STERLING

CAPITAL BROKERS

IN PARTNERSHIP WITH

PARALLEL49 BREWING COMPANY

Policy Number: 71013

Effective Date: January 1, 2024

All Eligible P49 Employee
Association Employees

GROUP BENEFIT PLAN

PACIFIC BLUE CROSS

Wawanesa Insurance

TELUS Health

STERLING
CAPITAL BROKERS

Disclaimer: The information provided in this booklet is strictly used for the purposes of providing employees with a brief summary of their Health and Dental benefit plan that has been chosen by their employer. Sterling Capital Brokers is not responsible or liable for any faults, amendments, or updates to the information specified in this booklet. It is advised that all parties contact their employer or assigned Benefits Administrator at Sterling Capital Brokers should they have any inquires or concerns. For all Registered Retirement Savings Plan (RRSP) inquiries and concerns, please contact the appropriate investment fund company or service representative at Sterling Capital Brokers.

CONTACT US

Contact information for your benefits administrator and sales representative can be found on SCB Connect.
If you require further assistance please contact us at support@sterlingcapitalbrokers.com

Last Updated: December 2023

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Your Benefits

Parallel 49 Brewing Company

71013

PACIFIC BLUE CROSS®

Group Name and Policy Number

Parallel 49 Brewing Company

All Employees

Policy Number 71013

Effective: January 1, 2024

Introduction

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

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

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

Defined terms are capitalized (e.g. Dependent). Pacific Blue Cross (PBC) and Blue Cross Life Insurance Company of Canada (Blue Cross Life) are referred to as "we", "us", or "our" in this booklet. We will refer to you, the employee/Member, as "you" or "your" in this booklet.

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

Coverage is provided through:

Pacific Blue Cross

Extended Health Care (EHC)

Dental Care

Blue Cross Life

Group Term Life

Dependent Life

Accidental Death & Dismemberment (AD&D)

Critical Illness

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

Privacy Policy

We have a Privacy Policy which governs our collection, use, and disclosure of personal information (including personal health information) about individuals who are Members or Dependents. The Privacy Policy requires us to keep such personal information confidential, but does permit use and disclosure of personal information in limited circumstances consistent with the proper administration of group benefit and insurance coverage plans.

A copy of our current Privacy Policy can be obtained from us on request and is also available on our website: *www.pac.bluecross.ca.* By participating in the group benefit and insurance plans, and submitting claims under those plans, you are consenting to the collection, use, and disclosure of your personal information pursuant to the terms of our Privacy Policy.

Table of Contents

Schedule of Benefits

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

Extended Health Care		
Deductible	No Deductible	
Reimbursement	**In Province/Territory Eligible Expenses**	
	Drugs indicated for the treatment of infertility	50%
	All other Prescription Drugs dispensed at a Preferred pharmacy	90%
	All other Prescription Drugs dispensed at a pharmacy that does not participate in our preferred Provider network	80%
	Paramedical Expenses	80%
	Vision Care & Eye Examinations	100%
	All other Eligible Expenses	100%
	Out-of-Province/Territory Eligible Expenses	
	Emergency	100%
	Non-Emergency	Same as In-Province/Territory
Plan Maximum	There is an unlimited lifetime maximum per person for in-province/territory Eligible expenses and a $5,000,000 lifetime maximum per person for out-of-province/territory emergency Eligible expenses, subject to the terms and conditions of the Group Contract.	
Termination	Age 85 or earlier retirement	
Dependent Children	See definition of Dependent	

Dental Care		
Deductible	No Deductible	
Reimbursement	**Plan A**	**Plan B**
	Basic Services	Major Restorative Services
	80%	50%
Frequency Plan Limits	**Each Calendar Year**	**Each Calendar Year**
Financial Limit Per Dependent Child	$1,500 Combined with Plan B	$1,500 Combined with Plan A
Financial Limit Per Member or Spouse	$1,500 Combined with Plan B	$1,500 Combined with Plan A
Financial Limit for Late Applicants	$250 per person for all dental services for first 12 months of coverage	
Termination	Age 85 or earlier retirement.	
Dependent Children	See definition of Dependent.	

Group Term Life	
Benefit Amount	$50,000
Living Benefit Amount	50% of the Group Term Life Benefit Amount, to a maximum of $50,000
Non Evidence Limit	$50,000
Benefit Reduction	Amount of insurance reduces by 50% at age 65, further 25% at age 70
Termination	Age 85 or earlier retirement.

Dependent Life		
Benefit Amount	**Spouse**	**Child**
	$10,000	$5,000
Dependent Children	See definition of Dependent	
Termination	Dependent insurance terminate on your 70th birthday or earlier retirement.	

Accidental Death & Dismemberment (AD&D)	
Principal Sum	An amount equal to the amount payable under your current group term life insurance.
Aggregate Limit	$3,000,000
Benefit Reduction	Amount of insurance reduces by 50% at age 65, further 25% at age 70
Termination	Age 85 or earlier retirement.

Critical Illness	
Benefit Amount	**Employee**
	$10,000
Payment Conditions	A full benefit may be payable for claims of up to 4 conditions and/or a partial benefit may be payable for up to 4 events as described in the Critical Illness Benefit: *Multiple Event Payment Conditions and Supplemental Partial Payment Conditions.*
Non Evidence Limit	$10,000
Survival Period	30 Days
Benefit Reduction	Amount of insurance reduces by 50% at age 65.
Termination	Employee insurance terminates at age 70 or earlier retirement.

General Information

Definitions

Benefit amount

means the reimbursement payable upon satisfaction of all conditions of the Contract.

Benefit review

means our process by which we evaluate or revise the coverage criteria for health products, services and supplies and/or health treatment options, drugs, and dental supplies, dental treatment options, and/or dental products.

Coverage effective date

means the date coverage becomes effective based on

1. your date of hire, and
2. the average 30 number of hours you work each week, and,
3. the 6 month waiting period selected by your employer, and
4. the Enrolment grace period.

Customary

means usual or traditional and well-established as determined by us.
This refers to:

1. the charges for products, services or supplies; and/or
2. the use of products, services or supplies during the course of a treatment for a medical condition

which do not exceed the general level of charges in the absence of insurance made by similar Providers in the area where the charge is incurred for a medical condition comparable in nature and severity to that being treated. The term "area" means a region large enough to obtain a representative cross section of similar Providers.

Deductible

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

Dentist

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

Dependent

means any of the following persons for whom coverage is provided under this Plan:

1. one Spouse of the Member
2. any unmarried child, stepchild, legally adopted child, or legal ward (but not a foster child) who is under age 21 and financially dependent on you or your Spouse, and
3. under age 25 if the unmarried child is also in full-time attendance at a recognized educational institute, and
4. any unmarried disabled child of any age who is living with and is financially dependent on you and/or Spouse and is incapable of self-sustaining employment. Disabled status is subject to approval by us. The Dependent must become disabled while covered as a Dependent under Clause 2 or 3 above.

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

Duplicate coverage

means that you (and your Dependents) are eligible to claim certain benefits under more than 1 plan.

Eligible drug

means a drug Health Canada has approved for specific indications and assigned a Drug Identification Number (DIN), and that we have approved following our Benefit review.

Eligible expense

means a charge for any service, supply and/or Eligible drug included in this booklet as a benefit that:

1. subject to our Benefit review, and in our assessment is a Customary charge that is medically necessary for health care and maintenance, or to maintain or restore teeth, and

2. was ordered or referred by a Physician, Dentist, or Nurse practitioner, unless otherwise specified in the benefit description, and

3. is not a cost normally paid, in whole or in part, or provided by a Government plan or any other Provider of health coverage, and

4. was incurred while coverage is valid for the expense being claimed. An expense is "incurred" on the date the service is provided or the supply is received, and

5. is provided by a Practitioner or Provider approved by us.

It does not include any payment to a pharmacy or a Practitioner, demanded or received by balanced billing, extra billing, or extra charging, which represents an amount in excess of the schedule of costs prescribed by the Government plan or in any PBC Provider agreement. Provincial/territorial plans low cost alternative and reference drug programs will not be applied unless specified in this booklet.

Enrolment grace period

means within 90 days from the coverage effective date.

Fee guide

means the Canadian provincial/territorial dental Fee guide that contains dental services and fees in effect on the date the dental services are performed.

Fee schedule

means Schedule 3 of the Pacific Blue Cross Fee schedule that contains eligible dental services, financial limits, treatment frequencies, and fees in effect on the date the dental services are performed.

Government Plan

means the health, drug, and dental benefit coverage that Canadian federal, provincial and/or territorial governments provide for their residents.

Hospital

means an institution that is licensed as an accredited Hospital that is staffed and operated for the care and treatment of in-patients and out-patients. Treatment must be supervised by Physicians and there must be registered nurses on duty 24 hours a day. Diagnostic and surgical capabilities must also exist on the premises or in facilities controlled by the establishment. A hospital is not an establishment used mainly as a clinic, extended or palliative care facility, rehabilitation facility, addiction treatment centre, convalescent, rest or nursing home, home for the aged or health spa. This also includes

facilities in which the cost for drugs is a covered benefit under the patient's Government plan.

For the purpose of the Contract, the chronic beds of a Hospital are not considered part of that Hospital.

Late applicant

means an employee or Dependent whose application for coverage was received by us after the Enrolment grace period.

Life event

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

Member

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

Non evidence limit

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

Physician

means a person legally licensed, certified, or registered to practice medicine and/or surgery, by the appropriate licensing, certification, or registration authority in the jurisdiction where the care or services are provided and acting within the scope of that license. Where no such authority exists, the person has a certificate of competency from the professional provincial/territorial or national body, which establishes standards of competence and conduct for Physicians. This excludes a Physician residing with or related to you or your Dependent. We reserve the right to refuse the service, medical supply, or equipment from the Physician based on ineligibility, or based on the Physician's qualifications or conduct.

Practitioner

means a person legally licensed, certified, or registered to practice a profession by the appropriate licensing, certification, or registration authority in the jurisdiction where the care or services are provided and acting within the scope of that license. Where no such authority exists, the person has a certificate of competency from the professional provincial/territorial or national body, which establishes standards of competence and conduct for that profession. This excludes a Practitioner residing with or related to you or your

Dependent. We reserve the right to refuse the service, medical supply, or equipment from the Practitioner based on ineligibility, or based on the Practitioner's qualifications or conduct.

Provider

means a person, group, or other entity currently licensed, certified, or registered to provide an eligible service, medical supply, or equipment by the appropriate licensing, certification, or registration authority in the jurisdiction where the services or equipment are provided or, where no such authority exists, has a certificate of competency from the professional body which establishes standards of competence and conduct for the profession, and is acting within the scope of that license. This excludes a Provider related to or residing with you or your Dependent. We reserve the right to refuse the service, medical supply or equipment from the Provider based on ineligibility, or based on the Provider's qualifications or conduct.

Spouse

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

Vendor

means an organization we have retained as an external Provider.

Member Information/Access to Records

1. Each Member who becomes insured under the Group Contract/Policy must receive an ID card if covered for Extended Health Care and/or Dental Care, and for all benefits a booklet outlining the benefits, the circumstances under which the insurance terminates, and the rights of the Member upon termination of the insurance. We will not be liable or responsible for errors or omissions, which occur when; our booklet is altered in any way. A booklet issued to or held by a Member who, for any reason, is not entitled to insurance under the Group Contract/Policy, is not valid.

2. Only the Member and Dependent(s) are entitled to the benefits of this Contract/Policy. A Member's coverage may be suspended immediately, without notice, if that Member or a Member's Dependent assists an ineligible person to obtain, or attempt to obtain, benefits to which they are not entitled. The persons involved must repay any amounts obtained in this manner to us. Any other fraudulent action by a Member or Dependent to obtain or attempt to obtain benefits will have similar consequences.

3. Use of an ID card by a person who is not entitled to coverage may result in prosecution of that person.

4. The terms of the Group Contract/Policy govern if they conflict with the information in a booklet.

5. Upon request, and at no charge to the Member, we will provide the Member with 1 copy of:

   (a) the Member's application for coverage

   (b) the current Contract/Policy

   (c) any written statement or other record provided to us as evidence of insurability of the Member.

6. A Member's access to the documents identified in clause 5 extends only to relevant information about a claim under the Group Contract/Policy or denial of such a claim.

7. A Member's access to the documents identified in clause 5 is subject to the *Personal Information Protection Act* and to the *Insurance Act* and their Regulations.

Integration with Government Plans

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

Effective Date of Coverage and Enrolment

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

You should apply for Dependent coverage (when applicable):

1. on the same date you apply for your own coverage, or

2. within the Enrolment grace period if you have a new Dependent.

Limitations:

1. If you are not actively at work on your coverage effective date, your coverage effective date will be delayed until you return to active full-time employment.

2. If we do not receive your application card within the required time limits, please refer to the Late Applicant section.

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

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

Late Applicants

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

Beneficiary

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

Identification (ID) Cards

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

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

Claims

1. All claims must be submitted to us in English.
2. We pay eligible claims when we receive all the required information within the required **time limits**. We encourage you to become familiar with the time periods allowed for claiming benefits. Under the Claims sections, we fully describe the claiming deadlines for each benefit. No payment will be made if we receive your claim after the time limits described in this booklet.

3. We may reject your claim if sufficient information is not provided to enable a full assessment of the claim, or if an attempt is made, except through unintentional error, to make an excessive claim, or if a claim is made for a person who is not entitled, or if any Group Contract/Policy exclusion applies.

4. The necessary claim forms are available from your Plan Administrator or on our website at *www.pac.bluecross.ca/member/*

5. The exchange rate on foreign currency is payable at the rate quoted by selected Canadian financial institutions for the date on which the expense was paid. Fluctuations in exchange rates are not our responsibility.

Duplicate Coverage

If you and your Spouse work for the same employer, please check with your Plan Administrator to see if Duplicate coverage is allowed for dental and extended health care benefits.

If you and your Spouse work for different employers and you are both enrolled for similar benefits, Duplicate coverage is allowed.

If you are eligible for Duplicate coverage, you and your family should discuss both plans (and what portion of the benefits you pay) to determine whether it is to your advantage to enrol under more than 1 plan.

Your Plan Administrator will advise you if you are eligible to waive certain benefits under this group plan.

Coordination of Benefits

If Duplicate coverage is allowed, we pay claims based on the rules of the Canadian Life and Health Insurance Association guidelines. They are:

1. The Member is always the primary claimant. The Spouse is always the secondary claimant.

2. Dependent children are always covered primarily under the parent who has the earliest birthdate in the year (month and day).

3. In situations of separation or divorce, the following order applies:

   (a) the plan of the parent with custody of the child

   (b) the plan of the Spouse of the parent with custody of the child

   (c) the plan of the parent not having custody of the child

   (d) the plan of the Spouse of the parent in c) above.

4. Total reimbursement shall never exceed 100% of the Eligible expenses.

General Exclusions

1. We will not be liable for any portion of an expense for which you or your Dependent is entitled to reimbursement:
   (a) under any other group or individual benefit plan or insurance policy, or
   (b) due to the legal liability of any other party.
2. In no event will benefits be payable for expenses resulting directly or indirectly from, or in any manner or degree associated with, any of the following:
   (a) war, whether declared or undeclared, or any act of war, or participation in a riot, insurrection, or civil commotion
   (b) suicide or any self-inflicted injury, whether intentional or unintentional, sustained while travelling outside the normal province/territory of residence
   (c) active duty in the military forces of any nation or international organization, or in any civilian noncombatant unit which serves with such forces in combat
   (d) a direct or indirect attempt at, or commission of, an indictable offense under the Criminal Code of Canada or similar law of any other country
   (e) false pretences or fraudulent misrepresentation
   (f) any injury, illness, or condition for which care is provided or may be provided or available without cost by public authorities or by a tax-supported agency, including preventive treatment and services available under any Workers' Compensation Act or similar plan.

Legal Action

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

Termination of Coverage

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

Right of Recovery

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

Survivor Benefit

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

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

Conversion to an Individual Plan

Should your group coverage terminate for any reason, you may purchase an individual plan from Pacific Blue Cross if you live in British Columbia, or an individual plan offered by your local Blue Cross organization if you live elsewhere in Canada.

To convert coverage you must ensure that your application and full payment is received by us or Blue Cross within 60 days of the date your group plan terminates. To be eligible to convert, you must have had coverage under a group plan with the same benefits for at least 6 months. Coverage will become effective immediately after your group coverage terminates.

If you qualify for 1 of our individual plans under the conversion option, we will waive the Pre-existing condition contained in the individual plan.

