Prepared for the employees of

VANGUARD INVESTMENT CANADA, INC.

As a leading managing general agent in Canada, ENCON Group Inc. develops and administers insurance programs and distributes them through a nationwide network of independent plan advisors and brokers to individuals, professionals, organizations and employers.

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Getting Started

Understanding Your Group Benefits Program

This information booklet has been prepared to give you an informal summary of the main features of your group benefits program. Please read this booklet carefully and keep it for future reference.

This booklet provides a summary of the plan. You may not be insured for all of the benefits referenced. Along with this benefits booklet, you will be issued a personalized Certificate of Insurance, which will identify the effective date of your coverage and your identification number.

You should consult your Certificate of Insurance to confirm which benefits you and, if applicable, your insured dependents are enrolled in.

Your Plan Administrator

Your Plan Administrator is the person within your organization who manages your company's group benefits program. This is the person you should contact if you need replacement benefit materials or require assistance with a benefit issue.

You will need to inform your Plan Administrator of the following, so that they can notify ENCON with the appropriate information:

- Dependent or coverage changes that may occur. These changes must be communicated within 31 days of the occurrence and include marriage, divorce, birth or adoption of a child, death of a family member, and the loss of a spouse's coverage.
- Beneficiary changes. These changes must be submitted in writing with an original ink signature.
- A change of home address. This address should be kept up-to-date for claims payment purposes.

Online Services

ENCON provides a variety of convenient online services for plan members:

- Download pre-filled administration and claim forms
- Download an electronic copy of your Benefits Booklet
- Set up Direct Deposit for your claim payments
- Review your claims history
- Determine when you are next eligible for benefits (i.e., dental recall visits, vision care)
- Access members-only EAP website
- View and update dependent details
- View beneficiary details and download forms to request changes

How to Register at www.encon.ca/groupbenefits

Go to www.encon.ca/groupbenefits, click on the "REGISTER" link located on the right-hand side of the screen, and follow the instructions to register.

Schedule of Benefits

Benefits Providers

Your group benefits program, provided to you by your employer and administered by ENCON Group Inc., is underwritten by the following companies:

SSQ, Life Insurance Company Inc.

- Basic Life Insurance
- Dependent Life Insurance
- Optional Life and Spousal Optional Life Insurance

Industrial Alliance Insurance and Financial Services Inc. ("Industrial Alliance")

- Basic Accidental Death & Dismemberment
- Optional Accidental Death & Dismemberment

Green Shield Canada

- Extended Health Care
- Emergency Travel Assistance
- Dental Care
- Health Care Spending Account

Plan Effective Date

Coverage for your employer's company first becomes effective on a specific day, known as the plan effective date. This is the earliest date you may join the plan. This plan was effective on May 15, 2011.

Eligibility

You become eligible to join the plan on the later of the plan effective date or, on the first day of your employment. You must also be a permanent, full-time employee working a minimum of 20 hours per week and a resident of Canada.

Retired employees are not eligible for coverage.

Please refer to the General Provisions section in the back of this booklet for further information, including:

- When your insurance starts.
- When your insurance terminates.

Basic Life Insurance

You are eligible for $25,000 of Basic Life Insurance.

Your benefit reduces by 50% at age 65 .

Note: If you have been declined for benefit coverage in the past, coverage can only be increased by providing evidence of insurability, satisfactory to the insurer.

Coverage terminates on the date you attain age 70 or retirement, whichever is earlier, and as outlined in the General Provisions section.

Basic Accidental Death & Dismemberment

In the event of accidental death, you are covered for the same amount as determined under the Basic Life Insurance Schedule of Benefits. Evidence of insurability is not required. Coverage terminates on the date you attain age 70 or retirement, whichever is earlier.

Dependent Life Insurance

Spouse	$5,000
Each Child	$2,500

A child is eligible for coverage from live birth.

Coverage terminates on the date you attain age 70 or retirement, whichever is earlier, and as outlined in the General Provisions section.

Optional Life Insurance

If you are under age 65, you may apply for this coverage:

- for yourself;
- for your spouse, provided he/she is under age 65; or
- for both you and your spouse.

Coverage is available in units of $10,000, subject to a maximum benefit of $250,000.

Evidence of insurability, satisfactory to the insurer, shall be required for all amounts of Optional Life. This coverage is available in addition to, not in lieu of, Basic Life and/or Dependent Life Insurance.

Coverage terminates: on the date you attain age 65 or retirement, whichever is earlier; coverage for your spouse terminates on the date your spouse attains age 65; or as outlined in the General Provisions section.

Optional Accidental Death & Dismemberment

Optional Accidental Death & Dismemberment benefits are available in units of $25,000 up to a maximum of $250,000.

This coverage is available in addition to Basic Accidental Death & Dismemberment.

Coverage terminates on the date you attain age 70 or retirement, whichever is earlier.

Extended Health Care

The following shows which expenses are considered eligible and the applicable coinsurance:

Hospital	100%	Semi-private
Drugs	80%	of the first $1,000 of eligible expenses and 100% thereafter
		Generic - Pay Direct Drug Plan included
Vision Care	100%	
Supplementary Medical	100%	

The coinsurance percentage is the amount you will be reimbursed for eligible expenses in excess of the deductible. The deductible, which is shown below, is the portion of eligible expenses that you must pay before you receive benefits.

Extended Health Care Deductible:

- Nil

The paramedical practitioner maximums are listed in the Extended Health Care section of this booklet.

The vision care maximum is $250 per person per 24 consecutive months.

The lifetime maximum for your Extended Health Care benefit is unlimited.

You must be insured under the provincial health plan to be eligible for Extended Health Care benefits. You must be insured for Extended Health Care in order to be eligible for Emergency Travel Assistance, Employee Assistance Program, Personal Medical Guidance Service and Second Medical Opinion Service benefits.

Coverage terminates on the date you attain age 70 or retirement, whichever is earlier, and as outlined under the General Provisions section.

Emergency Travel Assistance

The Green Shield Canada Travel Assistance has been made available to provide you with timely, efficient medical or travel assistance when you are out of province.

Coinsurance	100%

Deductible	Nil
Lifetime Maximum	Unlimited

Coverage is limited to the first 60 days of travel. However, for students who are studying out of province or out of country, coverage is limited to 12 months of travel, beginning in September and ending in August of the following year.

The maximum benefit per individual is as follows:

Emergency Services:	$5,000,000 per person per calendar year.
Out-of-province Referral Services:	$50,000 per person per calendar year.

In the event of an emergency, you must contact the Emergency Travel Assistance Medical Team within 48 hours of the commencement of treatment.

Coverage terminates on the date you attain age 70 or retirement, whichever is earlier, and as outlined in the General Provisions section.

Dental Care

The following shows which expenses are considered eligible and the applicable coinsurance:

Basic Services	100%
Major Restorative Services	50%
Orthodontics	50%

The coinsurance percentage is the amount you will be reimbursed for eligible expenses in excess of the deductible. The deductible, which is shown below, is the portion of eligible expenses that you must pay before you receive benefits.

Dental Care Deductible:

Nil

Fee Guide:
Benefits are paid in accordance with the current Fee Guide for General Practitioners in effect in the province where the service is rendered on the date the charge is incurred.

The standard oral examination frequency limit is six months.

The maximum benefit per individual is as follows:

Basic and Major Restorative Services combined $2,000 per person per calendar year.
Orthodontics $2,500 lifetime maximum for dependent children 18 years of age and under only.

Coverage terminates on the date you attain age 70 or retirement, whichever is earlier, and as outlined in the General Provisions section.

Health Care Spending Account

The following shows the annual credit amount that will be allocated to your Health Care Spending Account (HCSA).

Single	$300
Family	$500

This amount is allocated to your Health Care Spending Account on January 1 of each year. The HCSA benefit year runs from January 1 to December 31.

Your account has been set up with "rolling contributions." This means that any balance in your account on the last day of the benefit year will be carried forward to, but not beyond the end of, the next benefit year. Unpaid claims cannot be rolled over to the next benefit year and paid with that year's contributions.

Basic Life Insurance

Basic Life Insurance coverage provides for a benefit to be paid at the time of your death if you are insured under this plan at the time. The amount of benefit is according to your classification as described in the Schedule of Benefits.

Beneficiary

The benefit is paid to the beneficiary designated on your enrollment form. Your beneficiary may have the benefits paid as a lump sum or in a series of monthly instalments with the approval of the insurance company.

You may designate a new beneficiary at any time, subject to the laws governing such changes, by completing a form available from your employer. If you do not name a beneficiary, benefits will be paid to your estate.

Living Benefit

If you have been diagnosed with a terminal illness, you may request advance payment of a portion of your life insurance that would be payable upon your death. Your request must be approved. To be eligible, you must provide proof that your life expectancy must be 12 months or less. A letter from your physician that details your condition, diagnosis and prognosis is required for your request to processed.

The prepayment amount is equal to 50% of the amount of your life insurance to a maximum of $50,000. The prepaid amount is subject to any reduction in coverage scheduled to come into effect during the 24-month period following the date of your request. Upon your death, the amount payable to your designated beneficiary will be reduced by the amount of the "Living Benefit" payment.

Conversion Privilege

During the 31-day period following either the termination of your employment, or your classification changing to one in which you are not insured, you may convert the amount of your Basic Life Insurance, provided you are under 65 years of age or on the day you reach age 65, to any individual whole life or convertible one-year term or term to age 65 plan without submitting evidence of health. To exercise your conversion privilege, you must apply in writing to the insurer no later than 31 days after your insurance under this benefit ends.

The amount of the individual policy shall not exceed the total amount of Basic plus Optional Insurance for which you were insured when coverage was discontinued, subject to a maximum of $200,000 less any amount you become eligible for under a replacing contract of group life insurance.

The premium rate will be determined from your age, gender and smoking status at the time of conversion.

The conversion privilege does not apply for loss of insurance as a result of your reaching age 65.

Waiver of Premium

If you are under age 65 and become totally disabled while insured, are unable to perform any work for compensation or profit, or engage in any occupation, and are so disabled for at least six consecutive months, your insurance will continue in force without premium payment. Initial proof must be filed within 12 months of total disability and annually thereafter. The benefit terminates on the earliest of the date you:

- are no longer totally disabled;
- fail to provide satisfactory proof of your continuing disability;
- fail to be examined by a qualified physician as required by the insurance company; or
- attain age 65.

Optional Life Insurance

You may apply for additional term life insurance for yourself and/or for your spouse. Monthly premium rates are calculated according to the applicant's age, gender and smoking status. The Waiver of Premium and Conversion Privilege provisions described under Basic Life Insurance are also included under Optional Life Insurance.

Evidence of insurability satisfactory to the insurer is required for the full amount of chosen coverage.

No benefit will be paid for death resulting from self-destruction, whether sane or insane, within two years of your insurance becoming effective. Misstatement of non-smoker status shall mean the insurer will not pay any part of your Optional Life Insurance or your spouse's Optional Life Insurance, regardless of the cause of death.

To qualify as a non-smoker, you must submit evidence of insurability satisfactory to the insurer which supports total abstinence from smoking any tobacco product and cannabis for a one year period preceding the date of application for non-smoker status.

Dependent Life Insurance

Your spouse and dependent children are insured for the amounts shown in the Schedule of Benefits.

If a dependent, other than a newborn child, is confined to hospital or home on the date on which his or her Life Insurance would ordinarily commence, insurance on that dependent will not become effective until the dependent is no longer confined. Confinement at home shall mean that the dependent is unable to carry on any substantial part of the regular and customary duties or activities of a person in good health and of the same age and gender.

Beneficiary

You will be the beneficiary for the insurance provided for your dependents, unless otherwise directed. The benefit will be paid to your estate if you do not survive your dependent.

Conversion Privilege

During the 31-day period following your death, your classification changing to one in which you are not insured or your termination of employment, your spouse's and child's amount of Dependent Life Insurance may be converted, provided your spouse is under 65 years of age or on the day your spouse reaches age 65, to any individual whole life or convertible one-year term or term to age 65 plan without submitting evidence of health. The premium rate will be determined from your spouse's or child's age, gender and smoking status at the time of conversion.

The amount of the individual policy shall not exceed the amount of Basic plus Optional Insurance for which your spouse was insured when coverage was discontinued or the amount of Basic Insurance for which your child was insured when coverage was discontinued, subject to a maximum of $200,000 less any amount your spouse or child becomes eligible for under a replacing contract of group life insurance.

The conversion privilege does not apply for loss of insurance if insurance terminates when you (or your spouse) reach the age(s) specified in the Schedule of Benefits section.

Waiver of Premium

Waiver of premium coverage shall be the same as for Basic Life Insurance except that waiver of premium benefit ceases on the earlier of: a) the date the Waiver of Premium for Basic Life Insurance ceases, or b) the date the policy or coverage terminates.

Basic Accidental Death & Dismemberment

You, your eligible spouse and dependent children are covered for any accident resulting in death or dismemberment anywhere in the world - 24 hours per day - on or off the job. Benefits are payable in addition to any other insurance you may have.

Your Principal Sum will be equal to the approved Basic Life Insurance benefit coverage. If you are not approved for the full amount of Basic Life Insurance, your coverage will be limited to an amount equal to the non-evidence Life Insurance maximum. Your spouse and dependent children will automatically become insured for an amount of insurance as follows:

Spouse: 50% of the employee's Principal Sum if there are dependent children, 60% if there are no dependent children.

Children: 15% of the employee's Principal Sum (subject to a maximum of $50,000) if there is a spouse, 20% of the employee's Principal Sum (subject to a maximum of $75,000) if there is no spouse.

