximum Payable Amount per Covered Person**
Orthopaedic shoes: • Custom-made shoes • Open-toed shoes • In-flare or out-flare shoes • Shoes required for Denis Browne braces • Modified or adjusted prefabricated shoes • Modifications or adjustments to prefabricated shoes	Manufactured and billed by a centre recognized by DFS. In addition, the shoes and the modifications or adjustments to prefabricated shoes must be made by an orthotist who is a member in good standing of his professional governing body that is recognized by DFS. $500 per calendar year The maximum is combined with the maximum for foot orthoses
Foot orthoses	Manufactured and billed by a centre recognized by DFS. In addition, the orthoses, must be made by an orthotist who is a member in good standing of his professional governing body that is recognized by DFS. $500 per calendar year The maximum is combined with the maximum for orthopaedic shoes
Rigid or semi-rigid braces for limbs, trusses or casts	Purchase and repair Reasonable and Customary Charges
Spinal braces	Purchase and repair Reasonable and Customary Charges

PROSTHESES	
Eligible Expenses	**Limitations and/or Maximum Payable Amount per Covered Person**
Hearing aids	2 in any 36-month period, including initial batteries
Wigs	When required for temporary hair loss due to alopecia, chemotherapy or radiotherapy $1,500 lifetime
Breast prostheses	When required due to a mastectomy, up to • the cost of 2 external prosthesis in any 24-month period, and • 2 mastectomy brassieres per calendar year
Artificial limbs and myoelectric prosthetics	Purchase, repair or replacement when it is required due to a physiological change Reasonable and Customary Charges
Artificial eyes	Reasonable and Customary Charges One per calendar year plus repair

OTHER MEDICAL EQUIPMENT OR SUPPLIES	
Eligible Expenses	**Limitations and/or Maximum Payable Amount per Covered Person**
Glucose monitors	Reasonable and Customary Charges
Insulin pump supplies	Purchase Continuous glucose monitors: $4,000 per calendar year All other expenses: Reasonable and Customary Charges
Support stockings	Purchase 4 pairs in any 12-month period
Intrauterine devices or diaphragms	Reasonable and Customary Charges
TENS nerve stimulators and their supplies	Purchase or rental, at the option of DFS One every 5 calendar years
Catheters	Purchase Reasonable and Customary Charges
Ostomy supplies	Purchase Reasonable and Customary Charges
Tube feeding supplies	Purchase Reasonable and Customary Charges
Tracheotomy supplies	Purchase Reasonable and Customary Charges
Opaque glasses	Purchase, provided they are required during radiotherapy or psoriasis treatments Reasonable and Customary Charges

Compressive garments other than support stockings	Purchase One every 5 calendar years
Medicated dressings	Purchase Reasonable and Customary Charges
Stump-socks	10 per calendar year
Breast pumps	Purchase or rental, at the option of DFS Reasonable and Customary Charges
Apnea monitors	Purchase or rental, at the option of DFS Reasonable and Customary Charges
Oxygen and equipment required for its administration	Purchase or rental, at the option of DFS • Oxygen: Reasonable and Customary Charges • Equipment: One every 5 calendar years
Lymphoedema pumps	Purchase Reasonable and Customary Charges
Chest percussion accessories	Purchase Reasonable and Customary Charges
Enuresis sensors	Purchase or rental, at the option of DFS Reasonable and Customary Charges
Hospital beds	Purchase and repair, or rental, at the option of DFS, up to the cost of a non-electric hospital bed, unless the Covered Person's health condition requires an electric bed One in any 60-month period

Hospital bed supplies: • bed rails • trapeze bars • bedpans • head halters	Purchase or rental, at the option of DFS Reasonable and Customary Charges
Traction apparatus	Purchase or rental, at the option of DFS Reasonable and Customary Charges
Other therapeutic equipment and their supplies: • aerosol therapy equipment • insulin pumps • non-union bone stimulators • positive pressure airway ventilator machines (CPAP) or mandibular advancement splints Additional equipment may be included, as determined by DFS.	Purchase or rental, at the option of DFS Reasonable and Customary Charges

DIAGNOSTIC SERVICES	
Eligible Expenses	**Limitations and/or Maximum Payable Amount per Covered Person**
Imaging techniques Diagnostic laboratory tests	For diagnostic purposes Reasonable and Customary Charges

DENTAL TREATMENT DUE TO AN ACCIDENT	
Eligible Expenses	**Limitations and/or Maximum Payable Amount per Covered Person**
The services of a Dentist required to repair or replace sound teeth as a result of an accidental blow to the mouth A sound tooth is a natural tooth not affected by any pathology in itself or any adjacent structures. A natural tooth treated or repaired and restored to normal function is considered sound.	The accidental blow must occur while the Covered Person is covered under this Benefit or a comparable benefit in force immediately before the effective date of this Benefit. Within 90 days of the Accident: • dental care must be rendered, or • a treatment plan satisfactory to DFS must be submitted. No benefit is paid for services provided more than 24 months after the date of the Accident. Reimbursement of Eligible Expenses is governed by the current year Dental Association Fee Guide for General Practitioners where the Member resides. $500 lifetime

DETOXIFICATION	
Eligible Expenses	**Limitations and/or Maximum Payable Amount per Covered Person**
Room and board charges in a centre specializing in the treatment of alcoholism, drug, gambling or gaming addiction. The centre must be recognized by DFS	The Covered Person must require treatment under the supervision of a Physician. The cost of a semi-private room

VISION CARE	
Eligible Expenses	**Limitations and/or Maximum Payable Amount per Covered Person**
Eye exam	One in any period of • 24 months for adults, • 12 months for Children under age 18.
Eyeglasses, contact lenses and surgery	Purchase and replacement Eyeglasses and contact lenses must be prescribed by an ophthalmologist or optometrist and dispensed by an ophthalmologist, optometrist or optician, for vision correction. Laser surgery for vision correction Combined amount of $300 in any period of 24 months
Intraocular lenses	Purchase, as a replacement for natural crystalline in case of cataracts $200 lifetime

REFERRAL TREATMENT

Eligible Expenses are as below when incurred outside the Covered Person's province of residence due to a referral, subject to the following:

1) the service or treatment must not be available in Canada or in the Covered Person's province of residence,

2) the Covered Person must provide DFS with a letter of referral from a Physician from the province of residence he resides indicating that he is referred to another Physician,

3) DFS must give prior written approval, and

4) the provincial health and/or hospital insurance plans must pay a portion of the Eligible Expenses.

Eligible Expenses	Limitations and/or Maximum Payable Amount
Health Care Expenses	
Hospital room and board charges	In Canada: same coverage as provided for under the In Canada provision of this Benefit Outside Canada: semi-private room
Other hospital services	
Physician, surgeon or anaesthetist's fees	
Transportation Expenses	
Expenses to transport the Covered Person by a suitable means to a place of treatment competent to provide appropriate care.	
Expenses for an Immediate Family Member to be transported with the Covered Person to the place of treatment.	
Round-trip economy transportation for a qualified medical attendant when ordered by the attending Physician.	The attendant cannot be an Immediate Family Member, friend or Travelling Companion
Round-trip economy air, bus or train transportation by the most direct route for one Immediate Family Member to visit the Covered Person who must be confined for at least 7 days.	• The Covered Person must not be accompanied by an Immediate Family Member age 18 or over • The Living Expenses for the Immediate Family Member up to a maximum of $1,500 • The visit must be considered as beneficial to the patient by the attending Physician

On the death of a Covered Person, one round-trip economy air, bus or train transportation by the most direct route for one Immediate Family Member to the place of death for identification of the remains prior to repatriation.	The Covered Person must not be accompanied by an Immediate Family Member age 18 or over
On the death of a Covered Person, the cost to prepare and return the body or cremains to the place of residence by the most direct route (plane, bus or train).	$5,000 The cost of the casket or urn is not covered
<u>Living Expenses</u>	
The Covered Person's cost of meals and accommodation for the duration of his treatment. Additional child care expenses for Children not accompanying the Covered Person.	$200 per day per Covered Person for a maximum of 10 days. This maximum is for all these expenses combined
<u>Long-distance Telephone Charges</u>	
Long-distance telephone charges to reach an Immediate Family Member if the Covered Person is hospitalized.	• $50 per day up to an overall maximum of $200 per Period of Hospitalization • The Covered Person must not be accompanied by an Immediate Family Member age 18 or over • These expenses are eligible if no reimbursement has been made for Transportation Expenses for one Immediate Family Member to the Hospital
Overall Maximum Benefit	
Expenses incurred outside the province of residence, but within Canada	No maximum
Expenses incurred outside Canada	$50,000 per calendar year per Covered Person

TRAVEL INSURANCE

If a Covered Person incurs Medical Emergency expenses during the first 180 days of a stay outside their province of residence, DFS will reimburse the Eligible Expenses subject to the following conditions:

1) the person must be covered under a provincial health plan in Canada,

2) expenses must be eligible under the Extended Health Care Benefit, and

3) the Covered Person's health condition must be Stable prior to the Trip departure date.

The Member must contact DFS if the duration of the stay outside Canada is or may be longer than 180 days. Otherwise, the Covered Person may not be covered for Travel Insurance.

Medical decisions by a Physician or other health care professional employed by, under contract to, or designated by "Travel Assistance", are based on medical factors and, as such, will be conclusive in determining the need for the services outlined below.

Eligible Expenses	**Limitations and/or Maximum Payable Amount**
<u>Health Care Expenses</u>	
Hospital room and board charges until the Covered Person is discharged from hospital	Semi-private room
Other hospital services	
Physician, surgeon or anaesthetist's fees	
All other expenses eligible under the In Canada provision of this Benefit	
<u>Transportation Expenses</u> To be eligible, all the expenses listed below must be approved and arranged by "Travel Assistance"	
Expenses to repatriate the Covered Person, as soon as his health allows it, by a suitable means of Public Transportation to his place of residence to receive appropriate care.	These expenses are eligible if the means of transportation originally arranged for the return Trip cannot be used.