Pre-existing condition

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

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

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

Individual Travel Benefits

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

Member Profile

Your Pacific Blue Cross Member Profile is an online service that offers convenient and secure access to your benefit information 24 hours a day. Once logged in you will be able to make and track online claims, get information on benefit coverage and downloadable claim forms. To login, visit: *www.pac.bluecross.ca/member/*

Extended Health Care

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

Definitions

Compounded drug

means a drug prepared in a pharmacy following the National Association of Pharmacy Regulatory Authorities for pharmacy compounding, and meeting eligibility criteria as determined by us.

Dispensing fee

means a Pharmacy's fee for dispensing a prescription including professional and technical services as defined by the applicable provincial/territorial legislation.

Experimental

means not approved or broadly accepted and recognized by the Canadian medical profession as an effective, appropriate, and essential treatment of an illness or injury.

Life-sustaining non-prescription drugs

means drugs that are necessary to sustain life, do not legally require a prescription and that meet eligibility criteria as determined by our Benefit review.

Markup

means the total of all amounts added to the manufacturer's list price, meaning the published price at which the drug is available for purchase from the manufacturer in the applicable province/territory, and including any wholesale upcharge, retail markup, and any other amounts in excess of the manufacturer's list price.

Nurse practitioner

means a person legally licensed, certified, or registered to deliver specific health care services, by the appropriate licensing, certification, or registration authority in the jurisdiction where the care or services are provided and acting within the scope of that license. Where no such authority exists, the person has a certificate of competency from the professional provincial/territorial or national body, which establishes standards of competence and conduct for

Nurse practitioners. This excludes a Nurse practitioner residing with or related to you or your Dependent. We reserve the right to refuse the service, medical supply, or equipment from the Nurse practitioner based on ineligibility, or based on the Nurse practitioner's qualifications or conduct.

Pharmacist

means a person legally licensed, certified, or registered to practice pharmacy and/or dispense drugs, by the appropriate licensing, certification, or registration authority in the jurisdiction where the care or services are provided and acting within the scope of that license. Where no such authority exists, the person has a certificate of competency from the professional provincial/territorial or national body, which establishes standards of competence and conduct for Pharmacists. This excludes a Pharmacist residing with or related to you or your Dependent. We reserve the right to refuse the service, medical supply, or equipment from the Pharmacist based on ineligibility, or based on the Pharmacist's qualifications or conduct.

Preferred pharmacy

means a pharmacy that participates in our preferred Provider network. A list of current participating pharmacies is available on our website: *www.pac.bluecross.ca/member/.*

In-Province/Territory Eligible Expenses

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

1. Hospital

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

2. Emergency ambulance

   (a) charges for licensed ambulance service to and from the nearest Canadian Hospital equipped to provide the type of care essential to the patient

   (b) air transport will be covered when time is critical and the patient's physical condition prevents the use of another means of transport

   (c) emergency transport from one Hospital to another, only when the original Hospital has inadequate facilities

(d) charges for an attendant when medically necessary.

3. Drugs

Charges for an Eligible expense in a quantity we consider reasonable, and as approved by our Benefit review, and

(a) which are dispensed by a Pharmacist, Physician, Dentist, or Nurse practitioner, legally licensed, certified, or registered to practice by the appropriate licensing, certification, or registration authority in the jurisdiction where the care or services are provided and acting within the scope of that license, including:
   i. Life-sustaining non-prescription drugs
   ii. insulin preparations, diabetic test strips, lancets, needles, and syringes for diabetes management
   iii. injectable vitamin B12 for the treatment of pernicious anemia
   iv. allergy serums when administered by a Practitioner, or

(b) which legally require a prescription from a Provider legally authorized to do so, including:
   i. Compounded drugs
   ii. contraceptive drugs
   iii. drugs indicated for the treatment of infertility to a lifetime maximum of $4,000
   iv. vaccines to a maximum of $300 per calendar year

The ingredient cost of multi-source brand drugs plus Markup will be reduced to the ingredient cost of the lowest cost equivalent generic plus Markup. The ingredient cost of generic drugs and single source brand drugs plus Markup are eligible.

If we receive written confirmation from the prescribing Practitioner that there is a specific adverse effect that prevents the Member from taking the generic, the full ingredient cost of the multi-source brand drug plus Markup will be eligible.

The Markup is eligible up to our Customary level, as updated from time-to-time.

Specific high cost BC PharmaCare limited coverage drugs are identified by us as our Special Authority Enforcement list. We will reject claims for a drug on this list until we receive confirmation of BC PharmaCare's Special Authority decision for the drug. Once the BC PharmaCare decision (approved or declined) is on file with us, we will consider this drug as eligible based on:

(a) if BC PharmaCare approval is confirmed, the approval period determined by BC Pharmacare, or

(b) if the BC PharmaCare decision is to decline, and if the request otherwise meets our definition of an Eligible drug, the approval period as determined by us.

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

(a) acupuncturist $500

(b) audiologist $500

(c) chiropractor and one chiropractic x-ray combined $500

(d) dietitian $500

(e) homeopath $500

(f) massage Practitioner $500

(g) naturopath $500

(h) occupational therapist $500

(i) osteopath $500

(j) physiotherapist $500

(k) podiatrist and chiropodist combined $500

(l) psychologist, clinical counsellor, social worker and Online cognitive behavioural therapy combined $500

(m) speech language pathologist $500

(n) private duty care by a registered nurse for a person with an Acute condition in the person's home, limited to $10,000 per Calendar year or $25,000 lifetime, whichever occurs first.

5. Online Cognitive Behavioural Therapy
Charges for a program through an eligible Vendor to a maximum of $500 per calendar year combined with services of a psychologist, clinical counsellor and social worker.

"Online cognitive behavioural therapy" means an internet-based behavioural therapy program.

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

duplicate, or incomplete procedures, or for correcting unsuccessful procedures.

Accidental

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

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

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

   (a) oxygen

   (b) ostomy and ileostomy supplies

   (c) intrauterine contraceptive devices (IUD's)

   (d) walkers, canes and cane tips, crutches, casts, and trusses

   (e) splints and collars (but not elastic or foam supports), rigid support braces and permanent prostheses (artificial eyes, limbs, larynxes, and mastectomy forms), when prescribed by a Physician, physiotherapist, chiropractor, or Nurse practitioner, as medically necessary after diagnosis of the patient. Myoelectrical limbs are excluded, but we will pay the equivalent of a standard prosthesis

   (f) charges for the following items to the maximum amounts indicated per calendar year:

      i. mastectomy brassieres $250
      ii. stump socks $250
      iii. surgical stockings $250

   (g) wigs and hairpieces required as a result of medical treatment, injury, alopecia areata, alopecia universalis or alopecia totalis to a lifetime maximum of $500

   (h) orthopaedic shoes and orthotics

      i. when prescribed by a Physician, podiatrist, chiropractor, or Nurse practitioner, as medically necessary after diagnosis of the patient, custom made orthopaedic shoes (including repairs) and modifications to stock item footwear to a maximum in a calendar year period of $300. A custom made orthopaedic shoe is one fabricated from raw materials and specifically designed for the patient, based on a three-dimensional volumetric model of the patient's foot and lower leg

      ii. when prescribed by a Physician, podiatrist, chiropractor, physiotherapist, or Nurse practitioner, as medically necessary after diagnosis (including an in person biomechanical

assessment) of the patient, custom made orthotics to a maximum in a calendar year period of $300. A custom made orthotic is one fabricated from raw materials using a three-dimensional volumetric model of the patient's feet

(i) hearing aids and repairs to a maximum of $700 in a 4 calendar year period. Batteries, recharging devices, and other such accessories are not covered. Replacement will be covered only when the hearing aid cannot be repaired satisfactorily.

8. Standard durable medical equipment

   (a) Preauthorization is required from us for expenses in excess of $5,000

   (b) Charges for standard durable medical equipment when rented from a medical supplier. If unavailable on a rental basis, or required for a long term disability, purchase of these items from a Provider may be considered.

   (c) Repairs to purchased items. We will replace the item when it can no longer be made functional. We may request trade in or return of replaced equipment.

   (d) Reimbursement on rental equipment will be made monthly and will in no case exceed the total purchase price of similar equipment.

   (e) Standard durable equipment includes:

      i. manual wheelchairs, manual type hospital beds, and necessary accessories – electric wheelchairs and hospital beds will be covered only when the patient is incapable of operating the manual equivalent, otherwise we will pay the manual equivalent

      ii. medical heart monitors and cardiac screeners

      iii. continuous glucose monitors and supplies to a maximum of $2,000 in a calendar year period and blood glucose monitors

      iv. speech processors and headsets when prescribed for profound deafness subject to a 5 calendar year period

      v. bi-osteogen systems and growth guidance systems (when recommended by an orthopaedic surgeon)

      vi. breathing machines and appliances including respirators, compressors, percussors, suction pumps, oxygen cylinders, masks, and regulators

      vii. insulin infusion pumps for diabetics – when basic methods are not feasible

      viii. transcutaneous electric nerve stimulators (TENS) when prescribed for intractable pain

      ix. transcutaneous electric muscle stimulators (TEMS) required when, due to an injury or illness, all muscle tone has been lost.

9. Vision Care
   Charges for the purchase of eyewear when prescribed by a Physician or legally authorized optical Provider, and/or repair of eyewear and charges for contact lens fittings when performed by a Physician or legally authorized optical Provider, to a maximum of $200 in a 24 month period for adults and 12 month period for Dependent children. Charges for non prescription eyewear are not covered.

10. Eye Examinations
    Charges for one routine eye examination every 24 months for adults and every 12 months for Dependent children when performed by a Physician or legally authorized optical Provider.

Extended Health Benefit – Second Opinion™

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

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

1. AIDS
2. ALS
3. Alzheimer's disease
4. Any amputation
5. Any life threatening illness
6. Benign brain tumor
7. Cancer
8. Cardiovascular conditions
9. Chronic pelvic pain
10. Coma
11. Deafness
12. Embolism/Thrombophlebitis
13. Emphysema
14. Hip/knee replacement
15. Kidney failure

16. Loss of speech
17. Major or severe burns
18. Major organ transplant
19. Major trauma
20. Multiple sclerosis
21. Neuro-degenerative diseases
22. Paralysis
23. Parkinson's disease
24. Rheumatoid arthritis
25. Stroke
26. Sudden blindness due to illness

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

If you or your Dependents have been diagnosed with 1 of the conditions listed above, you can seek Second Opinion by calling 1-877-676-6439 (toll-free) between 5:00 am and 5:00 pm (Pacific time). You will be asked for your Pacific Blue Cross policy number, as shown on your ID card.

This benefit terminates:

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

Disease Support Programs

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

Services available, including but not limited to:

1. Support groups.
2. Tools for patient to take charge of their health.
3. Natural approaches to prevention and treatment.
4. Multidisciplinary team of Physicians and health care practitioners.
5. Individualized cancer survivorship plan.

Conditions and Limitations:

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

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

Out-of-Country Medical Referral Eligible Expenses

Benefits are payable for the following expenses incurred by you or your Dependent outside Canada:

1. Hospital Benefits - while confined as a patient or treated in a Hospital, the Hospital room charge and charges for services and supplies over and above that covered by the Government plan.
2. Professional Services - charges for Physician's services, and laboratory and x-ray services when ordered by the attending Physician over and above the amount allowed under the regulations of the Government plan.

Conditions and Limitations:

1. The treatment must be medically necessary, not available in Canada, and referred by a Physician resident in your province/territory of residence.
2. The Government plan must authorize the treatment and accept the appropriate financial responsibility.
3. Preauthorization is required from us for expenses in excess of $1,000.
4. The lifetime maximum benefit is $25,000.

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

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

Out-of-Province/Territory Emergency Eligible Expenses

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

1. Local ambulance services when immediate transportation is required to the nearest Hospital equipped to provide the treatment essential to the patient.

2. The Hospital room charge and charges for services and supplies when confined as a patient or treated in a Hospital, to a maximum of 90 days. If reasonably possible, we should be notified within 5 days of the patient's admission to Hospital. When the patient's condition has stabilized, we have the right, with the approval of the attending Physician, to move the patient by licensed ambulance service to the Hospital nearest the patient's home which is equipped and has space available to provide further medical treatment. Where transportation would endanger the patient's health, the 90 day limit may be extended with our expressed written consent.

3. Services of a Physician and laboratory and x-ray services.

4. Prescription drugs in sufficient quantity to alleviate an acute medical condition.

5. Other emergency services and/or supplies, if we would have covered them inside your province/territory of residence.

6. Charges, limited to the most economical means of transportation, for your Dependent child under 16 years of age to their place of residence in Canada in the event you and/or your Spouse is hospitalized and your child is left unattended. Arrangements for an escort to accompany your child will be made, if necessary.

7. Charges, limited to the most economical cost of one-way economy fare air transportation, less any amount reimbursed for unused return tickets, when the covered person's hospitalization delays the return trip. The

coverage is for both your airfare and the airfare of your Spouse, if required.

8. Charges, limited to return economy fare air transportation, for 1 immediate family member to visit you or your Dependent if hospitalized. You or your Dependent must have been travelling alone and confined to a Hospital for more than 7 days. An immediate family member is defined as a Spouse, child, parent, brother, sister, or a person with whom the insured person normally resides.

9. Charges relating to items 6), 7) and 8) are limited to a combined maximum expense of $5,000 per family per medical emergency.

10. Charges for accommodation for convalescence following hospitalization to a maximum of $75 per day per patient for a maximum of 5 days per medical emergency.

11. Charges for commercial accommodation and meals for an immediate family member while staying with a hospitalized Member or Dependent to a maximum of $100 per day up to 7 days per family per medical emergency.
    Limitation:
    Expenses only apply if the immediate family member had to travel to visit the patient, or if the immediate family member had to extend their stay beyond the scheduled date of their return trip.

12. Charges relating to the return of your vehicle (excluding commercial transport vehicles) to your place of residence or the nearest appropriate rental agency in the event you are unable to return it due to a medical emergency to a maximum of $500 per medical emergency.

13. Charges for the repatriation of a deceased Member and/or Dependent to their place of residence to a maximum of $5,000. In the event the deceased person is cremated outside their province/territory of residence, charges are limited to $1,500.

14. There is a $5,000,000 lifetime maximum per person for out-of-province/territory emergency Eligible expenses.

We will only cover Eligible expenses obtained within 180 days of the date you or your Dependent left the country of residence, which will reduce to 90 days once the Member or Dependent reaches age 70. If hospitalization occurs within the 180 or 90 day period, in-patient services are covered until the date of discharge up to a maximum of 90 days. You and your Dependents are required to provide proof of the date of departure and return date to your country of residence, when requested by us.

Emergency Travel Assistance

In emergencies which occur while you (and your Dependents) are travelling, during the first 180 days or 90 days after you initially leave your country of residence, medi-assist will coordinate the following services:

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

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

Exclusions

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

1. except as specifically included in this booklet: dentures or dental treatments, hearing aids, eyeglasses, contact lenses, surgical lens implants, or examinations for the prescription or fitting of any of these, x rays, Hospital coinsurance, support stockings, orthotics, arch supports, continuous glucose monitors and supplies, transportation charges incurred for elective treatment and/or diagnostic procedures or for health examinations of any kind, and professional services of Physicians, Dentists, or Nurse practitioners, or any person who renders a professional health service in the patient's province/territory of residence
2. except as specifically included in this booklet, we pay no drug expenses for:
   (a) food replacements, food supplements, and infant foods
   (b) administrative charges for injectable medications or infusions
   (c) drugs, related preparations, treatments, and services administered during treatment in an emergency room of a Hospital, or as an in-patient in a Hospital, or as an out-patient in a Hospital

(d) drugs, related preparations, treatments, and services administered in a government-funded clinic or treatment facility

(e) general anaesthetic, drugs not approved for sale and distribution in Canada, or medications available without a prescription, or any drug included as a benefit unless approved by our Benefit review process

(f) any expenses identified as exclusions under the Extended Health Care Benefit

3. personal comfort items, items purchased for athletic use, air humidifiers and purifiers, services of Victorian Order of Nurses or graduate or licensed practical nurses, services of religious or spiritual healers, occupational therapy, services and supplies for cosmetic, or Experimental purposes, public ward accommodation, rest cures, and medical laboratory tests

4. except as specifically included in this booklet: charges for completion of forms or written reports, communication costs, delivery and mailing or handling charges, interest or late payment charges, non-sharable or capital costs levied by local Hospitals, or charges for translating documents into English

5. any payment to a pharmacy, a Practitioner, Physician, Dentist, or Nurse practitioner (demanded or received by balanced billing, extra billing or extra charging) which represents an amount in excess of the schedule of costs prescribed by the Government plan

6. that portion of a claim normally covered by the Government plan which has been refused on the basis that the claim was not submitted within the Government plan's time limits

7. expenses incurred, outside your province/territory of residence, due to elective treatment and/or diagnostic procedures, or complications related to such treatment

8. expenses incurred, outside your province/territory of residence, due to therapeutic abortion, childbirth, or complications of pregnancy occurring within 2 months of the expected delivery date

9. charges incurred outside your province/territory of residence for continuous or routine medical care normally covered by the Government plan in your province/territory of residence

10. expenses of a Dependent hospitalized at the time of enrolment

11. services performed by a Pharmacist, Physician, Dentist, or Nurse practitioner, who is related to or residing with you or your Spouse

12. services, medical supplies or equipment rendered by a Provider or Practitioner not approved by Pacific Blue Cross

13. fees for ambulance services when an ambulance is called but not used

14. ambulance charges for work related illness or injury assessed by the Workers' Compensation Board to be your employer's responsibility

15. retroactive coverage and payment of any expense, including drugs that receive special authorization from provincial/territorial plans

16. any other item not specifically included as a benefit

17. legal cannabis, in any form, as defined by Health Canada unless a DIN is assigned to it.

