Your group insurance plan

UNITY HEALTH TORONTO

Policy No. 541254

CUPE Clerical Part-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.

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.
Employee
A person residing in Canada and employed by the Participating Employer on a part-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.

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.

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.

Medical Emergency

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

Member

An Employee covered under the policy.

Orthosis

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

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 Life Insurance,

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

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.

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.

Total Disability or Totally Disabled

1) During the first 24 months of disability, a of incapacity resulting from an Illness or Accident that entirely prevents the Member from performing the essential duties of his regular occupation,

2) after the first 24 months of disability have elapsed, a state of incapacity, resulting from an Illness or Accident, that entirely prevents the Member from working in any occupation that he is suited for 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.

   A Member is not considered disabled simply because an occupation that he is suited for by education, Training and Experience is not available in the area where he resides.

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driver's license to perform the duties of his occupation is not considered disabled simply because his license has been revoked or not renewed.

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
Not applicable	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 Member Basic Life Insurance Benefit, if application for coverage is completed within the time limit.

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 all the consecutive working days scheduled in the 10 calendar 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.

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 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.

2) Changes to the Extended Health Care and Dental Care 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.

3) 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 12 months.

AUTHORIZED LEAVE OF ABSENCE

The Participating Employer or Policyholder, acting on a basis precluding individual selection, may continue coverage of the Member. All 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 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 all benefits, or

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 Basic Life Insurance Benefit	The date of retirement

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 the expense is incurred or within 90 days of the termination of benefits, whichever is earlier.
Life Insurance Benefit	Any claim must be submitted to DFS within 6 years of the date of death.

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.

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:

- Basic Life Insurance 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 6 months of continuous Total Disability. 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.

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**
<u>Paramedical Services</u> 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
• Remount with occlusal equilibration	Covered under Major Restorative Services

• Therapeutic tissue conditioning	Covered under Major Restorative Services
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	
Implantology	
• Implant	
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.

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.

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
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 $150 x number of Completed Years of Service, up to $2,250

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 part-time or 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.

POST RETIREMENT COVERAGE

To be eligible to the Post Retirement Coverage, the Employee must be covered under the policy's Member Basic Life Insurance Benefit when retiring, and have accumulated years of service with the current Participating Employer and/or with another Participating Employer.

The amount of Post Retirement Coverage 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 part-time or full-time Employee.

Completed Years of Service means the years included within the 15-year period immediately preceding retirement 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.

Post Retirement Coverage Premium – Pay-As-You Go Life Coverage

The Post Retirement Coverage is effective when a Member retires, provided a monthly premium established by DFS is paid to DFS.

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.

CONVERSION PRIVILEGE

If the Life Insurance Benefit of a Member terminates or is reduced, the Member is entitled to convert his 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.

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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