Expenses for another person also covered under this Benefit to be repatriated at the same time as the Covered Person.	These expenses are eligible if the means of transportation originally arranged for the return Trip cannot be used.
Expenses for a suitable means of Public Transportation to repatriate the children accompanying and under the care of the Covered Person during the Trip if: • the Covered Person must be repatriated or hospitalized for more than 24 hours, and • nobody else can bring the children back to their home.	
Additional transportation to repatriate the cat or dog accompanying the Covered Person if: • the Covered Person must be repatriated, and • nobody else can bring the animal back to the Covered Person's place of residence.	$500 per Trip
The following fees for the transportation of the luggage of the Covered Person who must be repatriated: • excess luggage if brought back by another person, or • shipment of luggage to the Covered Person's place of residence if nobody else can bring it back.	$300 per Trip
Round-trip economy transportation for a qualified medical attendant when ordered by the attending Physician.	The attendant cannot be an Immediate Family Member, friend or Travelling Companion.

Round-trip economy air, bus or train transportation by the most direct route for one Immediate Family Member to visit the Covered Person who must be confined for at least 7 days.	• The Covered Person must not be accompanied by an Immediate Family Member age 18 or over. • The Living Expenses for the Immediate Family Member is limited to $1,500. • The visit must be considered as beneficial to the patient by the attending Physician.
Cost of returning the Covered Person's personal or rented Vehicle if: • the Covered Person suffers from a disability due to a Medical Emergency, • a Physician verifies that the disability prevents the Covered Person from operating this Vehicle, and • none of the Immediate Family Members accompanying the Covered Person are able to return it. Vehicle transportation professional agency expenses or the reasonable and necessary expenses incurred by the Covered Person for gas, meals, accommodation and a one-way economy class transportation.	The Vehicle must be in working condition to make the return Trip without mechanical problem $2,500 per trip
On the death of a Covered Person, one round-trip economy air, bus or train transportation by the most direct route for one Immediate Family Member to the place of death for identification of the remains prior to repatriation.	The Covered Person must not be accompanied by an Immediate Family Member age 18 or over.

On the death of a Covered Person: • the cost to prepare and return the body or cremains to the place of residence by the most direct route (plane, bus or train), or • the cost to prepare the body and the cost of cremation or burial if the body is not repatriated to the place of residence.	$5,000 The cost of the casket or urn is not covered
<u>Living Expenses</u>	
The cost of meals and accommodation if the Covered Person's return is delayed because of an Illness or Accident verified by a Physician. The Illness or Accident must be suffered by the Covered Person himself, an accompanying Immediate Family Member or a Travelling Companion. Additional child care expenses for Children not accompanying the Covered Person	$200 per day per Covered Person for a maximum 10 days per Trip, for all these expenses combined
<u>Long-distance Telephone Charges</u>	
Long-distance telephone charges to reach an Immediate Family Member if the Covered Person is hospitalized.	• $50 per day up to an overall maximum of $200 per Period of Hospitalization. • To be eligible, the Covered Person must not be accompanied by an Immediate Family Member age 18 or over. • These expenses are eligible if no reimbursement has been made for Transportation Expenses for one Immediate Family Member to the Hospital.
Overall Maximum Benefit	
All Eligible Expenses	$5,000,000 lifetime per Covered Person

RESTRICTIONS, LIMITATIONS AND EXCLUSIONS

DFS reserves the right to apply certain restrictions, limitations and exclusions namely to services, products or drugs that:

1) are used to treat specific conditions other than those for which they are approved by Health Canada,

2) are taken in a higher dose, greater quantity or at a frequency that exceeds DFS's criteria of good clinical practice, or

3) do not meet DFS's prior authorization criteria as of the date the expense is incurred.

Additional Restrictions Applicable to Drugs
All drugs are limited to a 100-day supply.

Limitations
Eligible Expenses are subject to the limitations and maximums specified in this benefit. **Alternate Benefit Clause** For each Eligible Expense for which several products are available on the market, reimbursement is limited to the lowest cost alternative product that represents reasonable treatment.

Additional Limitations Applicable to Drugs
For biologic drugs, DFS reserves the right to reimburse a less expensive biosimilar drug if available on the market.

General Exclusions

No reimbursement is made for:

1) services or treatments that a government health plan prohibits from being paid in whole or in part, except to the extent that it permits reimbursement of the excess amount,

2) services, treatments or supplies that a person received without charge or that may be reimbursed under any provincial or federal law, whether or not the person is covered under those laws,

3) Eligible Expenses which result directly or indirectly from the following:

   a) cosmetic treatment other than what provided for under this Benefit,

   b) committing or attempting to commit a criminal offence, including operating a vehicle while impaired as set out under the Criminal Code of Canada,

   c) any cause that payment is provided for under any Workers' Compensation Act or similar legislation or under any other government plan,

   d) war, whether declared or not, or service in the armed forces of any country, or participation in a riot, insurrection or civil commotion,

4) services, treatments or supplies which are experimental,

5) services, treatments or supplies provided by the Participating Employer,

6) services, treatments or supplies provided to the Covered Person by an Immediate Relative,

7) hospital stay if the stay is primarily for the participation in a therapeutic program, a therapy or a cure,

8) confinement in a Convalescent or Rehabilitation Centre if the stay is primarily for custodial care,

9) home nursing care services rendered solely for custodial care, supervision, companionship or psychotherapy,

10) robotic walking aid apparatus,

11) extra-depth shoes and off-the-shelf shoes that are regular stock,

12) charges for any surgically implanted item,

13) supports such as "Obus form" or similar devices,

14) physical exercise class or program of any kind,

15) therapeutic bath of any kind,

16) fasting therapy and related charges,

17) appliances, supplies and equipment conceived or customized for participation in sporting activities,

18) diagnostic services received in a hospital and expenses incurred for genetic testing,

19) dental services that are not due to an Accident or that are necessary because of food or an object placed purposely or accidentally in the mouth,

20) dental services and supplies for full mouth reconstructions, vertical dimension correction or any other temporomandibular joint dysfunction,

21) incontinence supplies,

22) expenses incurred for fertility treatment,

23) expenses incurred for the treatment of sexual dysfunction,

24) travel for health reasons or for medical examinations required for insurance, consultation or assessment purposes, or

25) services, treatments or supplies not included in the list of Eligible Expenses.

Additional Exclusions Applicable to Drugs

No reimbursement is made for:

1) drugs or products that are on DFS's list of excluded drugs or products. This list is available on DFS's website. In part, the list is based on the drug or product's effectiveness and cost, clinical practice guidelines and recommendations issued by health technology assessment agencies,

2) drugs or products that are or should be administered in a hospital or hospital setting, as determined by DFS. This includes drugs or products that require special supervision during treatment due to the severity of the patient's condition, the complexity of the treatment or for safety reasons. In part, DFS uses information from Health Canada approved product monographs and recommendations issued by health technology assessment agencies to make its determination,

3) contraceptives other than hormonal contraceptives,

4) sclerotherapy used primarily for cosmetic and not therapeutic purposes, including the Physician's fees,

5) the following, whether prescribed or not:

   a) shampoos and other scalp care products, including hair growth products,

   b) aesthetic products, sunscreens, soap and any other hygiene products,

   c) natural products and homeopathic products,

   d) disinfectants and non-medicated dressings,

   e) any infant milk formulas,

   f) dietary supplements,

   g) vitamins and minerals.

Additional Exclusions Applicable to Travel Insurance

"Travel Assistance" must be contacted immediately when a Medical Emergency outside the Member's province of residence requires services. Failure to contact "Travel Assistance" may result in limited reimbursement of any costs incurred or denial of the claim. DFS is not responsible for the availability or quality of the medical services even after repatriation.

No reimbursement is made:

1) if the purpose of the Trip is to receive medical or paramedical treatment or Hospital services,

2) for elective, non-emergency treatment or surgery that could have been provided in the province of residence of the Covered Person without endangering his life or health, even if the service is provided due to a Medical Emergency,

3) if the Covered Person did not agree to:

   a) the treatment prescribed by the Physician or "Travel Assistance",

   b) change hospital or clinic,

   c) be examined for diagnostic purposes,

   d) repatriation as recommended by "Travel Assistance",

4) for any Medical Emergency incurred in a country or region that the Canadian government issues an "avoid all travel" warning for prior to the Trip departure date.

   If a Covered Person is in a country, region or area for which a travel warning is issued during his Trip, the above does not apply. However, arrangements must be made to leave the country, region or area as soon as possible but no later than 14 days following the warning issuance,

5) if the Covered Person refuses to disclose to DFS necessary information regarding other insurance plans under which he also has travel coverage or if he refuses the use of the information by DFS,

6) if the expenses incurred are related to a health condition that is not Stable prior to the Trip departure date,

7) if a Physician advised the Covered Person not to travel,

8) for expenses resulting from a pregnancy, miscarriage, delivery or related complications, if these expenses are incurred after the first 32 weeks of pregnancy,

9) if, due to an Illness, the Covered Person's life expectancy is less than 12 months on the date the Trip is purchased,

10) for an Accident that occurs while travelling and resulting from the Covered Person participating in a sports activity in return for payment (including cash prizes) or a high-risk sport or activity, including without limitation:

a) hang gliding, paragliding and kitesurfing,

b) skydiving and free falling,

c) bungee jumping,

d) climbing and mountain climbing,

e) freestyle skiing and off-track skiing,

f) amateur scuba diving if the Covered Person does not hold at least a basic scuba diving licence from a certified school,

g) combat sports,

h) motorized race and motorized training activities,

11) for death or expenses directly or indirectly related to:

a) drug use, or

b) medication or alcohol abuse.

Medication abuse means intake in excess of the recommended dosage. Alcohol abuse means a blood alcohol content in excess of that allowed under the Criminal Code of Canada.

DENTAL CARE BENEFIT

This benefit is not insured by DFS. It is administered by DFS on behalf of the Policyholder.

SUMMARY OF BENEFITS

When DFS receives satisfactory Proof of Claim that a Covered Person incurred Eligible Expenses while covered under this Benefit, DFS will reimburse those expenses according to policy provisions.

Deductible	
Eligible Expenses	**Amount**
All Eligible Expenses	None
Percentage of Reimbursement	
Eligible Expenses	**Percentage**
Preventive Services	100%
Basic Services	100%
Major Restorative Services	50%
Orthodontics	50%
Maximum Benefit	
Eligible Expenses	**Amount**
Preventive and Basic Services	Unlimited
Major Restorative Services	Combined maximum of $2,000 per calendar year per Covered Person
Orthodontics	Lifetime maximum of $2,000 per Covered Person

BENEFIT PAYMENT

For all Eligible Expenses DFS will reimburse the portion of the charges in excess of the Deductible subject to the Percentage of Reimbursement and the applicable Fee Guide.