Claims

Electronic Claims

1. When submitting an electronic claim you must:

   (a) complete the claim form online and submit it electronically to us

   (b) keep original receipts and documentation to support the claim for 12 months from the date you submit the claim to us

   (c) if the claim is selected for review by us, you must submit the original receipts and supporting documentation electronically or by mail to us within 21 calendar days. If we do not receive this information within this time, your claim will be refused and your ability to submit electronic claims will be removed.

2. We reserve the right to remove your ability to submit electronic claims if you provide false, incomplete or misleading claims information. In such circumstances you will have to submit paper claims with supporting receipts and documentation.

3. You must provide explanation or proof to support the claim or any other information we consider necessary.

4. We must receive an electronic claim within 12 months from the date the expense was incurred. If your electronic claim is selected for review by us, we will accept the original receipts and supporting documentation after the 12 month deadline, but within 21 calendar days (see 1c) above) from the date of electronic submission.

5. Payment of the claim will be directed to you, unless we agree to your request to assign payment directly to a third party.

Pay Direct

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

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

Paper Claims

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

2. If you have Duplicate coverage, please review the *Coordination of Benefits* section under General Information. 2 separate claim forms (1 for the primary plan and 1 for the secondary plan) must be completed. The remittance statement from the first plan must be submitted to the second plan. Because claims information regarding the other plan is not retained on our files, be sure to provide information on the second plan on both claim forms. Incomplete claims will be returned for clarification.

3. Certain medical expenses are covered under the provincial/territorial plans. If you submit your claim to us before you submit your claim to the provincial/territorial plans, we will deduct what the provincial/territorial plans, would normally pay from your EHC claim. The balance of the EHC claim is then paid according to the plan design selected by your employer.

4. Accumulate receipts and when reasonable reimbursement is due, submit a claim as follows:

   (a) Obtain a claim form from your Plan Administrator or on our website at *www.pac.bluecross.ca/member*

   (b) Follow the instructions on the claim form. To avoid delay in claims payment, please include original receipts and all other requested information with your claim. (Photocopies of receipts are acceptable only when accompanied by a claims payment statement from another carrier).

   (c) We suggest you submit claims within **90 days** from the date the expense was incurred. However, we must receive your claim within 12 months from the date the expense was incurred. If not, your claim will not be paid under any circumstances.

(d) **We must receive the original claim form and original receipts. We will not accept a faxed or scanned claim form and/or receipts.**

Dental Care

Payment of Benefits

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

Plan A – Basic Preventive & Restorative Services

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

1. Diagnostic services
   (a) examinations:
      i. complete - 1 per lifetime by a general Practitioner and 1 per lifetime by a specialist
      ii. recall - 2 per calendar year
      iii. specific - 2 per calendar year
      iv. consultations (as a separate appointment)
   (b) x-rays
      i. diagnostic
      ii. panoramic - 1 per 60 month period
      iii. complete mouth series - 1 per 36 month period
      All x-rays combined shall not exceed the dollar limit for a complete mouth series.
   (c) diagnostic models - 1 set per calendar year.
2. Preventive services

(a) scaling, root planing, and gingival curettage – a combined yearly limit shown in our Fee schedule

(b) polishing- 2 per calendar year

(c) topical application of fluoride - 2 per calendar year

(d) fixed space maintainers

(e) preventive restorative resins and pit and fissure sealants - combined limit of 1 per tooth in a 2 year period. No age limit.

3. Restorative services

   (a) fillings to restore tooth surfaces broken down as a result of decay – limited to a dollar amount equal to a 5 surface filling per tooth in a 2 year period:

      i. amalgam (silver coloured) fillings

      ii. composite (tooth coloured) fillings on all teeth

   (b) metal prefabricated restorations on primary and permanent teeth - once per tooth in a 2 year period.

4. Endodontics – for the treatment of diseases of the pulp chamber and pulp canal including, but not limited to root canals - 1 per tooth per lifetime.

5. Periodontics – for the treatment of diseases of the soft tissue (gum) and bone surrounding and supporting the teeth, excluding bone and tissue grafts, but including the following:

   (a) occlusal adjustment and recontouring – a combined yearly limit shown in our Fee schedule

   (b) root planing, scaling, and gingival curettage – a combined yearly limit shown in our Fee schedule

   (c) osseous surgery – 1 per sextant in a 5 year period

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

6. Prosthetic repairs

   (a) removal, repairs, and recementation of fixed appliances

   (b) rebase and reline of removable appliances - a combined limit of 1 per upper and 1 per lower prosthesis in a 2 year period

   (c) tissue conditioning - 2 per upper and 2 per lower prosthesis in a 5 year period

   (d) gold foil – only when used to repair existing gold restorations.

7. Surgical services

(a) extractions

(b) other routine oral surgical procedures

(c) anesthesia in conjunction with surgery shall not exceed the dollar limit shown in our Fee schedule

Plan B – Major Restorative Services

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

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

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

1. Prosthodontic Services
   (a) removable
      i. complete upper and lower dentures
      ii. partial upper and lower dentures
   (b) fixed bridges.
2. Restorative Services
   (a) inlays and onlays
   (b) veneers
   (c) crowns and related services.

Limitations

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

Emergency Treatment Outside Your Province/Territory of Residence

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

Exclusions

The following are not Eligible expenses under your dental plan:

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

Claims

1. Present your ID card to your Dentist's office. It is important to ask if your dental benefits will cover the entire cost of your treatment. To avoid any misunderstanding, we suggest that your Dentist submit an outline of the proposed services to us **before you start treatment**. This is important especially when your Dentist is recommending extensive dental work. This will help you understand what portion of the Dentist's bill must be paid by you in the event that you wish to proceed with the treatment recommended by your Dentist.

2. We suggest that you submit claims within **90 days** of the completed date of services (earlier if possible). Failure to submit a claim within the 90 day limit will not invalidate the claim if it is submitted as soon as reasonably possible. However, in no event will we pay any claim or adjustment received later than **12 months** from the date the service is performed.

3. We require a separate claim form for each member of your family who has received dental services. Be sure to include the following information on the claim form:

   (a) name of the Dentist

   (b) name and birthdate of the person receiving the dental care

   (c) your policy and ID numbers (this information is on your ID card)

   (d) your home mailing address

   (e) whether you have coverage through another plan. Claims information regarding the other carrier is not retained on our files. If you or your Dependents are covered by 2 plans, your Dentist must complete 2 separate dental claim forms (1 for each plan). Incomplete claims will be returned for clarification.

4. Before your Dentist starts treatment, please ask them how billing is made. We may pay in either of 2 ways:

   (a) If you have paid your Dentist directly, we will reimburse you the Benefit amount when we receive:

      i. a claim form signed by the patient that is either submitted with a receipt or is signed by the dental Provider showing the services performed and the fee charged, or

      ii. an electronic claim showing the services performed and the fee charged. The dental Provider must have the consent of the patient on file to permit the disclosure of the patient's personal information between the Provider and Pacific Blue Cross.

   (b) For pay direct claims, we will pay the Benefit amount to the Dentist directly for services provided under this benefit plan when we receive:

i. a claim form showing the services performed and the fee charged, signed by the patient and the dental Provider, or
ii. an electronic claim showing the services performed and the fee charged. The dental Provider must have the consent of the patient on file to permit the disclosure of the patient's personal information between the Provider and Pacific Blue Cross.

Group Term Life

Payment of Benefit

If you die while insured, we will pay the amount of your group term life insurance to your beneficiary.

When you designate more than 1 person as beneficiary, we will assume the Benefit amount is to be divided equally, unless you specify otherwise. If your designated beneficiary is under age 18, you should appoint a trustee for this beneficiary and have a trust agreement drawn up and signed. This trustee will receive and give discharge for any Benefit amount which becomes payable while your beneficiary is a minor. If no beneficiary survives you, the Benefit amount will be paid to your estate.

Living Benefit

Terminal condition

means an injury or sickness from which there is no reasonable prospect of recovery, as determined by us, and which is expected to result in your death within 12 months.

If you have a Terminal condition, we will pay you the living Benefit amount shown in the Schedule of Benefits. You or your legal representative must submit a written request for this benefit and include written consent from your beneficiary (release form) and written proof of your medical condition from your attending Physician.

This Benefit amount is payable once. The amount of your group term life insurance benefit or the amount of insurance you can convert outlined under the conversion option is reduced by the amount you receive under this benefit.

Waiver of Premium

Should you become totally disabled prior to your 65th birthday and remain so for 6 months, the premium for your group term life insurance will be waived.

Conversion Option

You will be eligible to convert your group life insurance coverage to a personal life insurance policy issued by Blue Cross Life Insurance Company of Canada without having to answer any health questions. To qualify, you must be under age 65, and we must receive your application within 31 days of the date your employment terminates. This option does not apply to schedule reductions, or termination of coverage that becomes effective at a specified age.

The maximum coverage you can purchase will be the lesser of:

1. $200,000, or
2. the amount of group life insurance you had with us, or
3. the difference between the amount of group life insurance you had with us and the amount that is available through your new employer's group plan provided you become insured within 31 days following the termination of your coverage under this policy.

You may purchase less than the maximum amount of life insurance you are entitled to convert. However, you cannot apply for an amount which is lower than that for which Blue Cross Life customarily issues a policy. You will have a choice of 2 policies:

1. a term life insurance policy for 1 year, or
2. a term life insurance policy to age 65.

Your premium will be based on the prevailing standard rate charged by Blue Cross Life on the date your personal policy is issued.

Claims

In the event of your death, we must receive notice of your death within **30 days**, and a completed claim form along with any proof required, as requested by us, within **90 days**. However, no payment will be made on any claim submitted later than **1 year** from the date of death.

Dependent Life

Payment

Because you must enrol your Dependents for the dependent life insurance benefit, when 1 of your eligible Dependents dies, we will pay the Benefit amount to you.

Waiver of Premium

If your group term life insurance premium is waived because you are totally disabled, your premium for the dependent life insurance benefit will also be waived.

Exclusions

Dependents not residing in Canada or the USA or Dependents who are members of the armed forces in any country are not eligible for the dependent life insurance benefit.

Claims

We must receive notice of the death within **30 days** and a completed claim form along with any proof required as requested by us, within **90 days**. However, no payment will be made on any claim submitted later than **1 year** from the date of death.

Accidental Death & Dismemberment

Payment of Benefit

1. When death or loss occurs because of an accidental injury and within 365 days of the accident date, we will pay the Benefit amount in the absence of any Policy exclusions being found applicable:

   (a) to your beneficiary, for loss of life

   (b) to you, for any other loss.

2. Loss of use is covered, but only if such loss is permanent, total, and irrecoverable and has been continuous for 365 days from the date of the accident. In either of the following circumstances we will also consider your loss to be the result of injury:

   (a) when, due to an accident, you are unavoidably exposed to the elements and, as a result of this exposure and within 365 days of the date of the accident, you suffer a loss included in the table

   (b) when, due to the accidental wrecking, sinking, or disappearance of a conveyance in which you are riding, you disappear and your body is not found within 365 days, we will presume that you lost your life in the accident.

3. The Benefit amount will be paid according to the following table. Only 1 of the amounts, the largest specified, will be paid for all injuries resulting from any 1 accident. The principal sum (the amount for which you are insured) is shown in the Schedule of Benefits.

Table of Losses and Benefit Amounts Loss (includes loss of use)	*Benefit as portion of the Principal Sum*
Life	100%
Both Hands or Feet	100%
Entire Sight of Both Eyes	100%
One Hand and One Foot	100%
One Hand and Entire Sight of One Eye	100%
One Foot and Entire Sight of One Eye	100%
Speech and Hearing	100%
One Arm or One Leg	75%
One Hand or One Foot	66.6%
Entire Sight of One Eye	66.6%
Speech or Hearing	50%
Thumb and Index Finger of the Same Hand	33.3%
Four Fingers of the Same Hand	33.3%
Hearing in One Ear	25%
All Toes of the Same Foot	25%
Quadriplegia (complete paralysis of both upper and lower limbs)	200%
Paraplegia (complete paralysis of both lower limbs)	200%
Hemiplegia (complete paralysis of upper and lower limbs of one side of body)	200%

Repatriation Benefit

If you die due to an accident that occurs at least 150 kilometres from your normal place of residence, we will pay the actual expenses incurred (excluding the cost of a coffin) for:

1. preparing your remains for burial or cremation and the shipment of your body to the place of burial or cremation, or
2. the actual expense incurred (excluding the cost of a coffin) for burial or cremation at the place of death,

to a maximum of $10,000.

Rehabilitation Benefit

If you suffer a covered loss which requires you to take special training to enable you to work in an occupation for which you were not qualified prior to the loss, we will pay the reasonable and necessary expenses incurred within 3 years of the date of the accident, to a maximum of $10,000. Payment will not be made for travelling or clothing expenses or for room, board, and/or other ordinary living expenses.

Occupational Training Benefit for the Spouse

If you die due to an accident which requires your Spouse to take a formal training program to enable them to gain active employment in any occupation in which they would not otherwise be qualified, we will pay the reasonable and necessary expenses incurred for such training within 3 years of the date of your death, to a maximum of $10,000. Payment will not be made for travelling or clothing expenses or for room, board, and/or other ordinary living expenses.

Education Benefit

If you die due to an accident, we will pay an education benefit for each Dependent child who enrols full time in a recognized post secondary institution within 365 days of your death. We will pay the necessary and reasonable expenses actually incurred, subject to the lesser of 5% of the principal sum or $5,000 for each year your child continues their education on a full time basis, for a maximum of 5 years or until the age of 26, whichever occurs first.

To be eligible for this benefit, your unmarried child (including any stepchild, legally adopted child, or legal ward, but not a foster child) must be financially dependent on you or your Spouse at the time of your death. Payment will not be made for travelling or clothing expenses or for room, board, and/or other ordinary living expenses.

Family Travel Benefit

If you suffer a covered loss and are confined as an inpatient in a Hospital, or if you suffer from any illness or injury resulting in Hospital confinement for at least 4 days, and the confinement occurs more than 150 kilometres from your normal place of residence, we will pay the reasonable and necessary travelling expenses of 1 or more family members to visit you. The maximum benefit for all family members is $3,000 for return transportation and commercial accommodation costs combined. If personal transportation is used instead of public transportation, a rate of $0.20 per kilometre will apply.

Waiver of Premium

If your group term life insurance premium is waived because you are totally disabled, your premium for this coverage will also be waived, provided this benefit remains in effect.

Exclusions

No payment will be made for any loss that results from or is caused directly or indirectly, wholly or in part by any of the following:

1. suicide or any other self inflicted injury whether intentional or unintentional
2. participation in an assault or criminal offense, or an act incident thereto
3. civil commotion, insurrection, any act of war (whether declared or not) or hostilities between nations, or service in the military forces of any nation
4. travel or flight in or descent from any kind of aircraft as a member of the aircraft crew or having duties relating to the operation, maintenance, or control of the aircraft
5. riding as a passenger, pilot, operator, or member of the crew, in or on, boarding or alighting from or being struck by or making a forced landing with or from any aircraft owned, operated, or leased by the Policyholder
6. self-inflicted injury, whether intentional or unintentional, sustained while under the influence of any addictive or intoxicating substances unless as administered on the advice of a Physician
7. any disease or sickness either mental or physical, or medical procedure.

