Your group insurance plan

MARVELL SEMICONDUCTOR CANADA, INC.

Policy No. M00149

All Employees

Desjardins
Insurance
Life • Health • Retirement

Your Group Insurance Plan

MARVELL SEMICONDUCTOR CANADA, INC.

Policy No. M00149

All Employees

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

Booklet published on November 19, 2024

TABLE OF CONTENTS

YOU SHOULD KNOW	1
CONTACT US	2
DEFINITIONS	5
GENERAL PROVISIONS	15
ELIGIBILITY	16
APPLICATION	17
COMMENCEMENT OF COVERAGE	20
CONTINUATION OF COVERAGE DURING ABSENCE FROM WORK	22
TERMINATION OF BENEFITS AND COVERAGE	23
CLAIMS	25
WAIVER OF PREMIUM	29
EXTENDED HEALTH CARE BENEFIT	31
DENTAL CARE BENEFIT	59
SHORT TERM DISABILITY BENEFIT	70
LONG TERM DISABILITY BENEFIT	76
LIFE BENEFIT	82
ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT	86
SECOND MEDICAL OPINION SERVICES	91

YOU SHOULD KNOW

WHAT HAPPENS WITH THE DRUGS COVERAGE AT AGE 65?

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

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

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

or

- choose their provincial health care plan. They might then no longer be covered under the group benefit plan for drugs and other products included in their provincial health plan's list. This election is irrevocable.

The Participant must communicate with the administrator of the plan to obtain additional information.

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

TRAVELS ABROAD

A person must be covered under a provincial health plan in Canada to be eligible under the Travel Insurance.

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

ACCESS TO THE POLICY

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

CONTACT US

HEALTH AND DENTAL INQUIRIES

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

By e-mail at: Groupservice@dfs.ca

By phone at: 1-800-263-1810

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

HEALTH ASSISTANCE

Health Assistance is a confidential telephone service that is available 24 hours a day. This phone consultation service provides the Covered Person with a quick solution when non-emergency health issues arise. Qualified nurses are standing by to answer questions and give advice.

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

- General health
- Vaccinations
- Medical and natural remedies
- Childcare
- Local government resources

Health Assistance should be considered as a medical information complement. In the event of medical emergency, the nurse will recommend that the caller hang up and dial 911.

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

The Covered Person may contact HEALTH ASSISTANCE at any time.

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

TRAVEL ASSISTANCE SERVICE

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

1) 24-hour toll-free telephone assistance,

2) referral to Physicians or health-care facilities,

3) assistance for Hospital admission,

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

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

6) establishing and staying in contact with DFS,

7) handling arrangements in the event of death,

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

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

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

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

12) referral to lawyers if legal problems arise,

13) translation services for emergency calls,

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

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

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

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

GENERAL INQUIRIES

To obtain any other information, visit the "Contact us" section of DFS's website at **www.desjardins.com**.

HOW TO FILE A COMPLAINT

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

There are 3 ways to reach the Complaint handling team:

In writing, at the following address:

Complaint handling team

Desjardins Financial Security

100, rue des Commandeurs

Lévis (Québec) G6V 7N5

By e-mail at: complaints@desjardins.com

By phone at: 1-877-838-8185

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

DEFINITIONS

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

Accident

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

Actively at Work

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

Child

A person residing in Canada who, at the time of the event that results in a claim, has no spouse and is dependent upon the Participant or the Spouse for financial support and maintenance. A Child must be the Participant's or the Spouse's natural or adopted child. This also includes a child under the Participant's or the Spouse's parental authority or legal guardianship.

This Child must:

1) be under 21 years of age,

2) be under 26 years of age and a full-time student at an accredited educational institution, or

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

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

Continuing Medical Care
The treatment a Participant receives. It must be: 1) accepted by the medical profession as an effective, appropriate and essential treatment in the diagnosis or care of the specific Illness or injury, 2) reasonable, considered as standard practice, and 3) provided or prescribed by a Physician or, when DFS deems necessary, by a specialist in the appropriate field. This is not limited to examinations and tests and must be provided at the frequency required for the specific Illness or injury.
Convalescent/Rehabilitation Centre
An institution in Canada designated as such by law and recognized by DFS, and which: 1) provides care and treatment to patients under the supervision of a Physician or a registered nurse, 2) provides the services of a registered nurse on site and on duty 24 hours per day, and 3) maintains a daily record of each patient under the care of a Physician. Without limitation, this term does not include a home for the aged, chronically ill, mentally ill, rest home or a place for the care and treatment of alcoholism, drug addiction or any other dependency.
Covered Person
The Participant or their Dependent.
Day surgery
Outpatient surgery that allows an individual to return home on the same day as the surgical procedure is performed by a Physician. The procedure must require local or general anaesthesia. This does not include minor surgery performed in the office of a Physician.
Deductible
The amount of eligible expenses that a Covered Person must pay before reimbursement is made.

Dentist
A person licensed to practice dentistry by the appropriate authority in the jurisdiction where the services are provided.
Dependent
A Spouse or Child who resides in Canada. However, if a Dependent resides outside Canada they will be deemed to reside in Canada provided they are covered under a provincial medical plan in Canada and prior written approval is obtained from DFS.
Earnings
The regular rate of pay paid by the Employer, including dividends. Non-regular bonuses, non-regular overtime pay and any other non-regular remuneration are excluded.
Elements (forces of nature)
Natural disasters such as an earthquake, storm, flood, landslide or any other disaster of a similar nature.
Employee
A person residing in Canada and employed by the Employer on a full-time or part-time and permanent basis.
Employer
The Policyholder or any organization designated by the Policyholder and approved by DFS.
Equivalent Drug
A brand or generic drug, deemed interchangeable under the provincial law applicable where the drug is sold.
Evidence of Insurability
Any statement of an individual's physical health or other factual information that could have a bearing on the acceptance of the risk. Only Evidence of Insurability forms approved for use by DFS are acceptable.

Family Related Leave

Any leave of absence from work taken by a Participant in line with any provincial or federal legislation, or an agreement between the Participant and the Employer.

Hemiplegia

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

Hospital

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

1) medical and surgical treatment for sick or injured individuals, and
2) nursing care.

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

Hospitalization

1) For the Short Term Disability Benefit, to be admitted to a Hospital as an inpatient for more than 18 consecutive hours or any Hospital stay for Day Surgery,
2) for the Extended Health Care Benefit:
    a) to be admitted to a Hospital as an inpatient, or
    b) any Hospital stay for Day Surgery.

Illness

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

Immediate Family Member

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

Immediate Relative

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

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

Loss
1) For an arm, the complete severance through or above the elbow. 2) For a finger, the complete severance of 2 entire phalanges of one finger. 3) For a foot, the complete severance through or above the ankle joint but below the knee joint. 4) For a hand, the complete severance through or above the wrist but below the elbow joint. 5) For hearing, the complete and irrecoverable loss of hearing in one ear diagnosed by a duly qualified otolaryngologist and corresponding to an auditory threshold of greater than 90 decibels. 6) For a leg, the complete severance through or above the knee joint. 7) For sight, the total and irrecoverable loss of sight of one eye diagnosed by a duly qualified ophthalmologist, corresponding to a corrected visual acuity of 20/200 or less, or to a field of vision of less than 20 degrees. 8) For speech, the total, permanent and irreversible loss of the ability to speak due to injury or disease for a continuous period of 6 months. The diagnosis must be made by a licensed Physician. 9) For a thumb, the complete severance of one entire phalanx of the thumb. 10) For a toe, the complete severance of one entire phalanx of the big toe and all phalanges of the other toes.

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

Maternity Leave

Any leave of absence from work due to pregnancy as in agreement with any labour standards type legislation in effect in the Participant's province of residence.

The period of Maternity Leave includes 2 phases:

1) the "health related portion" that begins on the date of delivery and continues for 6 weeks (8 weeks for a Caesarean delivery). During this phase, the Participant is deemed Totally Disabled, and

2) the voluntary leave phase that follows the "health related portion". It ends when the Participant ceases to receive maternity benefits under any provincial or federal legislation.

Maximum Benefit Period

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

Medical Emergency

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

Net Earnings

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

1) income tax,

2) contributions to the Canada/Quebec Pension Plan,

3) contributions to the Employment Insurance, and

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

Orthosis

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

Palliative Care Establishment

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

1) provides care and treatment to patients under the supervision of a Physician, mainly during the terminal phase of their Illness,

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

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

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

Paraplegia

The total and irrecoverable paralysis of both lower limbs.