To be eligible, the services must be necessary and recommended by a Dentist and performed by:

1) a Dentist,

2) a dental hygienist when the services are within the scope of his license, or

3) a licensed denturist.

The incurred date of any Eligible Expense is the date the service is provided or the appliance is obtained. For the following, the date the expense is incurred is deemed:

1) the date of insertion of the appliance for a bridge, crown, denture or any other appliance, and

2) the date of the final treatment for root canal therapy.

PREDETERMINATION OF BENEFIT

When the total cost of any proposed dental treatment for a Covered Person is expected to exceed $500, the Member should submit a detailed treatment plan to DFS before treatment starts. The treatment plan should outline the type of treatment to be provided, the anticipated treatment dates and the cost of the treatment.

No reimbursement is made for charges incurred after the date the Member's coverage terminates, even if a predetermination was filed and benefits were determined by DFS prior to the termination date.

FEE GUIDE

Reimbursement of Eligible Expenses incurred in Canada is governed by the Provincial Dental Association Fee Guide for General Practitioners, dental hygienists or denturists or specialists of the province where the Member resides and recognized by DFS, for the calendar year during which the services are provided.

Reimbursement of Eligible Expenses incurred outside Canada is governed by the Provincial Dental Association Fee Guide for General Practitioners of the province where the Member resides and recognized by DFS, for the calendar year during which the services are provided.

In the absence of a fee guide recognized by DFS or if the fee guide is not recognized by DFS for the year expenses are incurred, Eligible Expenses are limited to the Reasonable and Customary Charges. Additional expenses related to Eligible Expenses for which no amount is set in the fee guide are limited to the Reasonable and Customary Charges. The Eligible Expenses for lab fees are limited to 67% of the amount for the corresponding procedure in the applicable Fee Guide.

ELIGIBLE EXPENSES

IN CANADA

PREVENTIVE SERVICES	
Eligible Expenses	**Limitations and/or Maximum per Covered Person**
Examinations	
• Complete oral examination	One every 2 calendar years
• Preventive or recall oral examination	One in any 9-month period (in any 6-month period for Covered Persons under age 25)
• Emergency oral examination	
• Specific oral examination	
Radiographs (X-rays)	
• Complete series of radiographs or panoramic radiographs	One complete series of radiographs and one panoramic radiograph every 2 calendar years
• Intraoral radiographs (except bitewing films)	
• Bitewing films	4 radiographs per calendar year
• Extraoral radiographs	Expenses covered, including temporomandibular joint radiographs One occlusal radiograph per calendar year
• Photography	

• Tomogram or tomography	
Lab Tests and Examinations	
• Microbiological testing	
• Biopsy	
• Pulp vitality test	
• Diagnostic cast	
Consultations	
• Consultation with a patient	
Preventive Services	
• Oral hygiene instruction	One unit in any 9-month period (once in any 6-month period for Covered Persons under age 25)
• Polishing	Once in any 9-month period (once in any 6-month period for Covered Persons under age 25)
• Fluoride treatment	Once in any 9-month period (once in any 6-month period for Covered Persons under age 25)
• Finishing restorations, including disking and recontouring of natural teeth to improve function	
• Pit and fissure sealants	For Children under age 19
• Interproximal disking	
• Space maintainer	For missing primary teeth and only for Children under age 18
Oral Surgery	
Extraction of impacted teeth	

BASIC SERVICES	
Eligible Expenses	**Limitations and/or Maximum per Covered Person**
Restorations	
• Amalgam restoration (metal fillings)	
• Composite restoration (white fillings)	
• Retentive pin for amalgam and composite restoration	
• Prefabricated restoration	
• Caries / trauma / pain control procedures (as a separate procedure from a restoration)	
Endodontics	
• Endodontic emergency and treatment of the pulp chamber	
• Root canal therapy	
• Periapical services	
• Miscellaneous endodontic services other than bleaching	

Periodontics	
• Periodontal surgery	
• Post-operative visit	
• Gingival curettage	
• Scaling and root planing	Combined maximum of 8 units per calendar year
• Periodontal bruxism appliance	One maxillary (upper arch) and one mandibular (lower arch) appliance every 2 calendar years The maximum is combined with the maximum for adjustment to a periodontal bruxism appliance
• Adjustment to a periodontal bruxism appliance	One maxillary (upper arch) and one mandibular (lower arch) appliance every 2 calendar years The maximum is combined with the maximum for periodontal bruxism appliance
• Occlusal equilibration	8 units in any 12-month period or One major and 3 minor in any 12-month period
Maintenance of Removable Dentures	
• Repair or addition	
• Relining or rebasing	One reline or one rebase every 2 calendar years
• Adjustment when performed at least 3 months after the initial insertion	Once in any 6-month period

Oral Surgery	
• Extraction other than extraction of impacted teeth	
• Removal of residual roots	
• Surgical exposure of teeth without orthodontic attachment	
• Alveolectomy, alveoplasty, stomatoplasty, tuberoplasty and osteoplasty	
• Alveolar ridge reconstruction	
• Extension of mucous folds	
• Excision in the oral cavity	
• Incision in the oral cavity	
• Frenectomy	
• Treatment of salivary glands	
• Antral surgery (sinuses)	
• Control of hemorrhage	
• Post-surgical care	
General Services	
• General anaesthesia, conscious or deep sedation	When administered in conjunction with a dental Eligible Expense
• Provision of facilities, equipment and support services for general anaesthesia or deep sedation	When administered in conjunction with a dental Eligible Expense

MAJOR RESTORATIVE SERVICES
Initial
Expenses incurred for an initial appliance are eligible if the appliance is necessary because at least one natural tooth is extracted while the Covered Person is covered under this Benefit or a comparable coverage under the Policyholder's group benefit plan in effect immediately prior to the effective date of this Benefit.
Replacement of a Prosthodontic Appliance
Replacement of an existing appliance by a permanent appliance, including an implant, is eligible if: 1) it is necessary because at least one natural tooth is extracted while the Covered Person is covered under this Benefit or a comparable coverage under the Policyholder's group benefit plan in effect immediately prior to the effective date of this Benefit, 2) the existing appliance is at least 3 years old, or 3) the existing appliance is temporary and is less than 12 months old. Reimbursement for the permanent appliance is reduced by the amount DFS previously reimbursed for the temporary appliance. After that period the temporary appliance is considered permanent.
Replacement - Other Restorations
Replacement of an existing restoration is eligible if: 1) the existing restoration is at least 60 months old, or 2) the existing restoration is temporary and is less than 12 months old. Reimbursement for the permanent restoration is reduced by the amount DFS previously reimbursed for the temporary restoration. After that period the temporary restoration is considered permanent.

Eligible Expenses	Limitations and/or Maximum per Covered Person
Removable Dentures	
• Complete denture	
• Partial denture	
• Remake	
• Remount with occlusal equilibration	
• Therapeutic tissue conditioning	
Fixed Prosthodontics	
• Bridgework (retainer and pontic)	
• Repair	
• Removal	
• Recementation	
Other Restorations	
• Veneer, gold foil, inlay, only, crown	
• Repair	
• Retentive pins, posts and cores	
• Recementation	
• Removal	

ORTHODONTICS
Eligible Expenses are only those listed below: • Orthodontic treatment to correct malocclusion • Myofunctional therapy • Complete orthodontic examination • Specific orthodontic examination • Cephalometric radiographs • Control of oral habits appliance

OUTSIDE CANADA

For dental treatment rendered outside Canada to be eligible, the services must be:

1) for emergency treatment only, and

2) included in the list of Eligible Expenses in Canada.

RESTRICTIONS, LIMITATIONS AND EXCLUSIONS

Restrictions
Late Application If the Member's application for the Dental Care Benefit is late, for either himself or his Dependents, reimbursement is limited to $300 per Covered Person for the first 36 months of coverage for Orthodontics and to $100 per Covered Person for the first 12 months of coverage for all other expenses.

Limitations
Eligible Expenses are subject to the limitations and maximums specified in this benefit. Any amount that exceeds the maximum indicated in the appropriate Fee Guide cannot be reimbursed.

Alternate Benefit Clause

When 2 or more courses of eligible dental treatment are available that adequately correct a dental condition, reimbursement is based on the cost of the least expensive eligible treatment that provides the Covered Person with adequate care.

For a crown or denture on implant, benefits are limited to the amount that would have been payable for a tooth supported crown or a non-implant related denture.

The concept of a suitable course of treatment can vary among dental professionals. This limitation is not meant to affect the treatment plan as agreed to by the professional and the Covered Person.

General Exclusions

No reimbursement is made for:

1) services or treatments that a government health plan prohibits from being paid in whole or in part, except to the extent that it permits reimbursement of the excess amount,

2) services, treatments or supplies that a person received without charge or that may be reimbursed under any provincial or federal law, whether or not the Covered Person is covered under those laws,

3) any dental treatment not approved by the Canadian Dental Association or that is considered experimental,

4) services, treatment or supplies provided by the Participating Employer,

5) charges made by a Dentist for broken appointments, claim forms or telephone advice,

6) Eligible Expenses that result directly or indirectly from:

   a) committing or attempting to commit a criminal offence, as set out under the Criminal Code of Canada,

   b) a cause that is the responsibility of a Workers' Compensation Act or similar legislation or any other government plan,

   c) war, whether declared or not, or service in the armed forces of any country, or participation in a riot, insurrection or civil commotion,

7) any dental treatment for cosmetic purposes, when the form and function of the teeth are satisfactory and no pathological condition exists,

8) audio-visual oral hygiene instruction,

9) nutritional counselling,

10) any dental services or supplies, including X-rays, provided for:

    a) full mouth reconstruction,

    b) vertical dimension correction, or

    c) the correction of temporomandibular joint dysfunctions,

11) bleaching,

12) expenses incurred for implantology, except for dentures on implants,

13) patient motivation (psychological evaluation),

14) expenses incurred to replace lost, mislaid or stolen dentures and appliances,

15) anaesthesia administered by acupuncture, by hypnosis or electronically,

16) mouth guards and appliances conceived or customized for participation in sporting activities,

17) semi-precision or precision attachments,

18) personal protective equipment, and

19) services, treatments or supplies not included in the list of Eligible Expenses.

MEMBER CUSTOM LONG TERM DISABILITY BENEFIT

SUMMARY OF BENEFITS

When DFS receives satisfactory Proof of Claim that the Member:

1) became Totally Disabled while covered under this Benefit and remained Totally Disabled during the Qualifying Period, and

2) is under Continuing Medical Care of a Physician in Canada,

DFS pays benefits according to policy provisions.