Claims

In the event of any loss for which this benefit is payable, we must receive notice within **30 days** of the date of loss, and a completed claim form along with any required proof as requested by us, within **90 days**. However, no payment will be made on any claim submitted later than **1 year** from the date of accident.

Critical Illness

Payment of Benefit

We will pay the amount of coverage in force in the event you or your Spouse are afflicted with a critical illness as defined in the *Covered Critical Conditions* below.

Definitions

As used in this benefit, the following terms apply:

Diagnosis

means the identification of a disease or condition by a scientific evaluation of physical signs, symptoms, history, laboratory test results, and procedures.

Insured person

means you (the employee) and/or your Spouse.

Life support

means the Insured person is under the regular care of a licensed Physician for nutritional, respiratory and/or cardiovascular support when irreversible cessation of all functions of the brain has occurred.

Specialist

means a licensed Physician who has been trained in the specific area of medicine relevant to the covered critical illness condition for which benefit is being claimed, and who has been certified by a specialty examining board professional, and is not the Insured person, the insured, a relative of or business associate of the Insured person.

In the absence or unavailability of a Specialist, and as approved by us, a condition may be diagnosed by a qualified Physician practicing in Canada or the United States of America.

Specialist includes, but is not limited to, cardiologist, neurologist, nephrologist, oncologist, ophthalmologist, burn Specialist and internist.

The Diagnosis and treatment of any covered condition must be undertaken by a Specialist or Physician licensed in Canada or the United States of America (or other such jurisdiction as may be approved by us).

Survival period

means that continuous period of time which must elapse between the date the definition of the critical illness is met and the date the benefit is payable, as long as the Insured person is still living, as indicated in the *Schedule of Benefits*.

Covered Critical Conditions

Critical illnesses resulting from sickness or disease are covered when the illness is considered severe as described in this booklet and the Policy. We will determine severity using the objective standardized medical testing and clinical evidence provided by the attending Physician or appropriate Specialist. Policy exclusions or waiting periods may be in effect.

Multiple Event Payment Conditions

A full Benefit amount will be paid for claims for up to 4 conditions subject to the limitation that once a benefit has become payable for a condition covered in 1 category (Category 1, 2, 3, or 4), the Insured person will not be covered under this Benefit for any future conditions specified under the same category. The condition categories and their respective conditions are shown in the following table:

Condition Categories	**Conditions**
Category 1	Cancer
Category 2	Aortic Surgery, Coronary Artery Bypass Surgery, Heart Attack, Heart Valve Replacement or Repair, Stroke
Category 3	Blindness, Deafness, Loss of Limbs, Loss of Speech, Occupational HIV Infection, Severe Burns
Category 4	Dementia including Alzheimer's Disease, Benign Brain Tumour, Coma, Kidney Failure, Loss of Independent Existence, Major Organ Failure on Waiting list, Major Organ Transplant, Motor Neuron Disease, Multiple Sclerosis, Paralysis, Parkinson's Disease and Specified Atypical Parkinsonian Disorders

This benefit is also subject to the following limitations:
Once a benefit has become payable as a result of an injury, accident, illness or disease, the Insured person will not be covered under this Benefit for another claim that is:

1. caused by, contributed to or occurs as a result of the same injury, accident, illness or disease, or
2. a result of any medical or surgical treatment for that same injury, accident, illness or disease.

Supplemental Partial Payment Conditions

A partial Benefit amount will be paid for each of following 4 events:

1. Coronary Angioplasty
2. Cancer (Non Life-Threatening) – Stage T1a or T1b (stage A) prostate Cancer
3. Cancer (Non Life-Threatening) – Stage 1A malignant melanoma
4. Cancer (Non Life-Threatening) – DCIS (ductal carcinoma in situ of the breast).

The partial benefit payment is in addition to the *Multiple Event Payment Conditions* Benefit and is subject to the following definitions, partial Benefit amounts and exclusions listed below:

Coronary angioplasty

is defined as the undergoing of an interventional procedure to unblock or widen a coronary artery that supplies blood to the heart to allow an uninterrupted flow of blood. The procedure must be determined to be medically necessary by a Specialist.

The benefit payable for a coronary angioplasty will be limited to 1 event and 15% of the amount of Critical Illness insurance applicable to the Insured person up to a maximum of $25,000.

3 Types of Cancer (Non Life-Threatening):

1. Stage T1a or T1b (stage A) prostate Cancer
2. Stage 1A malignant melanoma (melanoma less than or equal to 1.0 mm in thickness)
3. DCIS (ductal carcinoma in situ of the breast) requires confirmation by biopsy.

Exclusion:
No benefit will be payable under this condition if, within the first 90 days following the later of, the effective date of the coverage, or the date of last reinstatement of the coverage, the Insured person has any of the following:

1. signs, symptoms, investigations, referrals or medical consultations that lead to a Diagnosis of Cancer (covered or excluded under the Policy), regardless of when the Diagnosis is made; or

2. a Diagnosis of Cancer (covered or excluded under the Policy).

Medical information about the Diagnosis and any signs, symptoms, investigations or medical consultations leading to the Diagnosis must be reported to us within 6 months of the date of the Diagnosis. If this information is not provided within this period, we have the right to deny any claim for Cancer or, any critical illness caused by any Cancer or its treatment.

The benefit payable for each type of Cancer (Non-Life-Threatening) will be limited to 1 event and 15% of the amount of Critical Illness applicable to the Insured person up to a maximum of $25,000.

Category 1 Conditions:

Cancer (Life-Threatening)
is defined as a definite Diagnosis of a tumour, which must be characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. Types of Cancer include carcinoma, melanoma, leukemia, lymphoma, and sarcoma. The Diagnosis of Cancer must be made by a Specialist.

Exclusion:
No benefit will be payable under this condition if, within the first 90 days following the later of, the effective date of the coverage or the date of last reinstatement of the coverage, the Insured person has any of the following:

1. signs, symptoms, investigations, referrals or medical consultations that lead to a Diagnosis of Cancer (covered or excluded under the coverage), regardless of when the Diagnosis is made; or

2. a Diagnosis of Cancer (covered or excluded under the coverage).

Medical information about the Diagnosis and any signs, symptoms, investigations or medical consultations leading to the Diagnosis must be reported to us within 6 months of the date of the Diagnosis. If this information is not provided within this period, we have the right to deny any claim for Cancer or, any critical illness caused by any Cancer or its treatment.

No benefit will be payable for the following:

1. lesions described as benign, pre-malignant, uncertain, borderline, non-invasive, carcinoma in-situ (Tis), or tumors classified as Ta;

2. malignant melanoma skin Cancer that is less than or equal to 1.0 mm in thickness, unless it is ulcerated or is accompanied by lymph node or distant metastasis;

3. any non-melanoma skin Cancer, without lymph node or distant metastasis;

4. prostate Cancer classified as T1a or T1b, without lymph node or distant metastasis;

5. papillary thyroid Cancer or follicular thyroid Cancer, or both, that is less than or equal to 2.0 cm in greatest diameter and classified as T1, without lymph node or distant metastasis;

6. chronic lymphocytic leukemia classified less than Rai stage 1; or

7. malignant gastrointestinal stromal tumours (GIST) and malignant carcinoid tumours, classified less than AJCC Stage 2.

For purposes of the coverage, the terms Tis, Ta, T1a, T1b, T1 and AJCC Stage 2 are to be applied as defined in the American Joint Committee on Cancer (AJCC) cancer staging manual, 7th Edition, 2010.

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

Limitation for Category 1 Conditions
Once a benefit has become payable to an Insured person for Cancer (Life-Threatening), such person will not be covered under this Benefit for any future occurrences of Cancer (Life-Threatening).

No claim will become payable for any condition in Category 1 if it:

1. is subject to the *Pre-existing Condition Limitation* as defined in this Policy

2. was caused or contributed to by any illness, disease, naturally occurring condition, degenerative process, physical trauma, or surgery that the Insured person had symptoms or signs of, or had already been diagnosed with and made a successful claim for under this or any other prior policy issued by us or a prior carrier to the Group Policyholder

3. was caused or contributed to by any illness, disease, naturally occurring condition, degenerative process, physical trauma, or surgery in Categories 2, 3 or 4.

Category 2 Conditions:

Aortic surgery
is defined as the undergoing of surgery for disease of the aorta requiring excision and surgical replacement of any part of the diseased aorta with a graft. Aorta means the thoracic and abdominal aorta but not its branches.

The surgery must be determined to be medically necessary by a Specialist.

Exclusion:
No benefit will be payable under this condition for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

Coronary artery bypass surgery
is defined as the undergoing of heart surgery to correct narrowing or blockage of 1 or more coronary arteries with bypass graft(s). The surgery must be determined to be medically necessary by a Specialist.

Exclusion:
No benefit will be payable under this condition for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

Heart attack
is defined as a definite Diagnosis of the death of heart muscle due to obstruction of blood flow, that results in:

Rise and fall of biochemical cardiac markers to levels considered diagnostic of myocardial infarction, with at least 1 of the following:

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

The Diagnosis of Heart attack must be made by a Specialist.

Exclusion:
No benefit will be payable under this condition for:

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

Heart valve replacement or repair
is defined as the undergoing of surgery to replace any heart valve with either a natural or mechanical valve or to repair heart valve defects or abnormalities. The surgery must be determined to be medically necessary by a Specialist.

Exclusion:
No benefit will be payable under this condition for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

Stroke (Cerebrovascular Accident)
is defined as a definite Diagnosis of an acute cerebrovascular event caused by intra-cranial thrombosis or haemorrhage, or embolism from an extra-cranial source, with:

1. acute onset of new neurological symptoms, and
2. new objective neurological deficits on clinical examination,

persisting for more than 30 days following the date of Diagnosis. These new symptoms and deficits must be corroborated by diagnostic imaging testing. The Diagnosis of Stroke must be made by a Specialist.

Exclusion:
No benefit will be payable under this condition for:

1. Transient Ischaemic Attacks; or,
2. Intracerebral vascular events due to trauma; or,
3. Lacunar infarcts which do not meet the definition of Stroke as described above.

Limitation for Category 2 Conditions
Once a benefit has become payable for a condition covered under Category 2, the Insured person will not be covered under this Benefit for any future conditions specified under Category 2.

No claim will become payable for any condition in Category 2 if it:

1. is subject to the *Pre-existing Condition Limitation* as defined in this Policy
2. was caused or contributed to by any illness, disease, naturally occurring condition, degenerative process, physical trauma, or surgery that the Insured person had symptoms or signs of, or had already been diagnosed with and made a successful claim for under this or any other prior policy issued by us or a prior carrier to the Group Policyholder]
3. was caused or contributed to by any illness, disease, naturally occurring condition, degenerative process, physical trauma, or surgery in Categories 1, 3 or 4.

Category 3 Conditions:

Blindness
is defined as a definite Diagnosis of the total and irreversible loss of vision in both eyes, evidenced by:

1. the corrected visual acuity being 20/200 or less in both eyes; or,
2. the field of vision being less than 20 degrees in both eyes.

The Diagnosis of Blindness must be made by a Specialist.

Deafness
is defined as a definite Diagnosis of the total and irreversible loss of hearing in both ears, with an auditory threshold of 90 decibels or greater within the speech threshold of 500 to 3,000 hertz. The Diagnosis of Deafness must be made by a Specialist.

Loss of limbs
is defined as a definite Diagnosis of the complete severance of 2 or more limbs at or above the wrist or ankle joint as the result of an accident or medically required amputation. The Diagnosis of Loss of limbs must be made by a Specialist.

Loss of speech
is defined as a definite Diagnosis of the total and irreversible loss of the ability to speak as the result of physical injury or disease, for a period of at least 180 days. The Diagnosis of Loss of speech must be made by a Specialist.

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

Occupational HIV infection
is defined as a definite Diagnosis of infection with Human Immunodeficiency Virus (HIV) resulting from accidental injury during the course of the Insured person's normal occupation, which exposed the person to HIV contaminated body fluids.

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

Payment under this condition requires satisfaction of all of the following:

1. the accidental injury must be reported to us within 14 days of the accidental injury;

2. a serum HIV test must be taken within 14 days of the accidental injury and the result must be negative;

3. a serum HIV test must be taken between 90 days and 180 days after the accidental injury and the result must be positive;

4. all HIV tests must be performed by a duly licensed laboratory in Canada or the United States of America;

5. the accidental injury must have been reported, investigated and documented in accordance with current Canadian or United States of America workplace guidelines.

The Diagnosis of Occupational HIV infection must be made by a Specialist.

Exclusion:
No benefit will be payable under this condition if:

1. the Insured person has elected not to take any available licensed vaccine offering protection against HIV; or,

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

3. HIV infection has occurred as a result of non-accidental injury including, but not limited to, sexual transmission and intravenous (IV) drug use.

Severe burns
is defined as a definite Diagnosis of third-degree burns over at least 20% of the body surface. The Diagnosis of Severe burns must be made by a Specialist.

Limitation for Category 3 Conditions
Once a benefit has become payable for a condition covered under Category 3, the Insured person will not be covered under this Benefit for any future conditions specified under Category 3.

No claim will become payable for any condition in Category 3 if it:

1. is subject to the *Pre-existing Condition Limitation* as defined in this Policy

2. was caused or contributed to by any illness, disease, naturally occurring condition, degenerative process, physical trauma, or surgery that the Insured person had symptoms or signs of, or had already been diagnosed with and made a successful claim for under this or any other prior policy issued by us or a prior carrier to the Group Policyholder

3. was caused or contributed to by any illness, disease, naturally occurring condition, degenerative process, physical trauma, or surgery in Categories 1, 2 or 4.

Category 4 Conditions:

Benign brain tumour
is defined as a definite Diagnosis of a non-malignant tumour located in the cranial vault and limited to the brain, meninges, cranial nerves or pituitary gland. The tumour must require surgical or radiation treatment or cause irreversible objective neurological deficit(s). The Diagnosis of Benign brain tumour must be made by a Specialist.

Exclusion:
No benefit will be payable under this condition if, within the first 90 days following the later of, the effective date of the coverage or the date of last reinstatement of the coverage, the Insured person has any of the following:

1. signs, symptoms –investigations, referrals or medical consultations that lead to a Diagnosis of Benign brain tumour (covered or excluded under the Policy), regardless of when the Diagnosis is made; or
2. a Diagnosis of Benign brain tumour (covered or excluded under the Policy).

Medical information about the Diagnosis and any signs, symptoms, investigations or medical consultations leading to the Diagnosis must be reported to us within 6 months of the date of the Diagnosis. If this information is not provided within this period, we have the right to deny any claim for Benign brain tumour or, any critical illness caused by any Benign brain tumour or its treatment.

No benefit will be payable under this condition for pituitary adenomas less than 10 mm.

Coma
is defined as a definite Diagnosis of a state of unconsciousness with no reaction to external stimuli or response to internal needs for a continuous period of at least 96 hours, and for which period the Glasgow coma score must be 4 or less. The Diagnosis of Coma must be made by a Specialist.

Exclusion:
No benefit will be payable under this condition for:

1. a medically induced Coma; or,
2. a Coma which results directly from alcohol or drug use; or,
3. a Diagnosis of brain death.

Dementia, including Alzheimer's disease
is defined as a definite Diagnosis of Dementia, which must be characterized by a progressive deterioration of memory and at least 1 of the following areas of cognitive function:

1. aphasia (a disorder of speech);
2. apraxia (difficulty performing familiar tasks);
3. agnosia (difficulty recognizing objects); or
4. disturbance in executive functioning (e.g. inability to think abstractly and to plan, initiate, sequence, monitor, and stop complex behaviour), which is affecting daily life.

The Insured person must exhibit:

1. Dementia of at least moderate severity, which must be evidenced by a Mini Mental State Exam of 20/30 or less, or equivalent score on another generally medically accepted test or tests of cognitive function; and
2. evidence of progressive worsening in cognitive and daily functioning either by serial cognitive tests or by history over at least a 6 month period.

The Diagnosis of Dementia must be made by a Specialist.

Exclusion:
No benefit will be payable under this condition for affective or schizophrenic disorders, or delirium.

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

Kidney failure
is defined as a definite Diagnosis of chronic irreversible failure of both kidneys to function, as a result of which regular haemodialysis, peritoneal dialysis or renal transplantation is initiated. The Diagnosis of Kidney failure must be made by a Specialist.

Loss of independent existence
is defined as a definite Diagnosis of the total inability to perform, by oneself, at least 2 of the following 6 Activities of Daily Living for a continuous period of at least 90 days with no reasonable chance of recovery. The Diagnosis of Loss of independent existence must be made by a Specialist.