Parental Leave

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

Participant

An Employee covered under the policy.

Physician

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

Policyholder

The company or organization specified on the cover page of the policy.

Quadriplegia

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

Reasonable and Customary Charges
The charges generally paid for a like service or supply and limited to the lowest of: 1) the usual charge in the area where the services or supplies are provided, or 2) the suggested fee of the applicable governing body, on the date the expenses were incurred. For expenses incurred outside Canada, Reasonable and Customary Charges are those applicable in the province where the Participant resides.
Service Provider
The company that provides the Second Medical Opinion services.
Spouse
A person residing in Canada who, at the time of the event that results in a claim: 1) is legally married to or living in a civil union with the Participant, 2) is living with the Participant in a conjugal relationship for at least 12 months and has not been separated from the Participant for 90 days or more for a breakdown in the relationship, or 3) is living in a conjugal relationship with the Participant who is the natural parent of the Spouse's Child and has not been separated from the Participant for 90 days or more for a breakdown in the relationship. If 2 individuals fit the definition of Spouse, DFS will recognize only one Spouse as eligible. Recognition is in the following order: 1) the Spouse whom the Participant last designated as such, subject to approval of any Evidence of Insurability required under the policy, or 2) the Spouse to whom the Participant is legally married or with whom the Participant is living in a civil union.
Stable
The health condition of a Covered Person who within 30 days prior to the Trip departure date is not affected by any medical condition or is affected by a medical condition that: 1) does not require a change or no change is recommended in the treatment or dosage of prescribed drugs that may affect the medical condition significantly during the Trip, and 2) does not demonstrate any symptoms that indicate a significant deterioration of the medical condition during the Trip.

Subcontractor
The company that provides the Virtual Healthcare Service.
Total Disability or Totally Disabled
1) For the Short Term Disability Benefit, a state of incapacity, resulting from an Illness or Accident, that entirely prevents the Participant from performing the essential duties of their own occupation. 2) For all other benefits: a) during the Long Term Disability Benefit Elimination Period and the next 24 months, a state of incapacity resulting from an Illness or Accident that entirely prevents the Participant from performing the essential duties of their own occupation, b) after the Long Term Disability Benefit Elimination Period and the next 24 months, a state of incapacity, resulting from an Illness or Accident, that entirely prevents the Participant from working in any occupation that they are suited for by education, Training and Experience. Training and Experience means all of the knowledge and skills the Participant acquired while in school, in the performance of their current or former professional activities or during their non-working hours. A Participant is not considered disabled simply because an occupation that they are suited for by education, Training and Experience is not available in the area where they reside. A Participant who needs a government issued driver's license to perform the duties of their occupation is not considered disabled simply because their license has been revoked or not renewed.
Travelling Companion
A person age 18 or older who is not a Dependent Child and who is sharing travel arrangements with the Covered Person.
Travel Service Supplier
A travel agency, a travel wholesaler, a travel package organizer, a cruise operator or an airline that has a valid license and operating certificate issued by the appropriate Canadian or foreign authorities.

Trip
Any fixed period of time that: 1) arrangements have been made with any Travel Service Supplier, or 2) reservations have been made by the Covered Person for ground travel usually included in a travel package.
Vehicle
A car, a motor home or a van with a maximum load of 1,000 kilograms.

GENERAL PROVISIONS

MODIFICATION TO GOVERNMENT PLANS

If DFS's obligations under the policy are increased due to a modification to government plans, the policy continues to apply as if government plans did not change, unless otherwise agreed in writing by the Policyholder and DFS.

APPLICABLE LAWS AND JURISDICTION

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

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

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

INCONTESTABILITY

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

MISSTATEMENT OF AGE

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

CURRENCY

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

NUMBER AND GENDER

Where the context clearly requires, words in the singular include the plural. In addition, the policy is gender neutral.

ELIGIBILITY

EMPLOYEE ELIGIBILITY

An Employee is eligible for coverage on the date they meet the following requirements:

Number of hours worked per week	Waiting Period
30 hours	None

DEPENDENT ELIGIBILITY

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

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

Dependents cannot be covered unless the Participant is, except for the optional benefits or if the Dependent is covered under a survivor benefit provision.

APPLICATION

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

COVERAGE APPLICATION

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

1) Application within the time limit

An Employee must complete the required application form within 31 days of the date they are eligible.

2) Late application

a) All Benefits other than Dental Care Benefit

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

b) Dental Care Benefit

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

Evidence of Insurability

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

1) Long Term Disability Benefit

2) Basic Life Benefit

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

EXEMPTION PRIVILEGE

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

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

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

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

COVERAGE TYPES

The coverage types available under the policy are:

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

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

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

A life event is defined as:

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

2) birth or adoption of a child,

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

4) arrival of a Dependent in Canada,

5) death of a Dependent,

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

7) a Dependent Child returns to school.

BENEFICIARY

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

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

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

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

COMMENCEMENT OF COVERAGE

COMMENCEMENT OF PARTICIPANT COVERAGE

An Employee must be Actively at Work on the date their coverage becomes effective. If they are not Actively at Work on that date, their coverage will start on the first day they are next Actively at Work.

1) If application is made within the time limit

For all benefits except optional benefits, the coverage of any Employee is effective on the date they are eligible. For optional benefits, coverage is effective on the date the insurability of the Employee is approved by DFS.

2) If late application

Coverage is effective on the date the insurability of the Employee is approved by DFS.

COMMENCEMENT OF DEPENDENT COVERAGE

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

If a Participant already has Dependent coverage on the date they acquire a new Dependent, the coverage of that Dependent is effective on the date they become a Dependent, except for benefits requiring Evidence of Insurability. However, the Life Benefit for a newborn Child is effective from birth, including a stillborn child after at least 20 weeks of gestation, subject to all other terms and conditions of the policy provisions, including those above.

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

CHANGE IN AMOUNT OF COVERAGE AND BENEFIT

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

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

2) the date the insurability of the Covered Person is approved by DFS:

   a) if the new amount of coverage exceeds the Maximum without Evidence of Insurability, or

   b) if the request for change is received more than 31 days after the date of their eligibility for the change.

If a Participant is not Actively at Work on the date their coverage should change, then the change is effective on the first day they are next Actively at Work. However, if the Policyholder and DFS agree, the change is effective as if the Participant was Actively at Work.

CONTINUATION OF COVERAGE DURING ABSENCE FROM WORK

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

ILLNESS OR INJURY

All benefits that are in place immediately before the absence are continued during an absence due to Illness or injury that results in disability recognized by DFS. Premiums must continue to be paid unless the Participant is eligible for a premium waiver.

TEMPORARY LAY-OFF OR UNPAID LEAVE OF ABSENCE

The Participant is allowed to keep all benefits that are in place immediately before the absence, except for the Short Term and Long Term Disability Benefits. The benefits can be continued for any predetermined period as long as premiums continue to be paid. However, the coverage can only be continued for a maximum of 6 months. DFS must be advised of the scheduled return to work date prior to the start of the absence.

If the Participant decides not to keep their benefits, those benefits are reinstated, without Evidence of Insurability, on the date the Participant is again Actively at Work. DFS must be advised within 31 days following the return to work of the Participant otherwise, Evidence of Insurability is required.

MATERNITY, PARENTAL OR FAMILY RELATED ABSENCES AND LEAVES

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

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

    a) all benefits, or

    b) all benefits except for the Short Term and Long Term Disability Benefits,

2) discontinue all benefits.

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

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

STRIKE OR LOCK-OUT

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

TERMINATION OF BENEFITS AND COVERAGE

BENEFIT TERMINATION

Each Benefit terminates on the date specified below.

BENEFIT	TERMINATION DATE
Extended Health Care Benefit	The date of retirement
Dental Care Benefit	The date of retirement
Short Term Disability Benefit	The date of retirement
Long Term Disability Benefit	The Participant's 65th birthday or retirement, whichever comes first
Basic Life Benefit	The Participant's 71st birthday or retirement, whichever comes first
Optional Life Benefit	The Participant's 70th birthday or retirement, whichever comes first
Accidental Death and Dismemberment Benefit	The Participant's 71st birthday or retirement, whichever comes first

TERMINATION OF PARTICIPANT COVERAGE

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

1) the date they no longer qualify as an Employee,
2) the date they no longer belong to a class of Employees eligible for coverage,
3) the date their employment or contract with the Employer is terminated,
4) the end of the period for which the premiums are paid on their behalf,
5) the date they retire,
6) the date they are no longer Actively at Work, or
7) the date the policy terminates.