MEMBER CUSTOM LONG TERM DISABILITY BENEFIT

Percentage of Benefit based on the length of Continuous Service up to the first day of absence		
At least	**But less than**	**Percentage and Maximum of Benefit**
6 months	20 years	65% of monthly gross Earnings, rounded to the next $1, if not already a multiple No maximum Maximum without Evidence of Insurability: no evidence required if application is completed within the time limit
20 years	30 years	70% of monthly gross Earnings, rounded to the next $1, if not already a multiple No maximum Maximum without Evidence of Insurability: no evidence required if application is completed within the time limit
30 years		75% of monthly gross Earnings, rounded to the next $1, if not already a multiple No maximum Maximum without Evidence of Insurability: no evidence required if application is completed within the time limit

Minimum Benefit Payment
$50 per month, for benefits paid before age 65, after reductions
Qualifying Period
30 weeks including sick leave or the date the Member is no longer entitled to receive earnings or benefits under a salary continuance plan or short term disability income plan, whichever is later
Maximum Age to be Eligible
64 years and 22 weeks
Maximum Benefit Period
For Members with less than 10 years of service at the date of their disability: • If benefit payments start on or before the Member's 64th birthday, and the Member continues to be Totally Disabled, the Member's 65th birthday. • If benefit payments start after the Member's 64th birthday but before the Member's 65th birthday, and the Member continues to be Totally Disabled, 12 months after the Qualifying Period ends. For Members with 10 years or more of service at the date of their disability: up to the Member's death.
Taxability Status
Taxable

QUALIFYING PERIOD

The Qualifying Period is the period of continuous Total Disability that must be completed before disability benefits may be paid.

If Total Disability begins while on Temporary Lay-off, Authorized Leave of Absence, Maternity or Parental absence or leave, the Qualifying Period begins on the date the Member is scheduled to return to work, provided the Member can and does continue his coverage under this Benefit throughout the leave.

BENEFIT PAYMENT

Benefits are payable each month, starting on the date the Qualifying Period ends.

Benefits are paid for as long as the Member remains Totally Disabled, up to the Maximum Benefit Period.

Benefits are based on the Earnings immediately prior to the initial date of Total Disability.

Any payments for a period of less than one month are at the daily rate of 1/30th of the monthly benefit.

RECURRENT DISABILITY

Successive periods of Total Disability are considered recurrent if the Member is Actively at Work between occurrences for:

1) less than 3 consecutive weeks during the Qualifying Period, if due to the same or related cause, or

2) less than 6 consecutive months after the end of Member Long Term Disability benefits.

Successive periods of Total Disability due to entirely unrelated cause are considered recurrent unless the Member is Actively at Work for one day.

The Qualifying Period only needs to be served once if Total Disability is a Recurrent Disability.

REHABILITATION

At any time, DFS may require a Totally Disabled Member to take part in a rehabilitative program satisfactory to DFS. The purpose of a rehabilitative program is to return a Totally Disabled Member to remunerative employment that would provide an income equal or greater than the disability benefit for which the Member was covered when Total Disability began, adjusted annually by the Consumer Price Index. The activities of the rehabilitative program must:

1) be approved by DFS,

2) be medically approved by a Physician involved in treating the Member, and

3) involve, without limitation, one or more of

    a) assessment,

    b) counselling,

    c) medical or psychological treatment,

    d) a vocational retraining or education program,

    e) trial work, part-time work or modified work.

The Member is no longer eligible for benefit payments under this Benefit if he refuses:

1) to participate in a rehabilitative program, or

2) to take up rehabilitative employment,

considered appropriate by DFS.

REDUCTION OF BENEFITS

1) Direct Offset

a) Benefits payable are reduced by any:

i) amounts that the Member is eligible to receive under any Workers' Compensation Act or similar legislation,

ii) disability and early retirement benefits the Member is eligible to receive under the Canada Pension Plan or the Quebec Pension Plan excluding amounts payable on behalf of his Spouse or Children,

iii) Old Age Security benefits,

iv) amounts to indemnify salary loss under any no-fault automobile insurance plan, and

v) disability benefits payable by a private pension plan,

Cost-of-living increases given after benefits begin are not included in the sources mentioned above.

b) Benefits payable are not reduced by income from the following sources:

i) a policy which is solely an individual disability income policy,

ii) a disability attachment to an individual life insurance policy,

iii) a government plan providing disability income if DFS receives proof that the initial application has been declined and an appeal (filed within one year of the original decision to decline for those disability benefits) has been declined.

2) Indirect Offset

Benefits are further reduced so that the Member's total income from all sources does not exceed 85% of the gross monthly Earnings in effect immediately prior to the initial date of Total Disability.

The Member's total income from all sources includes any of the following that the Member receives or is eligible to receive:

a) any amounts payable under this Benefit,

b) any Earnings from the Participating Employer,

c) any disability benefits payable under:

   i) the Canada Pension Plan or the Quebec Pension Plan, excluding amounts payable on behalf of Dependents,

   ii) the Workers' Compensation Act or similar legislation for salary loss,

   iii) any other government plan, excluding benefits payable under the Employment Insurance Act, or

   iv) any other group or association insurance plan,

d) any amount payable by a private pension plan for disability, and

e) salary loss replacement paid any government no-fault automobile insurance plan.

Cost-of-living increases given after benefits begin are not included in total income from all sources.

3) Additional reduction in case of Rehabilitation

If a Member earns any income while taking part in a rehabilitative program, the benefits payable by DFS are reduced by 50% of the income earned from any rehabilitative program.

While the Member is taking part in a rehabilitative program, benefits and income identified under **Direct Offset** are added to the rehabilitative income so that his total income does not exceed 100% of his gross Earnings immediately prior to the initial date of Total Disability.

4) Amount payable under public plans

The Member is required to apply for all benefits available to him under any of the above plans or legislations. If he fails to apply, DFS may estimate the income that is otherwise payable under any government plan. The Member's benefits are reduced by this estimated amount. Any adjustments are made once the notice of the actual award is received.

LIMITATIONS AND EXCLUSIONS

Limitations

No benefits are payable for any period of Total Disability:

1) while the Member engages in any gainful occupation. This does not include rehabilitative program approved by DFS,

2) during a Parental or Family Related Leave, or the "voluntary leave portion" of the Maternity Leave for Total Disability occurring during this period,

3) during any absence from work due to a strike, lock-out, Leave of Absence or lay-off, for Total Disability occurring during this period,

4) while the Member is imprisoned due to conviction of an offence,

5) if the Member remains outside Canada for longer than 3 weeks regardless of the reason, unless DFS gives prior written consent,

6) for which the Member is required to provide satisfactory proof of continued Total Disability. Also the date the Member is required to undergo a medical examination at the request of DFS, but neglected or refused to do so, and

7) while the Member refuses to take part or participate in a rehabilitative program considered appropriate by DFS.

Exclusions

No benefits are payable for Total Disability resulting directly or indirectly from any one of the following causes:

1) war, whether declared or not, or service in the armed forces of any country, or participation in a riot, insurrection or civil commotion, and

2) committing or attempting to commit a criminal offence, excluding operating a vehicle while impaired, as set out under the Criminal Code of Canada.

TERMINATION OF BENEFIT PAYMENTS

Benefit payments end on the earliest of the date:

1) the Member is no longer Totally Disabled,

2) the Member dies,

3) benefits have been paid up to the Maximum Benefit Period for any one episode of Total Disability, or

4) this Benefit terminates.

LIFE INSURANCE BENEFIT

SUMMARY OF BENEFITS

When DFS receives satisfactory proof of claim that a person died while covered under this Benefit, DFS will pay the amount applicable to that person according to policy provisions.

CUSTOM BASIC LIFE INSURANCE BENEFIT

Member
Amount of Insurance
Option A: $5,000 **Option B:** 2 times annual Earnings, rounded to the nearest $500, if not already a multiple Maximum: $1,000,000 Maximum of $850,000 without Evidence of Insurability if application is completed within the time limit
Reduction
On the Member's 65th birthday, the Amount of Insurance is reduced to $300 x number of Completed Years of Service, up to $4,500

CUSTOM VOLUNTARY LIFE INSURANCE BENEFIT

Amount of Insurance		
Member	**Spouse**	**Each Child**
Any multiple of $10,000 Maximum $500,000	Any multiple of $10,000 Maximum $500,000	Any multiple of $5,000 Maximum $20,000

REDUCTION

The reduced Amount of Insurance is calculated using the number of Completed Years of Service in each capacity during which the Employee was covered under the policy and/or another Participating Employer's policy as a full-time Employee.

Completed Years of Service means the years included within the 15-year period immediately preceding age 65 during which, as determined by the Participating Employer:

1) the Member was providing Continuous Service,

2) the Member was satisfying any Qualifying Period, and

3) premiums were waived for the Member due to Total Disability.

SUICIDE EXCLUSION

No amount of Voluntary Life Insurance Benefit is paid if a person commits suicide or dies due to a suicide attempt, while sane or insane, within 2 years of the effective date of:

1) the person's coverage under this Benefit,

2) the reinstatement of his coverage, or

3) any subsequent increase to the amount of coverage.

Coverage or any increase in coverage is void. DFS's liability is limited to refunding the premiums paid.

EARLY PAYMENT

A Member whose life expectancy is less than 12 months may apply for payment of a portion of his amount of Basic Life Insurance Benefit subject to the following conditions:

1) approval is obtained from DFS,

2) the Member must attend any examination by a Physician designated by DFS when required,

3) the Member is competent to act, and

4) the Member is under age 64 at the time he makes the election.

The Early Payment is 90% of the amount of Basic Life Insurance Benefit applicable to the Member.

The Early Payment is in exchange for all other benefits under the Member Basic Life Insurance Benefit provisions.

The value of the Early Payment is:

1) the total amount of Early Payment paid, plus

2) the reasonable costs to verify the medical condition of the Member.

EARLY PAYMENT EXCLUSION

The Early Payment is not payable if there is any material misrepresentation or non-disclosure in the application. If the application or coverage is discovered to be void after the Early Payment is paid, the Value of the Early Payment will be repaid to DFS by the recipient of the Early Payment.

INCOME OPTION

A Member who has been permanently Totally Disabled for at least 2 years may apply for payment of a portion of his amount of Voluntary Life Insurance Benefit subject to the following conditions:

1) Member's Voluntary Life Insurance Benefit premiums are waived,

2) the Member must submit a request in writing.