Specific Loss Accident Indemnity

When injury results in any of the following losses within three hundred and sixty-five (365) days after the date of the accident, the insurer will pay:

For Loss of:

Life	100%
Brain Death	100%
Entire Sight of Both Eyes	100%
Speech and Hearing in Both Ears	100%
Entire Sight of One Eye	75%
Speech	75%
Hearing in Both Ears	75%
Hearing in One Ear	33-1/3%
All Toes of One Foot	25%

For Loss or Loss of Use of:

Both Arms or Both Legs	200%
Both Hands or Both Feet	200%
One Hand and One Foot	100%
One Hand and the Entire Sight of One Eye	100%
One Foot and the Entire Sight of One Eye	100%
One Arm or One Leg	75%
One Hand or One Foot	75%
Thumb and Index Finger or at Least Four Fingers of One Hand	33-1/3%

For Total Paralysis of:	
Quadriplegia (both upper and lower limbs)	200%
Paraplegia (both lower limbs)	200%
Hemiplegia (upper and lower limbs of one side of body)	200%

"Loss" whenever used with reference to hand or foot means complete severance at or above the wrist or ankle joint but below the elbow or knee joint; as used with reference to arm or leg means complete severance at or above the elbow or knee joint; as used with reference to thumb and fingers means complete severance at or above the metacarpophalangeal joint; as used with reference to toes means complete severance at or above the metatarsophalangeal joint; as used with reference to eye means the irrecoverable loss of the entire sight thereof; as used with reference to speech means the total and irrecoverable loss thereof; as used with reference to hearing means the total and irrecoverable loss thereof; and as used with reference to Quadriplegia, Paraplegia and Hemiplegia means the permanent and irrecoverable paralysis of such limbs.

"Loss of Use" means a loss which is permanent, total, irrecoverable and continuous for a period of 12 months from the date of the accident.

Indemnity provided under this section for all losses sustained by any one insured person as the result of any one accident will not exceed the following:

- with the exception of quadriplegia, paraplegia and hemiplegia, the Principal Sum.
- with respect to quadriplegia, paraplegia and hemiplegia, Two Times the Principal Sum, or the Principal Sum if loss of life occurs within 90 days after the date of the accident.

In no event will indemnity payable for all losses under this section exceed, in the aggregate, Two Times the Principal Sum as the result of the same accident.

In addition to the Specific Loss Schedule, AD&D includes the following benefits:

Cosmetic Disfigurement Benefit

If an insured suffers a third degree burn, a percentage of the Principal Sum, depending on the area of the body which was burned according to the following table, will be paid:

Body Part	Area Classification (A)	Maximum Allowable Percentage for Area Burned (B)	Maximum Percentage of Principal Sum Payable (C)
		%	%
Face, Neck, Head	**10**	**10.0**	**100.0**
Hand and Forearm	**5**	**5.0**	**25.0**
Either Upper Arm	**3**	**5.0**	**15.0**
Torso (front or back)	**2**	**18.0**	**36.0**
Either Thigh	**1**	**10.0**	**10.0**
Either Lower Leg (below knee)	**3**	**9.0**	**27.0**

The maximum percentage of Principal Sum Payable (C) is determined by multiplying the Area Classification (A) by the maximum allowable percentage for Area Burned (B). In the event of a 50% surface burn, the maximum allowable percentage for Area Burned (B) is reduced by 50%. This table only represents the maximum percentage of the Principal Sum Payable for any one accident. If the insured suffers burns in more than one area, as a result of any one accident, benefits will not exceed a maximum of $25,000.

Seat Belt Benefit

If an insured is driving or riding in a vehicle and wearing a properly fastened seat belt at the time of the accident, and such insured sustains a specific loss for which an amount of Principal Sum becomes payable under the program, the amount payable for such specific loss is increased by 10%.

The driver of the vehicle must hold a current and valid driver's license of a rating authorizing him to operate such vehicle and neither be intoxicated nor under the influence of drugs, unless such drugs are taken as prescribed by a physician at the time of the accident.

Hospital Indemnity

If any specific loss covered under the program confines you, your insured spouse or your insured dependent child to a hospital and such person is under the regular care and attendance of a physician, you will receive a daily benefit of 1/30th of 1% of your Principal Sum from the 1st day of hospitalization to a maximum of $2,500 per month and for a maximum duration of 365 days per accident. Hospitalization must begin while the insurance is in force for you or your dependents.

Hospitalization for treatment of any injury other than for a specific loss will also be covered in accordance with the above, if hospitalized for at least 4 days.

Family Transportation Benefit

If any specific loss covered under the program confines an insured to a hospital under the regular care and attendance of a physician, and such hospital is located at least 150 kilometres from the insured's residence, this benefit will pay the reasonable expenses actually incurred by a member of the insured's immediate family for accommodation and transportation via the most direct route to the insured's bedside, to a maximum of $15,000. Private transportation expenses are limited to $0.35 per kilometre travelled.

Room, board or other ordinary living, travelling or clothing expenses are not covered.

Parental Care Benefit

If you sustain accidental loss of life for which an amount of Principal Sum becomes payable under the program, 5% of your Principal Sum to a maximum of $5,000 will be paid to an eligible dependent parent who, at the time of the accident, is a resident in a licensed nursing care facility, or enrolled in a home health care program, or living in your residence, or receiving support and care provided by you.

Psychological Therapy Benefit

If injury results in a loss payable to an insured under the Specific Loss Accident Indemnity schedule and results in the insured requiring psychological therapy, as prescribed by a physician, reasonable and necessary expenses actually incurred will be paid, to a maximum of $5,000.

Child Enhancement Benefit

With the exception of loss of life, the percentages indicated under the "Specific Loss Accident Indemnity" section are quadrupled with respect to your insured dependent children but in no event will exceed the maximum amount stated.

This provision does not apply if loss of life occurs within 90 days after the date of the accident.

Education Benefit

If you sustain accidental loss of life for which an amount of Principal Sum becomes payable under the program, up to 5% of your Principal Sum, to a maximum of $10,000, will be paid for reasonable and necessary expenses actually incurred for each of your dependent children who are already enrolled in an institution of higher learning above the secondary school level or who will do so within 365 days after your death.

The benefit is payable annually, for each year up to four consecutive years that the child continues school on a full-time basis beyond the secondary school level.

Room, board or other ordinary living, travelling or clothing expenses are not covered.

If none of your insured dependent children satisfy the above requirements, an amount of $2,500 will be paid to your beneficiary.

Daycare Benefit

If you sustain accidental loss of life for which an amount of Principal Sum becomes payable under the program, up to 5% of your Principal Sum, to a maximum of $5,000, will be paid for reasonable and necessary expenses actually incurred for each of your dependent children under 13 years of age who are enrolled in a legally licensed daycare centre or who will do so within 365 days after your death. This includes a child who is born within nine months of your date of loss, provided the child was conceived prior to the date of loss.

The benefit is payable annually, for each year up to four consecutive years that the child remains enrolled in a legally licensed daycare centre.

Room, board or other ordinary living, travelling or clothing expenses are not covered.

If none of your insured dependent children satisfy the above requirements, an amount of $2,500 will be paid to your beneficiary.

Spousal Retraining Benefit

If you sustain accidental loss of life for which an amount of Principal Sum becomes payable under the program, and your spouse engages in a formal occupational training program in order to become qualified for active employment in an occupation otherwise not qualified, this benefit will refund expenses incurred within 3 years following the date of your death, to a maximum of $15,000.

Room, board or other ordinary living, travelling or clothing expenses are not covered.

Rehabilitation Benefit

If you sustain a specific loss for which an amount of Principal Sum becomes payable under the program and such injury requires your participation in a rehabilitation program in order to be qualified in a different occupation, this benefit will refund expenses actually incurred during the 3 year period following the loss, to a maximum of $15,000.

Room, board or other ordinary living, travelling or clothing expenses are not covered.

Workplace Modification and Accommodation Benefit

If injury requires special adaptive equipment and/or workplace modification for you to return to active full-time employment, the cost of these modifications will be paid, to a maximum of $5,000, provided the employer agrees in writing to provide such modification and accommodation to the workplace for the purpose of making it accessible and adaptable to your needs and acknowledges in writing that the performance of the essential duties of your occupation may be altered.

Home Alteration and Vehicle Modification Benefit

If injury requires the use of a wheelchair to be ambulatory, the cost of alterations to the insured's principal residence and/or the cost of modification to one motor vehicle utilized by the insured will be paid, subject to a maximum amount of the greater of $15,000 or 10% of the insured's Principal Sum amount to a maximum of $50,000, as the result of any one accident, provided such injury results in a loss payable under the Accidental Death, Dismemberment and Specific Loss Indemnity.

Air Bag Benefit

If, due to a vehicular accident, injury results in a loss payable under the Accidental Death, Dismemberment and Specific Loss Indemnity, the insured's amount of Principal Sum will be increased by 5%, provided that:

a) such loss occurs while the insured is a passenger or driver of a private passenger type vehicle equipped with either a single air bag, air bags for both the driver and the front passenger seats, or air bags for the driver, front passenger and rear passenger seats; and

b) the seat belt is in actual use and properly fastened at the time of the accident, and due proof of seat belt use must be provided as part of the written proof of loss.

Assault Benefit

If injury results in a loss payable under the Accidental Death, Dismemberment and Specific Loss indemnity, the Company will pay an additional indemnity equal to 10% of the applicable indemnity payable under that part, subject to a maximum of $25,000.00, if the injury is caused by an assault on premises owned or rented by the employer or if the assault occurred while the insured was traveling on company business.

No benefit will be payable under this part if the assault was the act of another employee or a member of the immediate family of the insured or a member of the insured's household.

Carjacking Benefit ($10,000)

If, injury sustained by the insured results in a loss payable under the Accidental Death, Dismemberment and Specific Loss Indemnity, the insured's amount of Principal Sum will be increased by 10%, if the injury occurs during a carjacking of an automobile that the insured was operating, getting into or out of, or, riding as a passenger.

Comatose Benefit

If an injury does not cause loss of life, but results in a coma or comatose state, the Company will pay 1% of the Principal Sum (less any sum paid under the Accidental Death, Dismemberment and Specific Loss Indemnity) for each month the coma or comatose state continues, subject to an overall maximum of $50,000.00. Payments commence at the end of the waiting period and are subject to a maximum of 100 consecutive months.

Permanent Total Disability

If an injury totally and permanently disables an insured, under age 65, within 12 months of the date of the accident, preventing an insured from engaging in any and every occupation, the Company will pay, provided such disability has continued for a period of 12 consecutive months and is total, continuous and permanent at the end of this period, the Principal Sum less any amounts paid or payable under the Accidental Death, Dismemberment and Specific Loss Indemnity as the result of the same accident.

Public Transportation Benefit

If an injury results in loss of life and indemnity becomes payable under the Accidental Death, Dismemberment and Specific Loss Indemnity, the Company will pay an additional amount equal to 100% of the Principal Sum if, at the time of the accident, the insured was riding as a passenger in a regularly scheduled public land, air or water conveyance licensed to carry fare-paying passengers, including a train, bus, taxi, subway, tramway, boat or commercial airplane.

Identification Benefit

If injury results in loss of life, and requires body identification, the expenses actually incurred by a member of the immediate family for lodging, board and transportation by the most direct route will be paid, provided the body is located at least 150 kilometres from the member of the immediate family's residence and the identification of the body is required by the police or a similar law enforcement agency having authority over such matters, to a maximum of $15,000.

If transportation occurs in a vehicle or device other than one operated under the license for the conveyance of passengers for hire, then reimbursement of transportation expenses will be limited to a maximum of $0.35 per kilometre travelled.

Repatriation Benefit

If an insured sustains accidental loss of life for which an amount of Principal Sum becomes payable under the program, repatriation benefits up to $15,000 will be paid for the reasonable and necessary expenses actually incurred for the transportation of the body to the city of residence, including the preparation of the body for transportation.

Funeral Expense Benefit

If an injury sustained by an insured results in loss of life, an additional amount is payable for funeral expenses actually incurred, to a maximum of $5,000.

Bereavement Benefit

If you sustain an injury that results in loss of life, reasonable and necessary expenses actually incurred by your spouse and dependent children for up to six (6) sessions of grief counselling, by a professional counsellor will be paid, to a maximum of $1,000.

Common Disaster Benefit

If you and your insured spouse both sustain accidental loss of life as a result of a common accident or two separate accidents occurring within the same 24-hour period, and such losses become payable under the program, your spouse's amount of coverage will be increased to the same level as yours, subject to an overall total for you and your spouse of $1,000,000.

Limited Air Travel Coverage

An insured is covered only while flying as a passenger in any aircraft holding a current and valid certificate of airworthiness (other than an aircraft owned, operated, leased or chartered by or on behalf of your employer) and operated by a person holding a current and valid pilot's license with a rating authorizing him to pilot such aircraft. Coverage also applies while flying as a passenger in a military aircraft.

Exposure and Disappearance

Unavoidable exposure to the elements will be covered under the program as any other loss, provided such exposure is sustained as the result of a covered accident and the loss for which indemnity would be payable occurs within 1 year of the accident.

An insured will be presumed to have suffered accidental loss of life if the insured's body is not found within 1 year after the disappearance, sinking or wrecking of the conveyance in which the insured was riding at the time of the accident.

Waiver of Premium

If, as the result of total disability, you are approved for Waiver of Premium and remain eligible for such under the terms of your employer's Basic Life Insurance contract, you need not pay any further premiums under this program for yourself, your insured spouse and your insured dependent children.

Premiums will continue to be waived until the earliest of the following dates:

- the date the program terminates;
- the date you reach age 65; or
- the date you cease to be totally disabled.

The insurer reserves the right to request proof of disability from time to time as may be reasonably required. Failure to provide proof satisfactory to the insurer may result in termination of the waiver of premium benefit.

All terms and provisions of the program will apply during the period your premiums are waived, including provisions relating to reductions in amounts of insurance.

Extended Family Coverage

In the event of your death due to an injury for which benefits are payable, the coverage will be continued for your spouse and your insured dependent children for a period of six months, provided payment of premium is continued.

Continuation of Coverage

Coverage will be continued for up to 12 months for you, your insured spouse and your insured dependent children during any approved leave of absence, temporary layoff, maternity or parental leave, provided payment of premium is continued. Coverage will be continued for any approved disability leave until you reach 65 years of age, qualify for Waiver of Premium benefits or return to work in any capacity, whichever is earlier.