TERMINATION OF DEPENDENT COVERAGE

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

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

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

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

REINSTATEMENT OF COVERAGE

If an Employee's coverage terminates due to termination of employment and they are then rehired within 6 months, they are eligible for the reinstatement of their coverage on the date they resume employment. Application for reinstatement must be made within 31 days of the rehire date.

If an Employee does not qualify for reinstatement, they are considered a new Employee.

SURVIVOR BENEFIT

This provision applies to the following:

- Extended Health Care Benefit
- Dental Care Benefit

In the event of the Participant's death and subject to policy provisions, coverage continues for their Dependents, without premium payment, until the earliest of:

1) 24 months from the date of death,

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

3) the date the Benefit or policy terminates.

FRAUD

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

CLAIMS

NOTICE AND PROOF OF CLAIM

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

BENEFIT	TIME LIMIT
Extended Health Care Benefit	All claims, with receipts included, must be submitted to DFS within 12 months of the date the expense is incurred.
Dental Care Benefit	All claims, with receipts included, must be submitted to DFS within 12 months of the date the expense is incurred.
Short Term Disability Benefit	• Written proof of a claim must be submitted to DFS within 90 days of the initial date of Total Disability. • Subsequent written proof of continuing Total Disability satisfactory to DFS must be submitted to DFS upon request.
Long Term Disability Benefit	• Initial written notice of a claim must be submitted to DFS within 30 days of the expiry of the Elimination Period, and • initial written proof must be submitted to DFS within 90 days of the expiry of the Elimination Period. • When Total Disability is recurrent, written notice of a claim must be submitted to DFS within 30 days of the date of recurrence, and • written proof must be submitted to DFS within 90 days of the date of the recurrence. • Subsequent written proof of continuing Total Disability satisfactory to DFS must be submitted to DFS upon request.

Life Insurance Benefit	• Notice of claim must be submitted to DFS within 30 days of the date of death, and • the written proof of claim must be submitted within 90 days of the date of death.
Accidental Death and Dismemberment Benefit	• Notice of claim must be submitted to DFS within 30 days of the date of the Accident, and • the written proof of claim must be submitted within 90 days of the date of the Accident.

Failure to submit notice or proof of claim within the prescribed time limit does not invalidate the claim if the notice and proof of the claim are sent as soon as reasonably possible. However, no payment is made if the notice and proof of claim are sent more than 12 months after the date the expenses are incurred or the date of the event that results in a claim.

If the policy terminates, no payment is made unless the notice and proof of claim is submitted to DFS within 120 days of the date of termination of the policy.

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

SUBMISSION OF CLAIMS

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

Drugs and other Health Care Expenses
If the direct payment method is used for drug expenses, the Participant is not required to submit a claim to DFS. For all other medical expenses, the Participant is not required to submit a claim to DFS if the professional or service provider uses the Electronic Data Interchange (EDI).

Dental Care
The Participant is not required to submit a claim to DFS if the Dentist uses the Electronic Data Interchange (EDI). DFS reserves the right to require radiographs, photographs and other types of diagnostics such as specialist reports, periodontal charts and study models.

Death
Before settling any claim, DFS requires satisfactory written proof of: 1) death, including a medical report or death certificate, the cause and circumstances of the death, 2) eligibility of the deceased at the time of death, 3) date of birth of the deceased, and 4) right of the claimant to receive the proceeds. DFS may also require any other information it deems useful. In the case of a disappearance, DFS will pay the claim on presentation of a declaratory judgment of death.

CO-ORDINATION OF BENEFITS

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

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

Travel Insurance Expenses

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

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

MEDICAL EXAMINATIONS

From time to time, DFS is entitled to have a claimant examined by a health professional appointed by DFS.

SUBROGATION

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

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

RIGHT OF RECOVERY

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

WAIVER OF PREMIUM

This provision applies to the following Benefits:

- Short Term Disability Benefit
- Long Term Disability Benefit
- Basic Life Benefit
- Optional Life Benefit
- Basic Accidental Death and Dismemberment Benefit

1) Beginning of the Waiver of Premium

A Participant under age 65 who becomes Totally Disabled while covered under the policy may be entitled to have their premiums waived at the end of the Elimination Period of the Long Term Disability Benefit. The Participant must submit proof of Total Disability satisfactory to DFS.

2) Termination of the Waiver of Premium

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

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

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

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

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

e) the date the Participant retires, or

f) the date the coverage of the Participant terminates or the date the Benefit is cancelled or the policy terminates, except for the Life Benefit and the Long Term Disability Benefit.

3) Recurrent Total Disability

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

4) Notice and Proof of Total Disability

For the Participant to be eligible for Waiver of Premium, DFS must receive notice and proof of Total Disability within the time limit specified for the Long Term Disability Benefit under the NOTICE AND PROOF OF CLAIM provision of the CLAIMS section.

Failure to submit notice or proof within the prescribed time limit does not invalidate the Waiver of Premium if the notice and proof are sent as soon as reasonably possible. However, no Waiver of Premium is granted if the notice and proof are sent more than 12 months after the date the Participant became Totally Disabled.

EXTENDED HEALTH CARE BENEFIT

SUMMARY OF BENEFITS

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

Deductible	
Eligible Expenses	**Amount**
All expenses	None
Percentage of Reimbursement	
Eligible Expenses	**Percentage**
Drugs	1) Generic drugs: 100% of the lowest priced Equivalent Drug available on the market 2) Brand name drugs: 100% of the brand name drug if no Equivalent Drug is available on the market or 100% of the lowest priced Equivalent Drug available on the market
Referral Treatment	80%
All other expenses	100%

BENEFIT PAYMENT

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

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

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

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

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

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

Preferred Providers Network

DFS may select suppliers for the distribution of services, treatments or supplies and may restrict payment for Eligible Expenses purchased at another supplier.

ELIGIBLE EXPENSES

IN CANADA

Eligible Expenses are those listed below and incurred:

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

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

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

DRUGS

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

   a) by law require a prescription, or

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

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

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

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

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

4) Prior Authorization Drugs

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

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

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

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

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

Patient Support Program

This program is offered by DFS. It provides support to help Covered Persons manage their health and medication. DFS may require Covered Persons to enroll in this program in order for the drug expenses to be reimbursed.

Patient Assistance Program

This program is offered by some drug manufacturers to provide Covered Persons with information, education and financial assistance if they are prescribed certain drugs. DFS may require Covered Persons to enroll in this program in order for the drug expenses to be reimbursed.

Other Eligible Drug Expenses	Maximum Payable Amount per Covered Person
Vaccines	Reasonable and Customary Charges
Fertility treatment	Drugs and treatment, $15,000 combined per calendar year, including genetic testing

HOSPITALIZATION	
Eligible Expenses	**Maximum Payable Amount per Covered Person**
Hospital Charges for confinement in a Hospital for each day of acute care Hospitalization	The difference between the cost of a ward and a semi-private room
Palliative Care Establishment Charges for confinement in a Palliative Care Establishment	$40 per day up to a lifetime maximum of 180 days
Convalescent/Rehabilitation Centre Charges for confinement in a Convalescent or Rehabilitation Centre, for any period of confinement that begins within 14 days of discharge from a Hospital Successive periods of confinement are considered the same period of confinement if they: • result from the same Illness or Accident, and • are separated by less than 60 consecutive days during which the Covered Person is not hospitalized.	$40 per day up to 180 days per period of confinement

HEALTH PROFESSIONALS	
Eligible Expenses	**Maximum Payable Amount per Covered Person**
<u>Paramedical Services</u> Services of the following professionals if they are practicing within their recognized field and are members in good standing of their professional governing body that is recognized by DFS. Medical recommendation is not required unless specified.	For each type of professional, only one visit per day is eligible
• acupuncturist	$500 per calendar year
• audiologist	$500 per calendar year
• chiropractor	$500 per calendar year, plus $50 per calendar year for x-rays
• dietician or nutritionist	Combined amount of $500 per calendar year
• homeopath	$500 per calendar year
• massage therapist, orthotherapist, kinesiotherapist or kinotherapist	Combined amount of $500 per calendar year
• naturopath	$500 per calendar year
• occupational therapist	$500 per calendar year
• osteopath	$500 per calendar year, plus $50 per calendar year for x-rays
• physiotherapist, physiotherapy technologist, sports therapist or kinesiologist	Combined amount of $500 per calendar year
• podiatrist or chiropodist	Combined amount of $500 per calendar year, plus $50 per calendar year for x-rays

• psychologist, social worker, guidance counsellor, psychotherapist, psychoeducator, registered clinical counsellor, Canadian certified counsellor, marriage counsellor, marriage/couple/family therapist, psychoanalyst or sexologist	Combined amount of $500 per calendar year
• speech therapist	$500 per calendar year
Home Nursing Care Nursing services given at home by a registered nurse or a licensed practical nurse, provided the services are within the competence of that nurse. The nurse must not be related to the Participant or to any of their Dependents by birth or marriage and must not ordinarily reside in their or their Dependent's home.	$10,000 per calendar year

GENDER AFFIRMATION

DFS will reimburse the following Eligible Expenses if:

- the Covered Person has received a diagnosis of persistent gender dysphoria, and
- the expenses are incurred in Canada.