Activities of Daily Living are:

1. bathing – the ability to wash oneself in a bathtub, shower or by sponge bath, with or without the aid of assistive devices;
2. dressing – the ability to put on and remove necessary clothing, braces, artificial limbs or other surgical appliances with or without the aid of assistive devices;

3. toileting – the ability to get on and off the toilet and maintain personal hygiene with or without the aid of assistive devices;

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

5. transferring – the ability to move in and out of a bed, chair or wheelchair, with or without the aid of assistive devices; and

6. feeding – the ability to consume food or drink that already has been prepared and made available, with or without the use of assistive devices.

Major organ failure on waiting list
is defined as a definite Diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be medically necessary. To qualify under Major organ failure on waiting list, the Insured person must become enrolled as the recipient in a recognized transplant centre in Canada or the United States of America that performs the required form of transplant surgery. For the purposes of the Survival period, the date of Diagnosis is the date of the Insured person's enrolment in the transplant centre. The Diagnosis of the Major organ failure must be made by a Specialist.

Major organ transplant
is defined as a definite Diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be medically necessary. To qualify under Major organ transplant, the Insured person must undergo a transplantation procedure as the recipient of a heart, lung, liver, kidney or bone marrow, and limited to these entities. The Diagnosis of the Major organ failure must be made by a Specialist.

Motor neuron disease
is defined as a definite Diagnosis of 1 of the following: amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease), primary lateral sclerosis, progressive spinal muscular atrophy, progressive bulbar palsy, or pseudo bulbar palsy, and limited to these conditions. The Diagnosis of Motor neuron disease must be made by a Specialist.

Multiple sclerosis
is defined as a definite Diagnosis of at least 1 of the following:

1. 2 or more separate clinical attacks, confirmed by magnetic resonance imaging (MRI) of the nervous system, showing multiple lesions of demyelination; or,

2. well-defined neurological abnormalities lasting more than 6 months, confirmed by MRI imaging of the nervous system, showing multiple lesions of demyelination; or,

3. a single attack, confirmed by repeated MRI imaging of the nervous system, which shows multiple lesions of demyelination which have developed at intervals at least 1 month apart.

The Diagnosis of Multiple sclerosis must be made by a Specialist.

Paralysis
is defined as a definite Diagnosis of the total loss of muscle function of 2 or more limbs as a result of injury or disease to the nerve supply of those limbs, for a period of at least 90 days following the precipitating event. The Diagnosis of Paralysis must be made by a Specialist.

Parkinson's disease and Specified atypical parkinsonian disorders
is defined as a definite Diagnosis of primary Parkinson's disease, a permanent neurologic condition which must be characterized by bradykinesia (slowness of movement) and at least 1 of: muscular rigidity or rest tremor. The Insured person must exhibit objective signs of progressive deterioration in function for at least 1 year, for which the treating neurologist has recommended dopaminergic medication or other generally medically accepted equivalent treatment for Parkinson's disease.

Specified atypical parkinsonian disorders are defined as a definite Diagnosis of progressive supranuclear palsy, corticobasal degeneration, or multiple system atrophy.

The Diagnosis of Parkinson's disease or a Specified atypical parkinsonian disorder must be made by a neurologist.

Exclusions:
No benefit will be payable for Parkinson's disease or Specified atypical parkinsonian disorders if, within the first year following the later of, the effective date of the Policy, or the date of last reinstatement of the Policy, the Insured person has any of the following:

1. signs, symptoms or investigations that lead to a Diagnosis of Parkinson's disease, a Specified atypical parkinsonian disorder or any other type of parkinsonism, regardless of when the Diagnosis is made; or

2. a Diagnosis of Parkinson's disease, a Specified atypical parkinsonian disorder or any other type of parkinsonism.

Medical information about the Diagnosis and any signs, symptoms or investigations leading to the Diagnosis must be reported to us within 6 months of the date of the Diagnosis. If this information is not provided within this

period, we has the right to deny any claim for Parkinson's disease or Specified atypical parkinsonian disorders or, any critical illness caused by Parkinson's disease or Specified atypical parkinsonian disorders or its treatment.

No benefit will be payable under Parkinson's disease and Specified atypical parkinsonian disorders for any other type of parkinsonism.

Limitation for Category 4 Conditions

Once a benefit has become payable for a condition covered under Category 4, the Insured person will not be covered under this Benefit for any future conditions specified under Category 4.

No claim will become payable for any condition in Category 4 if it:

1. is subject to the *Pre-existing Condition Limitation* as defined in this Policy
2. was caused or contributed to by any illness, disease, naturally occurring condition, degenerative process, physical trauma, or surgery that the Insured person had symptoms or signs of, or had already been diagnosed with and made a successful claim for under this or any other prior policy issued by us or a prior carrier to the Group Policyholder
3. was caused or contributed to by any illness, disease, naturally occurring condition, degenerative process, physical trauma, or surgery in Categories 1, 2 or 3.

Pre-existing Condition Limitation

A Pre-existing condition means any sickness or injury, or any symptoms of a health condition, whether diagnosed or not, for which the Insured person:

1. exhibited either signs or symptoms
2. received treatment, care or services (including diagnostic measures);
3. has been prescribed medication;
4. consulted a Physician or was referred for a consultation,
5. was sustained or contracted, or
6. where treatment would have been sought by a prudent individual

during the 24 months period before your coverage, or any portion of your coverage, began.

This Policy does not provide a benefit or an increased amount of insurance for any Critical Illness caused by, contributed to by, or resulting from a Pre-existing condition with the following exceptions:

1. This exclusion will not apply to a Critical Illness which occurs more than 24 months after the effective date of:

   (a) the Benefit amount that the Insured person is eligible to receive when they first become insured, or

   (b) any additional Benefit amount that the Insured person becomes insured for at a later date due to a change in the Benefit amount provided by this Policy.

When a Critical Illness is claimed within 24 months of the effective date of this benefit, benefits may be payable to an employee who was insured by the prior carrier at the time of transfer and was actively at work and insured under this benefit on its effective date. Continuous time insured under both policies will be considered. The benefit will be determined according to this Policy's *Schedule of Benefits* but will not exceed the least of:

1. the employee's Benefit amount under this Policy, or
2. the prior carrier's maximum benefit, or
3. the non evidence limit amount under the prior carrier's policy, if the employee only qualified for that amount under the prior carrier's policy.

Exclusions

No benefit is payable for any condition resulting from, or related to, any of the following:

1. an accident, except as described under *Covered Critical Conditions*
2. war, whether declared or undeclared, or any act of war, or participation in a riot, insurrection, or civil commotion
3. committing or attempting to commit, directly or indirectly, a criminal offence
4. an injury that occurs when the Insured person is intoxicated with a blood alcohol level, which exceeds the legal limit in the jurisdiction where the injury occurs. This includes an injury sustained while driving any form of transportation including an automobile, truck, motorcycle, moped, bicycle, snowmobile or boat
5. an injury that occurs as a result of; underwater activities, (including but not limited to, scuba diving and snuba diving), hang gliding, parachuting, paragliding, motor vehicle race or speed competition on land and/or water, amateur or professional boxing, bungee jumping, B.A.S.E jumping, cliff diving, mountain climbing, back country skiing, off piste and/or heliskiing

6. the use, consumption, or ingestion of any addictive or intoxicating substances including, but not limited to drugs and alcohol
7. making or attempting to make an aerial flight as a pilot or a member of the aircraft crew or having any duties in connection with such a flight. Making or attempting to make a flight for the purpose of instruction, training or testing. Any intentional descent from an aircraft in flight
8. riding as a passenger, pilot, operator, or member of the crew on any aircraft owned, operated, or leased by the Policyholder, or an employer whose employees are eligible to be Insured persons under this Policy. This includes boarding or alighting from, being struck by, or making a forced landing with that aircraft
9. any condition due to or resulting, directly or indirectly, from self-inflicted injury or sickness, whether intentional or not intentional
10. active duty in the military forces of any nation or international organization, or in any civilian noncombatant unit, which serves with such forces in combat
11. services of any Physician who resides with, or is the Spouse, parent, brother, sister or child of the employee.

Extension of Coverage

If you cease to be actively at work due to an injury, sickness, or a critical illness, you will be considered to still be employed and eligible for continued coverage until the earliest of:

1. recovery from the condition, or
2. the termination of employment with your employer, or
3. the termination of this Policy, or
4. 1 year from the date last worked.

Conversion Option

You will be eligible to convert your critical illness insurance coverage to a personal critical illness policy issued by Blue Cross Life without having to answer any health questions. To qualify, you must be under age 65, and we must receive your application within 31 days of the date your employment terminates. This option does not apply to schedule reductions, or termination of coverage that becomes effective at a specified age.

The maximum coverage you can purchase will be the lesser of:

1. $100,000, or

2. the amount of group critical illness insurance you had with us, or

3. the difference between the amount of group critical illness insurance you had with us and the amount that is available through your new employer's group plan - provided you become insured within 31 days following the termination of your coverage under this policy.

You may purchase less than the maximum amount of critical illness insurance you are entitled to convert. However, you cannot apply for an amount which is lower than that for which Blue Cross Life customarily issues a policy.

Your premium will be based on the prevailing standard rate charged by Blue Cross Life on the date your personal policy is issued.

If your Spouse's critical illness insurance coverage ends or reduces for any reason other than at your request, they may purchase a conversion critical illness insurance policy.

Critical illness conversion is not available for your children.

Claim Procedure

To receive the Benefit amount, we must receive the claim within 1 year of the end of the Survival period.

Proof of claim must be provided on forms approved by us. We may require other information we consider necessary for the assessment of the claim. We may require consultation and/or treatment by a Physician specializing in the treatment of the condition.

Costs incurred in providing proof of claim are not eligible for reimbursement under this Policy.

Notes

PACIFIC BLUE CROSS®

Local	**604 419-2000**
Toll-free	**1 877 PAC-BLUE**
Website	**pac.bluecross.ca**

Mailing Address
PO Box 7000
Vancouver, BC V6B 4E1

Street Address
4250 Canada Way
Burnaby, BC V5G 4W6

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GROUP BENEFIT PLAN

Plan Member Booklet

All Other Eligible Employees

Parallel 49 Brewing Company & St. Augustine's Enterprises Ltd.

Group Plan #s **SCB1003**
SCB1004

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INTRODUCTION

The information in this booklet is important to you as a Plan Member and should be kept in a safe place known to you.

This booklet provides the information you need to know about the group coverage available to you through your Employer's group plan (the "**Plan**") with The Wawanesa Life Insurance Company ("**Wawanesa Life**").

This is a summary of the Plan; more details are contained in the group contract between your Employer as the Plan Sponsor and Wawanesa Life. Your Employer has retained Wawanesa Life to administer the Plan and provide claims adjudication expertise.

Your group coverage may be modified after this booklet is issued. The actual terms and conditions of coverage and benefits contained in the contract between your Employer and Wawanesa Life will always override any outdated information contained in your booklet.

In no event will the contract automatically be amended to increase coverage and cover benefits that are currently provided through the provincial health care system and which may, in the future, be de-listed, de-regulated, or reduced. Your Employer reserves the right to review such changes and determine whether such services will become a covered expense under the Plan.

Upon your request, Wawanesa Life will provide you with a copy of:

- your application for group coverage;
- your Health Questionnaire; and
- the group benefits plan (which is the group contract between your Employer and Wawanesa Life referenced above).

PROTECTING YOUR PRIVACY

Protecting your privacy and the confidentiality of your personal information is fundamental to the way we do business and is the responsibility of every employee of Wawanesa Life. We collect personal information to provide you with the services and benefits to which you are entitled as a Plan Member.

Wawanesa Life has a Personal Information Protection Policy that tells you about our commitment to ensuring that your personal information and privacy are protected. Our Policy complies with applicable privacy law. To obtain more information on our Policy and privacy practices, visit our website at www.wawanesalife.com or contact the:

Privacy Officer, The Wawanesa Life Insurance Company
236 Carlton St, Winnipeg, Manitoba, Canada, R3C 1P5
Email: privacy@wawanesa.com
Phone: 1-844-241-0226

PLAN SUMMARY

The following is a brief summary of your coverage provided through the Plan. More detailed information is contained in each benefit section and should be consulted for any applicable limitations, restrictions, or exclusions.

Eligibility Requirements

Waiting Period	6 months
Required Number of Hours	Minimum 30 hours per week

Waiver of Premium

Qualifying Period	112 days
Definition of Disability	Own occupation during the Qualifying Period plus the next 24 months and any occupation thereafter
Coverage Termination Age	When the Plan Member attains age 65 or retires, whichever comes first

Plan Member Short-Term Disability (STD) - SCB1003

Benefit Formula	66.7% of your weekly Earnings
Benefit Amount	The maximum amount available is $1,000 per week, rounded to the next higher $1
Taxable Status	Non-Taxable
Qualifying Period	0 days as a result of Hospitalization 0 days as a result of Injury 7 days as a result of Illness
Maximum Benefit Period	Benefits are payable up to a maximum period of 16 weeks
Coverage Termination Age	When the Plan Member attains age 70 or retires, whichever comes first

Plan Member Long-Term Disability (LTD) - SCB1004

Benefit Formula	66.7% of the first $2,250 of your monthly Earnings; plus 50% of the next $3,500 of your monthly Earnings; plus 44% of the balance of your monthly Earnings
Benefit Amount	The maximum amount available is $6,000 per month
Definition of Disability	Own occupation during the Qualifying Period plus the next 24 months and any occupation thereafter
Qualifying Period	112 days
Taxable Status	Non-Taxable
Cost-of-Living Adjustment	Not available under this Plan
Maximum Benefit Period	Up to age 65
Survivor Income Benefit	Not available under this Plan
Coverage Termination Age	When the Plan Member attains age 65 (minus the Qualifying Period) or retires, whichever comes first

ELIGIBILITY FOR COVERAGE

Employee

For you to become eligible as a Plan Member under the Plan, you must have coverage under a Provincial Health Plan. You are eligible for coverage:

a) on the effective date of the Plan if you satisfy the Waiting Period, and work for the Required Number of Hours, outlined in the Eligibility Requirements specified in the Plan Summary (the "**Eligibility Requirements**"); or
b) after the effective date of the Plan on the date you meet the Eligibility Requirements specified in the Plan Summary.

Application for Coverage

When you first apply for coverage:

- You must complete all applicable sections of the Group Enrollment Form and return it to your Employer. To be a Plan Member under the Plan, your application should be signed no later than 31 days after the completion of your Waiting Period and received by Wawanesa Life within 45 days of the completion of your Waiting Period. Group Enrollment Forms signed or received after these dates will be considered Late Applications and will require you to submit Medical Evidence. Your acceptance into the Plan is based on the health information provided, is subject to the terms and conditions contained in the group contract between your Employer and Wawanesa Life, and is not guaranteed.

Beneficiaries you designated under a prior plan have not been transferred to this Plan.

Beneficiary designations in respect of Quebec Residents only:

a) Your designation, in a form of writing other than a will, of your married or civil union spouse as Beneficiary cannot be changed, unless otherwise stipulated. The designation of any other person as beneficiary can be changed unless otherwise stipulated in a separate form of writing other than a will;
b) Designations and revocations are valid only from the day Wawanesa Life is advised of such changes in writing. Where several irrevocable designations of Beneficiaries are made separately and at different times, they are given priority according to their dates of receipt by Wawanesa Life. Wawanesa Life is discharged by payment in good faith in accordance with these rules to the last known person entitled to it;
c) Separation from bed and board does not affect the rights of your spouse; and
d) Divorce or nullity of marriage or the dissolution or nullity of a civil union causes any designation of your spouse to lapse.

Coverage Effective Date

You must first complete a period of continuous active employment with your Employer before your coverage becomes effective. This period of time is known as your Waiting Period and it must be satisfied before you can be considered eligible for coverage. Refer to the Plan Summary for information on your Waiting Period.

When you complete your Group Enrollment Form:

a) during the Waiting Period, your coverage will become effective when the Waiting Period has been satisfied;
b) within 31 days after you have satisfied the Waiting Period and become eligible for coverage, your coverage will become effective on the day you sign the form provided such signed form is delivered to Wawanesa Life within 45 days of the completion of your Waiting Period; and
c) more than 31 days after you first become eligible for coverage, you will be required to submit Medical Evidence. Wawanesa Life will review this information and determine if you are eligible for coverage. If your enrollment is approved, your coverage is effective on the day Wawanesa Life gives its approval.

If you are away from work because of Illness or Injury on the day that your coverage should be effective, or the day when an increase in your coverage should take effect, your coverage effective date or increased coverage effective date will be delayed until you return to work for 1 full day.