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

Conversion Privilege

Upon termination of your insurance and provided the program is still in effect, you may convert your own insurance (but not your insured spouse's or your insured dependent children), without evidence of insurability to an individual accident insurance policy. You may elect an amount equal to or lower than the amount of the Principal Sum in force at the time of termination.

You must apply within 31 days of the termination of your coverage.

Co-ordination of Benefits

The total maximum payable in combination with the similar benefit maximum provided under any other policy issued to you will not exceed the actual expenses incurred or the maximum amount of benefit provided, whichever is less: Repatriation Benefit, Daycare Benefit, Family Transportation Benefit, Spousal Retraining Benefit, Rehabilitation Benefit, Education Benefit, Identification Benefit, Workplace Modification and Accommodation Benefit, and Home Alteration and Vehicle Modification Benefit.

Aggregate Limit

$2,500,000 is the maximum payable to all insureds involved in any one accident.

Exclusions

- Suicide or any attempt thereat or intentionally self-inflicted injury while sane or insane.
- Declared or undeclared war or any act thereof.
- Active full-time service in the armed forces of any country.
- Flying as a pilot or crew member of any aircraft.
- Flying as a passenger or otherwise in any aircraft owned, operated, leased or chartered by your employer.
- Flying in any vehicle or device for aerial navigation except as provided in the Limited Air Travel Coverage section.

Beneficiary

Benefits payable in the event of loss of life are payable to the beneficiary or beneficiaries designated in writing by you and on file with your Plan Administrator. If there is no such beneficiary designation, such indemnity shall be payable to your estate. All other benefits payable, including those payable to your spouse or dependent children, are payable to you with the exception of indemnities payable under the Family Transportation, Parental Care, Education, Daycare, Spousal Retraining, Workplace Modification and Accommodation, Identification, Repatriation, Funeral Expense and Bereavement benefits.

In the situation where the policy replaces an existing policy issued to the employer, the beneficiary designation recorded under the replaced policy will be deemed to be valid and of full force and effect until changed in writing by the insured.

Every action or proceeding against an insurer for the recovery of insurance money payable under the policy is absolutely barred unless commenced within the time set out in the Insurance Act or other applicable legislation.

Optional Accidental Death & Dismemberment

Optional AD&D allows you to purchase additional accident coverage for yourself as well as for your spouse and dependent children. You will be covered for any accident resulting in death or dismemberment anywhere in the world - 24 hours per day - on or off the job. Benefits are payable in addition to any other insurance you may have.

Amount of Insurance

You may select any amount of coverage for yourself from a minimum of $25,000 to a maximum of $250,000 in units of $25,000.

You may also elect to insure your family. Your spouse will be insured for 60% of the benefit you have selected for yourself if there are no eligible children, and 50% if there are eligible children. Each dependent child will be insured for 15% of the benefit you have selected for yourself, subject to a maximum of $25,000. If there is no eligible spouse, each eligible child is insured for 20% up to a maximum of $37,500.

In the event that you and your spouse are both employed at the same company, you both may enroll in the benefit. However, one would select Single Coverage Only and the other may elect the Family Coverage. If only one of you elects to enroll in the plan, the other will be insured under the Family Plan as the spouse.

Specific Loss Accident Indemnity

When injury results in any of the following losses within three hundred and sixty-five (365) days after the date of the accident, the insurer will pay:

For Loss of:	
Life	100%
Brain Death	100%
Entire Sight of Both Eyes	100%
Speech and Hearing in Both Ears	100%
Entire Sight of One Eye	75%
Speech	75%
Hearing in Both Ears	75%
Hearing in One Ear	33-1/3%
All Toes of One Foot	25%

For Loss or Loss of Use of:

Both Arms or Both Legs	200%
Both Hands or Both Feet	200%
One Hand and One Foot	100%
One Hand and the Entire Sight of One Eye	100%
One Foot and the Entire Sight of One Eye	100%
One Arm or One Leg	75%
One Hand or One Foot	75%
Thumb and Index Finger or at Least Four Fingers of One Hand	33-1/3%

For Total Paralysis of:

Quadriplegia (both upper and lower limbs)	200%
Paraplegia (both lower limbs)	200%
Hemiplegia (upper and lower limbs of one side of body)	200%

"Loss" whenever used with reference to hand or foot means complete severance at or above the wrist or ankle joint but below the elbow or knee joint; as used with reference to arm or leg means complete severance at or above the elbow or knee joint; as used with reference to thumb and fingers means complete severance at or above the metacarpophalangeal joint; as used with reference to toes means complete severance at or above the metatarsophalangeal joint; as used with reference to eye means the irrecoverable loss of the entire sight thereof; as used with reference to speech means the total and irrecoverable loss thereof; as used with reference to hearing means the total and irrecoverable loss thereof; and as used with reference to Quadriplegia, Paraplegia and Hemiplegia means the permanent and irrecoverable paralysis of such limbs.

"Loss of Use" means a loss which is permanent, total, irrecoverable and continuous for a period of 12 months from the date of the accident.

Indemnity provided under this section for all losses sustained by any one insured person as the result of any one accident will not exceed the following:

- with the exception of quadriplegia, paraplegia and hemiplegia, the Principal Sum.
- with respect to quadriplegia, paraplegia and hemiplegia, Two Times the Principal Sum, or the Principal Sum if loss of life occurs within 90 days after the date of the accident.

In no event will indemnity payable for all losses under this section exceed, in the aggregate, Two Times the Principal Sum as the result of the same accident.

In addition to the Specific Loss Schedule, the following benefits are included:

Cosmetic Disfigurement Benefit

If an insured suffers a third degree burn, a percentage of the Principal Sum, depending on the area of the body which was burned according to the following table, will be paid:

Body Part	Area Classification (A)	Maximum Allowable Percentage for Area Burned (B) %	Maximum Percentage of Principal Sum Payable (C) %
Face, Neck, Head	**10**	**10.0**	**100.0**
Hand and Forearm	**5**	**5.0**	**25.0**
Either Upper Arm	**3**	**5.0**	**15.0**
Torso (front or back)	**2**	**18.0**	**36.0**
Either Thigh	**1**	**10.0**	**10.0**
Either Lower Leg (below knee)	**3**	**9.0**	**27.0**

The maximum percentage of Principal Sum Payable (C) is determined by multiplying the Area Classification (A) by the maximum allowable percentage for Area Burned (B). In the event of a 50% surface burn, the maximum allowable percentage for Area Burned (B) is reduced by 50%. This table only represents the maximum percentage of the Principal Sum Payable for any one accident. If the insured suffers burns in more than one area, as a result of any one accident, benefits will not exceed a maximum of $25,000.

Seat Belt Benefit

If an insured is driving or riding in a vehicle and wearing a properly fastened seat belt at the time of the accident, and such insured sustains a specific loss for which an amount of Principal Sum becomes payable under the program, the amount payable for such specific loss is increased by 10%.

The driver of the vehicle must hold a current and valid driver's license of a rating authorizing him to operate such vehicle and neither be intoxicated nor under the influence of drugs, unless such drugs are taken as prescribed by a physician at the time of the accident.

Hospital Indemnity

If any specific loss covered under the program confines you, your insured spouse or your insured dependent child to a hospital and such person is under the regular care and attendance of a physician, you will receive a daily benefit of 1/30th of 1% of your Principal Sum from the first day of hospitalization to a maximum of $2,500 per month and for a maximum duration of 365 days per accident. Hospitalization must begin while the insurance is in force for you or your dependents.

Hospitalization for treatment of any injury other than for a specific loss will also be covered in accordance with the above, if hospitalized for at least four days.

Family Transportation Benefit

If any specific loss covered under the program confines an insured to a hospital under the regular care and attendance of a physician, and such hospital is located at least 150 kilometres from the insured's residence, this benefit will pay the reasonable expenses actually incurred by a member of the insured's immediate family for accommodation and transportation via the most direct route to the insured's bedside, to a maximum of $15,000. Private transportation expenses are limited to $0.35 per kilometre travelled.

Room, board or other ordinary living, travelling or clothing expenses are not covered.

Parental Care Benefit

If you sustain accidental loss of life for which an amount of Principal Sum becomes payable under the program, 5% of your Principal Sum to a maximum of $5,000 will be paid to an eligible dependent parent who, at the time of the accident, is a resident in a licensed nursing care facility, or enrolled in a home health care program, or living in your residence, or receiving support and care provided by you.

Psychological Therapy Benefit

If injury results in a loss payable to an insured under the Specific Loss Accident Indemnity schedule and results in the insured requiring psychological therapy, as prescribed by a physician, reasonable and necessary expenses actually incurred will be paid, to a maximum of $5,000.

Child Enhancement Benefit

With the exception of loss of life, the percentages indicated under the "Specific Loss Accident Indemnity" section are quadrupled with respect to your insured dependent children but in no event will exceed the maximum amount stated.

This provision does not apply if loss of life occurs within 90 days after the date of the accident.

Education Benefit

If you sustain accidental loss of life for which an amount of Principal Sum becomes payable under the program, up to 5% of your Principal Sum, to a maximum of $10,000, will be paid for reasonable and necessary expenses actually incurred for each of your dependent children who are already enrolled in an institution of higher learning above the secondary school level or who will do so within 365 days after your death.

The benefit is payable annually, for each year up to 4 consecutive years that the child continues school on a full-time basis beyond the secondary school level.

Room, board or other ordinary living, travelling or clothing expenses are not covered.

If none of your insured dependent children satisfy the above requirements, an amount of $2,500 will be paid to your beneficiary.

Daycare Benefit

If you sustain accidental loss of life for which an amount of Principal Sum becomes payable under the program, up to 5% of your Principal Sum, to a maximum of $5,000, will be paid for reasonable and necessary expenses actually incurred for each of your dependent children under 13 years of age who are enrolled in a legally licensed daycare centre or who will do so within 365 days after your death. This includes a child who is born within nine months of your date of loss, provided the child was conceived prior to the date of loss.

The benefit is payable annually, for each year up to four consecutive years that the child remains enrolled in a legally licensed daycare centre.

Room, board or other ordinary living, travelling or clothing expenses are not covered.

If none of your insured dependent children satisfy the above requirements, an amount of $2,500 will be paid to your beneficiary.

Spousal Retraining Benefit

If you sustain accidental loss of life for which an amount of Principal Sum becomes payable under the program, and your spouse engages in a formal occupational training program in order to become qualified for active employment in an occupation otherwise not qualified, this benefit will refund expenses incurred within 3 years following the date of your death, to a maximum of $15,000.

Room, board or other ordinary living, travelling or clothing expenses are not covered.

Rehabilitation Benefit

If you sustain a specific loss for which an amount of Principal Sum becomes payable under the program and such injury requires your participation in a rehabilitation program in order to be qualified in a different occupation, this benefit will refund expenses actually incurred during the 3 year period following the loss, to a maximum of $15,000.

Room, board or other ordinary living, travelling or clothing expenses are not covered.

Workplace Modification and Accommodation Benefit

If injury requires special adaptive equipment and/or workplace modification for you to return to active full-time employment, the cost of these modifications will be paid, to a maximum of $5,000, provided the employer agrees in writing to provide such modification and accommodation to the workplace for the purpose of making it accessible and adaptable to your needs and acknowledges in writing that the performance of the essential duties your occupation may be altered.

Home Alteration and Vehicle Modification Benefit

If injury requires the use of a wheelchair to be ambulatory, the cost of alterations to the insured's principal residence and/or the cost of modification to one motor vehicle utilized by the insured will be paid, subject to a maximum amount of the greater of $15,000 or 10% of the insured's Principal Sum amount to a maximum of $50,000, as the result of any one accident, provided such injury results in a loss payable under the Accidental Death, Dismemberment and Specific Loss Indemnity.

Air Bag Benefit

If, due to a vehicular accident, injury results in a loss payable under the Accidental Death, Dismemberment and Specific Loss Indemnity, the insured's amount of Principal Sum will be increased by 5%, provided that:

a) such loss occurs while the insured is a passenger or driver of a private passenger type vehicle equipped with either a single air bag, air bags for both the driver and the front passenger seats, or air bags for the driver, front passenger and rear passenger seats; and

b) the seat belt is in actual use and properly fastened at the time of the accident, and due proof of seat belt use must be provided as part of the written proof of loss.

Assault Benefit

If injury results in a loss payable under the Accidental Death, Dismemberment and Specific Loss indemnity, the Company will pay an additional indemnity equal to 10% of the applicable indemnity payable under that part, subject to a maximum of $25,000.00, if the injury is caused by an assault on premises owned or rented by the employer or if the assault occurred while the insured was traveling on company business.

No benefit will be payable under this part if the assault was the act of another employee or a member of the immediate family of the insured or a member of the insured's household.

Carjacking Benefit ($10,000)

If, injury sustained by the insured results in a loss payable under the Accidental Death, Dismemberment and Specific Loss Indemnity, the insured's amount of Principal Sum will be increased by 10%, if the injury occurs during a carjacking of an automobile that the insured was operating, getting into or out of, or, riding as a passenger.

Comatose Benefit

If an injury does not cause loss of life, but results in a coma or comatose state, the Company will pay 1% of the Principal Sum (less any sum paid under the Accidental Death, Dismemberment and Specific Loss Indemnity) for each month the coma or comatose state continues, subject to an overall maximum of $50,000.00. Payments commence at the end of the waiting period and are subject to a maximum of 100 consecutive months.

Permanent Total Disability

If an injury totally and permanently disables an insured, under age 65, within 12 months of the date of the accident, preventing an insured from engaging in any and every occupation, the Company will pay, provided such disability has continued for a period of 12 consecutive months and is total, continuous and permanent at the end of this period, the Principal Sum less any amounts paid or payable under the Accidental Death, Dismemberment and Specific Loss Indemnity as the result of the same accident.