Eligible Expenses	Maximum Payable Amount per Covered Person
Surgeries and treatments not covered under the provincial medical plan: • Breast and chest surgeries • Genital surgeries • Thyroid chondroplasty (Adam's apple surgery) • Vocal cords surgeries • Electrolysis or laser hair removal	$10,000 lifetime

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

MEDICAL EQUIPMENT OR SUPPLIES	
MOBILITY AIDS	
Eligible Expenses	**Limitations and/or Maximum Payable Amount per Covered Person**
Walkers, canes or crutches	Purchase or rental, at the option of DFS Reasonable and Customary Charges
Wheelchairs	Purchase and repair, or rental, at the option of DFS, up to the cost of a non-motorized wheelchair, unless the Covered Person's health condition requires a motorized wheelchair One in any 60-month period, plus initial batteries for an eligible motorized wheelchair
Patient lifts	Purchase or rental, at the option of DFS, of a mechanical or hydraulic device $2,000 every 5 calendar years
Exterior access ramps	Purchase One in a lifetime, up to $2,000

ORTHOPAEDIC SUPPLIES	
Eligible Expenses	**Limitations and/or Maximum Payable Amount per Covered Person**
Orthopaedic shoes: • Custom-made shoes • Open-toed shoes • In-flare or out-flare shoes • Shoes required for Denis Browne braces • Modified or adjusted prefabricated shoes • Modifications or adjustments to prefabricated shoes	Manufactured and billed by a centre recognized by DFS. In addition, the shoes and the modifications or adjustments to prefabricated shoes must be made by an orthotist who is a member in good standing of their professional governing body that is recognized by DFS. • One pair per calendar year, up to $500 for adults • 2 pairs per calendar year, up to $500 for Children under age 18
Foot orthoses	Manufactured and billed by a centre recognized by DFS. In addition, the orthoses, must be made by an orthotist who is a member in good standing of his professional governing body that is recognized by DFS. • One pair per calendar year, up to $300 for adults • 2 pairs per calendar year, up to $300 for Children under age 18
Rigid or semi-rigid braces for limbs, trusses or casts	Purchase and repair Reasonable and Customary Charges
Spinal braces	Purchase and repair Reasonable and Customary Charges

PROSTHESES	
Eligible Expenses	**Limitations and/or Maximum Payable Amount per Covered Person**
Hearing aids	$700 in any 60-month period, including initial batteries
Wigs	When required for temporary hair loss due to alopecia, chemotherapy or radiotherapy $300 lifetime
Breast prostheses	When required due to a mastectomy, up to: • the cost of external prostheses, and • $200 in any 24-month period, including the purchase of 2 mastectomy brassieres
Artificial limbs and myoelectric prosthetics	• Purchase, up to $10,000 per prosthesis • Repair, up to $10,000 per repair • Replacement when it is required due to a physiological change up to $10,000 per prosthesis
Artificial eyes	Purchase and repair Reasonable and Customary Charges

OTHER MEDICAL EQUIPMENT OR SUPPLIES	
Eligible Expenses	**Limitations and/or Maximum Payable Amount per Covered Person**
Support stockings	Purchase of support stockings at least 20 mm/Hg 4 pairs per calendar year
Intrauterine devices or diaphragms	Combined amount of $50 per calendar year

TENS nerve stimulators and their supplies	Purchase or rental, at the option of DFS $700 in any 60-month period
Catheters	Purchase Reasonable and Customary Charges
Ostomy supplies	Purchase Reasonable and Customary Charges
Paraplegics supplies	Purchase Reasonable and Customary Charges
Tube feeding supplies	Purchase Reasonable and Customary Charges
Tracheotomy supplies	Purchase Reasonable and Customary Charges
Opaque glasses	Purchase, provided they are required during radiotherapy or psoriasis treatments Reasonable and Customary Charges
Compressive garments other than support stockings	Purchase Reasonable and Customary Charges
Medicated dressings	Purchase Reasonable and Customary Charges
Stump socks	10 per calendar year
Breast pumps	Purchase or rental, at the option of DFS Reasonable and Customary Charges
Positive pressure airway ventilator machines (CPAP) or mandibular advancement splints	Purchase or rental, at the option of DFS One in any 60-month period

Apnea monitors	Purchase or rental, at the option of DFS Reasonable and Customary Charges
Oxygen and equipment required for its administration	Purchase or rental, at the option of DFS Reasonable and Customary Charges
Lymphoedema pumps	Purchase Reasonable and Customary Charges
Chest percussion accessories	Purchase Reasonable and Customary Charges
Enuresis sensors	Purchase or rental, at the option of DFS Reasonable and Customary Charges
Hospital beds	Purchase and repair, or rental, at the option of DFS, up to the cost of a non-electric hospital bed, unless the Covered Person's health condition requires an electric bed One in any 60-month period
Hospital bed supplies: • bed rails • trapeze bars • bedpans • head halters	Purchase or rental, at the option of DFS Reasonable and Customary Charges
Traction apparatus	Purchase or rental, at the option of DFS Reasonable and Customary Charges
Standing aids	Purchase or rental, at the option of DFS Reasonable and Customary Charges
Speech aids	Purchase or rental, at the option of DFS $1,000 lifetime

Daily living aids: • shower bars, bathtub bars • shower chairs • grab bars • standard commodes • bathtub rails • elevated toilet seats	Purchase or rental, at the option of DFS Reasonable and Customary Charges
Glucose monitors	One monitor in any 36-month period, up to $300
Insulin pumps	One pump in any 48-month period, up to $5,000
Insulin pump supplies	Purchase Reasonable and Customary Charges
Other therapeutic equipment and their supplies: • aerosol therapy equipment • non-union bone stimulators Additional equipment may be included, as determined by DFS.	Purchase or rental, at the option of DFS Each piece of equipment is limited to one in any 60-month period $10,000 lifetime combined for any or all of the eligible equipment and their supplies

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

DENTAL TREATMENT DUE TO AN ACCIDENT	
Eligible Expenses	**Limitations and/or Maximum Payable Amount per Covered Person**
The services of a Dentist required to repair or replace sound teeth as a result of an accidental blow to the mouth A sound tooth is a natural tooth not affected by any pathology in itself or any adjacent structures. A natural tooth treated or repaired and restored to normal function is considered sound.	The accidental blow must occur while the Covered Person is covered under this Benefit or a comparable benefit in force immediately before the effective date of this Benefit. Within 12 months of the Accident: • dental care must begin, or • a treatment plan satisfactory to DFS must be submitted. No benefit is paid for services provided more than 24 months after the date of the Accident. Reimbursement of Eligible Expenses is governed by the current year Dental Association Fee Guide for General Practitioners where the Participant resides.