The income paid is 1/3 of the amount of Voluntary Life Insurance Benefit applicable to the Member on the date he becomes Totally Disabled.

The balance of the amount of Voluntary Life Insurance Benefit remains in force and premiums continue to be waived.

CONVERSION PRIVILEGE

If the Life Insurance Benefit of a Member terminates or is reduced (not solely at the Member's request for the Voluntary Life Insurance Benefit), the Member is entitled to convert his and his Dependents' amount of insurance to an individual policy (subject to any minimum amount) without Evidence of Insurability, up to the lesser of:

1) $200,000, or

2) the difference between the amount of Life Insurance Benefit in force on the date of termination of coverage and the amount of insurance that the Member is eligible for under another group life insurance at the time he exercises his conversion right.

A written application for conversion must be submitted to DFS within 31 days of the date of termination of his coverage under this Benefit.

The amount of Life Insurance Benefit that a Member is eligible to convert is reduced by the amount of any in force individual Life Insurance Benefit that he previously converted under the terms of this provision. Any amount converted under any other group insurance policy issued by DFS is also reduced from the amount the Member is eligible to convert.

If the Member is under age 65, the individual policy issued by DFS is one of the plans designated for conversion by DFS.

If the Member is aged 65 or over, the individual policy is a regular permanent plan issued by DFS.

The individual policy takes effect after 31 days immediately following the date of termination of his coverage under this Benefit.

If a Member dies within 31 days of termination of his coverage under this Benefit, the amount he is able to convert is eligible to be paid.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

SUMMARY OF BENEFITS

When DFS receives satisfactory Proof of Claim that:

1) a Covered Person suffered one of the losses specified below within 365 days of an Accident,

2) the loss is the direct result of the Accident, independent of any other cause, and

3) the Accident and the loss occurred while the Person is covered under this Benefit,

DFS will pay the amount as specified in the Schedule of Losses and all other policy provisions.

BASIC ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

Amount of Insurance		
Member	**Spouse**	**Each Child**
Equal to the Basic Life Insurance Benefit	Not covered	Not covered
Reduction		
None		

VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

Amount of Insurance		
Member	**Spouse**	**Each Child**
Any multiple of $25,000 Maximum $500,000	Any multiple of $25,000 Maximum $500,000	$50,000

SCHEDULE OF LOSSES

The amount payable is based on the percentage of the amount of insurance specified in the Summary of Benefits.

Loss of	Percentage
Life	100%
Sight of Both Eyes	100%
Both Hands or Both Feet	100%
Both Arms or Both Legs	100%
One Hand and Sight of One Eye	100%
One Foot and Sight of One Eye	100%
Hearing in Both Ears and Speech	100%
One Hand and One Foot	100%
Hearing in Both Ears or Speech	100%
One Arm or One Leg	75%
One Hand or One Foot	75%
Sight of One Eye	75%
Hearing in One Ear	50%
Thumb and Index Finger of the Same Hand	33 1/3%
At least Four Fingers of the Same Hand	33 1/3%
Four Toes of One Foot	25%

Loss of Use of	Percentage
Both Arms or Both Legs	100%
Both Hands or Both Feet	100%
One Hand and One Foot	100%
One Arm or One Leg	75%
One Hand or One Foot	75%
Hemiplegia, Paraplegia, Quadriplegia	200%

DISAPPEARANCE

If a Covered Person disappears due to an Accident involving the sinking or disappearance of a conveyance in which he is riding and his body is not found within 365 days of the Accident, it is presumed that the Covered Person died due to the Accident unless there is evidence to the contrary.

EXPOSURE TO THE ELEMENTS (FORCES OF NATURE)

Loss due to unavoidable exposure to the Elements is considered an Accident.

REHABILITATION
(Applicable to the basic benefit only)

If a Member requires training because of an eligible loss, DFS reimburses the reasonable and necessary training expenses actually incurred, up to a maximum of $15,000, provided that:

1) the Member requires the training in order to qualify for employment in an occupation he would otherwise not engage in except for the loss, and

2) expenses are incurred within 3 years of the date of the Accident.

FAMILY TRANSPORTATION AND HOTEL ACCOMMODATION (Applicable to the basic benefit only)

If a Covered Person is confined in a Hospital due to an eligible loss under this Benefit, DFS reimburses the reasonable expenses incurred by members of his Immediate Relatives for hotel accommodation and transportation by the most direct route to the Hospital, up to a lifetime maximum of $1,500 for all expenses combined, provided that:

1) he is confined as an inpatient,

2) the Hospital is located more than 150 kilometres from his normal place of residence, and

3) he is under the regular care of a Physician.

REPATRIATION (Applicable to the basic benefit only)

If a Covered Person dies due to an Accident, DFS reimburses the reasonable and customary expenses incurred for preparation of the body for burial or cremation and transportation of the body from the place of the Accident to the Covered Person's place of residence in Canada, up to a maximum of $15,000, provided that:

1) the Accident occurs 50 kilometres or more from his normal place of residence, and

2) the loss of life benefit is eligible to be paid under this Benefit.

HOME OR VEHICLE CONVERSION (Applicable to the basic benefit only)

DFS reimburses the initial costs of converting the following if the Covered Person suffers an eligible loss requiring the use of a wheelchair, proof of payment is required:

1) the Covered Person’s home so that it is wheelchair-accessible, and

2) one Vehicle belonging to the Covered Person so that he can access this vehicle and/or drive it.

Reimbursement is limited to one conversion for each expense and an overall maximum of $10,000.

Reimbursement is only made if:

1) the modifications made to the home are done by one or more people approved by a licensed organization that offers support and assistance to wheelchair users, and

2) the modifications made to the vehicle are done by one or more people authorized by the provincial motor vehicle office in the Covered Person’s province of residence.

EDUCATION COSTS
(Applicable to the basic benefit only)

If a Member dies due to an Accident DFS reimburses an Education Costs benefit for each Child if:

1) on the date of the Accident the Child is enrolled as a full-time student in an institution of higher learning above the secondary school level, and

2) the loss of life benefit is eligible to be paid under this Benefit.

The Education Costs Benefit includes all reasonable and necessary expenses for tuition fees incurred after the Member's death, up to

1) 5% of the amount that the Member is covered for under this Benefit on the date of his death, and

2) an overall maximum of $5,000 per year for a maximum of 4 years.

DAY CARE BENEFIT
(Applicable to the basic benefit only)

If a Member dies due to an Accident, DFS reimburses any cost of day care if:

1) the dependent Child is under age 13,

2) the Child is enrolled in a licensed day care centre within one year of the Member's death, and

3) the loss of life benefit is eligible to be paid under this Benefit.

The Day Care Benefit includes all reasonable and necessary expenses for day care, up to

1) 5% of the amount that the Member is covered for under this Benefit on the date of his death, and

2) an overall maximum of $5,000 for each Child.

SPOUSAL RETRAINING
(Applicable to the basic benefit only)

If the Spouse is covered under the policy on the date the Member dies due to an Accident, DFS reimburses the reasonable and necessary expenses actually incurred by the Spouse to take part in a formal occupational training program. Reimbursement is limited to a maximum of $15,000 provided that:

1) the Spouse requires training in order to gain the skills necessary to perform the duties of a specific occupation he otherwise does not have sufficient qualifications for,

2) the expenses are incurred within 3 years of the date of the Accident, and

3) the loss of life benefit is eligible to be paid under this Benefit.

LIMITATIONS AND EXCLUSIONS

Limitations

For multiple losses to the same limb from a single Accident, the maximum amount payable is the loss in the schedule with the highest percentage. Payment for all losses caused by a single Accident cannot exceed:

1) 200% of the Amount of Insurance for Hemiplegia, Paraplegia and Quadriplegia, or

2) 100% of the Amount of Insurance for other losses.

Exclusions

No payment is paid for a loss resulting in whole or in part, directly or indirectly from any of the following:

1) suicide or intentionally self-inflicted injury, while sane or insane,

2) an Illness that does not result from an Accident, but that appears at the time of the Accident,

3) service in the armed forces of any country,

4) travel or flight aboard, or boarding or alighting from any aircraft if, when the loss occurred:

   a) the Covered Person was operating, learning to operate or serving as a member of the crew, or

   b) the aircraft was being used for crop dusting, crop spraying, seeding, skywriting, racing, testing, exploration or any purpose other than transportation.

Under the REHABILITATION, EDUCATION COSTS, DAY CARE BENEFIT and SPOUSAL RETRAINING provisions, costs for room and board, ordinary travelling, living and clothing expenses are not eligible.

DSF does not pay for the following services, if they are reimbursed from other sources or covered under another benefit of the policy:

- REHABILITATION,
- REPATRIATION,
- SPOUSAL RETRAINING,
- FAMILY TRANSPORTATION AND HOTEL ACCOMMODATION,
- DAY CARE BENEFIT, and
- HOME OR VEHICLE CONVERSION.

CONVERSION PRIVILEGE

If the Accidental Death and Dismemberment Benefit of a Member under age 65 terminates or is reduced not solely at the Member's request, the Member is entitled to convert his and his Dependents' amount of insurance to an individual policy without Evidence of Insurability.

The terms, conditions and restrictions applicable under the CONVERSION PRIVILEGE provision of the Life Insurance Benefit applies to any individual policy available under this Benefit.

CRITICAL ILLNESS BENEFIT

SUMMARY OF BENEFITS

When DFS receives satisfactory Proof of Claim for a Critical Illness, DFS will pay the Amount of Insurance then in force according to policy provisions:

1) a Specialist diagnosed a Covered Person as having one of the Eligible Illnesses, and

2) when the diagnosis of an Eligible Illness is first made, the individual is covered for this Benefit.

In addition, to be eligible, a surgery listed in the Eligible Illnesses provision must be:

1) medically necessary,

2) performed in compliance with the written advice of a Specialist, and

3) performed by a Physician in Canada.

OPTIONAL CRITICAL ILLNESS BENEFIT

MEMBER	
Type of Plan	**Amount of Insurance**
Enhanced	Any multiple of $10,000 Maximum $150,000 Maximum of $50,000 without Evidence of Insurability if application is completed within the time limit

Dependents		
Amount of Insurance		
Type of Plan	**Spouse**	**Each Child**
Enhanced	Any multiple of $10,000 Maximum: $150,000 Maximum of $40,000 without Evidence of Insurability if application is completed within the time limit	Any multiple of $5,000 Maximum: $10,000

ELIGIBLE ILLNESSES

CRITICAL ILLNESSES – ENHANCED PLAN

The following Critical Illnesses apply to all Covered Persons.