Public Transportation Benefit

If an injury results in loss of life and indemnity becomes payable under the Accidental Death, Dismemberment and Specific Loss Indemnity, the Company will pay an additional amount equal to 100% of the Principal Sum if, at the time of the accident, the insured was riding as a passenger in a regularly scheduled public land, air or water conveyance licensed to carry fare-paying passengers, including a train, bus, taxi, subway, tramway, boat or commercial airplane.

Identification Benefit

If injury results in loss of life, and requires body identification, the expenses actually incurred by a member of the immediate family for lodging, board and transportation by the most direct route will be paid, provided the body is located at least 150 kilometres from the member of the immediate family's residence and the identification of the body is required by the police or a similar law enforcement agency having authority over such matters, to a maximum of $15,000.

If transportation occurs in a vehicle or device other than one operated under the license for the conveyance of passengers for hire, then reimbursement of transportation expenses will be limited to a maximum of $0.35 per kilometre travelled.

Repatriation Benefit

If an insured sustains accidental loss of life for which an amount of Principal Sum becomes payable under the program, repatriation benefits up to $15,000 will be paid for the reasonable and necessary expenses actually incurred for the transportation of the body to the city of residence, including the preparation of the body for transportation.

Funeral Expense Benefit

If an injury sustained by an insured results in loss of life, an additional amount is payable for funeral expenses actually incurred, to a maximum of $5,000.

Bereavement Benefit

If you sustain an injury that results in loss of life, reasonable and necessary expenses actually incurred by your spouse and dependent children for up to six (6) sessions of grief counselling, by a professional counsellor will be paid, to a maximum of $1,000.

Common Disaster Benefit

If you and your insured spouse both sustain accidental loss of life as a result of a common accident or two separate accidents occurring within the same 24-hour period, and such losses become payable under the program, your spouse's amount of coverage will be increased to the same level as yours, subject to an overall total for you and your spouse of $500,000.

Limited Air Travel Coverage

An insured is covered only while flying as a passenger in any aircraft holding a current and valid certificate of airworthiness (other than an aircraft owned, operated, leased or chartered by or on behalf of your employer) and operated by a person holding a current and valid pilot's license with a rating authorizing him to pilot such aircraft. Coverage also applies while flying as a passenger in a military aircraft.

Exposure and Disappearance

Unavoidable exposure to the elements will be covered under the program as any other loss, provided such exposure is sustained as the result of a covered accident and the loss for which indemnity would be payable occurs within 1 year of the accident.

An insured will be presumed to have suffered accidental loss of life if the insured's body is not found within 1 year after the disappearance, sinking or wrecking of the conveyance in which the insured was riding at the time of the accident.

Waiver of Premium

If, as the result of total disability, you are approved for Waiver of Premium and remain eligible for such under the terms of your employer's Basic Life Insurance contract, you need not pay any further premiums under this program for yourself, your insured spouse and your insured dependent children.

Premiums will continue to be waived until the earliest of the following dates:

- the date the program terminates;
- the date you reach age 65; or
- the date you cease to be totally disabled.

The insurer reserves the right to request proof of disability from time to time as may be reasonably required. Failure to provide proof satisfactory to the insurer may result in termination of the waiver of premium benefit.

All terms and provisions of the program will apply during the period your premiums are waived, including provisions relating to reductions in amounts of insurance.

Extended Family Coverage

In the event of your death due to an injury for which benefits are payable, the coverage will be continued for your spouse and your insured dependent children for a period of six months, provided payment of premium is continued.

Continuation of Coverage

Coverage will be continued for up to 12 months for you, your insured spouse and your insured dependent children during any approved leave of absence, temporary layoff, maternity or parental leave, provided payment of premium is continued. Coverage will be continued for any approved disability leave until you reach 65 years of age, qualify for Waiver of Premium benefits or return to work in any capacity, whichever is earlier.

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

Conversion Privilege

Upon termination of your insurance and provided the program is still in effect, you may convert your own insurance (but not your insured spouse's or your insured dependent children), without evidence of insurability to an individual accident insurance policy. You may elect an amount equal to or lower than the amount of the Principal Sum in force at the time of termination.

You must apply within 31 days of the termination of your coverage.

Co-ordination of Benefits

The total maximum payable in combination with the similar benefit maximum provided under any other policy issued to you will not exceed the actual expenses incurred or the maximum amount of benefit provided, whichever is less: Repatriation Benefit, Daycare Benefit, Family Transportation Benefit, Spousal Retraining Benefit, Rehabilitation Benefit, Education Benefit, Identification Benefit, Workplace Modification and Accommodation Benefit, and Home Alteration and Vehicle Modification Benefit.

Aggregate Limit

$2,500,000 is the maximum payable to all insureds involved in any one accident.

Exclusions

- Suicide or any attempt thereat or intentionally self-inflicted injury while sane or insane.
- Declared or undeclared war or any act thereof.
- Active full-time service in the armed forces of any country.
- Flying as a pilot or crew member of any aircraft.
- Flying as a passenger or otherwise in any aircraft owned, operated, leased or chartered by your employer.
- Flying in any vehicle or device for aerial navigation except as provided in the Limited Air Travel Coverage section.

Beneficiary

Benefits payable in the event of loss of life are payable to the beneficiary or beneficiaries designated in writing by you and on file with your Plan Administrator. If there is no such beneficiary designation, such indemnity shall be payable to your estate. All other benefits payable, including those payable to your spouse or dependent children, are payable to you with the exception of indemnities payable under the Family Transportation, Parental Care, Education, Daycare, Spousal Retraining, Workplace Modification and Accommodation, Identification, Repatriation, Funeral Expense and Bereavement benefits.

In the situation where the policy replaces an existing policy issued to the employer, the beneficiary designation recorded under the replaced policy will be deemed to be valid and of full force and effect until changed in writing by the insured.

Every action or proceeding against an insurer for the recovery of insurance money payable under the policy is absolutely barred unless commenced within the time set out in the Insurance Act or other applicable legislation.

Extended Health Care

Employee and Dependent Coverage

Health benefits are designed to help meet the medical and hospital expenses incurred by you and your family. In the event you or an insured dependent incurs an eligible expense, as listed below and as shown in the Schedule of Benefits, you will be paid a percentage (coinsurance) of the expense, in excess of the deductible for that year.

Lifetime Maximum Benefit

The total lifetime benefit payable in respect to you or your dependents is unlimited.

Eligible Expenses - Hospital

Preferred Accommodation in Canadian Hospitals

The difference between the charges made for ward and semi-private room and board in a licensed Canadian hospital. Such charges shall not be subject to the deductible.

Eligible Expenses - Drugs

Reasonable and customary charges incurred for medically necessary generic drugs and medicines as specified in the Schedule of Benefits which:

- are dispensed by a licensed pharmacist or physician legally authorized to dispense such drugs and medicines, and
- are prescribed by a physician or other professional authorized by provincial legislation to prescribe medicines for the treatment of an illness or injury and are either:

  a) drugs requiring the prescription of a physician or other health practitioner as permitted by law; or

  b) other specified drugs and medicines which have been identified as covered expenses and are by convention usually not dispensed without a physician's prescription; or

  c) injectable preparations identified as eligible and allergy serums; or

  d) insulin preparations, test strips, diabetic needles and syringes.

When there is more than one drug that is suitable to treat your condition, your plan allows for reimbursement based on the cost of the lowest priced equivalent drug. Should you decide to purchase a higher priced drug, you may pay the difference unless your medical or dental practitioner has written that there is to be no substitution of the prescribed drug or medicine.

Note: Lifestyle drugs are not covered, including but not limited to smoking cessation aids, anti-obesity drugs, drugs prescribed in connection with fertility treatment and erectile dysfunction.

No benefit shall be payable for any single purchase of drugs which would not reasonably be used within 90 days from the date of purchase.

Drugs Covered Under the Quebec Universal Drug Plan Formulary

Drugs not covered under the group plan but listed in the Quebec Universal Drug Plan formulary, will be reimbursed in accordance with the Quebec Universal Drug Plan.

A child age 22 to 25 inclusive will be considered a dependent if in full-time attendance at an accredited school, college or university.

Coverage will be maintained with payment of premium for a minimum period of 30 days in the event of strike, lock-out or any other organized work stoppage.

At age 65, you have the choice of being insured either by the Régie de l'assurance maladie du Québec (RAMQ) or under this policy. If you choose to be covered under this policy an annual premium will be charged. A decision to take coverage under the RAMQ plan is considered irrevocable and you cannot at a later date apply for drug coverage under the group plan.

Eligible Expenses - Vision Care

Reasonable and customary charges for vision care as follows:

a) lenses and frames for eyeglasses or contact lenses not covered in (b), or laser eye surgery, when prescribed by an ophthalmologist or optometrist, subject to the Vision Care Maximum shown in the Schedule of Benefits;

b) contact lenses prescribed for severe corneal astigmatism, severe corneal scarring, Keratoconus (conical cornea) or Aphakia, provided visual acuity can be improved to at least the 20/40 level by contact lenses but cannot be improved to that level by spectacle lenses, subject to the Vision Care Maximum shown in the Schedule of Benefits.

Eligible Expenses - Supplementary Health Care

Reasonable and customary charges for supplementary health care expenses as follows:

- licensed Convalescent Care Facility, subject to a daily maximum benefit equal to the charge made for semi-private accommodation for not more than 120 days of confinement per calendar year. Confinement must begin following a minimum of three consecutive days of hospital confinement and prior to the insured's 65th birthday;
- medical services (excluding custodial care, psychological or personal counselling) provided by a Registered Nurse (R.N.) or Registered Practical Nurse/Licensed Practical Nurse (R.P.N. / L.P.N.) which are rendered while the insured is not confined to a hospital subject to an overall maximum benefit of $10,000 in any calendar year provided such nurse is not a resident in your home or a relative of your family. These charges will be considered eligible expenses only if recommended by a physician and if medically necessary. For the purpose of this policy, custodial care is defined as assistance with daily living or tasks which a layperson could perform;
- professional ambulance service, other than airline, to and from the nearest hospital qualified to provide the necessary treatment.
- emergency transportation (except while travelling outside the insured's province of residence) by airline to and from the nearest hospital qualified to provide the necessary treatment. Such emergency transportation includes, if medically required, transportation costs for a medical attendant who is neither a resident in your home nor a relative of your family;
- rental (or, at the benefits provider's option, purchase) of durable medical or surgical equipment required for therapeutic purposes and as approved by the benefits provider;

- rental (or, at the benefit provider's option, purchase) of crutches, custom-made braces and the purchase of prostheses;
- necessary dental treatment required as the result of an accidental injury to natural teeth when necessitated by a direct blow to the mouth and not by an object wittingly or unwittingly placed in the mouth, provided the accident occurred while insured under this coverage, subject to a maximum benefit of $5,000 per accident. As determined by the benefit provider, only such charges directly related to such an accidental injury are considered a covered medical expense. The dental work must be completed within 12 months of the accident to be considered a covered medical expense;
- custom-made orthopedic shoes and orthotics which have been specially designed and molded for the insured individual and are required to correct a diagnosed physical impairment. The custom-made orthopedic shoes or orthotics must have been prescribed by a podiatrist, chiropodist or MD and dispensed by an orthotist, pedorthist, podiatrist, chiropodist or chiropractor. Such charges are limited to a maximum benefit of $200 per orthopedic shoe up to a maximum of $400 in any calendar year, or up to a maximum of $400 in any calendar year for orthotics;
- laboratory tests and x-rays not covered by your provincial health care plan, subject to a maximum benefit of $500 per calendar year per individual;
- purchase of hearing aids (excluding batteries) provided by a certified clinical audiologist, subject to a maximum benefit of $500 per person in any three consecutive years;
- eye examinations performed by a qualified optometrist or ophthalmologist, once every 24 months, where provincial health care plan coverage of eye exams is not available.

Paramedical Practitioners

Charges for the services of the following paramedical practitioners, when operating within their field of expertise and when certified, registered or licensed by the appropriate provincial or federal body, are eligible for reimbursement subject to the conditions and calendar year maximums shown below:

Practitioner	Covered	MD Referral Required	Annual Maximum
Speech Therapist	Yes	No	$500
Clinical Psychologist	Yes	No	$500
Osteopath	Yes	No	$500
Chiropractor	Yes	No	$500
Physiotherapist	Yes	No	$500
Naturopath	Yes	No	$500
Acupuncturist	Yes	No	$500
Chiropodist/Podiatrist	Yes	No	$500
Massage Therapist	Yes	Yes	$500

Charges for x-rays are covered, subject to a maximum benefit of $20 per calendar year for all specialties combined.

Exclusions

The foregoing list of eligible expenses shall not include any of the following:

- charges which are considered an insured service of any provincial government plan;
- charges which were considered an insured service of any provincial government plan at the time this plan/benefit was issued and subsequently were modified, suspended or discontinued;
- charges for general health examinations, and examinations required for use of third party;
- charges for a surgical procedure or treatment performed primarily for beautification, or charges for hospital confinement for such surgical procedure or treatment;
- charges for medical treatment or surgical procedures by a physician;
- charges for transport or travel, other than as specifically provided under eligible expenses;
- charges not specified in the foregoing list of eligible medical expenses;
- charges for services or supplies which are furnished without the recommendation and approval of a physician acting within the scope of his license;
- charges which are not medically necessary to the care and treatment of any existing or suspected injury, disease or pregnancy;
- charges which are from an occupational injury or disease covered by any Workplace Safety Insurance Board or similar legislation;
- charges which would not normally have been incurred but for the presence of this insurance or for which you are not legally obligated to pay;
- charges which the benefits provider is not permitted, by any law or regulation, to cover;
- charges for dental work where a third party is responsible for payment for such charges;
- charges for bodily injury resulting directly or indirectly from war or act of war (whether declared or undeclared), insurrection or riot, or hostilities of any kind;
- charges for services or supplies resulting from any intentionally self-inflicted wound;
- charges for drugs, sera, injectable drugs or supplies which are not approved by Health Canada or are experimental or limited in use whether or not so approved;
- charges for experimental medical procedures or treatment not approved by the Canadian Medical Association or the appropriate medical specialty society;
- charges made by a physician for travel, broken appointments, communication costs, filling in of forms, or physician's supplies.