DETOXIFICATION	
Eligible Expenses	**Limitations and/or Maximum Payable Amount per Covered Person**
Room and board charges in a centre specializing in the treatment of alcoholism, drug, gambling or gaming addiction. The centre must be recognized by DFS	The Covered Person must require treatment under the supervision of a Physician. $80 per day, up to $2,500 lifetime

VISION CARE	
Eligible Expenses	**Limitations and/or Maximum Payable Amount per Covered Person**
Eye exam	One in any period of 12 months
Eyeglasses, contact lenses and surgery	Purchase and replacement Eyeglasses and contact lenses must be prescribed by an ophthalmologist or optometrist and dispensed by an ophthalmologist, optometrist or optician, for vision correction. Laser surgery for vision correction Combined amount of $300 in any period of: • 24 months for adults, • 12 months for Children under age 18.
Intraocular lenses	Purchase, as a replacement for natural crystalline in case of cataracts Reasonable and Customary Charges
Contact lenses (special condition)	Contact lenses to restore the visual acuity of the best eye to at least 20/40 when eyeglasses cannot get this result Reasonable and Customary Charges

REFERRAL TREATMENT

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

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

2) the Covered Person must provide DFS with a letter of referral from a Physician from the province of residence they reside indicating that they are referred to another Physician,

3) DFS must give prior written approval, and

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

Eligible Expenses	Limitations and/or Maximum Payable Amount
Health Care Expenses	
Hospital room and board charges	In Canada: same coverage as provided for under the In Canada provision of this Benefit Outside Canada: semi-private room
Other hospital services	
Physician, surgeon or anaesthetist's fees	
Transportation Expenses	
Expenses to transport the Covered Person by a suitable means to a place of treatment competent to provide appropriate care.	
Expenses for an Immediate Family Member to be transported with the Covered Person to the place of treatment.	
Round-trip economy transportation for a qualified medical attendant when ordered by the attending Physician.	The attendant cannot be an Immediate Family Member, friend or Travelling Companion

<table>
<tr><td>Round-trip economy air, bus or train transportation by the most direct route for one Immediate Family Member to visit the Covered Person who must be confined for at least 7 days.</td><td>The Covered Person must not be accompanied by an Immediate Family Member age 18 or over
The Living Expenses for the Immediate Family Member up to a maximum of $1,500
The visit must be considered as beneficial to the patient by the attending Physician</td></tr>
<tr><td>On the death of a Covered Person, one round-trip economy air, bus or train transportation by the most direct route for one Immediate Family Member to the place of death for identification of the remains prior to repatriation.</td><td>The Covered Person must not be accompanied by an Immediate Family Member age 18 or over</td></tr>
<tr><td>On the death of a Covered Person, the cost to prepare and return the body or cremains to the place of residence by the most direct route (plane, bus or train).</td><td>$5,000
The cost of the casket or urn is not covered</td></tr>
<tr><td colspan="2"><u>Living Expenses</u></td></tr>
<tr><td>The Covered Person's cost of meals and accommodation for the duration of their treatment.
Additional child care expenses for Children not accompanying the Covered Person.</td><td>$200 per day per Covered Person for a maximum of 10 days. This maximum is for all these expenses combined</td></tr>
<tr><td colspan="2"><u>Long-distance Telephone Charges</u></td></tr>
<tr><td>Long-distance telephone charges to reach an Immediate Family Member if the Covered Person is hospitalized.</td><td>$50 per day up to an overall maximum of $200 per Period of Hospitalization
The Covered Person must not be accompanied by an Immediate Family Member age 18 or over
These expenses are eligible if no reimbursement has been made for Transportation Expenses for one Immediate Family Member to the Hospital</td></tr>
</table>

Overall Maximum Benefit	
Expenses incurred outside the province of residence, but within Canada	No maximum
Expenses incurred outside Canada	$50,000 per calendar year per Covered Person

TRAVEL INSURANCE

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

1) the person must be covered under a provincial health plan in Canada,
2) expenses must be eligible under the Extended Health Care Benefit, and
3) the Covered Person's health condition must be Stable prior to the Trip departure date.

The Participant must contact DFS if the duration of the Covered Person's stay outside Canada is or may be longer than 180 days, otherwise, that person may not be covered for Travel Insurance.

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

Eligible Expenses	Limitations and/or Maximum Payable Amount
Health Care Expenses	
Hospital room and board charges until the Covered Person is discharged from hospital	Semi-private room
Other hospital services	
Physician, surgeon or anaesthetist's fees	
All other expenses eligible under the In Canada provision of this Benefit	

<table>
<tr><td colspan="2"><u>Transportation Expenses</u>

To be eligible, all the expenses listed below must be approved and arranged by "Travel Assistance"</td></tr>
<tr><td>Expenses to repatriate the Covered Person, as soon as their health allows it, by a suitable means of Public Transportation to their place of residence to receive appropriate care.</td><td>These expenses are eligible if the means of transportation originally arranged for the return Trip cannot be used.</td></tr>
<tr><td>Expenses for another person also covered under this Benefit to be repatriated at the same time as the Covered Person.</td><td>These expenses are eligible if the means of transportation originally arranged for the return Trip cannot be used.</td></tr>
<tr><td>Expenses for a suitable means of Public Transportation to repatriate the children accompanying and under the care of the Covered Person during the Trip if:
• the Covered Person must be repatriated or hospitalized for more than 24 hours, and
• nobody else can bring the children back to their home.</td><td></td></tr>
<tr><td>Additional transportation to repatriate the cat or dog accompanying the Covered Person if:
• the Covered Person must be repatriated, and
• nobody else can bring the animal back to the Covered Person's place of residence.</td><td>$500 per Trip</td></tr>
<tr><td>The following fees for the transportation of the luggage of the Covered Person who must be repatriated:
• excess luggage if brought back by another person, or
• shipment of luggage to the Covered Person's place of residence if nobody else can bring it back.</td><td>$300 per Trip</td></tr>
</table>

<table>
<tr><td>Round-trip economy transportation for a qualified medical attendant when ordered by the attending Physician.</td><td>The attendant cannot be an Immediate Family Member, friend or Travelling Companion.</td></tr>
<tr><td>Round-trip economy air, bus or train transportation by the most direct route for one Immediate Family Member to visit the Covered Person who must be confined for at least 7 days.</td><td>The Covered Person must not be accompanied by an Immediate Family Member age 18 or over.
The Living Expenses for the Immediate Family Member is limited to $1,500.
The visit must be considered as beneficial to the patient by the attending Physician.</td></tr>
<tr><td>Cost of returning the Covered Person's personal or rented Vehicle if:
the Covered Person suffers from a disability due to a Medical Emergency,
a Physician verifies that the disability prevents the Covered Person from operating this Vehicle, and
none of the Immediate Family Members accompanying the Covered Person are able to return it.
Vehicle transportation professional agency expenses or the reasonable and necessary expenses incurred by the Covered Person for gas, meals, accommodation and a one-way economy class transportation.</td><td>The Vehicle must be in working condition to make the return Trip without mechanical problem

$2,500 per trip</td></tr>
<tr><td>On the death of a Covered Person, one round-trip economy air, bus or train transportation by the most direct route for one Immediate Family Member to the place of death for identification of the remains prior to repatriation.</td><td>The Covered Person must not be accompanied by an Immediate Family Member age 18 or over.</td></tr>
</table>

<table>
<tr><td>On the death of a Covered Person:
• the cost to prepare and return the body or cremains to the place of residence by the most direct route (plane, bus or train), or
• the cost to prepare the body and the cost of cremation or burial if the body is not repatriated to the place of residence.</td><td>$5,000
The cost of the casket or urn is not covered</td></tr>
<tr><td colspan="2"><u>Living Expenses</u></td></tr>
<tr><td>The cost of meals and accommodation if the Covered Person's return is delayed because of an Illness or Accident verified by a Physician. The Illness or Accident must be suffered by the Covered Person themselves, an accompanying Immediate Family Member or a Travelling Companion.
Additional child care expenses for Children not accompanying the Covered Person.</td><td>$200 per day per Covered Person for a maximum 10 days per Trip, for all these expenses combined</td></tr>
<tr><td colspan="2"><u>Long-distance Telephone Charges</u></td></tr>
<tr><td>Long-distance telephone charges to reach an Immediate Family Member if the Covered Person is hospitalized.</td><td>• $50 per day up to an overall maximum of $200 per Period of Hospitalization.
• To be eligible, the Covered Person must not be accompanied by an Immediate Family Member age 18 or over.
• These expenses are eligible if no reimbursement has been made for Transportation Expenses for one Immediate Family Member to the Hospital.</td></tr>
<tr><td colspan="2">Overall Maximum Benefit</td></tr>
<tr><td>All Eligible Expenses</td><td>$5,000,000 lifetime per Covered Person</td></tr>
</table>

RESTRICTIONS, LIMITATIONS AND EXCLUSIONS

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

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

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

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

Additional Restrictions Applicable to Drugs

Maintenance drugs are limited to a 100-day supply. All other drugs and products are limited to a 34-day supply.

Limitations

Eligible Expenses are subject to the limitations and maximums specified in this benefit.

Alternate Benefit Clause

For each Eligible Expense for which several products are available on the market, reimbursement is limited to the lowest cost alternative product that represents reasonable treatment.

Additional Limitations Applicable to Drugs

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

Limitations and Exclusions Applicable to the Preferred Providers Network

Benefits may be limited or no reimbursement made for drugs or supplies available at a supplier in the Preferred Providers Network, but purchased elsewhere.