Alzheimer's Disease
Definitive diagnosis of a progressive, degenerative disease of the brain. The Covered Person must exhibit the loss of intellectual capacity involving impairment of memory and judgement that results in a significant reduction in mental and social functioning. The Covered Person must also require a minimum of 8 hours of daily supervision. **Exclusions**: No benefit is payable under this condition for all other organic dementing brain disorders and psychiatric illnesses.
Aortic Surgery
Surgery for disease of the aorta requiring excision and surgical replacement of the aorta with a graft. Aorta refers to the thoracic and abdominal aorta, but not its branches. To qualify, the Covered Person must be alive for at least 30 days after the surgery and satisfy the Survival Period definition.
Aplastic Anemia
Definitive diagnosis of a chronic, persistent bone marrow failure, confirmed by biopsy. This must result in anemia, neutropenia and thrombocytopenia requiring blood product transfusion, and treatment with at least one of the following: 1) marrow stimulating agents, 2) immunosuppressive agents, or 3) bone marrow transplantation.
Bacterial Meningitis
Definitive diagnosis of meningitis confirmed by cerebrospinal fluid that shows growth of pathogenic bacteria in culture. This must result in a documented neurological deficit lasting for at least 90 days from the date of diagnosis. **Exclusion**: No benefit is payable under this condition for viral meningitis.

Benign Brain Tumour

Definitive diagnosis of a non-malignant tumour located in the cranial vault and limited to the brain, meninges, cranial nerves or pituitary gland. The tumour must require surgical or radiation treatment or cause Irreversible, objective neurological deficit(s).

Exclusion: No benefit is payable under this condition for pituitary adenomas less than 10 mm.

Exclusion Period: No benefit is payable under this condition if, within the first 90 days following the later of:

1) the date of Commencement of Coverage,

2) the effective date of last reinstatement of coverage under this Benefit,

the Covered Person had any of the following:

1) signs, symptoms or investigations that lead to a diagnosis of Benign Brain Tumour without regard to the eligibility of the diagnosis or when the diagnosis is made, or

2) a diagnosis of Benign Brain Tumour without regard to the eligibility of the diagnosis.

The medical information described above must be reported to DFS within 6 months of the date of the diagnosis. DFS has the right to deny any claim for Benign Brain Tumour or for any Critical Illness caused by any Benign Brain Tumour or its treatment if this information is not provided.

Blindness

Definitive diagnosis of the total and Irreversible loss of vision in both eyes, evidenced by:

1) corrected visual acuity being 20/200 or less in both eyes, or

2) the field of vision being less than 20 degrees in both eyes.

Cancer (Life-Threatening)

Definitive diagnosis of a tumour characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue.

Exclusions: No benefit is payable under this condition for the following non-life-threatening cancers:

1) carcinoma in situ,

2) Stage 1A malignant melanoma (melanoma less than or equal to 1.0 mm in thickness, not ulcerated and without Clark level IV or level V invasion),

3) any non-melanoma skin cancer that has not metastasized,

4) Stage A (T1a or T1b) prostate cancer.

Exclusion Period: No benefit is payable under this condition if, within the 90 days immediately following the later of:

1) the date of Commencement of Coverage,

2) the effective date of last reinstatement of coverage under this Benefit,

the Covered Person had any of the following:

1) signs, symptoms or investigations that lead to a diagnosis of cancer covered or excluded, regardless of when the diagnosis was made,

2) a diagnosis of cancer covered or excluded under this Benefit.

The medical information must be reported to DFS within 6 months of the date of diagnosis. DFS has the right to deny any claim for Cancer or any Specific Illness or Critical Illness caused by any Cancer or its treatment if this information cannot be provided.

Coma

Definitive diagnosis of a state of unconsciousness with no reaction to external stimuli or response to internal needs for a continuous period of at least 96 hours. The Glasgow Coma Score must be 4 or less during this period.

Exclusion: No benefit is payable under this condition for the following:

1) a medically induced coma,

2) a coma which results directly from alcohol or drug use,

3) a diagnosis of brain death.

Coronary Artery Bypass Surgery

Heart Surgery to correct a narrowing or blockage of one or more coronary arteries with bypass graft(s).

To qualify, the Covered Person must be alive for at least 30 days after the surgery and satisfy the Survival Period definition.

Exclusion: No benefit is payable under this condition for non-surgical or trans-catheter techniques such as balloon angioplasty or laser relief of an obstruction.

Deafness

Definitive diagnosis of the total and Irreversible loss of hearing in both ears, with an auditory threshold of 90 decibels or greater within the speech threshold of 500 to 3,000 hertz.

Dilated Cardiomyopathy

Definitive diagnosis of impaired ventricular function resulting in significant physical impairment of at least Class III of the New York Heart Association (NYHA) Classification of Cardiac Impairment. The Diagnosis must be confirmed by a new echocardiography demonstrating abnormal cardiac function and a persistent low ejection fraction (less than 40%) for at least 3 months.

NYHA Class III cardiomyopathy impairment means that the patient is comfortable at rest and is symptomatic during less than ordinary daily activities despite the use of medication and dietary adjustment. There must be evidence of abnormal ventricular function on physical examination and in laboratory studies.

To qualify, the Covered Person must be alive for at least 30 days after the diagnosis and satisfy the Survival Period definition.

Exclusion: ischemic and toxic causes (including alcohol and prescription or non-prescription drug use) are excluded under this condition.

Fulminant Viral Hepatitis

Definitive diagnosis of a sub-massive to massive necrosis of the liver caused by any virus leading to sudden liver failure. All of the following conditions must be met:

1) a rapidly decreasing liver size as confirmed by abdominal ultrasound,
2) necrosis involving entire lobules leaving only a collapsed reticular framework (available histology to be included),
3) rapidly deteriorating liver function tests, and
4) deepening jaundice.

Exclusion: No benefit is payable under this condition for the following:

1) chronic hepatitis,

2) liver failure caused by alcohol, toxins or drugs.

Heart Attack

Definitive diagnosis of the death of heart muscle due to blood flow obstruction that resulted in the rise and fall of biochemical cardiac markers to levels considered diagnostic of myocardial infarction. At least one of the following must be present:

1) heart attack symptoms,

2) new electrocardiogram (ECG) changes consistent with a heart attack, or

3) development of new Q waves during or immediately following an intra-arterial cardiac procedure including without limitation coronary angiography and coronary angioplasty.

To qualify, the Covered Person must be alive for at least 30 days after the diagnosis and satisfy the Survival Period definition.

Exclusions: No benefit is payable under this condition for the following:

1) elevated biochemical cardiac markers as a result of an intra-arterial cardiac procedure including without limitation, coronary angiography and coronary angioplasty, in the absence of new Q waves, or

2) ECG changes suggesting a prior myocardial infarction that does not meet the Heart Attack definition as described above.

Heart Valve Replacement

Surgery to replace any heart valve with either a natural or mechanical valve.

To qualify, the Covered Person must be alive for at least 30 days after the surgery and satisfy the Survival Period definition.

Exclusion: heart valve repair is excluded under this condition.

Kidney Failure

Definitive diagnosis of chronic Irreversible failure of both kidneys to function resulting in regular hemodialysis, peritoneal dialysis or for which renal transplantation is initiated.

Liver Failure Of Advanced Stage

Definitive diagnosis of liver failure due to cirrhosis and resulting in all of the following:

1) permanent jaundice,

2) ascites, and

3) encephalopathy.

Exclusion: No benefit is payable under this condition for liver disease secondary to alcohol or drug use.

Loss Of Independent Existence

Definitive diagnosis of:

1) the total inability to independently perform at least 2 of the following 6 activities of daily living, or

2) cognitive impairment, as defined below,

for a continuous period of at least 90 days with no reasonable chance of recovery.

Activities of daily living are:

1) bathing – the ability to wash oneself in a bathtub, shower or by sponge bath with or without the aid of equipment,

2) dressing – the ability to put on and remove necessary clothing including braces, artificial limbs or other medical appliances,

3) toileting – the ability to get on and off the toilet and maintain personal hygiene,

4) bladder and bowel continence – the ability to manage bowel and bladder function with or without protective undergarments or medical appliances so that a reasonable level of hygiene is maintained,

5) transferring – the ability to move in and out of a bed, chair or wheelchair with or without the use of equipment,

6) feeding – with or without the use of adaptive utensils, the ability to consume food or drink that has been prepared and made available to the individual.

Cognitive impairment means mental deterioration and loss of intellectual ability evidenced by deterioration in memory, orientation and reasoning. These must be measurable and result from a demonstrable organic cause as diagnosed by a Specialist. The degree of cognitive impairment must be sufficiently severe as to require a minimum of 8 hours of daily supervision.

Determination of a cognitive impairment is made on clinical data and valid standardized measures of such impairments.

Exclusion: No benefit is payable under this condition for any mental or nervous disorder without a demonstrable organic cause.

Loss Of Limbs

Definitive Diagnosis of the complete severance of 2 or more limbs at or above the wrist or ankle joint as the result of an Accident or medically required amputation.

Loss Of Speech

Definitive Diagnosis of the total and Irreversible loss of the ability to speak as the result of physical injury or disease, for a period of at least 180 days.

Exclusion: No benefit is payable under this condition for all psychiatric related causes.

Major Organ Failure On Waiting List

Definitive Diagnosis of the Irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, for which transplantation is medically necessary. The Covered Person must become enrolled as the recipient in a recognized transplant centre in Canada or in the United States that performs the required form of transplant surgery. In the case of a Definitive Diagnosis of the Irreversible failure of the heart, the Covered Person must be alive for at least 30 days after the diagnosis and satisfy the Survival Period definition. For the purposes of the Survival Period, the date of Diagnosis is the date of the Covered Person's enrollment in the transplant centre.

Major Organ Transplant

Medically necessary transplantation due to a definitive diagnosis of the Irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow. To qualify under Major Organ Transplant, the Covered Person must undergo a transplantation procedure as the recipient of a heart, lung, liver, kidney or bone marrow, and limited to these organs or tissues. In the case of a heart transplant, the Covered Person must be alive for at least 30 days after the surgery and satisfy the Survival Period definition.