Benefit Continuance for Surviving Dependents

Extended Health Care coverage for dependents shall continue without premium payment following your death for up to a maximum of 24 months from the date of death or to the date the policy or benefit terminates, whichever is earlier.

Emergency Travel Assistance, Employee Assistance Program, Personal Medical Guidance Service and Second Medical Opinion Service benefits continue throughout the survivor benefit period.

Emergency Travel Assistance

Employee and Dependent Coverage

You are only eligible for the Emergency Travel Assistance benefit if you are covered for the Extended Health Care benefit. Refer to your Certificate of Insurance to determine if you are covered for these benefits.

Reimbursement of eligible benefits for emergency services will be made only if the services were required as a result of emergency illness or injuries that occurred while you were vacationing or travelling for other than health reasons. Eligible travel benefits will be reasonable and customary charges in the area where they were received, less the amount payable by your provincial health care plan.

Upon notification of the necessity for treatment of an accidental injury or medical emergency, the patient must contact the Travel Assistance within 48 hours of commencement of treatment.

Emergency means a sudden, unexpected occurrence (disease or injury) that requires immediate medical attention. This includes treatment (non-elective) for immediate relief of severe pain, suffering or disease that cannot be delayed until you or your dependent is medically able to return to your province of residence. Any invasive or investigative procedures must be pre-approved by the Emergency Travel Assistance Medical Team.

Benefit Details

Eligible benefits are limited to the maximum days per trip shown in the Schedule of Benefits commencing with the date of departure from your province of residence. If you are hospitalized on the last day shown in the Schedule of Benefits, benefits will be extended until the date of discharge.

Hospital Services and Accommodation

Up to a standard ward rate in a public general hospital.

Medical/Surgical Services

When rendered by a legally qualified physician or surgeon to relieve the symptoms of, or to cure an unforeseen illness or injury.

Emergency Transportation

- By land ambulance to the nearest qualified medical facility.
- By air ambulance - the cost of air evacuation (including a medical attendant when necessary) between hospitals and for hospital admission into Canada when approved in advance by your provincial health care plan or to the nearest qualified medical facility.

Referral Services
For hospital services and accommodation, up to a standard ward rate in a public general hospital, and/or medical surgical services rendered by a legally qualified physician or surgeon.

Prior to the commencement of any referral treatment, written pre-authorization from your provincial health care plan and Green Shield Canada must be obtained. Your provincial health insurance plan may cover this referral benefit entirely. You must provide Green Shield Canada with a letter from your attending physician stating the reason for the referral, and a letter from your provincial health care plan outlining their liability. Failure to comply in obtaining pre-authorization will result in non-payment.

Services of a Registered Private Nurse
Up to a maximum of $5,000 per calendar year, at the reasonable and customary rate charged by a qualified nurse (R.N.) registered in the jurisdiction in which treatment is provided. You must contact the Travel Assistance for pre-approval.

Diagnostic Laboratory Tests and X-rays
When prescribed by the attending physician. Except in emergency situations, the Travel Assistance must pre-approve these services (i.e., cardiac catheterization or angiogram, angioplasty and bypass surgery).

Reimbursement of Prescriptions
Drugs, serums and injectables which require a prescription by law and are prescribed by a legally qualified medical practitioner (vitamins, patent and proprietary drugs are excluded).

Medical Appliances
Including casts, crutches, canes, slings, splints and/or the temporary rental of a wheelchair when deemed medically necessary and required due to an accident which occurs, and when the devices are obtained outside your province of residence.

Treatment by a Dentist
Only when required due to a direct accidental blow to the mouth up to a maximum of $2,000. Treatments (prior to and after return) must be provided within 90 days of the accident.

Coming Home
When your emergency illness or injury is such that

- The Assistance Medical Team specifies in writing that you should immediately return to your province of residence for immediate medical attention, reimbursement will be made for the extra cost incurred for the purchase of a one-way economy airfare, plus the additional economy airfare if required to accommodate a stretcher, to return you by the most direct route to the major air terminal nearest the departure point in your province of residence.
- This benefit assumes that you are not holding a valid open-return air ticket. Charges for upgrading, departure taxes, cancellation penalties or airfares for accompanying family members or friends are not included.
- The Assistance Medical Team or commercial airline stipulates in writing that you must be accompanied by a qualified medical attendant, reimbursement will be made for the cost incurred for one round-trip economy airfare and the reasonable and customary fee charged by a medical attendant who is not your relative by birth, adoption or marriage and is registered in the jurisdiction in which treatment is provided, plus overnight hotel and meal expenses if required by the attendant.

Return Trip Delay - Transportation

Charges incurred for delay of the return trip of a covered person due to the hospitalization of that person or another covered person with whom the individual is travelling, limited to the cost of one-way economy class transportation.

Return of Dependent Children

Charges incurred for the return of dependent children to their residence in Canada in the event you or your spouse is hospitalized and the children are left unattended. The children must be under 16 years of age. Arrangements for an escort to accompany the children will be made if necessary.

Returning Your Personal Use Motor Vehicle

The cost involved to your residence or nearest appropriate vehicle rental agency when you are unable to due to sickness, physical injury or death, up to a maximum of $1,000 per trip.

Meals and Accommodation

Up to $1,500 (maximum of $150 per day for up to 10 days) will be reimbursed for the extra costs of commercial hotel accommodation and meals incurred by you when you remain with a travelling companion or a person included in the "family" coverage, when the trip is delayed or interrupted due to an illness, accidental injury to or death of a travelling companion.

Transportation to the Bedside

Round-trip economy airfare by the most direct route from your province of residence, for any one spouse, parent, child, brother or sister, and up to $150 per day for a maximum of five days for meals and accommodation at a commercial establishment will be paid for that family member to:

- be with you or your covered dependent when confined in hospital. This benefit requires that the covered person must eventually be an inpatient for at least seven days outside your province of residence, plus the written verification of the attending physician that the situation was serious enough to have required the visit.
- identify a deceased prior to release of the body.

Return Airfare

If the personal use motor vehicle of you or your covered dependent is stolen or rendered inoperable due to an accident, reimbursement will be made for the cost of a one-way economy airfare to return you by the most direct route to the major airport nearest your departure point in your province of residence.

Return of Deceased

Up to a maximum of $5,000 toward the cost of embalming or cremation in preparation for homeward transportation in an appropriate container of yourself or your covered dependent when death is caused by illness or accident. The body will be returned to the major airport nearest the point of departure in your province of residence.

Travel Assistance Service

The following services are available 24 hours per day, seven days per week through the international medical service organization. These services include:

- Access to Pre-trip Assistance (prior to departure), including Canada Direct Calling Codes, information about vaccinations, government-issued travel advisories, and VISA/document requirements for entry into country of destination,
- Multilingual assistance,
- Assistance in locating the nearest, most appropriate medical care,
- International preferred provider networks,

- The Assistance Medical Team's consultative and advisory services, including second opinion and review of appropriateness and analysis of the quality of medical care,
- Assistance in establishing contact with family, personal physician and employer as appropriate,
- Monitoring of progress during treatment and recovery,
- Emergency message transmittal services,
- Translation services and referrals to local interpreters as necessary,
- Verification of coverage facilitating entry and admissions into hospitals and other medical care providers,
- Special assistance regarding the co-ordination of direct claims payment,
- Co-ordination of embassy and consular services,
- Management, arrangement and co-ordination of emergency medical transportation and evacuation as necessary,
- Management, arrangement and co-ordination of repatriation of remains,
- Special assistance in making arrangements for interrupted and disrupted travel plans resulting from emergency situations to include:

  a) The return of unaccompanied travel companions

  b) Travel to the bedside of a stranded person

  c) Rearrangement of ticketing due to accident or illness and other travel-related emergencies

  d) The return of a stranded personal use motor vehicle and related personal items
- Knowledgeable legal referral assistance,
- Co-ordination of securing bail bonds and other legal instruments,
- Special assistance in replacing lost or stolen travel documents including passports,
- Courtesy assistance in securing incidental aid and other travel-related services, and
- Emergency and payment assistance for major health expenses.

How Travel Assistance Service Works

For assistance, dial 1-800-936-6226 within Canada and the United States or call collect 0-519-742-3556 when traveling outside Canada and the United States. These numbers appear on your ENCON Benefits Card.

Quote the Travel Assistance group number and your Identification Number, found on your ENCON Benefits Card, and explain your medical emergency. You must always be able to provide your Identification Number and your provincial health insurance plan number.

A multilingual Assistance Specialist will provide direction to the best available medical facility or legally qualified physician able to provide the appropriate care.

Upon admission to a hospital or when consulting a legally qualified physician or surgeon for major emergency treatment, Green Shield Canada will guarantee the provider (hospital, clinic or physician), that you have both provincial health insurance plan coverage and travel benefits as detailed above. The provider may then bill Green Shield Canada directly for these approved services.

The Assistance Medical Team will follow your progress to ensure that you are receiving the best available medical treatment. These physicians also keep in constant communication with your family physician and your family, depending on the severity of your condition.

When calling collect while travelling outside Canada and the United States, you may require a Canada Direct Calling Code. In the event that a collect call is not possible, keep your receipts for phone calls made to the Travel Assistance and submit them for reimbursement upon your return to Canada.

Travel Limitations

- Benefits will be eligible only if existing or pre-diagnosed conditions are completely stable (in the opinion of the Travel Assistance Medical Team) at the time of departure from your province of residence. Green Shield Canada reserves the right to review your medical information at the time of claim.
- The eligible benefits must be required for the immediate relief of acute pain or suffering as recommended by a legally qualified physician or surgeon. Eligible benefits will not be reimbursed for treatment or surgery that could reasonably be delayed until you return to your province of residence.
- Reimbursement for eligible benefits will be made only if your provincial health care plan covers and provides payment toward the cost of the services received.
- Coverage becomes effective at the time you or your dependent crosses the provincial border departing from your province of residence and terminates upon crossing the border returning to your province of residence on the return home. If traveling by air, coverage becomes effective at the time the aircraft takes off in the province of residence and terminates when the aircraft lands in the province of residence on the return home.
- Upon notification of the necessity for treatment of an accidental injury or medical emergency, the Travel Assistance Medical Team reserves the right to determine whether repatriation is appropriate if the patient's medical condition will require immediate or scheduled care. Such repatriation is mandatory, where the Travel Assistance Medical Team determines that the patient is medically fit to travel and appropriate arrangements have been made to admit the patient into the provincial government health care system of their province of residence. Repatriation will ensure continued coverage under the plan. Should the patient opt not to be repatriated or elects to have such treatment or surgery outside their province of residence, the expense of such continuing treatment will not be an eligible benefit.
- The patient must contact the Travel Assistance within 48 hours of commencement of treatment. Failure to notify them within 48 hours may result in benefits being limited to only those expenses incurred within the first 48 hours of any and each treatment/incident or the plan maximum, whichever is the lesser of the two.
- Air ambulance services will only be eligible if:

  a) they are pre-approved by the Travel Assistance;

  b) there is a medical need for you or your dependent to be confined to a stretcher or for a medical attendant to accompany you during the journey;

  c) you or your dependent are admitted directly to a hospital in your province of residence;

  d) medical reports or certificates from the dispatching and receiving legally qualified physicians are submitted to the Travel Assistance; and

  e) proof of payment (including air ticket vouchers or air carrier invoices) is submitted to the Travel Assistance.
- If planning to travel in areas of political or civil unrest, or in areas where Foreign Affairs and International Trade Canada (DFAIT) has issued a formal travel warning regarding non-essential travel, contact the Travel Assistance for pre-travel advice, as they may be unable to guarantee assistance services.
- Green Shield Canada reserves the right, without notice, to suspend, curtail or limit its services in any area in the event of political or civil unrest, including rebellion, riot, military uprising, labour disturbance or strike, act of God, or refusal of authorities in a foreign country to permit Green Shield Canada to provide service. This includes travel in any area if at the time of booking the trip (including delay of travel), or before your departure date, Foreign Affairs and International Trade Canada (DFAIT) issued a formal travel warning advising Canadians to avoid all or non-essential travel to that specific country, region or city due to a likely or actual epidemic or pandemic, (non-essential travel will be deemed as anything other than a significant medical or family emergency, such as the death of

a family member).

- No services will be provided during any trip undertaken for the purpose of seeking medical treatment or advice unless pre-authorized as outlined in Referral Services.

Exclusions

Eligible Benefits do not include and reimbursement will not be made for:

- any claims arising directly or indirectly from any medical condition you suffer or contract in a specific country, region or city due to an epidemic or pandemic, if at the time of booking the trip (including delay of travel), or before your departure date, Foreign Affairs and International Trade Canada (DFAIT) issued a formal travel warning advising Canadians to avoid all or non-essential travel to that specific country, region or city. In this exclusion a medical condition is limited to the reason for which the formal travel warning was issued and includes complications arising from such medical condition;
- treatment or services required for ongoing care, rest cures, health spas, elective surgery, check-ups or travel for health purposes, even if the trip is on the recommendation of a physician;
- treatment or service that you elect to have performed outside Canada when the medical condition would not prevent your return to Canada for such treatment;
- treatment or service required as a result of suicide, attempted suicide, intentionally self-inflicted injury of you, a traveling companion or immediate family member while sane or insane;
- amounts paid or payable under any Workplace Safety Insurance Board or similar plan;
- hospital and medical care for childbirth occurring within eight weeks of the expected delivery date from the date of departure or deliberate termination of pregnancy;
- treatment or service provided in a chronic care or psychiatric hospital, chronic unit of a general hospital, Long Term Care facility, health spa or nursing home;
- services received from a chiropractor, chiropodist, podiatrist or for osteopathic manipulation;
- cataract surgery or the purchase of eyeglasses or hearing aids;
- Green Shield Canada does not assume responsibility for nor will it be liable for any medical advice given, but not limited to a physician, pharmacist or other health care provider or facility recommended by the Travel Assistance.