General Exclusions

No reimbursement is made for:

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

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

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

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

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

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

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

4) services, treatments or supplies which are experimental,

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

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

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

8) confinement in a Chronic Care Establishment,

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

10) surgeries and treatments for the reversal of a Gender Affirmation surgery,

11) robotic walking aid apparatus,

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

13) charges for any surgically implanted item, except for the expenses listed in the Gender Affirmation provision,

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

15) physical exercise class or program of any kind,

16) therapeutic bath of any kind,

17) fasting therapy and related charges,

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

19) diagnostic services received in a hospital and expenses incurred for genetic testing, unless genetic testing is required for fertility treatment,

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

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

22) incontinence supplies,

23) expenses incurred for the treatment of sexual dysfunction,

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

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

Additional Exclusions Applicable to Drugs

No reimbursement is made for:

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

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

3) contraceptives other than hormonal contraceptives,

4) sclerotherapy,

5) smoking cessation aids,

6) the following, whether prescribed or not:

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

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

   c) natural products and homeopathic products,

   d) disinfectants and non-medicated dressings,

   e) any infant milk formulas,

   f) dietary supplements,

   g) vitamins and minerals.

Additional Exclusion Applicable to the Patient Support Program

A Covered Person who refuses to enroll in the program might not be eligible for reimbursement of the drug expenses.

Additional Exclusion Applicable to the Patient Assistance Program

A Covered Person who refuses to enroll in the program might not be eligible for reimbursement of the drug expenses.

Additional Exclusions Applicable to Travel Insurance

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

No reimbursement is made:

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

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

3) if the Covered Person did not agree to:

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

   b) change hospital or clinic,

   c) be examined for diagnostic purposes,

   d) repatriation as recommended by "Travel Assistance";

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

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

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

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

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

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

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

    a) hang gliding and paragliding,

    b) kitesurfing, if the Covered Person does not hold at least a level 3 IKO certification,

    c) skydiving and free falling,

    d) bungee jumping,

    e) outdoor climbing when not top-roping,

    f) mountain climbing on a trail rated class 4 or 5 on the Yosemite Decimal System,

    g) freestyle skiing during training, competition practice or a competition,

    h) off-track skiing outside of the marked and supervised trails of a ski station,

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

    j) combat sports,

    k) motorized race and motorized training activities.

ADDITIONAL SERVICES

VIRTUAL HEALTHCARE SERVICE

Virtual Healthcare Service consists of exclusively virtual access to a nurse practitioner or Physician via a secure mobile application and web platform. This service allows certain remote health services and the exchange of related information between the Subcontractor and the Covered Person through telecommunications and technology. It is a tool for improving health, productivity and attendance at work. The goal is to provide Participants and their covered Dependents with fast and confidential access to professional resources to help them deal with various types of problems.

The service is rendered by nurse practitioners or Physicians who comply with the guidelines of their respective professional bodies, including those specific and applicable to virtual healthcare.

Virtual Healthcare Service is available under the Extended Health Care Benefit of the policy, to Participants and eligible Dependents who are covered under this Benefit.

If a Participant or one of their covered Dependents use the Virtual Healthcare Service offered by the Subcontractor and described below, the Covered Person has no out-of-pocket expenses, subject to any limitation relating thereto. Supporting documents are required for the use of this service, in particular for identification of the Covered Person and for the renewal of a prescription.

Services offered

The services offered, if medically appropriate, include:

1) triage, according to the symptoms of the Covered Person,

2) diagnosis of common medical problems,

3) medical and health advice,

4) writing prescriptions, prescription renewals, requests for laboratory tests and requests for imaging examinations,

5) referral to specialists or health professionals,

6) the production of a medical note to prescribe an absence from work of up to 3 days, if the condition of the Covered Person so requires.

Common medical problems may include, but are not limited to:

1) common illnesses such as colds, flu, infections, digestive disorders, minor injuries, skin problems and allergies,

2) post-examination follow-ups such as X-ray results and laboratory analysis results,

3) the management of chronic diseases such as diabetes, high blood pressure and heart conditions,

4) certain mental health problems,

5) issues related to anemia, smoking cessation, weight loss and travel medicine.

Limitations

Virtual Healthcare Service is subject to the regulatory limitations and conditions associated with virtual healthcare applicable in the province of residence of the Covered Person.

Some medical problems are not supported by Virtual Healthcare Service, such as those resulting from work-related accidents, motor vehicle accidents or disability management.

DENTAL CARE BENEFIT

SUMMARY OF BENEFITS

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

Deductible	
Eligible Expenses	**Amount**
All Eligible Expenses	None
Percentage of Reimbursement	
Eligible Expenses	**Percentage**
Preventive Services	100%
Basic Services	100%
Major Restorative Services	50%
Orthodontics	50%
Maximum Benefit	
Eligible Expenses	**Amount**
Preventive, Basic and Major Restorative Services	Combined maximum of $2,500 per calendar year per Covered Person
Orthodontics	Lifetime maximum of $2,000 per Covered Person

BENEFIT PAYMENT

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

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

1) a Dentist,

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

3) a licensed denturist.

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

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

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

PREDETERMINATION OF BENEFIT

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

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

FEE GUIDE

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

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

In the absence of a fee guide recognized by DFS or if the fee guide is not recognized by DFS for the year expenses are incurred, Eligible Expenses are limited to the Reasonable and Customary Charges. Additional expenses related to Eligible Expenses for which no amount is set in the fee guide as well as lab fees are limited to the Reasonable and Customary Charges.

ELIGIBLE EXPENSES

IN CANADA

PREVENTIVE SERVICES	
Eligible Expenses	**Limitations and/or Maximum per Covered Person**
Examinations	
• Complete oral examination	One in any 24-month period
• Preventive or recall oral examination	One in any 6-month period
• Emergency oral examination	
• Specific oral examination	2 per calendar year
Radiographs (X-rays)	
• Complete series of radiographs or a panoramic radiograph	One in any 24-month period
• Intraoral radiographs (except bitewing films)	
• Bitewing films	One series of films in any 6-month period
• Extraoral radiographs	
• Photography	
Lab Tests and Examinations	
• Microbiological testing	
• Biopsy	
• Pulp vitality test	
• Diagnostic cast	

Consultations	
• Consultation with a patient	
Preventive Services	
• Oral hygiene instruction	Once in a lifetime
• Polishing	Once in any 6-month period
• Fluoride treatment	Once in any 6-month period
• Finishing restorations, including disking and recontouring of natural teeth to improve function	
• Pit and fissure sealants	
• Interproximal disking	
• Space maintainer	
• Control of oral habits appliance	
• Scaling and root planing	14 units per calendar year

BASIC SERVICES	
Eligible Expenses	**Limitations and/or Maximum Covered Person**
Restorations	
• Amalgam restoration (metal fillings)	
• Composite restoration (white fillings)	
• Retentive pin for amalgam and composite restoration	

• Prefabricated restoration	
• Caries / trauma / pain control procedures (as a separate procedure from a restoration)	
Endodontics	
• Endodontic emergency and treatment of the pulp chamber	
• Root canal therapy	
• Periapical services	
• Miscellaneous endodontic services other than bleaching	
Periodontics	
• Periodontal surgery	
• Post-operative visit	4 visits per calendar year
• Gingival curettage	One whole mouth in any 60-month period
• Periodontal bruxism appliance	One maxillary (upper arch) and one mandibular (lower arch) appliance in any 24-month period
• Adjustment to a periodontal bruxism appliance	Once per calendar year
• Occlusal equilibration	8 units in any 12-month period or One major and 3 minor equilibrations in any 12-month period
Maintenance of Removable Dentures	
• Repair or addition	
• Relining	

• Rebasing	
• Adjustment when performed at least 3 months after the initial insertion	Once in any 6-month period
Oral Surgery	
• Extraction	
• Removal of residual roots	
• Surgical exposure of teeth without orthodontic attachment	
• Alveolectomy, alveoplasty, stomatoplasty, tuberoplasty and osteoplasty	
• Alveolar ridge reconstruction	
• Extension of mucous folds	
• Excision in the oral cavity	
• Incision in the oral cavity	
• Frenectomy	
• Treatment of salivary glands	
• Antral surgery (sinuses)	
• Control of hemorrhage	
• Post-surgical care	
General Services	
• General anaesthesia, conscious or deep sedation	When administered in conjunction with a dental Eligible Expense
• Provision of facilities, equipment and support services for general anaesthesia or deep sedation	When administered in conjunction with a dental Eligible Expense

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

• Remount with occlusal equilibration	
• Therapeutic tissue conditioning	
Fixed Prosthodontics	
• Bridgework (retainer and pontic)	
• Repair	
• Removal	
• Recementation	
Other Restorations	
• Veneer, gold foil, inlay, onlay and crown	
• Repair	
• Retentive pin, post and core	
• Recementation	
• Removal	

ORTHODONTICS
Eligible Expenses are those listed below and incurred for a Dependent Child under age 18: • Orthodontic treatment to correct malocclusion • Myofunctional therapy • Complete orthodontic examination • Specific orthodontic examination • Cephalometric radiographs

OUTSIDE CANADA

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

1) for emergency treatment only, and

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

RESTRICTIONS, LIMITATIONS AND EXCLUSIONS

Restrictions

Late Application

If the Participant's application for the Dental Care Benefit is late, for either themselves or their Dependents, reimbursement is limited to $250 per Covered Person for the first 12 months of coverage and Orthodontics are not eligible for any reimbursement for the first 24 months of coverage.