Coverage Termination

Your coverage will end on the earliest of:

a) the date you are no longer an Employee;
b) the date you no longer have Provincial Health Plan coverage;
c) the date you are no longer eligible for coverage under an eligible Class;
d) the date you are no longer working the Required Number of Hours (as specified in the Plan Summary);
e) the date you cease to be Actively at Work, unless the Termination of Coverage Exceptions apply;
f) the date your Employer terminates your coverage;
g) the date you enter active service with the armed forces of any country;
h) the date the Plan terminates, or the date coverage terminates for an eligible Class to which you belong;
i) the date you reach the Coverage Termination Age, as specified under each coverage in the Plan Summary;
j) the date you retire; or
k) the date you die.

Termination of Coverage Exceptions

Coverage for you may be continued for a period of time if you are absent from work. The following examples describe in general terms when coverage may be continued. You should confirm with your Plan Administrator the specific details of your absence from work and its effect on your continued eligibility for coverage, which is generally subject to the terms and conditions of the group contract between your Employer and Wawanesa Life.

- **Due to Illness or Injury**

  If you are absent from work because you are Ill or Injured, coverage, excluding Disability, can continue on a premium-paying basis for up to 24 months. Some of your benefits may be continued without premium if you submit a Waiver of Premium claim prior to the filing deadline and the claim is approved by Wawanesa Life.

- **Due to Maternity, Parental, or Compassionate Care Leave of Absence**

  If you are absent from work because of a Maternity Leave of Absence, Parental Leave of Absence, or Compassionate Care Leave of Absence, all coverage can continue for the leave period according to the legislation in your province of residence.

- **Due to Other Leave of Absence or Temporary Lay-off**

  If you are absent from work due to an Other Leave of Absence or Temporary Lay-off, coverage, excluding Disability, can continue for up to 120 days after your last day of work.

- **Legislated Coverage Extension**

  When legislation mandates that coverage under the Plan must continue for a limited period after your employment terminates, Wawanesa Life will extend coverage for the minimum period required by law, provided that:

  a) your Employer continues your coverage without interruption and pays all the premium for the extension of coverage period; and
  b) the group contract between your Employer and Wawanesa Life remains in force.

Plan Members in Quebec

If you are a resident of the Province of Quebec, meeting all residency criteria as outlined by the Quebec Government (a "**Quebec Resident**"), and any applicable laws declared by the Province of Quebec impose mandatory minimum entitlements in connection with any of the benefits provided by the Plan to Quebec Residents, including any minimum entitlements provided by the Civil Code of Quebec, CQLR, c. CCQ-1991, the Act respecting Prescription Drug Insurance, CQLR c. A-29.01 and its regulations, and the Regulation under the Act respecting Insurance, CQLR, c. A-32.1, r.1, the benefits provided by this Plan will, only in relation to Quebec Residents, meet the minimum entitlements allowed by such applicable laws. If this Plan allows benefits greater than the mandatory minimum entitlements, Quebec Residents will receive the superior entitlements allowed under this Plan.

MAKING A CLAIM

Forms and Submission

Claims may be submitted using a paper claim form. You can access claim forms on the Wawanesa Life website at www.wawanesalife.com. Select the Group Tab, then the Group Forms section to find the appropriate form. Once completed, the claim form and required information indicated on the 2nd page of the form must be submitted to Wawanesa Life for processing. Incomplete claim submissions may result in the request for additional information and delay the payment of your claim.

Making a claim for Disability Benefits or Waiver of Premium Benefits will require 3 separate forms to be completed by you, your Employer, and your Physician. Wawanesa Life must receive all medical information in order to assess your claim for Disability Benefits or Waiver of Premium Benefits.

Proof of Claim

Wawanesa Life will require proof of your claim. Obtaining proof will be at your expense. The proof required will depend on the circumstances and context of your claim, including type of claim. Some examples of proof are:

a) receipts or bills;
b) medical or dental reports;
c) x-rays; and
d) prescriptions.

Recovery of Claim Amounts from a Third Party

Where coverage exists for Plan Member Short-Term Disability and Plan Member Long-Term Disability Benefits under the Plan and under a third-party plan, Wawanesa Life may pay you benefits eligible under the Plan while the entitlement for third-party benefits is being concluded by the third party, if you enter into a reimbursement agreement with Wawanesa Life thereby agreeing to:

a) take all steps necessary to receive from the third-party plan benefits for which you are entitled; and
b) repay Wawanesa Life the amount received from the third-party plan for these same benefits.

Wawanesa Life reserves the right to pursue recovery directly from third parties on your behalf.

Claim Exclusions

No benefit will be paid under the Plan for claims arising directly or indirectly from, as a result of, or in connection with:

a) charges for a missed, late, or cancelled appointment;
b) charges for the completion of forms;
c) expenses considered to be facility fees, service fees, block fees, or tray fees;
d) treatment or care for cosmetic purposes;
e) experimental treatment or care;
f) expenses incurred for ordinary living expenses such as room, board, travel, or clothing;
g) services performed by a person ordinarily resident in the home of the Plan Member or related to the Plan Member by birth or marriage;
h) the committing of or an attempt to commit an offence under the *Criminal Code* (Canada), RSC 1985, C-46, as amended, or under the criminal laws of any other jurisdiction (where the events giving rise to the claim occurred in such other jurisdiction), whether or not the Plan Member is charged for or convicted of an offense;
i) use of any prohibited or controlled substance, any substances listed under the *Controlled Drugs and Substances Act* (Canada), SC 1996, c 19, as amended including all Schedules or any substance listed under comparable legislation in another jurisdiction if such use occurred in that jurisdiction, unless taken as prescribed by a licensed Physician;
j) an accident, deemed to be a criminal offence under the *Criminal Code* (Canada), RSC 1985, C-46, as amended, or under the criminal laws of any other jurisdiction, occurring while the Plan Member was operating a Vehicle, Off-road Vehicle, vessel, or aircraft while the Plan Member was under the influence of:
    i) any prohibited or controlled substance;
    ii) cannabis; or
    iii) any intoxicant where the Plan Member's blood contained more than 80 milligrams of alcohol per 100 milliliters of blood at the time of the accident;
k) war, insurrection, the hostile actions of any armed forces, or participation in a riot or civil commotion, whether the Plan Member is an active or passive participant; or
l) medical or surgical care which is not Medically Necessary, except when attributable to an Illness or Injury.

Refer to the benefit sections of this booklet for additional exclusions (together with the claim exclusions listed above, the "**Claim Exclusions**"). These Claim Exclusions do not apply to the Plan Member Short-Term Disability Benefit.

Claim Submission Deadlines

Claims received outside the time frames specified under this Claim Submission Deadlines section will be denied.

Claim forms and proof that benefits are payable must be submitted by you or on your behalf and received by Wawanesa Life at its Executive Office as follows:

a) for a Plan Member Short-Term Disability claim, within 30 days from the end of the Qualifying Period; and
b) for a Plan Member Long-Term Disability claim or a Waiver of Premium claim, within 180 days from the end of the Qualifying Period.

If your coverage terminates due to termination of a benefit provision or termination of the Plan and is replaced by another insurer within 31 days of the termination date, a claim for a loss that occurred prior to the Plan's termination date may be submitted up to 6 months from the date of termination for loss of income due to Disability.

Legal Action

Subject to the terms and conditions of the group contract between your Employer and Wawanesa Life, every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the insurance legislation applicable to your province of residence.

WAIVER OF PREMIUM

Waiver of Premium may be applicable to Plan Member Long-Term Disability benefits, if covered under the Plan.

Wawanesa Life will only assess your request for Waiver of Premium when all of the following conditions are met:

a) you are covered for Waiver of Premium on the date you are Disabled;
b) you are Disabled as defined under this Benefit and remain so throughout the Long-Term Disability Qualifying Period; and
c) your Employer continues to pay the premium for you throughout the Long-Term Disability Qualifying Period.

Premiums for Long-Term Disability coverage are waived only during the period when you receive Long-Term Disability Benefits under the Plan.

In order to be considered for the Waiver of Premium Benefit you must satisfy the Definition of Disability specified in the Plan Summary.

The availability of work will not be considered by Wawanesa Life in assessing your Disability.

If you must hold a government permit or license to perform your duties, you will not be considered Disabled solely because such permit or license has been withdrawn, cancelled, suspended, or not renewed.

Termination of Waiver of Premium

The Waiver of Premium will cease to apply and will terminate on the earliest of:

a) the date you no longer meet the Definition of Disability specified in the Plan Summary;
b) the date you do not supply Wawanesa Life with appropriate Medical Evidence documenting that your Illness or Injury continues and that you remain Disabled;
c) the date you no longer receive from a Physician regular, ongoing care, and treatment appropriate for the disabling condition, as determined by Wawanesa Life;
d) the date you do not attend an Independent Assessment by an examiner selected by Wawanesa Life;
e) the date you work in any occupation for earnings or profit;
f) the date you reach the Coverage Termination Age specified under Waiver of Premium in the Plan Summary; or
g) the date you die.

PLAN MEMBER SHORT-TERM DISABILITY

Your Plan Member Short-Term Disability coverage is designed to provide you with income protection if you become Disabled while covered under the Plan.

You may become eligible for Plan Member Short-Term Disability Benefits after satisfying the Qualifying Period specified in the Plan Summary. The Qualifying Period is the amount of time that you are absent from work due to an Injury or Illness before you can be considered eligible for benefits.

"**Disability**" or "**Disabled**" is the restriction or lack of ability due to an Illness or Injury, which prevents you from performing the essential duties of your own occupation. A particular condition will only qualify as an Injury under this definition if it arises within 30 days after the Accident which causes the condition. If the condition does not arise within that time frame, it will be considered an Illness.

The availability of work will not be considered by Wawanesa Life in assessing your Disability.

If you must hold a government permit or license to perform your duties, you will not be considered Disabled solely because such permit or license has been withdrawn, cancelled, suspended, or not renewed.

In order to receive benefits:

a) you must be covered for this Benefit on the date of Disability;
b) you must be Disabled as defined under this Benefit and remain so throughout the Qualifying Period and the Maximum Benefit Period (as specified in the Plan Summary);
c) you must suffer a total loss of Earnings from your Employer; and
d) Wawanesa Life must receive Plan Member Short-Term Disability premium for you throughout the Qualifying Period (as specified in the Plan Summary).

Your Plan Member Short-Term Disability Benefit payment will be reduced by any income you receive or are entitled to receive from the following sources:

a) any motor vehicle insurance plan or policy which provides Disability Benefits, as long as any benefits payable under the Employment Insurance Act are not considered when determining the amount of benefits payable under this Plan or policy, and as long as such deduction is not prohibited by law;
b) earnings received from any Employer, including severance earnings and any vacation pay you accrue during any period of Disability;
c) Employer-sponsored salary continuance or wage loss replacement plan; and
d) Canada Pension Plan, Quebec Pension Plan, or similar government plan benefits that are considered earnings per section 35 of the Employment Insurance Regulation.

Wawanesa Life may offer the Rehabilitative Return-to-Work Plan to assist you in returning to gainful employment. In considering whether a Rehabilitative Return-to-Work Plan is appropriate for you, Wawanesa Life will consider:

a) the nature, extent, and expected duration of your Disability;
b) your education, training, or experience; and
c) the nature, scope, and objectives of the Rehabilitative Return-to-Work Plan.

If you are not available, do not cooperate, or do not participate in the prescribed Rehabilitative Return-to-Work Plan you will not receive Disability Benefits.

You may continue to receive benefits for the Maximum Benefit Period as long as you are Disabled and under the care of a Physician.

When Benefit Payments Stop

Your benefit payments will be stopped for any period that you:

a) are not receiving from a Physician Reasonable and Customary and ongoing care and treatment appropriate for the disabling condition, as determined by Wawanesa Life;
b) are receiving maternity, parental, or compassionate care benefits from an Employment Insurance program or a provincial program providing similar benefits;
c) suffer an Illness or Injury during Lay-off;
d) are on leave of absence during which you become Disabled, unless your Employer is required to pay benefits during this period as a result of legislation;
e) are Disabled and then take an approved leave of absence, unless your Employer is required to pay benefits during this period as a result of legislation; or
f) are incarcerated in a prison, correctional facility, or psychiatric hospital by order of authority of a criminal court.

Termination of Plan Member Short-Term Disability Payments

Your benefit payments will terminate on the earliest of:

a) the date you cease to meet the Benefit definition of Disabled;
b) the date on which benefits have been paid up to the Maximum Benefit Period specified in the Plan Summary; or
c) the date you die.

If none of the above apply and you have received 26 weeks of benefit, Disability Benefit payments will stop the date you reach the Coverage Termination Age specified in the Plan Summary.

Recurrent Disability

If you return to work for less than 2 weeks and become Disabled again due to the same or related Illness or Injury, Wawanesa Life will waive the Qualifying Period. This recurrence will be considered a continuation of the same Disability, and benefits will be based on your earnings when you first became Disabled. Benefits for all recurrences will not be paid for a combined period that is longer than the Maximum Benefit Period specified in the Plan Summary.

Exclusions

No amount will be payable under this Short-Term Disability Benefit for:

a) any Disability resulting from any Illness or Injury for which Workers Compensation benefits are payable;
b) treatment or care for cosmetic purposes, except when directly attributable to an Illness or Injury;
c) the committing of or an attempt to commit an offence under the *Criminal Code* (Canada), RSC 1985, C-46, as amended, or under the criminal laws of any other jurisdiction (where the events giving rise to the claim occurred in such other jurisdiction);
d) use of any prohibited or controlled substance, any substances listed under the *Controlled Drugs and Substances Act* (Canada), SC 1996, c 19, as amended including all Schedules or any substance listed under comparable legislation in another jurisdiction if such use occurred in that jurisdiction, unless taken as prescribed by a licensed Physician, if receiving treatment for drugs or alcohol abuse;
e) an accident, deemed to be a criminal offence under the *Criminal Code* (Canada), RSC 1985, C-46, as amended, or under the criminal laws of any other jurisdiction, occurring while you were operating a Vehicle, Off-road Vehicle, vessel, or aircraft while you were under the influence of:
    i) any prohibited or controlled substance;
    ii) cannabis; or
    iii) any intoxicant where your blood contained more than 80 milligrams of alcohol per 100 milliliters of blood at the time of the accident;
f) war, insurrection, or the hostile actions of any armed forces or participation in a riot or civil commotion, whether you are an active or passive participant;
g) any period you are working in any occupation for earnings or profit except as provided under the Rehabilitative Return-to-Work Plan;
h) any period you fail or refuse to participate or cooperate in a prescribed Return-to-Work Plan;
i) any period you are not supplying Wawanesa Life with satisfactory Medical Evidence documenting how your Illness or Injury causes restrictions or lack of ability, such that you are prevented from performing the essential duties of your own occupation; or
j) any period you are not attending or refuses to attend an Independent Assessment by an examiner selected by Wawanesa Life.

Benefit Tax Status

If you pay the premium for your Plan Member Short-Term Disability coverage, any benefit you receive will be provided on a tax-free basis.

If your Employer pays any part of your premium for your Plan Member Short-Term Disability coverage, any benefit you receive will be taxable income to you.

PLAN MEMBER LONG-TERM DISABILITY

Your Plan Member Long-Term Disability coverage is designed to provide you with income protection if you become Disabled while covered under the Plan.

You may become eligible for Plan Member Long-Term Disability Benefits after satisfying the Qualifying Period specified in the Plan Summary. The Qualifying Period is the amount of time that you are absent from work due to an Injury or Illness before you can be considered eligible for benefits.

"**Disability**" or "**Disabled**" means that solely because of an Illness or Injury, you are unable to work at your own occupation during the qualifying period and the next 24 months. Thereafter, Disability means that you are unable to work at any occupation that you may qualify for because of your training, education, or experience.

The availability of work will not be considered by Wawanesa Life in assessing your Disability.

If you must hold a government permit or license to perform your duties, you will not be considered Disabled solely because such permit or license has been withdrawn, cancelled, suspended, or not renewed.

A particular condition will only qualify as an Injury under this definition of Disability or Disabled if it arises within 30 days after the Accident which causes the condition. If the condition does not arise within that time frame, it will be considered an Illness.

In order to receive benefits:

a) you must be covered for this Benefit on the date of Disability;
b) you must be Disabled as defined under this Benefit and remain so throughout the Qualifying Period and the Maximum Benefit Period (as specified in the Plan Summary);
c) you must suffer a total loss of Earnings from your Employer; and
d) Wawanesa Life must receive Plan Member Long-Term Disability premium for you throughout the Qualifying Period (as specified in the Plan Summary).