Employee Assistance Program

Life happens. Let us help.

Your Employee Assistance Program (EAP) can offer you help when you need it most - from everyday challenges to complex issues, and everything in-between. Your EAP is a confidential and voluntary support service that can help you take the first step towards change. The EAP is completely confidential within the limits of the law and there is no cost to use the program.

Access Support Services

You and your eligible dependents can receive support over the telephone, in person, online and through a variety of issue-based health and wellness resources. For each concern you are experiencing, you can receive a series of sessions. You can also take advantage of online tools to help manage personal well-being.

You'll get practical, relevant support, fast and in a way that is most suited to your preferences, learning approach and lifestyle. Caring professionals are available 24 hours a day to help you select a support option that works best for you.

What can the EAP help me with?

The EAP offers solutions for a wide range of life's challenges, which may include:

- Family issues and parenting
- Nutrition questions
- Child- and eldercare resources
- Drugs, alcohol, gambling and smoking concerns
- Workplace challenges
- Financial concerns
- Relationship issues
- Legal worries
- Physical health concerns
- Crisis situations
- Depression, grief and stress

Professional Counselling

The EAP counsellor network is a multi-disciplinary team of professionals who have master's degrees or PhDs in the fields of psychology, clinical social work or educational psychology. Counselling is accessed voluntarily by employees and is strictly confidential. As always, a thorough assessment of employee concerns, needs and preferences will first be conducted to determine the best suited mode of treatment.

Modes of counselling include:

In-Person Counselling

- Counselling sessions are held in an office at a pre-determined appointment time

Telephonic Counselling

- Works well for individuals reluctant to access face-to-face services
- Also good for those living in remote, rural and northern locations

E-Counselling

- Professional counselling service delivered via written email exchange
- Counselling without the rigidity of appointments; access anytime from anywhere!
- SSL-secure website maintains the highest level of security for all correspondence
- You can access E-Counselling via Shepell·fgi's Members Only website at www.workhealthlife.com and via My EAP, Shepell·fgi's mobile device application

Text-Based Self-Help Counselling

- Access to a collection of clinician-complied comprehensive text-based, solution-focused resources and information
- Convenient self-directed counselling provides ultimate flexibility and privacy

Video Counselling

- Real-time, professional counselling delivered via the Internet using a webcam and Internet software
- A solution for those living in remote, rural and northern locations
- Video Counselling software ensures absolute security and confidentiality

First Chat

- Instant connection to a professional counsellor for immediate issue exploration
- Provides ultimate convenience ideal for those most comfortable with real-time online communication
- First Chat software provides the utmost security and confidentiality
- You can access First Chat via Shepell·fgi's Members Only website at www.workhealthlife.com

WorkLife Solutions

WorkLife Solutions is a confidential, advisory service that is available through your EAP to assist you and your family in balancing work/life issues. Shepell·fgi's professional WorkLife Specialists provide telephone assessment, consultation, support information and resource referrals. This service is available 24 hours a day, seven days a week. WorkLife Solutions services include:

Expectant and New Parents

Shepell·fgi's Parenting Specialists will address any questions you might have about imminent parenthood or a new baby.

Childcare

Childcare Specialists provide access to a wide range of information and resources to address your childcare needs or concerns.

Children and Adults with Special Needs

Provides information and resources on issues such as attention deficit disorder, parent support groups and newly diagnosed conditions.

School Age Decisions

WorkLife Specialists provide you with customized packages of resources and educational materials on schools, tutors, special needs schools, after-school programs and more. Assistance is also provided in researching universities and colleges, scholarship opportunities, etc.

Practical Parenting
Addresses issues that range from toilet training and sleeping through the night, to setting limits with your teenagers.

Youthline
Offers teens and their parents an opportunity to talk to someone outside the family to gain information, support and an objective point of view. Offered to children ages 12-19 and young adults ages 20-25.

Homecare
Homecare Specialists consult with those who need information and support around caring for partners or older relatives. Provides you information on, and access to, free, subsidized and private community services.

Eldercare Services
Eldercare Specialists can assist you with practical resources, support and strategies for those who are caregivers of a sick or frail family member.

Relationship Information
Combines support and information when seeking strategies and resources for making your relationship work.

Resiliency Coaching
The Resiliency Coaching program is specifically designed to help you find a point of focus in life, reduce overall stress and remove irritants. It can also provide a helping hand to those who want to change direction in some area of life.

Legal Advisory
Shepell·fgi can also assist you with professional legal consultation or provide a referral to a local lawyer if required. Can include issues such as family law, buying and selling a home, tenant rights, small claims court, equal rights, financial planning, etc. Some exceptions may apply.

Financial Advisory
Offers advice, support, debt counselling and referrals to community resources to assist in taking control over your finances. Information encompasses debt management, pension/severance packages, RRSP/RESP, budgeting, financial aspects of divorce, etc.

Career Advisory
Helps you identify career direction and choices, assess interests and skill-sets, and develop strategies to enhance work satisfaction and performance. Career Specialists can also assist you with stress or work/life issues, retirement and lifestyle issues.

Nutritional Counselling
Registered Dieticians provide you with a nutritional assessment and consultation to help individuals achieve their nutritional goals and improve overall health and well-being.

Smoking Cessation
Support to help you become a 'life-long quitter' includes educational materials, clinical assessment, self-analysis, customized smoking cessation strategies and relapse prevention techniques.

Naturopathic Wellness Services

Telephonic consultation will provide information about naturopathic medicine and how it works in context with the body. You will receive health and wellness information on choices related to physiology, diet, lifestyle and mental-emotional well-being, including preventative strategies. Naturopathic wellness services cover these important areas:

- Sleeping Healthy
- Aging Well (includes 'The Menopausal Years' and 'Entering Andropause')
- Stress-free Living
- Workplace Wellness (includes shift work related issues)

Health & Wellness Resource Packages

The Health and Wellness Resource Package, a solution-focused collection of resources and information, is currently available on any one of seven parenting, relationship, nutrition or work-related topics.

Each Health and Wellness Resource Package contains an integrated set of easy-to-use, practical articles, tip sheets and reference materials that will help you:

- understand your issue thoroughly with the latest books, articles and information sheets written by subject matter experts;
- assess where you are and where you need to go with surveys, checklists and self-assessment questionnaires; and
- plan and problem-solve with tips, tactics and tools that give you what you need to take action and evaluate your progress.

You receive the benefit of an in-depth risk assessment conducted during their first call to Shepell·fgi's 24/7 Clinical Call Centre. A professional screening process carefully 'triages' you to determine what type of service will best meet your needs. Your preference for service delivery is always balanced with clinical best practices. Those whose needs are appropriately addressed by a package will receive a Health & Wellness Resource Package.

Work - Health - Life Online

This website is also available to you through your EAP, and addresses work, health and life related questions and issues that you may be experiencing through unlimited online access to an extensive collection of expert health and wellness information and related links. This is your go-to EAP resource! Visit www.workhealthlife.com to get started.

You can also register for members-only services at www.workhealthlife.com. Click on the SIGN UP NOW button at the top of the screen and type in the name of your company. Then select "EAP Program - ENCON" and proceed to Step 2 of the registration process.

My EAP Mobile Device Application

Discover information, support and practical solutions for issues that impact your work, health and life directly on your mobile device. **My EAP** is the world's first and only mobile device application providing fast and easy self-service access to expert information.

Using materials from www.workhealthlife.com, My EAP features robust, high quality resources including:

- Expert health and wellness articles
- LifeSpeak expert videos on demand
- Secure and confidential E-Counselling

My EAP is free to download on your mobile device. Visit www.shepellfgi.com/myeap or www.workhealthlife.com.

Connect with the EAP Service

Connect to people and resources that can make a difference in your life. Your call will be answered by a professional Client Care Representative who will ask for some basic information, listen to and discuss your concerns, and help you select a support option that works best for you.

You may access your EAP at the following numbers:

Canada-wide English.....1-800-238-8663
Canada-wide French.....1-800-363-3872
Telephone Device for the Deaf (TDD) English.....1-800-363-6270
Telephone Device for the Deaf (TDD) French.....1-800-263-8035

Personal Medical Guidance Service

Your Personal Medical Guidance, provided through WorldCare[SM], provides a unique service which helps you actively participate in decisions regarding your medical care. Personal Medical Guidance assists you in understanding and interpreting complex medical information so you can make informed decisions about your health. Personal Medical Guidance helps you make sense out of your health care needs by increasing understanding and helping you focus on the real decision-making questions.

This service is available to you and your family provided you are covered for Extended Health Care benefits. Health care coverage must be in force at the time the Personal Medical Guidance service is requested. No pre-existing condition limitation applies.

WorldCare

Founded in Boston, Massachusetts in 1992, WorldCare is a pioneer and leader in providing global e-health services and solutions. Committed to medical excellence, WorldCare has partnered with some of the top academic medical centres in the United States to provide access to specialist and subspecialist e-consultation and clinical care of the highest quality. WorldCare aims to complement and support local physician-patient relationships and medical institutions by bringing them access to over 20,500 acclaimed specialists and subspecialists with over $4.3 billion in annual biomedical research funding.

WorldCare's network of provider hospitals, called The WorldCare Consortium[SM], consists of the following top-ranked medical institutions in the United States:

- Boston Children's Hospital
- Duke University Health System
- Jefferson University and Hospitals
- Mayo Clinic
- Partners Healthcare System (which includes Brigham and Women's Hospital, Massachusetts General Hospital and Dana-Farber/Partners CancerCare)
- Penn Medicine
- UCLA Healthcare

Access the Personal Medical Guidance Service

A simple process is in place:

- You contact WorldCare by phone to initiate the Personal Medical Guidance service.
- A WorldCare nurse or physician works with you to gather relevant medical records and helps you understand what your doctor(s) has(have) written about your condition, care and existing treatment plan.
- WorldCare will then provide you a Personal Medical Guidance Report containing helpful information and guidelines.

The Personal Medical Guidance Report

When the Personal Medical Guidance service is provided, you will have access to a customized detailed research report. This report can be a valuable long-term resource, and can include:

- A clear easy-to-understand overview of the medical condition
- Answers to specific research questions you may have posed
- Various treatments and therapies available based on the latest clinical research
- Suggested questions to discuss with a doctor before starting treatment

- Possible side-effects and complications
- Clinical trials available, and options for participation, if desired
- Reference sources, such as medical societies, associations, support organizations, discussion boards, etc.

How to Obtain Personal Medical Guidance

If you would like to utilize the Personal Medical Guidance service, your first step is to contact WorldCare - call toll free or send your request via fax, mail or email to:

WorldCare
7 Bulfinch Place
Suite 301
Boston, MA 02114
www.worldcare.com

Toll Free: 1-877-676-6439
Fax: 1-877-266-1150
Email: MemberCare@worldcare.com

Second Medical Opinion Service

Your Second Medical Opinion Service, provided through WorldCare[SM], provides independent second medical opinions from nationally-ranked hospitals in the United States. Through WorldCare's service, patients and their physicians have immediate access to leading edge medical expertise from world-renowned research and academic hospitals. You and your attending physician are provided with confirmation or modification of your original diagnosis and treatment recommendations, including alternative treatments and/or therapies.

This service is available to you and your family provided you are covered for Extended Health Care benefits. You are eligible to receive two second medical opinions per family per year, up to a lifetime maximum of six. Health care coverage must be in force at the time the second opinion is requested. No pre-existing condition limitation applies.

WorldCare

Founded in Boston, Massachusetts in 1992, WorldCare is a pioneer and leader in providing global e-health services and solutions. Committed to medical excellence, WorldCare has partnered with some of the top academic medical centres in the United States to provide access to specialist and subspecialist e-consultation and clinical care of the highest quality. WorldCare aims to complement and support local physician-patient relationships and medical institutions by bringing them access to over 20,500 physicians, scores of nationally and internationally acclaimed specialists and subspecialists with over $4.3 billion in annual biomedical research funding.

WorldCare's network of provider hospitals, called The WorldCare Consortium[SM], consists of the following top-ranked medical institutions in the United States:

- Boston Children's Hospital
- Duke University Health System
- Jefferson University and Hospitals
- Mayo Clinic
- Partners Healthcare System (which includes Brigham and Women's Hospital, Massachusetts General Hospital and Dana-Farber/Partners CancerCare)
- Penn Medicine
- UCLA Healthcare

Access the Second Medical Opinion Service

A simple three-step process is in place:

- You contact WorldCare by phone, email, fax or mail to request a second medical opinion.
- WorldCare works with your physician to gather medical records, and determines the medical institution or institutions best suited to address the medical condition.
- The designated physician team reviews your records and provides an independent second opinion to you and your doctor. If necessary, WorldCare can co-ordinate a call between your physician and the lead physician on the team that supplied the second opinion to discuss outstanding questions on your case.

There is an average turnaround time of four working days once the complete medical information is received and pathology, if any, is reviewed, while emergency cases can be completed within hours.

The Patient Management Consultation

When a second medical opinion is provided, you and your physician will receive a comprehensive, multi-disciplinary report, known as the Patient Management Consultation. This report consists of a review of your medical records and a Second Medical Opinion Package, which includes a diagnosis and treatment plan, background information on the physician(s) and medical institution(s) rendering the opinion, educational materials about your illness, and various local and online support services available to you. Your original medical records will be returned to you and your physician at this time.

WorldCare has rigorous procedures in place to ensure quality and safeguard privacy. Electronic transfer of records is done using FDA-cleared compression and encryption technology, and handling of all information is consistent with HIPAA guidelines and the Canadian Personal Information Protection and Electronic Documents Act (PIPEDA).

Medical records and opinions are permanently stored in WorldCare's secure database to facilitate follow-up or future second opinions.