Limitations

Eligible Expenses are subject to the limitations and maximums specified in this benefit.

Any amount that exceeds the maximum indicated in the appropriate Fee Guide cannot be reimbursed.

Alternate Benefit Clause

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

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

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

General Exclusions

No reimbursement is made for:

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

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

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

4) charges made by a Dentist for missed appointments, claim forms or telephone advice,

5) Eligible Expenses that result directly or indirectly from:
   a) committing or attempting to commit a criminal offence, as set out under the Criminal Code of Canada,
   b) a cause that is the responsibility of a Workers' Compensation Act or similar legislation or any other government plan,
   c) war, whether declared or not, or service in the armed forces of any country, or participation in a riot, insurrection or civil commotion,

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

7) audio-visual oral hygiene instruction,

8) nutritional counselling,

9) any dental services or supplies, including X-rays, provided for:
   a) full mouth reconstruction,
   b) vertical dimension correction, or
   c) the correction of temporomandibular joint dysfunctions,

10) bleaching,

11) expenses incurred for implantology, except for crowns or dentures on implants,

12) patient motivation (psychological evaluation),

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

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

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

16) semi-precision or precision attachments, and

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

SHORT TERM DISABILITY BENEFIT

SUMMARY OF BENEFITS

When DFS receives satisfactory Proof of Claim that the Participant:

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

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

DFS pays benefits according to policy provisions.

Percentage and Maximum of Benefit
75% of weekly gross Earnings, rounded to the next $1, if not already a multiple, up to a maximum of $1,384
Elimination Period
• Nil in case of Accident • 7 calendar days in case of Illness • Nil if hospitalized
Maximum Benefit Period
17 weeks
Taxability Status
Taxable

ELIMINATION PERIOD

The Elimination Period is the period of continuous Total Disability that must be completed before disability benefits may be paid. It terminates on the later of:

1) the date the Elimination Period shown in the Summary of Benefits is completed, or

2) the date the Participant consults a Physician.

To qualify for the Elimination Period for an Accident, the Accident must be confirmed by a Physician and sustained not more than 30 days prior to the initial date of Total Disability. Failure to do so means that the Elimination Period for Illness applies.

If Total Disability begins during an absence from work, the Elimination Period begins:

1) on the first day of Total Disability, in case of a Parental or Family Related Leave or the "voluntary leave portion" of a Maternity Leave, or

2) on the date the Participant is scheduled to return to work for any other absence or leave,

provided the Participant can and does continue their coverage under this Benefit throughout the leave.

BENEFIT PAYMENT

Benefits are payable each week, starting on the date the Elimination Period ends.

Benefits are payable during the "health related portion" of a Maternity Leave. The maternity benefits payable under any public or private plan are deducted from the benefits payable for this period.

In case of a Total Disability that begins during an absence from work for a Maternity, Parental or Family Related Leave, benefits are payable on the later of:

1) the end of the Elimination Period, or

2) the scheduled return to work date.

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

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

Any payments for a period of less than one week are at the daily rate of 1/7 of the weekly benefit.

RECURRENT DISABILITY

If benefits were paid under this Benefit and the Participant becomes Totally Disabled again, that period of disability is considered a recurrence of the previous Total Disability if the Participant is Actively at Work between the occurrences for less than 2 consecutive weeks if Total Disability is for the same or related cause.

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

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

REHABILITATION

At any time, DFS may require a Totally Disabled Participant to take part in a rehabilitative program satisfactory to DFS. The activities of the rehabilitative program must be approved by DFS.

The Participant will no longer be eligible for benefit payments under this Benefit for any period while he:

1) refuses to participate in a rehabilitative program, or

2) does not participate actively and in good faith in the rehabilitative program.

REDUCTION OF BENEFITS

1) Direct offset

Benefits payable are reduced by any:

a) amount that the Participant is eligible to receive under any Workers' Compensation Act or similar legislation,

b) benefits the Participant is eligible to receive under the Canada Pension Plan or the Quebec Pension Plan excluding amounts payable on behalf of Dependents or any survivor's benefits,

c) salary loss replacement the Participant is eligible to receive under any provincial government no-fault automobile insurance plan that does not include Employment Insurance benefits in its payments,

d) salary loss replacement paid under any other federal or provincial legislation if considered earnings by Employment Insurance,

e) severance or wrongful dismissal payments, and

f) Earnings paid by the Employer including sick pay.

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

2) Additional reduction in case of Rehabilitation

If the Participant earns any income as part of a rehabilitative program, the benefits payable by DFS are reduced by the following formula:

$$(A \div B) \times C = \text{amount of reduction}$$

A = income earned from any rehabilitative program

B = Earnings of the Participant immediately prior to initial date of Total Disability

C = benefits otherwise payable under this Benefit.

While the Participant is taking part in a rehabilitative program, benefits are reduced so that their total income from all sources does not exceed 100% of their weekly gross Earnings immediately prior to the initial date of Total Disability.

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

a) any amounts paid under this Benefit,

b) any Earnings paid by the Employer,

c) any benefits the Participant is eligible to receive under the Canada Pension Plan or the Quebec Pension Plan, excluding benefits payable on behalf of their Dependents or any survivor's benefits,

d) any disability benefits the Participant is eligible to receive under any Workers' Compensation Act or similar legislation,

e) any amounts payable from a retirement or pension plan provided by the Policyholder, and

f) any salary loss payments the Participant is eligible to receive under any provincial government no-fault automobile insurance plan that does not include Employment Insurance benefits in its payments.

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

3) Amount payable under public plans

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

4) Lump-sum payment

If the Participant receives a lump-sum payment from any of the sources above, that payment is converted to an equivalent weekly amount and reduced from the Participant's benefit payments.

LIMITATIONS AND EXCLUSIONS

Limitations

No benefits are paid for any period of Total Disability:

1) while the Participant is not under Continuing Medical Care for the Illness or Accident causing the Total Disability,

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

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

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

5) if the Participant remains outside Canada for longer than 3 months regardless of the reason, unless:
    a) DFS gives prior written consent to continue paying benefits during this period, or
    b) the Participant is outside Canada for medical treatment that is eligible under the Employment Insurance Act,

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

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

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

Exclusions

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

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

2) committing a criminal offence as set out under the Criminal Code of Canada,

3) surgery for cosmetic purposes, unless it is required as a result of an Accident or an Illness,

4) alcohol or drug abuse unless the Participant is:

   a) actively taking part in an appropriate therapeutic program supervised by a Physician on an on-going basis, and

   b) receiving Continuing Medical Care or treatment for rehabilitation.

TERMINATION OF BENEFIT PAYMENTS

Benefit payments end on the earliest of the date:

1) the Participant is no longer Totally Disabled,

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

3) this Benefit terminates. If a Participant is Totally Disabled prior to attaining the age this Benefit terminates and on attaining it, they are still so disabled and have not yet received 15 weeks of benefit payments for that disability, coverage will be extended to the earliest of the date:

   a) 15 weeks of benefits have been paid,

   b) They are no longer Totally Disabled, or

   c) they retire.

LONG TERM DISABILITY BENEFIT

SUMMARY OF BENEFITS

When DFS receives satisfactory Proof of Claim that the Participant:

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

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

DFS pays benefits according to policy provisions.