Your Plan Member Long-Term Disability Benefit payment will be reduced by any income you receive or are entitled to receive from:

a) Workers Compensation or similar coverage, excluding automatic cost-of-living increases that occur after the benefit becomes payable under the Plan;
b) Canada Pension Plan, Quebec Pension Plan, or similar government plans, excluding dependent benefits and automatic cost-of-living increases that occur after the benefits begin;
c) any vacation pay you accrue during any period of Disability; and
d) any motor vehicle insurance plan or policy, unless prohibited by law.

Your Plan Member Long-Term Disability Benefit payment will be further reduced so that your total income from All Sources (as defined below) does not exceed 85% of your pre-disability earnings if this Benefit is taxable, or 85% of your pre-disability earnings after income tax and statutory deductions if this Benefit is non-taxable.

"**All Sources**" include those stated above and any benefit you are entitled to receive from:

a) any group, association, or franchise plan;
b) any retirement or pension plan;
c) earnings or payments from any Employer such as salary, severance payments, or vacation pay;
d) self-employment; and
e) any other government plan.

Partial Disability Plan

Once Wawanesa Life determines you are Disabled, where appropriate and at Wawanesa Life's discretion, you may be required to participate in a partial disability return-to-work plan to assist you in returning to pre-disability occupation for a reduced number of hours per week (a "**Partial Disability Plan**"). Wawanesa Life is under no obligation to approve or continue the Partial Disability Plan for you. The decision to approve or discontinue the Partial Disability Plan will be made solely by Wawanesa Life.

During the Partial Disability Plan, you may receive regular salary from your Employer for any hours worked plus Plan Member Long-Term Disability Benefits. Plan Member Long-Term Disability Benefits will be reduced by the percentage of your normal work week represented by the Partial Disability Plan.

If you are not available, do not cooperate, or do not participate in the prescribed Partial Disability Plan, you will not receive Plan Member Long-Term Disability Benefits.

If you no longer participate in the Partial Disability Plan, evidence satisfactory to Wawanesa Life documenting why you cannot participate in the Partial Disability Plan will be required.

Your participation in the Partial Disability Plan will be limited to your own occupation period, as specified in the definition of Disability.

Rehabilitative Return-to-Work Plan

Once Wawanesa Life determines you are Disabled, where appropriate and at Wawanesa Life's discretion, you may be required to participate in a plan, designed by Wawanesa Life acting reasonably (for the purposes of this Plan Member Long-Term Disability Benefit, the "**Rehabilitative Return-to-Work Plan**") to assist you in returning to gainful employment. In considering whether a Rehabilitative Return-to-Work Plan is appropriate for you, Wawanesa Life will consider:

a) the nature, extent, and expected duration of your Disability;
b) your education, training, or experience; and
c) the nature, scope, and objectives of the Rehabilitative Return-to-Work Plan.

If you are not available or do not cooperate or participate in Wawanesa Life's recommended rehabilitation activities, you will no longer be entitled to Plan Member Long-Term Disability Benefits.

You may continue to receive benefits for the Maximum Benefit Period as long as you are Disabled and under the care of a Physician. If your Plan Member Long-Term Disability Benefit would otherwise terminate because your Employer terminates the group benefits plan with Wawanesa Life and you are still Disabled, your benefit payment may continue to the end of the Maximum Benefit Period specified in the Plan Summary but will not continue past the Coverage Termination Age specified in the Plan Summary. You must continue to be Disabled to the end of the Maximum Benefit Period.

When Benefit Payments Stop

Your benefit payments will stop for any period that you:

a) are not receiving from a Physician Reasonable and Customary and ongoing care and treatment appropriate for the disabling condition, as determined by Wawanesa Life;
b) are on Lay-off and the date of Disability is within 2 months of the notice period;
c) are on leave of absence during which you become Disabled, unless your Employer is required to pay benefits during this period as a result of legislation;
d) are Disabled and then take an approved leave of absence, unless your Employer is required to pay benefits during this period as a result of legislation; or
e) are incarcerated in a prison, correctional facility, or psychiatric hospital by order of authority of a criminal court.

Termination of Plan Member Long-Term Disability Benefit Payments

Your benefit payments will terminate on the earliest of:

a) the date you cease to meet the Benefit definition of Disabled;
b) the date you work in any occupation for earnings or profit, except as provided under the Partial Disability Plan or the Rehabilitative Return-to-Work Plan;
c) the date you fail or refuse to participate or cooperate in a prescribed Partial Disability Plan or a prescribed Rehabilitative Return-to-Work Plan;
d) the date you do not supply Wawanesa Life with appropriate Medical Evidence documenting how your Illness or Injury causes restrictions or lack of ability, such that you remain Disabled as defined in the Benefit;
e) the date you do not attend an Independent Assessment by an examiner selected by Wawanesa Life;
f) the date on which benefits have been paid up to the Maximum Benefit Period specified in the Plan Summary;
g) the date you reach the Coverage Termination Age specified in the Plan Summary; or
h) the date you die.

Recurrent Disability

If you return to work for less than 6 months and become Disabled again due to the same or related Illness or Injury, Wawanesa Life will waive the Qualifying Period. This recurrence will be considered a continuation of the same Disability and benefits will be based on your earnings when you first became Disabled. Benefits for all recurrences will not be paid for a combined period that is longer than the Maximum Benefit Period specified in the Plan Summary.

A Disability due to causes unrelated to the previous Disability is considered separate if:

a) benefit approval has ceased or benefit payments have stopped for the previous Disability; and
b) you have returned to work for at least 1 full day.

Pre-existing Plan Member Long-Term Disability Exclusion

In addition to the Claim Exclusions listed in the “Making a Claim” section in this booklet, no amount will be payable under this Plan Member Long-Term Disability Benefit for any Disability directly or indirectly related to a Pre-existing Condition which causes Disability within the first 12 months of coverage under the Benefit. A Pre-existing Condition for the purposes of this Pre-existing Plan Member Long-Term Disability Exclusion provision is any Injury or Illness (whether diagnosed or not) for which you were treated or attended to by a Physician, or for which drugs were prescribed, within 90 days prior to the date your coverage under the Benefit became effective.

Benefit Tax Status

If you pay the premium for your Plan Member Long-Term Disability coverage, any benefit you receive will be provided on a tax-free basis.

If your Employer pays any part of your premium for your Plan Member Long-Term Disability coverage, any benefit you receive will be taxable income to you.

WHEN YOU HAVE QUESTIONS

If you have any questions regarding your group plan, contact our Customer Service department at:

1-800-665-7076
www.wawanesalife.com

Notes:

GLOSSARY

Accident or Accidental Injury

An occurrence due to external, violent, sudden, or fortuitous causes beyond the control of the Plan Member.

Actively at Work or Active Work

At work for the Plan Sponsor on an active, permanent, Full-time Basis, Part-time Basis, or Seasonal Basis, and being able to perform all the usual and customary duties of your occupation at the location directed by the Plan Sponsor, provided that such location must be either:

a) the Plan Sponsor's usual place of business; or
b) at another location in Canada, including your home.

For greater certainty, under no circumstances will the following be "Actively at Work" or "Active Work":

a) any period of time during which you are performing temporary or contract employment;
b) any period of time where you are working less than the Required Number of Hours specified in the Plan Summary; or
c) any period of time during which you are absent from work due to Lay-off or strike.

Benefit Amount With Evidence

The maximum amount of coverage available to a Plan Member who has made an application for additional coverage, submitted Medical Evidence, and been approved for coverage by Wawanesa Life.

Benefit Amount Without Evidence

The maximum amount of coverage available to a Plan Member without making an application for additional coverage and without submitting Medical Evidence to Wawanesa Life.

Chronic Care

Care for medically diagnosed conditions where significant improvement or deterioration is unlikely within the next 12 months.

Clerical Error

A clerical error is an unintentional mistake in writing or copying data.

Compassionate Care Leave of Absence

The period of unpaid leave to which you are entitled as set out by legislation governing the Plan Sponsor to care for or support a critically ill family member who has a significant risk of death.

Consumer Price Index

The Consumer Price Index for Canada is published by the Government of Canada. It covers a 12-month period ending on September 30th of each year.

Convalescent Hospital

A part of a hospital, or a licensed institution with a transfer agreement with a hospital, which provides care and treatment during the recovery process of sick and injured persons as in-patients. The patient must be under the care and personal attendance of a Physician and confined to such convalescent hospital for recuperative purposes. The institution must also meet the following conditions:

a) The facility must provide the care, treatment, and rehabilitation for the patients on a continuous 24-hour basis with the assistance of Professional Nursing Services;
b) Charges for Ward care for the Plan Members are covered by the Provincial Insurance Plan; and
c) The facility must not be used primarily as a clinic or for Chronic Care.

The term Convalescent Hospital, as used in this Plan, will not include a rest home, nursing home, a home for the aged, a place for custodial care, or an institution used primarily for treatment of a specific illness or disease.

Diagnosis or Diagnosed

In respect of Plan Member Long-Term Disability, this is the identification of an Illness or Injury as confirmed in writing by a Physician. A diagnosis made outside of Canada must be confirmed in Canada.

Disability or Disabled

Unless a particular benefit section contains an alternative definition of “Disability” or “Disabled”, for the purposes of this Plan, Disability or Disabled will mean the restriction or lack of ability due to an Illness or Injury which prevents you from performing the essential duties of your own occupation or any occupation.

If a particular benefit section contains an alternative definition of “Disability” or “Disabled”, the specific definition of Disability or Disabled used in the provisions related to that benefit section will apply in the context of that benefit instead of the foregoing definition.

Earnings

Your regular annual earnings, which are reportable on your T4, paid by the Plan Sponsor and reported to Wawanesa Life, exclusive of bonuses, dividends, and overtime.

In the first 12 months of service, Earnings will be calculated as the average of regular monthly earnings which are reportable on your T4, paid by the Plan Sponsor and reported to Wawanesa Life, exclusive of bonuses, dividends, and overtime, over the available length of service with the Plan Sponsor.

Where you are paid commission, Earnings will be the average of earnings from the previous 24 months, which are reportable on your T4, paid by the Plan Sponsor and reported to Wawanesa Life, exclusive of bonuses, dividends, and overtime. If you are employed for less than 24 months, Earnings will be the average over the available length of service with the Plan Sponsor.

If your benefit under Plan Member Short-Term Disability is less than the benefit that would be payable under the Employment Insurance Act, Earnings will be increased by the amount of bonuses, overtime, or incentive pay, earned on a regular basis, required to calculate the amount of benefit payable under the Employment Insurance Act.

For the purposes of determining the amount of your benefit at the time of claim, your Earnings will be the lesser of:

a) the amount reported on the benefit claim form; or
b) the amount reported by the Plan Sponsor to Wawanesa Life and for which premiums have been paid.

Earnings after Statutory Deductions

The Earnings, less deductions normally made for Employment Insurance, Canada/Quebec Pension Plan, federal tax, and provincial income tax.

Employee

A person who:

a) is directly employed by the Employer on a permanent and Full-time, Part-time, or Seasonal basis;
b) is compensated for services by the Employer;
c) receives a yearly T4 tax slip for Earnings paid by the Employer;
d) has not been terminated from employment from the Employer; and
e) is residing in Canada.

Employer

The Plan Sponsor or any subsidiary or affiliated company of the Plan Sponsor which employs the Plan Member.

Experimental

Not approved or broadly accepted and recognized by the Canadian medical profession as an effective, appropriate, and essential treatment of an Illness or Injury, in accordance with Canadian medical standards.

Full-time Basis

A normal work schedule, working at least the minimum Required Number of Hours specified in the Plan Summary every week.

Hospital

A legally licensed institution operating under any federal or provincial health or insurance act whose primary purpose is the care and treatment of sick and injured persons as in-patients, and which:

a) is eligible to receive payments under a government hospital plan;
b) provides 24-hour nursing service by registered nurses, and has a Physician in regular attendance; and
c) is not a rehabilitation or convalescent hospital, rest home, nursing home, a home for the aged, a place for custodial care, or an institution used primarily for treatment of a specific illness or disease.

For the purpose of the Plan, the Chronic Care and convalescent beds of a Hospital are not considered to be part of the Hospital.

Hospitalization

Admittance to a Hospital as an in-patient.

With respect to the Plan Member Short-Term Disability Benefit under this Plan, Hospitalization also includes being admitted to a Hospital as an out-patient for Medically Necessary surgical procedures, chemotherapy, or laser treatment.

Illness or Disease or Sickness

An unhealthy condition of body or mind; being ill as a result of disease, sickness, malady, or ailment.

Immediate Family Member

A person who is a spouse, son, daughter, father, mother, brother, sister, grandmother, grandfather, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, or sister-in-law of the Plan Member.

In-Patient

A patient confined to a Hospital for more than 24 hours on the recommendation of a Physician.

Independent Assessment

Independent examinations, assessments, or tests performed by one or more Medical Practitioners or Paramedical Practitioners and includes without limitation medical assessments, psychological assessments, physical assessments, neuro-psychological evaluations, physiological assessments, functional-capacity assessments, psychometric assessments, and neuro-psychological testing.

Injury

A bodily injury resulting from an Accident, resulting directly and independently of all other causes.

Lay-off

A period during which you are laid off work and for which there is no fixed recall date.

Leave of Absence

A period of absence from work for which the dates are fixed by legislation or by mutual agreement between the Plan Sponsor and the Plan Member. Leave of Absence includes Maternity Leave of Absence, Parental Leave of Absence, and Compassionate Care Leave of Absence.

Licensed or Certified or Registered

The status of a person who legally engages in medical, paramedical, pharmaceutical, and dental practices by virtue of a legal license, certification, or registration issued by the appropriate authority, in the province, territory, state, or country where the service is provided.

In the case of paramedical service providers, if no such authority exists, the person must possess a level of education and a certificate of competency from the professional body which establishes standards of competency and conduct for such profession acceptable to Wawanesa Life.

Maternity Leave of Absence

The period of formal maternity leave to which an Employee is entitled by legislation governing the Employer.

For the purposes of the Plan, Maternity Leave of Absence will be deemed to commence on the earlier of:

a) the date fixed by mutual agreement between the Employee and the Employer; or
b) the date the child is born.

Medical Evidence

A health declaration, together with any required medical information, completed by the appropriate Employee on forms approved by Wawanesa Life. Medical information must be satisfactory to Wawanesa Life. Additional medical information may be required for Wawanesa Life to assess the eligibility for coverage.

Medical Practitioner

A Medical Practitioner is:

a) a person who is legally licensed to practice as a Pharmacist in the province, territory, state, or country where the service is provided;
b) a nurse who is legally licensed to practice as a Nurse Practitioner in the province, territory, state, or country where the service is provided;
c) a Doctor of Medicine who is legally licensed to practice medicine as a Physician in the province, territory, state, or country where the service is provided and who is registered by the College of Physicians and Surgeons in the province, territory, state, or country in which the person is practicing; or
d) a Doctor of Medicine who is legally licensed to practice a specialty of medicine as a Specialist in the province, territory, state, or country where the service is provided and who must be properly registered in accordance with applicable law in the appropriate governing body, or other regulatory agency, in the province, territory, state, or country in which the person is practicing.

The Medical Practitioner cannot be related to, or be, the Plan Sponsor or a Plan Member.

Medically Necessary

Broadly accepted and recognized by the Canadian medical profession as effective, appropriate, and essential in the treatment of an Illness or Injury, or for the maintenance of health, in accordance with generally accepted Canadian medical standards of care.

Non-smoker

This means a person who has not used any tobacco or nicotine products for the 12-month period immediately preceding the date on which the application for coverage is made.

Nurse Practitioner

A nurse who is registered with the governing regulatory body in the province, territory, state, or country where they are legally licensed to practice.

Off-road Vehicle

Means any wheeled or track-motorized vehicle designed or adapted for cross-country travel on land, water, ice, snow, marsh, swamp land, or other natural terrain and includes, but is not limited to:

a) a snowmobile;
b) an all-terrain vehicle;
c) a mini-bike, dirt-bike, and trail-bike;
d) a miniature vehicle such as a dune or sport buggy;
e) an off-road maintenance machine;
f) an amphibious vehicle; or
g) a 4-wheel-drive motor vehicle, motorcycle, or snow vehicle that is being driven elsewhere than on a highway, whether or not it is registered under The Drivers and Vehicles Act.

Paramedical Practitioner

A person who is legally Licensed, Certified, or Registered to provide paramedical services within the scope of their specialty or profession in the province, territory, state, or country where the service is provided.

Parental Leave of Absence

The period of formal childcare leave to which an Employee is entitled by legislation governing the Employer.

Part-time Basis

A part-time work schedule, working at least the minimum Required Number of Hours specified in the Plan Summary every week.