Right of Refusal

Consortium physicians make every effort to provide a consultation based upon the information provided. In certain cases, the medical information submitted may not be sufficient, or of adequate quality to render an opinion (e.g. if the quality of the submitted imaging is sub-standard for interpretation and you do not provide optimal imaging, the radiologist will maintain the right to refuse delivery of a diagnostic report). In such cases, WorldCare will inform you of the reasons for the inability to deliver a report within 24 hours. You will have the opportunity to deliver additional or alternative material to WorldCare.

Covered Medical Conditions

You are entitled to receive second opinions for the following acute, complicated and serious medical conditions:

AIDS
Alzheimer's Disease
Any Amputation
Life Threatening Illness
Benign Brain Tumor
Cancer
Cardiovascular Conditions
Chronic Pelvic Pain
Coma
Deafness
Emphysema
Hip and Knee Replacement
Loss of Speech
Major Burns
Major Organ Transplants
Major Trauma
Multiple Sclerosis
Neuro Degenerative Diseases
Paralysis
Parkinson's Disease
Renal Insufficiency or Kidney Failure
Rheumatoid Arthritis
Stroke
Sudden Blindness Due to Sickness
Thrombophlebitis and Embolism

Exclusions

Conditions resulting from the following are excluded from coverage:

- attempted suicide, self-inflicted injuries or injuries caused by a third person with the patient's knowledge;
- alcohol or drug abuse;

- radioactive contamination;
- war or warlike operations (whether war is declared or not), riot, civil commotion, revolution, insurrections, conspiracy, or any events or causes which determine the proclamation or maintenance of martial law or state of siege;
- natural disasters such as fire, flood, earthquake, tornado, hurricane, and other Acts of God; or
- poisoning or poisonous gas inhalation.

How to Obtain a Second Medical Opinion

If you would like to request a second medical opinion for one of the covered illnesses, your first step is to contact WorldCare - call toll free or send your request via fax, mail or email to:

WorldCare
7 Bulfinch Place
Suite 301
Boston, MA 02114
www.worldcare.com

Toll Free: 1-877-676-6439
Fax: 1-877-266-1150
Email: MemberCare@worldcare.com

Consult the Second Medical Opinion Benefits Guide for complete details about the process. Log in at www.encon.ca/groupbenefits to download the guide (located under My Benefits), or contact your plan administrator.

Dental Care

Employee and Dependent Coverage

As the wording of this dental coverage is technically oriented, you may wish to take this booklet with you when you visit your dentist.

In the event you incur in a calendar year any of the eligible expenses listed below, and also listed in the Schedule of Benefits, you will be paid a percentage (coinsurance) of such expenses in excess of the deductible for that year. The percentage (coinsurance) and deductible are specified in the Schedule of Benefits.

Maximum Benefit

The total benefits payable are subject to the maximums specified in the Schedule of Benefits.

Extension of Benefits

No benefits for Eligible Expenses will be paid for claims incurred after the termination of the group benefits program or after your insurance under this coverage ceases.

Alternate Benefits and Submission of Treatment Plan

Where there exists more than one customarily employed and professionally adequate method of treating injury or disease to the teeth, the benefits provider reserves the right to determine eligible expenses on the basis of an alternate benefit.

As a service to you, the benefits provider will advise you in advance of the amount of its liability when a proposed course of treatment is expected to exceed $500. To use this service, simply have your dentist submit a treatment plan, including pre-treatment x-rays if the proposed treatment involves crowns, bridgework or implants.

Eligible Expenses

Charges for the following supplies and services are considered Eligible Expenses if they do not exceed the reasonable and customary charges in accordance with the Fee Guide and the maximum shown in the Schedule of Benefits.

Eligible Expenses - Basic Services

Diagnostics

Procedures required to assist the dentist in evaluating existing conditions and determining any further dental care which may be required subject to the following limitations:

- oral examinations: standard oral examinations as shown in the Schedule of Benefits;

- x-rays: single diagnostic x-rays; complete series or equivalent once every two years;
- study casts: once per year;
- consultations.

Preventive Therapy
Procedures intended to eliminate or reduce the need for future dental treatment subject to the following limitations:

- preventive visits for scaling, including root planing (where one unit of time = 15 minutes):
  a) for adults and for children age 13 years and older;
  b) for children under the age of 13 years limited to one unit of time every six consecutive months;
- polishing: limited to one unit of time every six consecutive months;
- topical fluoride: once every six consecutive months;

Extractions
Removal of teeth.

Endodontics
Endodontic procedures including root canal therapy.

Periodontics

- Adjunctive Services as follows: Periodontal scaling and/or Root planing (up to 10 time units per calendar year, limited to eight time units in one session), Acute infections, Occlusal Adjustment, Provisional splinting;
- Surgical Services as follows: gingival curettage, gingivoplasty, gingivectomy or osseous surgery;
- Special Periodontal Appliances.

Basic Restorative Dentistry
The basic procedures used to restore the natural teeth to their normal functions by the use of silver amalgam, silicate, synthetic or inlay restorations (fillings), including white fillings on molar teeth. In addition, sedative dressings are covered.

Oral Surgery
Routine oral surgical procedures as follows: surgical removal of impacted teeth, residual roots and associated post-operative care.

Anaesthesia
Anaesthesia where reasonably and customarily required in conjunction with extractions or eligible oral surgery.

Repairs, Relining and Rebasing of Dentures
Repair or relining and rebasing of dentures, including addition of new teeth, but not including the cost of dentures, their replacement or duplication.

Eligible Expenses - Major Restorative Services

Dentures
The initial installation of dentures and replacement of existing dentures is covered if:

- It is required because of extraction or loss of one or more teeth after the individual became insured under this plan; or
- The existing dentures are at least five years old and no longer serviceable.

Replacement of lost or stolen dentures, the duplication of dentures and personalization or characterization of dentures is not covered.

Extensive Restorative Dentistry

Those procedures, including onlays and crowns, used to restore the natural teeth to their normal functions where the tooth, as a result of extensive caries or fracture, cannot be restored with a filling. When a tooth can be restored with amalgam or composite restorations, benefits will be determined based on the usual costs of such a restoration. Existing onlays and crowns must be at least five years old and no longer serviceable.

Bridgework

Recementing and replacement of the facing or veneer of the bridge.

The initial installation of bridgework and replacement of existing bridgework is only covered if:

- It is required because of extraction or loss of one or more teeth after the individual became insured under this plan, or
- The existing bridge is at least five years old and no longer serviceable.

Implant Treatment

Implantology including tooth implantation and surgical insertion of fabricated implants.

Eligible Expenses - Orthodontics

The diagnosis or correction of teeth irregularities and malocclusion of jaws, by wire appliances, braces or other mechanical aids, commonly known as "straightening of the teeth". These include active space retainers or orthodontic appliances, for the purpose of repositioning or moving of the teeth.

Exclusions and Limitations

For dentures and bridges:

- payments will not be made for any dental procedure in respect of teeth extracted or missing before the employee or dependent became insured for that procedure except for appliance replacement as specifically stated under Eligible Expenses.
- no benefit will be payable for the initial installation (or addition) of prosthetic devices unless such installation (or addition) is required primarily due to teeth that were missing or extracted after becoming insured under this plan for prosthetic devices.

For implants, payments will be limited to one attempt per tooth (frequency once per lifetime). Payments for crowns on implants will be limited to once every 10 years. Payments will not be made for implants on the second molar or wisdom teeth.

No benefit is payable for the following:

- services or supplies that are primarily for cosmetic dentistry;
- charges which were considered an insured service of any provincial government plan at the time this plan/benefit was issued and subsequently were modified, suspended or discontinued;

- services or supplies which are not furnished by a legally qualified dentist or denturist acting within the scope of his license;
- any charge for an injury resulting from war, riot, insurrection or participation in a criminal act;
- any miscellaneous charges such as counselling or instruction, travel, broken appointments, communication costs or filling in of forms;
- any charge resulting from any intentionally self-inflicted injury;
- any services covered in whole or in part by any government plan, services for which no charge is made, or services which the benefits provider is not permitted by law to cover;
- any charge for services which would not normally have been incurred, but for the presence of this insurance, or for which you are not required to pay;
- any hospital charges for board and room and related services and supplies;
- any dental examinations required by a third party;
- services or supplies which are not medically necessary to the care and treatment of any existing or suspected injury, or disease; or
- diagnostic procedures in connection with any benefit categories excluded as eligible expenses.

Benefit Continuance for Surviving Dependents

Dental Care coverage for dependents shall continue without premium payment following your death for up to a maximum of 24 months from the date of death or to the date the policy or benefit terminates, whichever is earlier.

Health Care Spending Account

Your Health Care Spending Account (HCSA) will have credits allocated to it, according to your employee classification, on January 1 of each year. The credit amounts are listed in the Schedule of Benefits.

Benefit Year

Your HCSA is based on a calendar year and runs from January 1 through December 31.

How It Works

You will receive credits as shown in the Schedule of Benefits which can be used to reimburse you for eligible expenses incurred during the benefit year. When you submit an HCSA claim you will be reimbursed for eligible expenses, up to the balance in your account. If the balance in your account is insufficient, your claims will be pended and processed when you have accumulated additional credits.

Any balance in your account on the last day of the benefit year will be carried forward to, but not beyond the end of, the next benefit year. Unpaid claims cannot be rolled over to the next benefit year and paid with that year's contributions.

Maternity, Adoption or Parental Leave

If you elect to continue benefits under your group plan during your leave, credits will continue to be allocated to your Health Care Spending Account. If you elect not to continue benefits under your group plan, credits will not be allocated to your Health Care Spending Account. In both cases, you may continue to submit claims for expenses incurred prior to or during the period of your leave until your HCSA credits are exhausted.

Eligible Expenses

Eligible Expenses are those items that would qualify as a medical expense tax credit under the Income Tax Act of Canada. These are outlined in the Income Tax Act regulations and CRA Interpretation Bulletins. This does not include an item for which you or your dependent is eligible for reimbursement under a group benefit plan or provincial health insurance plan. In addition to the list of items below, eligible expense would include:

- a deductible expense on your income tax return, as outlined in the Income Tax Act regulations and Canada Revenue Agency (CRA) interpretation bulletins; and
- an item for which you are not receiving benefits coverage under a provincial health insurance plan or under your group benefit plan or your spouse's group benefit plan. You can be reimbursed for the amount of the deductible, the percentage not covered by the group benefit plan, or the amount in excess of group benefit plan maximums.

Following is an overview of many of the items included in CRA Interpretation Bulletin IT-519R2 "Medical Expense and Disability Tax Credits and Attendant Care Expenses Deduction" of the Income Tax Act. Please note these examples are subject to change.

- Out-of-pocket expenses not reimbursed through your group benefit plan. This would be any applicable deductible, benefit percentage or amounts exceeding any applicable benefit plan maximums.

- Fees for Professional Services, such as acupuncturist (qualified medical practitioner), chiropodist (podiatrist), chiropractor, Christian Science practitioner, dentist, naturopath, nurse, optometrist, physician, physiotherapist, psychologist (when licensed by the province to provide therapy or rehabilitation), speech therapist (for pathological or audiological impediments), therapeutist (therapist). Medical practitioners must be registered in the jurisdiction in which the services are rendered.
- Fees for Dental Care services Diagnostic, preventive, endodontics, periodontics, restorative and orthodontics.
- Drugs and medicines (preparations or substances) prescribed by medical practitioner, including over-the-counter drugs.
- Eyeglasses and contact lenses or other devices for the treatment or correction of a vision defect, as prescribed by a licensed medical practitioner or optometrist.
- Fees paid to a public or licensed private hospital (as defined in the Income Tax Act).
- Fees paid for facilities and services, such as care in a nursing home; a self-contained domestic establishment; or a special school, institution or other place required by reason of a mental or physical handicap; care of a person who has been certified to be mentally incompetent; or a blind person; and full-time attendants or care in a nursing home (for those confined to a bed or wheelchair).
- Ambulance fees for transportation to or from hospitals.
- Hearing aids.
- Premiums paid to a private insurer for medical or hospital coverage.
- Costs of acquisition, care and maintenance (including food and veterinarian care) of a dog specially trained to assist a person who is blind, deaf, or severely impaired in the use of arms or legs.
- Costs of arranging and having a bone marrow or organ transplant, including legal fees, insurance premiums, travel, meal and accommodation expenses.
- Reasonable home renovations for persons who lack normal physical development or who have severe and prolonged mobility impairment, to enable them to be mobile and functional within the dwelling.
- Fees paid for Medical Equipment and Devices, which are prescribed by a medical practitioner, including:
    - Artificial eye; limb; artificial kidney machine (including reasonable installation, home alteration and operating costs);
    - Blood sugar level measuring devices for diabetes;
    - Brace for a limb;
    - Colostomy and ileostomy pads;
    - Crutches;
    - Diapers, disposable briefs, catheters, catheter trays, tubing or other products required by persons who are incontinent on account of illness, injury or affliction;
    - Heart monitoring or pacing devices;
    - Hospital bed (when required at home);
    - Needles and syringes;
    - Wheelchair;
    - Wigs made to order and required as a result of abnormal hair loss due to disease, accident or medical treatment;
    - Power-operated lift designed exclusively for use by disabled individuals (to allow access to different levels of a building, to assist in gaining access to a vehicle, or to place wheelchairs in or on a vehicle);
    - Device designed exclusively to enable an individual with a mobility impairment to operate a vehicle;
    - Device designed to assist a person in entering or leaving a bathtub or shower, or getting on or off the toilet;
    - Device to aid the hearing of a deaf person;
    - Electronic speech synthesizers that enable mute individuals to communicate using a portable keyboard;
    - Synthetic speech systems, Braille printers and large print-on-screen devices that enable blind persons to utilize computers; and
    - Monitors which can be attached to babies identified as being prone to sudden infant death syndrome and which sound an alarm when the baby stops breathing.

A complete listing of eligible expenses can be found in the CRA Interpretation Bulletin IT-519R2, "Medical Expense and Disability Tax Credits and Attendant Care Expense Deduction" as amended from time to time. This is available on the Internet site at http://www.cra-arc.gc.ca/tx/ndvdls/tpcs/ncm-tx/rtrn/cmpltng/ddctns/lns300-350/330/llwbl-eng.html. For additional information you can consult a CRA office or call the Green Shield Customer Service Centre at 1-888-711-1119.