Motor Neuron Disease

Definitive diagnosis of one of the following conditions:

1) amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease),
2) primary lateral sclerosis,
3) progressive spinal muscular atrophy,
4) progressive bulbar palsy, or
5) pseudo bulbar palsy.

Multiple Sclerosis

Definitive diagnosis of at least one of the following:

1) 2 or more separate clinical attacks confirmed by magnetic resonance imaging (MRI) of the nervous system that show multiple lesions of demyelination,
2) well-defined neurological abnormalities lasting more than 6 months confirmed by MRI imaging of the nervous system that show multiple lesions of demyelination, or
3) a single attack, confirmed by repeated MRI imaging of the nervous system that show multiple lesions of demyelination that developed at intervals at least one month apart.

Muscular Dystrophy

Definitive diagnosis of hereditary muscle disorders with slow and progressive deterioration leading to increasing weakness and disability. The diagnosis must be supported by DNA analysis, electromyography and muscle biopsy.

Occupational HIV Infection

Definitive diagnosis of infection with Human Immunodeficiency Virus (HIV) resulting from accidental injury during the course of the Covered Person's normal occupation that exposed the person to HIV contaminated body fluids. All of the following conditions must be met:

1) the accidental injury must be reported to DFS within 14 days of the accident,
2) an HIV serum test must be taken within 14 days of the accidental injury and the result must be negative,
3) an HIV serum test must be taken between 90 days and 180 days after the accidental injury and the result must be positive,
4) all HIV tests must be performed by a duly licensed laboratory in Canada or in the United States, and

5) the accidental injury must be reported, investigated and documented in accordance with current Canadian or United States workplace guidelines.

The accidental injury leading to the infection must have occurred after the later of the date of Commencement of Coverage, or the effective date of last reinstatement of coverage.

Exclusions: No benefit is payable under this condition for the following:

1) the Covered Person refused any available licensed vaccine offering protection against HIV,

2) a licensed cure for HIV infection has become available prior to the accidental injury, or

3) HIV infection has occurred due to non-accidental injury including without limitation, sexual transmission and intravenous (IV) drug use.

Paralysis

Definitive diagnosis of the total loss of muscle function of 2 or more limbs due to injury or disease to the nerve supply to those limbs. The paralysis must last for at least 90 days following the causative event.

Parkinson's Disease

Definitive diagnosis of primary idiopathic Parkinson's disease. The diagnosis must be made by a duly qualified neurologist and must be based on at least 2 of the following clinical indicators:

1) muscle rigidity,

2) tremors,

3) bradykinesia.

Exclusions: No benefit is payable under this condition for all other types of parkinsonism.

Primary Pulmonary Hypertension (Idiopathic Pulmonary Arterial Hypertension And Familial Pulmonary Arterial Hypertension)

Definitive diagnosis of primary pulmonary hypertension with a substantial right ventricular enlargement confirmed by investigations (including cardiac catheterization) and resulting in permanent, Irreversible physical impairment to the degree of at least Class IV of the New York Heart Association (NYHA) Classification of Cardiac Impairment.

The NYHA Classification of Cardiac Impairment states the following about Class IV: "*Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest*."

To qualify, the Covered Person must be alive for at least 30 days after the diagnosis and satisfy the Survival Period definition.

Exclusion: No benefit is payable under this condition for all other types of pulmonary arterial hypertension.

Progressive Systemic Sclerosis

Definitive diagnosis of progressive systemic scleroderma with systemic involvement of the heart, lungs or kidneys. The diagnosis must be unequivocally supported by biopsy and serological evidence.

Exclusion: No benefit is payable under this condition for the following:

1) localized scleroderma (linear scleroderma or morphea),
2) eosinophilic fasciitis, or
3) CREST syndrome.

Severe Burns

Definitive diagnosis of third-degree burns over at least 20% of the body surface.

Stroke (Cerebrovascular Accident)

Definitive diagnosis of an acute cerebrovascular event caused by intracranial thrombosis, hemorrhage or embolism from an extra-cranial source, with:

1) acute onset of new neurological symptoms, and
2) new objective neurological deficits on clinical examination persisting for more than 30 days following the date of diagnosis.

These new symptoms and deficits must be corroborated by diagnostic imaging testing.

To qualify, the Covered Person must be alive for at least 30 days after the diagnosis and satisfy the Survival Period definition.

Exclusions: No benefit is payable under this condition for the following:

1) transient ischæmic attacks,
2) intracerebral vascular events due to trauma,
3) lacunar infarctions that do not meet the definition of Stroke as described above.

The following Eligible Illnesses apply to Dependent Children only.

Cerebral Palsy
Definitive diagnosis of a chronic disorder appearing in the first few years of life due to damage to the motor areas of the brain.
Congenital Heart Disease
Definitive diagnosis of any serious cardiac malformation present at birth for which corrective Surgery has been performed. To qualify, the Covered Person must be alive for at least 30 days after the surgery and satisfy the Survival Period definition.
Cystic Fibrosis
Definitive diagnosis of a genetic disease affecting the sweat and mucous glands particularly in the lungs and digestive system, characterized by excess production of thick mucous leading to chronic progressive respiratory disease and nutritional problems.
Down Syndrome
Definitive diagnosis of a congenital condition caused by an extra copy of chromosome 21.
Serious Cerebral Lesion
Definitive diagnosis of any lesion characterized by an invasive development problem or serious intellectual deficiency that prevents a Dependent Child from performing the basic activities of daily living. The Child must also require daily professional specialized services for treatment, rehabilitation, re-education or schooling.

Serious Mental Deficiency
Definitive diagnosis of a deficiency that when evaluated through standard testing, demonstrates an IQ under 70.
Spina Bifida Cystica
Definitive diagnosis of a congenital defect, caused by failure of the spine to close properly allowing the spinal cord and its protective covering (meninges) to protrude through the skin. **Exclusion**: No benefit is payable under this condition for Spina Bifida Occulta.

SPECIFIC ILLNESSES
(Applicable to the Member and Spouse only)

A Covered Person can claim for only one Specific Illness during the course of his lifetime.

If the Covered Person is diagnosed with one of the Specific Illnesses, DFS pays an amount equal to 10% of the Amount of Insurance specified in the Summary of Benefits to a maximum of $25,000. This amount is payable in addition to the Amount of Insurance for a Critical Illness.

Coronary Angioplasty
An interventional procedure to unblock or widen a coronary artery that supplies blood to the heart to allow an uninterrupted flow of blood. To qualify, the Covered Person must be alive for at least 30 days after the surgery and satisfy the Survival Period definition.
Ductal Carcinoma In Situ Of The Breast
Non-invasive breast cancer originating in the ducts of the breast. The diagnosis must be confirmed by biopsy.
Stage A (T1a or T1b) Prostate Cancer
A clinically unapparent malignant tumour localized in the prostate that is neither palpable nor visible by imaging. The diagnosis must be confirmed by pathological examination of prostate tissue.
Stage 1a Malignant Melanoma
Diagnosis of a melanoma less than or equal to 1.0 mm in thickness that does not have ulceration or Clark level IV or V invasion. The diagnosis must be confirmed by biopsy.

No benefit is payable under the above conditions other than Coronary Angioplasty if, within the first 90 days following the later of:

1) the date of commencement of coverage,

2) the effective date of last reinstatement of coverage under this Benefit,

the Covered Person has any of the following:

1) signs, symptoms or investigations that lead to a diagnosis of cancer covered or excluded under this Benefit, regardless of when the diagnosis is made,

2) a diagnosis of cancer covered or excluded under this Benefit.

This medical information above must be reported to DFS within 6 months of the date of the diagnosis. DFS has the right to deny any claim for Cancer or for any Specific Illness or Critical Illness caused by any Cancer or its treatment if this information is not provided.

If an amount has been paid under this Benefit for a previous diagnosis of a Critical Illness, any subsequent diagnosis of a Critical Illness can only be claimed under the MULTIPLE OCCURRENCES provision.

CANCER RECURRENCE
(Applicable to the Member and Spouse only)

DFS pays the Amount of Insurance specified in the Summary of Benefits if a Covered Person receives the diagnosis of a life-threatening Cancer subsequent to a prior cancer diagnosis if:

1) more than 60 months have passed since the prior diagnosis of Cancer, and

2) no treatment directly or indirectly related to cancer has been received within that 60-month period. Treatment does not mean preventative medications and follow up visits to the Physician.

The subsequent diagnosis of Cancer must be made while coverage is in force.

MULTIPLE OCCURRENCES
(Applicable to the Member and Spouse only)

1) If a Covered Person is diagnosed with a Critical Illness after a benefit payment was made for an eligible illness, DFS pays the Amount of Insurance specified in the Summary of Benefits provided the diagnosis is made at least 90 days after the settlement of the most recent claim.

2) If a Covered Person is diagnosed with a Critical Illness after a benefit payment was made for a Specific Illness, DFS pays:

   a) the Amount of Insurance specified in the Summary of Benefits provided the Critical Illness is diagnosed at least 90 days after the settlement of the prior claim, or

b) the Amount of Insurance specified in the Summary of Benefits less the amount paid for the Specific Illness, if the Critical Illness is diagnosed less than 90 days after the settlement of the prior claim.

Payment of any amount under this section is subject to the restrictions specified in the RE-ENTRY EXCLUSIONS provision below.

RE-ENTRY EXCLUSIONS
(Applicable to the Member and Spouse only)

ENHANCED PLAN

If a Covered Person receives payment for a Specific or Critical Illness, coverage automatically continues provided premium continues to be remitted. The Covered Person can claim a subsequent Critical Illness, subject to the following restrictions.