Pharmacist

A Doctor of Pharmacy with a current license to practice as a Pharmacist without restriction in the province, territory, state, or country where the service is provided.

Physician

A qualified Doctor of Medicine, licensed to practice medicine and surgery without restriction under the laws of the province, territory, state, or country where the services are provided, or the Diagnosis is made.

Plan

The Plan is a plan of group coverage under which benefits are available to eligible Employees of the Plan Sponsor. The Plan is part of the Contract agreed to between the Plan Sponsor and Wawanesa Life.

Plan Administrator

The person or company appointed by the Employer to manage the Plan on behalf of the Employer. The Plan Administrator's contact information is provided to each Plan Member by the Employer.

Plan Member

An Employee who is covered under the Plan and who has Provincial Health Plan coverage.

Plan Sponsor

See Employer.

Pre-existing Condition

An Illness or Injury for which the Plan Member sought medical investigation, diagnosis, treatment, care, medication, or medical advice, or for which there were symptoms which would have caused a person to seek medical investigation, diagnosis, treatment, care, medication, or medical advice prior to becoming insured under the Plan and within the time period specified in the specific benefit provisions of the Plan.

Prior Plan

A plan of group coverage held by the Plan Sponsor that immediately precedes the effective date of the Plan and which the Plan replaces.

Professional Nurse

A registered nurse, licensed practical nurse, or registered nursing assistant, who is currently licensed and registered with the appropriate nursing association for the province, territory, state, or country where the services are rendered.

Provincial Health Plan

Any plan which provides hospital, medical, or dental benefits established by the provincial government in the province where the Plan Member lives.

Qualifying Period

A period of continuous Disability, starting with the first day of Disability, which you must complete in order to qualify for benefits. The Qualifying Period is specified in the Plan Summary.

Except for Plan Member Short-Term Disability Benefits, if the period of Disability is interrupted by a return to Active Work for a single period of 7 consecutive days or less, the Qualifying Period will be considered to be uninterrupted, but the days you were Actively at Work will be added to the end of the Qualifying Period.

Reasonable and Customary

Within the usual range of charges being made or services being provided by others of similar standing in the area in which the charge is incurred, as determined by Wawanesa Life.

Seasonal Basis

Working at least 9 months out of every 12 months and at least the minimum Required Number of Hours specified in the Plan Summary every week during the 9 months.

Specialist

A Specialist is a Medical Practitioner.

Temporary Lay-off

A period during which you are laid off work and for which there is a fixed recall date.

Vehicle

A passenger automobile, motorcycle, motor home, truck, farm tractor, garden tractor, or golf cart with a gross vehicle weight of less than 8,000 pounds, provided no such vehicle is licensed to carry passengers for hire.

Waiting Period

A period of continuous, active employment with the Plan Sponsor within an eligible Class, following which you become eligible for coverage. The Waiting Period is specified under Eligibility Requirements in the Plan Summary.

Ward or Standard Room

A Hospital room with 3 or more beds which provides standard accommodation for patients.

The Wawanesa Life Insurance Company

236 Carlton St
Winnipeg, Manitoba, Canada
R3C 1P5

1-888-997-9965

www.wawanesalife.com

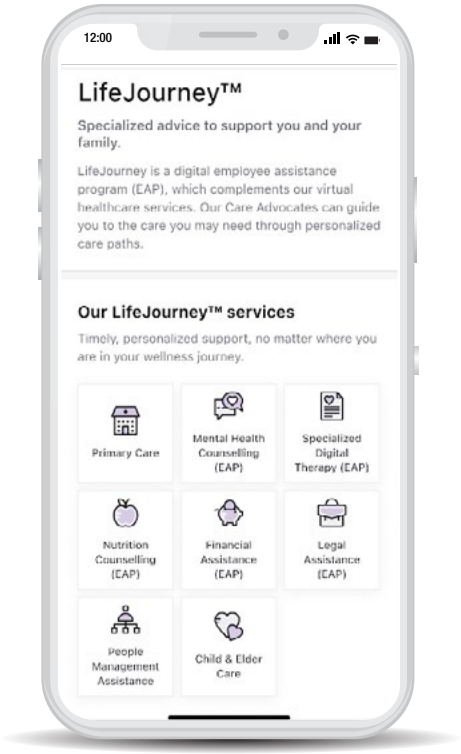
This Plan has been arranged through:

David Haines
Sterling Capital Brokers Ltd.
David@sterlingcapitalbrokers.com
647-824-3433

TELUS Health LifeJourney: What you need to know.

You now have access to LifeJourney™, an evolution of an employee assistance program (EAP) that is designed to help support all aspects of your health and wellbeing. LifeJourney offers 24/7 virtual access to compassionate care advocates who are there to support you with guidance and personalized care paths throughout your wellness journey.

How it works



Care advocates

Connect with our care advocates who are trained to offer mental health support and are committed to providing quality, holistic care.

Intake assessment

Complete our optional biopsychosocial assessment measuring various dimensions of wellness.

Primary care

Access our virtual 24/7, on-demand primary care for ongoing physical and mental health support, whether you need a new or refill prescription, a specialist referral, a diagnosis or more.

Mental health

Solution-focused mental health support through virtual counseling with specialists, Specialized Digital Therapy (dCBT) and personal crisis management.

Work/life balance

Convenient access to support for various life milestones, including legal and financial assistance, nutritional counselling, and child and elder care.

Wellbeing resources

Focused on prevention, these resources are designed to help you improve your wellbeing through lifestyle changes.

What's included:

Service	Description	Estimated wait time
Intake	Encrypted video consult or chat with a care advocate to develop a personalized care path.	On-demand.
Virtual primary care	Virtual primary care with a nurse or nurse practitioner via encrypted video consult or chat.	On-demand.
Work/life balance	Legal and financial assistance with a lawyer or financial professional via video consult or chat, as well as nutritional counseling, child and elder care services, and people management assistance support with a professional.	Scheduled appointment.
Wellbeing resources	Access a self-directed wellbeing assessment and curated library of content, all geared towards building and maintaining healthy lifestyle habits.	On-demand.
Mental health	Personal crisis management with the help of a nurse or nurse practitioner via encrypted video consult or chat.	On-demand, between 45 and 120 seconds.
	Specialized Digital Therapy (dCBT), a self-guided online program supervised by a mental health therapist.	Same day access. Feedback on modules within 72 hrs.
	Mental health counselling (solution-focused) via virtual appointment with a mental health specialist.	Scheduled appointment.

Have questions? Contact us at help@vc.telushealth.com

TELUS Health

TELUS Health LifeJourney: FAQ.

What is TELUS Health LifeJourney™?

LifeJourney is a rethinking of the traditional EFAP (employee & family assistance program). With 24/7 access to compassionate care, LifeJourney delivers holistic, personalized, human-centered care plans. Friendly care advocates design personalized care plans and stay with employees at every stage of their journey.

What is an employee & family assistance program?

An employee and family assistance program is a voluntary, work-based program including confidential assessments, short-term counselling and follow-up services to employees and their family dependents who have personal and/or school or work-related problems.

Which services are offered?

LifeJourney has been designed to provide convenient and flexible access to consultations and support in several areas:

- Primary care[1]
- Mental health support
- Specialized digital therapy (based on digital Cognitive Behavioural Therapy or dCBT)
- Financial and legal assistance
- People management assistance
- Child and elder care
- Nutritional counselling
- Wellbeing assessment and library

Users are guided through the services by a care advocate who can help create a personalized care plan and book all the necessary appointments.

Can my family use it? What are the limitations?

All accounts include coverage to your spouse/partner and dependent children under the age of 26 whose permanent address is the same as yours. Please note, this service is not applicable to any other family members living with you other than the members previously stated (i.e. parents).

How do I register?

You can sign up using the unique link you received in your activation email from TELUS Health. Once you've activated your account, you will be able to add your family members.

How do I access LifeJourney?

Mobile:

For app users, the TELUS Health Virtual Care mobile app is available for download from the App Store and Google Play.

If you have an iOS device, please visit our Apple App Store page.

If you have an Android device, please visit our Google Play Store page.

Desktop:

If you prefer a web-based application, you can access care on the TELUS Health Virtual Care user portal.

How do I reset my password?

If you would like to change your password, sign into your account and click on the change your password link in the Profile tab.

If you have forgotten your password, enter your email here to receive your unique password reset link.

How long does my registration last?

Your LifeJourney membership is active as long as you are covered by your plan sponsor.

Do I have to pay for LifeJourney?

Accessing LifeJourney is free for you. Based on the package selected by your plan sponsor, certain services will be included, while other services may be charged out of pocket. The latter fees may be reimbursed in whole or in part by your plan sponsor's extended health care coverage. In this case you will receive a receipt of service upon appointment completion for you to claim reimbursement afterwards to your health benefit or insurance provider.

How often can I use LifeJourney?

You can use it as often as you need. Your care advocate will provide you with an update on your care path and LifeJourney membership, every time.

What is a care advocate?

A care advocate is a trained professional dedicated to communicating empathetically to offer support to employees and their immediate family members. All care advocates have experience working in health and administration and are committed to providing integrated holistic care.

How can I connect with a care advocate?

Look for the tile that says "LifeJourney™" on your app's home screen to access the services covered by LifeJourney. You can communicate with care advocates through the platform, by video call or chat, 24/7. If you need technical support, please email help@vc.telushealth.com.

How many sessions do I have access to?

The number of sessions varies based on the service and package your employer has selected. Please refer to your onboarding documentation for detailed information regarding service inclusions.

Will my personal information be shared with my employer or anyone else?

No, your personal health information is completely private.[2] TELUS Health acts with integrity in all situations and confidentiality is taken very seriously. Data reporting to your employer is aggregate, including metrics such as registration rates, engagement rates and activity data, and doesn't contain any personal health information. All video consults are end-to-end encrypted, and instant messages are treated as part of your medical record in strict compliance with provincial and federal privacy laws.

What are some common situations where LifeJourney can provide support?

LifeJourney can help with things like stress, anxiety and depression, eating disorders, grief and bereavement, relationship challenges (including marital, divorce and child-parent), stress related illness, financial or legal concerns, addictions and more. You can also contact LifeJourney for concerns beyond those outlined above, and a care advocate will work with you to build a personalized care path.

What happens during my first appointment?

While speaking to a care advocate by chat and by video, you will typically be asked to complete an optional BioPsychoSocial Assessment (BPSA), after which the care advocate will build a personalized care path for you, schedule appointments and ensure you are supported throughout your journey.

Is LifeJourney available after business hours?

LifeJourney is available 24/7. You can speak at any point in time with a care advocate. Appointments with dedicated professionals are scheduled during business hours.

Questions? help@vc.telushealth.com

TELUS Health

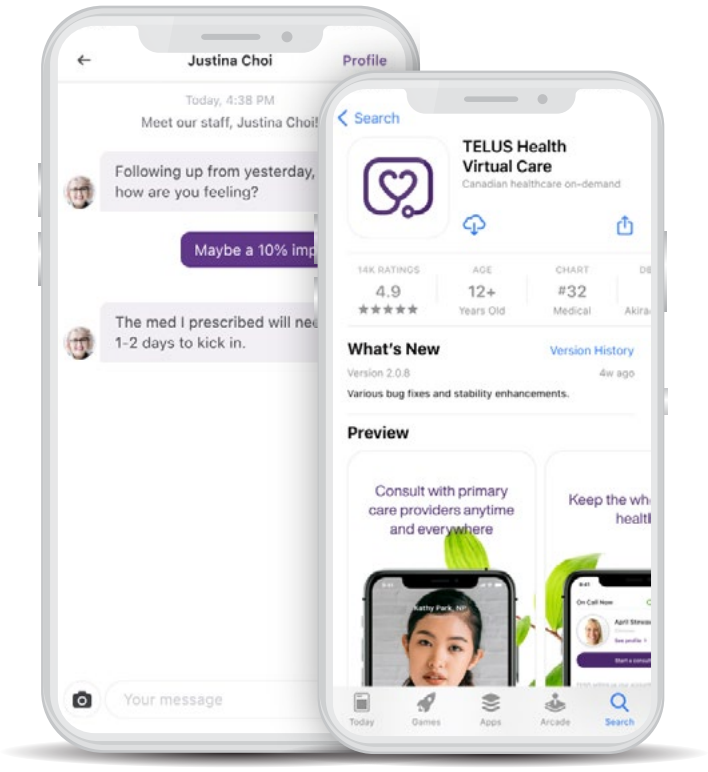
1. When paired with TELUS Health Virtual Care. 2. If you are considered at imminent risk of harming yourself or others, TELUS Health may be legally obligated to share your information with appropriate parties to provide immediate support.

THS4567-10-2022

Compassionate care, every step of the way.

TELUS Health Virtual Care is a health and wellness service that's ready to help anytime, anywhere in Canada.

Avoid unnecessary trips to the clinic or delays in getting the assistance you need. You and your immediate family† can consult healthcare professionals on-demand, straight from a smart device or computer, through encrypted text and video.



We can help you with:

- Medical advice
- Diagnosis
- Mental health support*
- Referrals
- Prescriptions and refills
- Labs
- Imaging
- Nutrition consultation*
- Physical therapy*

Need help? help@vc.telushealth.com

Virtual Care

TELUS Health

†Spouse and children under the age of 26, *Additional fees may apply for appointments with specialists and may be available in select provinces.

THS3718-09-2021

How to **activate your account.**

Gain access to your very own personal health and wellness resource that you can keep in your back pocket.

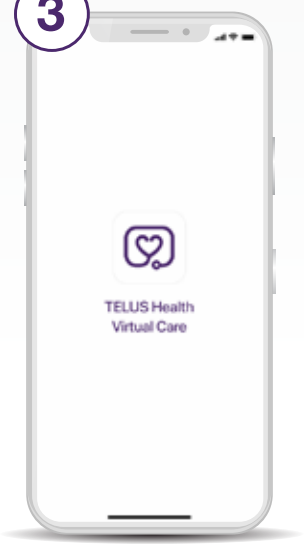
1

Click on your unique activation link.

2

Use the same email address to create your account.

3

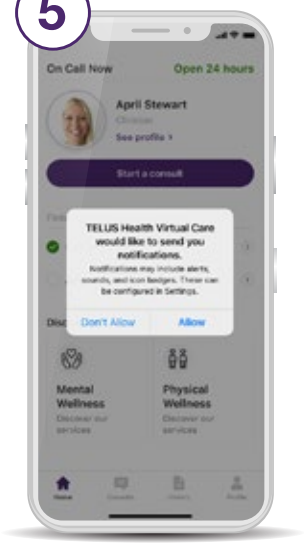


Download from the App Store or Google Play.

4

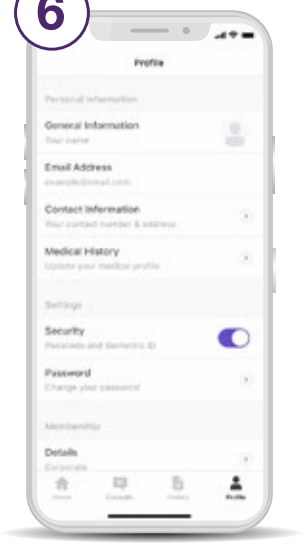
Use your account credentials to sign in to the app.

5



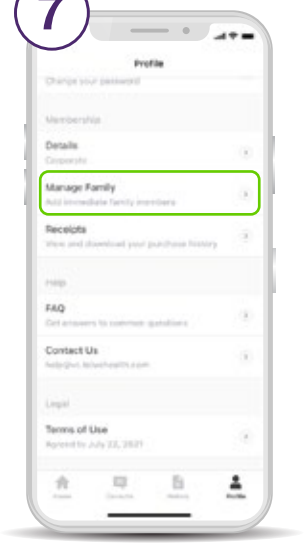
Ensure you have enabled notifications.

6



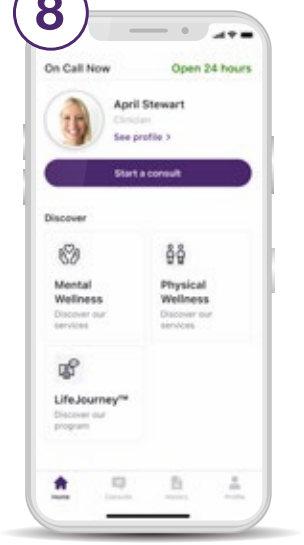
Set up your profile under the Profile tab.

7



Scroll down the Profile tab to add family members.

8



Start a consult from the home screen as soon as you need care.

Need help? Contact us at help@vc.telushealth.com

TELUS Health

THS3181-09-2021