An example of expenses not eligible for reimbursement are premiums paid to provincial medical or hospitalization plans and medical costs for which the person is reimbursed or is entitled to be reimbursed. It is at all times governed by the non-eligible expenses, restrictions and limitations set forth in the Income Tax Act.

Your Health Care Spending Account is governed at all times by the rules and regulations of the Income Tax Act. In the event of a dispute the Income Tax Act shall prevail.

General Provisions

When Your Insurance Starts

Your insurance comes into effect on the latest of the following dates if you are actively at work on that date:

- the date you become eligible;
- the date you apply; or
- if Evidence of Insurability is required, the date it is approved.

If you contribute to the cost of the benefits, an enrollment form must be completed within 31 days of your eligibility date. Otherwise, evidence of health satisfactory to the insurance company must be submitted and approved before you will be eligible for benefits.

If you are not actively at work on the date your insurance would normally be effective or change, then the date on which commencement or change will take place will be the first day on which you are again actively at work.

Commencement of Dependent Coverage

Coverage for your dependent(s) commences on the date you become eligible. Health evidence is not required provided application is made within 31 days after the date of eligibility.

If you are initially enrolled for single coverage and later acquire a dependent, you must apply for dependent coverage. Coverage will be effective from the date of application provided the request is made within 31 days of acquiring dependents. If application is made after 31 days, evidence of good health will be required for each dependent.

When dependent coverage is in effect, notification of a new dependent is still required or claims service will be affected.

Evidence of Insurability

Evidence of Insurability is required if:

- you apply for insurance more than 31 days after becoming eligible to apply;
- the amount of insurance you are eligible for exceeds or increases beyond the Non-Evidence Maximum;
- you reapply after your insurance has terminated due to non-payment of premium.

When Your Insurance Terminates

Your insurance terminates on the earliest of the following:

- non-payment of premium;
- a change in your classification to one not insured;
- termination of your coverage;

- termination or amendment of the Policy;
- your commencing active duty in any armed forces;
- the date outlined in the Schedule of Benefits.

Insurance for your dependents terminates on the earliest of the following:

- termination of your coverage;
- the date your dependent is no longer an eligible dependent;
- the date your dependent attains the specified age limit;
- non-payment of premium;
- termination or amendment of the Policy.

Note: In the event you are absent from work due to sickness, injury, layoff or leave of absence, your group benefits may continue if the required premiums are paid. Continued coverage may be subject to pre-approval.

Eligible Dependents

The following are considered eligible dependents:

- Unmarried children who are under age 22, or under age 25 if attending an accredited school, college, or university as a full-time student. Dependent children must be dependent on you for support and not employed at a regular full-time job.
- Functionally impaired children who are totally dependent upon you for support. For the purposes of this plan, functionally impaired shall mean an unmarried person who was insured as a dependent prior to becoming functionally impaired who is wholly dependent upon you for support and maintenance within the terms of the Income Tax Act.
- A child of your spouse provided:

  a) he/she is also your biological child; or

  b) your spouse is living with you and has custody of the child.
- Your spouse as the result of a valid civil or religious ceremony, or a person with whom you have cohabited for a minimum of 6 consecutive months and who has been publicly represented as your spouse.

Note: Divorced or separated spouses (with or without a court order or separation agreement) are not eligible for coverage.

Change in Amounts of Insurance

A change in the amount of your insurance shall become effective on the date of change, if you are actively at work for that full scheduled working day, otherwise on the first day thereafter on which you are actively at work.

Change in Government-sponsored Programs

The medical, dental and hospital benefits under this group insurance plan are provided in conjunction with government-sponsored provincial programs. In the event coverage under any provincial program is modified, suspended or discontinued, the group insurance plan will not automatically assume responsibility for any services or products previously covered under the provincial programs.

Medical Information Bureau (MIB)

The MIB is a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members.

The insurers or their reinsurers may periodically report information to the MIB. If you apply to receive life or health insurance coverage from another MIB member company or submit a claim for benefits to such a company, the MIB upon request will supply the other insurer with the information on file.

The insurers or their reinsurers may also release information in its file to other life and health insurance companies to whom you may apply for insurance or submit a claim for benefits. All information obtained will be treated as confidential.

Upon your request, the MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the MIB and seek a correction. Their address is:

Medical Information Bureau
330 University Avenue, Suite 501, Toronto, Ontario M5G 1R7

Co-ordination of Benefits

Payment of Extended Health Care, Emergency Travel Assistance and Dental Care benefits shall be co-ordinated so that benefits from all plans do not exceed 100% of the eligible claim. For this purpose, the benefits provider has a right to receive and release information on benefits and if necessary, collect any overpayments made by it.

Time Limitations

A claim for Life Insurance benefits must be submitted within six months of the date of death.

A claim for Long Term Disability benefits must be submitted within six months of the end of the Elimination Period.

A claim for Weekly Indemnity benefits must be submitted within six months from the date of disability.

A claim for Waiver of Premium benefits must be submitted within 12 months of the date of disability.

A claim for Accidental Death & Dismemberment must be submitted within 90 days of the accident but not later than 12 months following the date of the accident.

A claim for Critical Illness, either a Covered Condition benefit or an AdvanceCare benefit, must be submitted within 90 days of the date of diagnosis.

Health and dental claims must be received within 180 days following the end of the calendar year in which the loss is incurred.

Health Care Spending Account claims must be received within 180 days following the end of the calendar year in which the expense was incurred.

However, in the event of termination of insurance, all claims must be received within 90 days following the date of termination of your insurance or the date following termination of a coverage or the policy.

Submitting Claims

How to Submit a Claim

If you have Extended Health, ETA and/or Dental benefits, you will receive an ENCON Benefits Card. Please refer to your Certificate of Insurance to confirm you benefit coverage.

Prescription Drug Claims

Pay Direct Plan - Show your Benefits Card to your pharmacist, who will submit claims directly to the benefits provider. You will only pay the amount not covered by your plan.

Reimbursement Plan - Show your Benefits Card to your pharmacist, who will submit claims electronically to the benefits provider. You will pay the full amount at the time of sale and eligible expenses will be reimbursed.

Prescription drug claim questions should be directed to Green Shield Canada at 1-888-711-1119.

Other Medical Claims

The Benefits Card can also be used for other types of claims, such as vision and paramedical claims. Service providers will require the name of the carrier and the employee's Identification Number. Show your service provider your Benefits Card in case the claim may be submitted electronically.

Medical claim questions should be directed to Green Shield Canada at 1-888-711-1119.

Emergency Travel Assistance Claims

The ETA policy and phone numbers are listed on your Benefits Card. If you require emergency medical assistance while traveling, you should contact Green Shield Canada Travel Assistance immediately. This multilingual call centre, which operates 24 hours a day, 365 days a year, will ensure you get the care you need without incurring unnecessary expenses.

Green Shield Canada Travel Assistance
Within Canada 1-800-936-6226
Outside of Canada 0-519-742-3556

If you pay out-of-pocket for any medical expenses, keep the receipts. Your provincial health plan and the benefits provider will reimburse you for eligible expenses upon your return. Claims should be submitted to:

Green Shield Canada Travel Assistance
Allianz Global Assistance
4273 King Street East
Kitchener, Ontario
N2P 2E9

Health Care Spending Account (HCSA) Claims

If you have Extended Health Care and/or Dental Care benefits and a Health Care Spending Account under this group plan, you can choose to have all claims co-ordinated with your HCSA. This means any part of the expense not covered under your insured plan will automatically be considered under your HCSA. Each time you submit a claim, you must indicate your intent to co-ordinate payment with your HCSA on the claim form.

Claims that are not co-ordinated with another benefit can be submitted directly to Green Shield Canada for adjudication.

Only expenses incurred prior to the date of termination of employment, retirement, death, or leave of absence greater than thirty days (other than Maternity, Adoption or Parental Leave) will be eligible for reimbursement.

HCSA claim questions should be directed to Green Shield Canada at 1-888-711-1119.

Dental Claims

Your dental services provider can now submit both pre-determination requests and dental claims electronically. Show your card to your provider, who will submit the request or claim electronically. You will only pay the amount not covered by your plan.

Dental claim questions should be directed to Green Shield Canada at 1-888-711-1119.

Other Claims

For Life, Long Term Disability, Weekly Indemnity, AD&D and/or Critical Illness insurance questions, please contact your Plan Administrator for details.

Common Insurance Terms

Actively at Work
An employee shall be considered actively at work for the purposes of insurance if on the date in question the employee reports for work at the usual place of employment with the employer, which is outside of the employee's home, and is able to perform all of the usual and customary duties of his/her occupation on a regular full-time basis. If an employee does not customarily so report, or if the usual place of employment with the employer is not outside the home, an employee shall be considered actively at work if at any time on the date in question the employee is neither (i) hospital confined, nor (ii) disabled to a degree that the employee could not have then reported to a place of employment outside the home and performed all the usual and customary duties of his/her occupation on a regular and full-time basis.

An employee who is not disabled is also deemed to be actively at work if his/her absence is due only to a period of leave or a non-working day.

Beneficiary
The beneficiary is a person designated by the insured to receive the benefit proceeds when the insured dies.

Claim
A claim is a notification to the insurance company that details an insured person's loss and request for payment of benefits under the policy.

Class
A class is a group of employees as defined in your Group Insurance Application (e.g., "salaried employees", or "Alberta staff").

Client Number
Your organization has been assigned an eight-digit Client Number, which is your ENCON file number. The Client Number is not used by other companies or individuals, or in the claims process.

Coinsurance
Coinsurance percentage is the amount that an employee will be reimbursed for a claimed eligible expense, in excess of any applicable deductible.

Deductible
The portion of eligible expenses that the insured must pay before a benefits provider will pay any claim. The deductible may be a per claim or annual amount.

Earnings
Earnings are defined as follows:

For self-employed or contract workers, partners or sole proprietors, eligible earnings are based on net income as indicated on the Net Income Line of the T1 General tax return and substantiated by CRA's Notice of Assessment.

For salaried employees, eligible earnings shall mean the employee's normal earnings and shall include regular bonuses, regular overtime, commissions, profit sharing plans and shift differentials. Earnings shall not include sporadic bonus, sporadic overtime, incentive pay and automobile allowance.

For salespersons, eligible earnings shall mean the employee's Employment Income before deductions less any Taxable Allowances and Benefits as specified on the immediately preceding year's T4 slip.

If there is a difference between the actual annual earnings and those reported by the employer for premium purposes, the lesser of the two amounts will be considered the annual earnings amount under this policy.

Elimination Period
With respect to disability insurance, the Elimination Period is the period of time that must elapse after the onset of illness or disability before the insured person is eligible for benefits.

Emergency
Means a sudden, unexpected occurrence (disease or injury) that requires immediate medical attention.

Evidence of Insurability
Evidence of insurability is any statement or proof of a person's physical condition, medical history, occupation, leisure activities or other factors which may affect his/her acceptance for insurance. This evidence is usually requested to supplement information provided on an application form and is required so that the insurer can accurately assess the risk for insurance.

Insured
Means a plan member and any eligible dependents.

Late Applicant
An enrollment or a change in coverage request is considered to be late if it is submitted more than 31 days after the employee's eligibility date for coverage or more than 31 days after the occurrence that prompted the change in coverage. Late applicants are required to submit evidence of insurability in order to obtain group insurance coverage.

Leave of Absence
This means a period of time away from work mutually agreed to by you and your employer. In the case of maternity leave of absence, the leave shall begin and finish on dates agreed to by you and your employer or as required by Provincial or Federal Law.

Misrepresentation
A misstatement, falsehood or omission which may influence an insurer's approval or rejection of the risk (i.e., the person to be insured). Misrepresentation is grounds for employee coverage and/or policy termination.

Medical Underwriting
The process of assessing whether a person can be insured based on his/her medical history. An insurance company will review the medical history of the applicant and, based on the health of the applicant, determine if coverage can be made available.

The process of being medically underwritten can take anywhere from four to eight weeks, depending on the amount of coverage requested, the type of additional medical information required and how quickly the medical information is provided.

Non-Evidence Maximum (NEM)
A non-evidence maximum is the maximum amount of coverage an employee can receive without providing evidence of insurability. Non-evidence maximums will usually apply to life and disability benefits. This is sometimes referred to as a non-evidence limit or NEL.

Non-Smoker
A person who has totally abstained from smoking all tobacco products and cannabis for a one year period immediately preceding the date of his/her application for Non-Smoker Status.

Non-Taxable Benefits
When an employee pays for full premium cost of Weekly Indemnity and/or Long Term Disability benefits, benefits that are received are not taxable.

Overage Children
These are children of covered employees who are older than the usual maximum age for benefit coverage but may qualify for continued coverage because they are full-time students or because they are functionally impaired and dependent on the employee for support.

Plan Effective Date
Coverage for your employer's company first becomes effective on a specific day, known as the plan effective date. This is the earliest date you may join the plan.

Pre-existing Condition
A sickness or injury for which the insured received medical treatment, consultation, care or services including diagnostic measures, or had taken prescribed drugs or medicines for a specific period prior to the insured's effective date.

Reasonable and Customary
The usual fee charged in a geographic area by a health or dental provider for a specific medical procedure or service.

These reasonable and customary amounts are established by a benefits provider using a combination of their own claims data, the published fee schedules from provincial/territorial associations, typical reasonable and customary fees for provincial/territorial associations without published fee schedules and surveyed responses from practitioners within specific provinces/territories when information from associations is not available.

Taxable Benefits
When an employer pays any portion of the premium for Weekly Indemnity and/or Long Term Disability benefits, the benefits an employee will receive are taxable.

Waiting Period
The waiting period is the period of time each new employee must work for your organization before becoming eligible to join your plan. The employee's "eligibility date" is the day following the end of the waiting period.