Following a claim for:	**the Covered Person cannot claim for:**
Alzheimer's Disease	Alzheimer's Disease or Loss of Independent Existence
Aortic Surgery	Alzheimer's Disease, Aortic Surgery, Coma, Coronary Angioplasty, Coronary Artery Bypass Surgery, Heart Attack, Heart Valve Replacement, Kidney Failure, Loss of Independent Existence, Major Organ Failure on Waiting List, Major Organ Transplant, Stroke or Liver Failure of Advanced Stage
Aplastic Anemia	Aplastic Anemia, Cancer (life-threatening), Ductal Carcinoma in situ of the Breast, Loss of Independent Existence, Stage A (T1a or T1b) Prostate Cancer or Stage 1A malignant melanoma
Bacterial Meningitis	Bacterial Meningitis, Blindness, Coma, Deafness, Loss of Independent Existence, Loss of Speech, Paralysis or Stroke
Benign Brain Tumour	Bacterial Meningitis, Benign Brain Tumour, Blindness, Coma, Deafness, Loss of Independent Existence, Loss of Speech, Paralysis or Stroke
Blindness	Blindness or Loss of Independent Existence

Following a claim for:	the Covered Person cannot claim for:
Cancer (life-threatening)	Aplastic Anemia, Cancer (life-threatening) unless all the requirements in the CANCER RECURRENCE BENEFIT provision have been met, for Ductal Carcinoma *in situ* of the Breast, Loss of Independent Existence, Stage A (T1a or T1b) Prostate Cancer, Stage 1A malignant melanoma or Liver Failure of Advanced Stage
Coma	Blindness, Coma, Deafness, Loss of Independent Existence, Loss of Speech, Paralysis or Stroke
Coronary Artery Bypass Surgery	Alzheimer's Disease, Aortic Surgery, Coma, Coronary Angioplasty, Coronary Artery Bypass Surgery, Heart Attack, Heart Valve Replacement, Kidney Failure, Loss of Independent Existence, Major Organ Failure on Waiting List, Major Organ Transplant, Stroke or Liver Failure of Advanced Stage
Deafness	Deafness or Loss of Independent Existence
Dilated Cardiomyopathy	Alzheimer's Disease, Aortic Surgery, Coma, Coronary Angioplasty, Coronary Artery Bypass Surgery, Dilated Cardiomyopathy, Heart Attack, Heart Valve Replacement, Kidney Failure, Loss of Independent Existence, Major Organ Failure on Waiting List, Major Organ Transplant, Stroke or Liver Failure of Advanced Stage

Following a claim for:	the Covered Person cannot claim for:
Fulminant Viral Hepatitis	Cancer (life-threatening), Ductal Carcinoma *in situ* of the Breast, Fulminant Viral Hepatitis, Loss of Independent Existence, Major Organ Failure on Waiting List, Major Organ Transplant, Stage A (T1a or T1b) Prostate Cancer, Stage 1A malignant melanoma or Liver Failure of Advanced Stage
Heart Attack	Alzheimer's Disease, Aortic Surgery, Coronary Angioplasty, Coronary Artery Bypass Surgery, Coma, Heart Attack, Heart Valve Replacement, Kidney Failure, Loss of Independent Existence, Major Organ Failure on Waiting List, Major Organ Transplant, Stroke or Liver Failure of Advanced Stage
Heart Valve Replacement	Alzheimer's Disease, Aortic Surgery, Coronary Angioplasty, Coronary Artery Bypass Surgery, Coma, Heart Valve Replacement, Heart Attack, Kidney Failure, Loss of Independent Existence, Major Organ Failure on Waiting List, Major Organ Transplant, Stroke or Liver Failure of Advanced Stage
Kidney Failure	Coma, Heart Attack, Kidney Failure, Loss of Independent Existence, Major Organ Failure on Waiting List, Major Organ Transplant, Stroke or Liver Failure of Advanced Stage
Liver Failure of Advanced Stage	Coma, Heart Attack, Kidney Failure, Loss of Independent Existence, Major Organ Failure on Waiting List, Major Organ Transplant, Stroke or Liver Failure of Advanced Stage
Loss of Independent Existence	A second claim; coverage under this Benefit ends with the prior claim.

Following a claim for:	the Covered Person cannot claim for:
Loss of Limbs	Loss of Independent Existence or Loss of Limbs
Loss of Speech	Loss of Independent Existence or Loss of Speech
Major Organ Failure on Waiting List	Aplastic Anemia, Cancer (life-threatening), Coma, Ductal Carcinoma in situ of the Breast, Heart Attack, Kidney Failure, Loss of Independent Existence, Major Organ Failure on Waiting List, Major Organ Transplant, Stage A (T1a or T1b) Prostate Cancer, Stage 1A malignant melanoma, Stroke or Liver Failure of Advanced Stage
Major Organ Transplant	Aplastic Anemia, Cancer (life-threatening), Coma, Ductal Carcinoma *in situ* of the Breast, Heart Attack, Kidney Failure, Loss of Independent Existence, Major Organ Failure on Waiting List, Major Organ Transplant, Stage A (T1a or T1b) Prostate Cancer, Stage 1A malignant melanoma, Stroke or Liver Failure of Advanced Stage
Motor Neuron Disease	Blindness, Coma, Deafness, Heart Attack, Loss of Independent Existence, Loss of Speech, Motor Neuron Disease, Paralysis or Stroke
Multiple Sclerosis	Blindness, Coma, Deafness, Kidney Failure, Loss of Independent Existence, Loss of Speech, Multiple Sclerosis, Paralysis or Stroke
Muscular Dystrophy	Blindness, Coma, Deafness, Dilated Cardiomyopathy, Heart Attack, Heart Valve Replacement, Kidney Failure, Loss of Independent Existence, Loss of Speech, Major Organ Failure on Waiting List, Major Organ Transplant, Muscular Dystrophy, Paralysis, Stroke or Liver Failure of Advanced Stage

Following a claim for:	the Covered Person cannot claim for:
Occupational HIV Infection	Blindness, Cancer (life-threatening), Coma, Deafness, Ductal Carcinoma *in situ* of the Breast, Kidney Failure, Loss of Independent Existence, Loss of Speech, Occupational HIV Infection, Paralysis, Stage A (T1a or T1b) prostate Cancer, Stage 1A malignant melanoma, Stroke or Liver Failure of Advanced Stage
Paralysis	Coma, Loss of Independent Existence, Loss of Speech or Paralysis
Parkinson's Disease	Coma, Loss of Independent Existence, Loss of Speech, Paralysis or Parkinson's Disease
Primary Pulmonary Hypertension	Aortic Surgery, Coma, Coronary Angioplasty, Coronary Artery Bypass Surgery, Dilated Cardiomyopathy, Heart Attack, Heart Valve Replacement, Kidney Failure, Loss of Independent Existence, Major Organ Failure on Waiting List, Major Organ Transplant, Primary Pulmonary Hypertension, or Stroke
Progressive Systemic Sclerosis	Progressive Systemic Sclerosis, Aortic Surgery, Blindness, Coma, Coronary Angioplasty, Coronary Artery Bypass Surgery, Cancer (life-threatening), Ductal Carcinoma in situ of the Breast, Heart Attack, Kidney Failure, Liver Failure of Advanced Stage, Loss of Independent Existence, Multiple Sclerosis, Paralysis, Stage 1A malignant melanoma, Stage A (T1a or T1b) Prostate Cancer, Stroke, Major Organ Failure on Waiting List or Major Organ Transplant
Severe Burns	Loss of Independent Existence, Paralysis or Severe Burns

Following a claim for:	the Covered Person cannot claim for:
Stroke (cerebrovascular accident)	Alzheimer's Disease, Aortic Surgery, Coma, Coronary Angioplasty, Coronary Artery Bypass Surgery, Heart Attack, Heart Valve Replacement, Kidney Failure, Loss of Independent Existence, Major Organ Failure on Waiting List, Major Organ Transplant, Stroke or Liver Failure of Advanced Stage

EXCLUSIONS

Pre-existing condition

No amount is paid for any Specific or Critical Illness that results directly or indirectly from a condition or symptom(s) for which:

1) medical expenses are incurred, treatment is received, drugs or medicine is prescribed and/or taken or a Physician or healthcare practitioner is consulted, or

2) an ordinarily prudent person would seek diagnosis, care or treatment,

within the 24-month period preceding the date of the Covered Person's Commencement of Coverage or effective date of last reinstatement of coverage.

This restriction applies only to amounts equal to or below the Non-Evidence Maximum of Insurability specified in the Summary of Benefits. However, if the Covered Person is continuously covered for more than 24 months or has submitted Evidence of Insurability satisfactory to DFS for an amount in excess of the amount specified in the Summary of Benefits as the Non-Evidence Maximum of Insurability, this restriction does not apply.

If the Covered Person is covered under a comparable benefit under the Policyholder's prior group insurance policy for any period of time immediately prior to the Effective Date of this Benefit, that period of time will be taken into account for this restriction.

All other exclusions

No amount is paid for any Specific or Critical Illness resulting directly or indirectly from any of the following:

1) intentionally self-inflicted injury, voluntary exposure to an illness or attempted suicide while sane or insane,

2) war, whether declared or not, or active service in the armed forces of any country or participation in a riot, insurrection or civil commotion,

3) committing or attempting to commit a criminal offence, including operating a vehicle while impaired as set out under the Criminal Code of Canada,

4) alcohol abuse,

5) the use of any medication, narcotic, intoxicant or any other harmful substance, except when taken as prescribed or recommended by a Physician, and

6) any cancer that is diagnosed prior to the date of Commencement of Coverage when the same cancer either recurs or metastasizes after that date, unless all the requirements in the CANCER RECURRENCES provision have been met.

GEOGRAPHIC LIMITATIONS

If an Eligible Illness is diagnosed outside of Canada the Covered Person may submit a claim for consideration upon their return to Canada. The diagnosis must be confirmed by an appropriate Specialist licensed to practice in Canada.

CONVERSION PRIVILEGE (Applicable to the Member and Spouse only)

If a Covered Person's coverage terminates due to:

1) termination of the Member's employment,

2) termination of eligibility for coverage under the policy,

3) termination of a period of Total Disability after which the Member did not return to work for the Participating Employer,

and that person is 65 or younger, he is entitled to convert any Amount of Insurance to an individual policy without Evidence of Insurability. Eligible Illnesses are limited to those provided under the individual policy and are subject to the conditions indicated therein. The minimum amount that can be converted is $5,000 and the maximum amount is limited to the lesser of:

1) the Amount of Insurance in effect on the date of termination, or

2) a total aggregate amount of $200,000.

The person must submit written application for conversion to DFS within 31 days of the termination of his coverage under this Benefit. The individual policy takes effect after 31 days immediately following the date of termination of his coverage under this Benefit.

If a Covered Person receives the diagnosis of an Eligible Illness within 31 days of termination of coverage under this Benefit, the amount he is eligible to convert is payable.

Once a person is paid the whole Amount of Insurance for a Critical Illness he is no longer entitled to convert his coverage.

Our commitment to you

We will always be here to answer your questions. You can rely on our knowledgeable team to deliver outstanding service and process your claims efficiently. We are here to help you stay healthy and to give you advice and financial support when you need them most.

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