Percentage and Maximum of Benefit
68.5% of the first $2,500 of monthly gross Earnings, plus 50.5% of the next $2,500 and 42.5% of the balance, rounded to the next $1, if not already a multiple Maximum $13,500 Maximum of $9,750 without Evidence of Insurability if application is completed within the time limit
Elimination Period
17 weeks or the end of the Maximum Benefit Period for the Short Term Disability Benefit
Maximum Age to be Eligible
64 years and 35 weeks
Maximum Benefit Period
To age 65
Taxability Status
Non-taxable

ELIMINATION PERIOD

The Elimination Period is the period of continuous Total Disability that must be completed before disability benefits may be paid. It terminates on the later of:

1) the date the Elimination Period shown in the Summary of Benefits is completed, or

2) the date the Participant consults a Physician.

If Total Disability begins during an absence from work, the Elimination Period begins:

1) on the first day of Total Disability, in case of a Parental or Family Related Leave or the "voluntary leave portion" of a Maternity Leave, or

2) on the date the Participant is scheduled to return to work, for any other absence or leave,

provided the Participant can and does continue their coverage under this Benefit throughout the leave.

BENEFIT PAYMENT

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

Benefits are payable during the "health related portion" of a Maternity Leave.

In case of a Total Disability that begins during an absence from work for a Maternity, Parental or Family Related Leave, benefits are payable on the later of:

1) the end of the Elimination Period, or

2) the scheduled return to work date.

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

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

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

RECURRENT DISABILITY

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

1) less than 2 consecutive weeks during the Elimination Period, or

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

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

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

REHABILITATION

At any time, DFS may require a Totally Disabled Participant to take part in a rehabilitative program satisfactory to DFS. The activities of the rehabilitative program must be approved by DFS.

The Participant will no longer be eligible for benefit payments under this Benefit for any period while he:

1) refuses to participate in a rehabilitative program, or

2) does not participate actively and in good faith in the rehabilitative program.

REDUCTION OF BENEFITS

1) Direct Offset

Benefits payable are reduced by any:

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

b) benefits the Participant is eligible to receive under the Canada Pension Plan or the Quebec Pension Plan excluding amounts payable on behalf of Dependents or any survivor's benefits,

c) salary loss replacement the Participant is eligible to receive under any provincial government no fault automobile insurance plan that does not include Employment Insurance benefits in its payments,

d) salary loss replacement paid under any other federal or provincial legislation if considered earnings by Employment Insurance,

e) severance or wrongful dismissal payments,

f) Earnings paid by the Employer including sick pay, and

g) disability benefits payable by a private pension plan.

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

2) Indirect Offset

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

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

a) any amounts paid under this Benefit,

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

c) any benefits the Participant is eligible to receive under the Canada Pension Plan or the Quebec Pension Plan excluding amounts payable on behalf of Dependents or any survivor's benefits,

d) any salary loss replacement the Participant is eligible to receive under any provincial government no fault automobile insurance plan that does not include Employment Insurance benefits in its payments,

e) any salary loss replacement paid under any other federal or provincial legislation if considered earnings by Employment Insurance,

f) any disability benefits payable under any employer group insurance plan,

g) any severance or wrongful dismissal payments,

h) any Earnings paid by the Employer including sick pay, and

i) any amount payable by a private pension plan for disability.

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

3) Additional reduction in case of Rehabilitation

If the Participant earns any income while taking part in a rehabilitative program, the benefits payable by DFS are reduced by the following formula:

$$(A \div B) \times C = \text{amount of reduction}$$

A = Income earned from any rehabilitative program

B = Earnings of the Participant immediately prior to initial date of Total Disability

C = benefits otherwise payable under this Benefit.

While the Participant is taking part in a rehabilitative program, benefits are reduced so that their total income from all sources does not exceed 100% of their monthly Net Earnings immediately prior to the initial date of Total Disability.

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

4) Amount payable under public plans

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

5) Lump-sum payment

If the Participant receives a lump-sum payment from any of the sources above, the payment is reduced by the lesser of:

a) the lump-sum payment converted to an equivalent monthly amount over a period of 60 months, or

b) the number of months of disability that the lump sum is paid for.

LIMITATIONS AND EXCLUSIONS

Limitations

No benefits are payable for any period of Total Disability:

1) while the Participant is not under Continuing Medical Care for the Illness or Accident causing the Total Disability,

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

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

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

5) if the Participant remains outside Canada for longer than 3 months regardless of the reason, unless:

   a) DFS gives prior written consent to continue paying benefits during this period, or

   b) the Participant is outside Canada for medical treatment that is eligible under the Employment Insurance Act,

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

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

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

Pre-existing condition exclusion

No benefits are payable for any Total Disability that:

1) began during the first 12 months of the Participant's coverage, and
2) was, directly or indirectly, the result of a condition or symptoms, whether diagnosed or not, and for which, during the 3-month period immediately prior to the effective date of coverage:
   a) the Participant is treated by a Physician, or
   b) prescribed drugs are taken.

If the policy has been in force for less than 12 months, the 12-month period includes any period that the Participant is covered under a comparable benefit under the Employer's prior group insurance policy in effect immediately prior to the Effective Date of the policy.

Other exclusions

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

1) war, whether declared or not, or service in the armed forces of any country, or participation in a riot, insurrection or civil commotion,
2) committing a criminal offence as set out under the Criminal Code of Canada,
3) surgery for cosmetic purposes, unless it is required as a result of an Accident or an Illness,
4) alcohol or drug abuse unless the Participant is:
   a) actively taking part in an appropriate therapeutic program supervised by a Physician on an on-going basis, and
   b) receiving Continuing Medical Care or treatment for rehabilitation.

TERMINATION OF BENEFIT PAYMENTS

Benefit payments end on the earliest of the date:

1) the Participant is no longer Totally Disabled,
2) benefits have been paid up to the Maximum Benefit Period for any one episode of Total Disability,
3) the Participant retires, or
4) this Benefit terminates.

LIFE BENEFIT

SUMMARY OF BENEFITS

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

BASIC LIFE BENEFIT

Participant
Amount of Insurance
2 times annual Earnings, rounded to the next higher $1,000, if not already a multiple Minimum $10,000 Maximum $1,000,000 Maximum of $700,000 without Evidence of Insurability if application is completed within the time limit
Reduction
The Amount of Insurance is reduced by 50% on the Participant's 65th birthday.

Dependents	
Amount of Insurance	
Spouse	**Each Child**
$10,000	$5,000
Reduction	
None	

OPTIONAL LIFE BENEFIT

Participant
Amount of Insurance
Any multiple of $10,000 Minimum $20,000 Maximum $300,000

Dependents	
Amount of Insurance	
Spouse	**Each Child**
Any multiple of $10,000 Minimum $20,000 Maximum $300,000	Not covered

SUICIDE EXCLUSION

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

1) the person's coverage under this Benefit,

2) the reinstatement of their coverage, or

3) any subsequent increase to the amount of coverage.

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

The 2 year period mentioned above must be uninterrupted. It includes any period that the person is covered under a comparable benefit under the Employer's prior group insurance policy in effect immediately prior to the Effective Date of the policy.

LIVING BENEFIT

A Totally Disabled Participant whose life expectancy is less than 24 months may apply for payment of a portion of their amount of Basic Life Benefit subject to the following conditions:

1) approval is obtained from DFS,
2) the Participant must attend any examination by a Physician designated by DFS when required,
3) the Participant must qualify for approval for the Waiver of Premium Benefit under the Basic Life Benefit of the policy, and
4) any designated irrevocable Beneficiary must sign a consent to such payment on a form provided by DFS.

The Living Benefit is 50% of the amount of Basic Life Benefit applicable to the Participant. The amount cannot be less than $5,000 or more than $100,000.

On the death of the Participant, the Value of the Living Benefit is deducted from the amount of Life Benefit otherwise payable had the Living Benefit not been paid.

The Value of the Living Benefit is:

1) the total amount of the Living Benefit paid,
2) the reasonable costs to verify the medical condition of the Participant, plus
3) interest calculated on the Living Benefit from the payment date until the date of death.

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

LIVING BENEFIT EXCLUSION

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

CONVERSION PRIVILEGE

If the Life Benefit of a Participant aged 65 or younger terminates, the Participant is entitled to convert their and their Dependents' amount of insurance to an individual policy (subject to any minimum amount) without Evidence of Insurability, up to the lesser of:

1) the amount of insurance that is lost because of termination,

2) the maximum amount required by legislation in the Participant's province of residence, or

3) the difference between the amount of Life Benefit in force on the date of termination of coverage and the amount of insurance that the Participant is eligible for under another group life insurance at the time they exercise their conversion right.

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

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

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

If a Participant dies within 31 days of termination of their coverage under this Benefit, the amount they are able to convert is eligible to be paid.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

SUMMARY OF BENEFITS

When DFS receives satisfactory Proof of Claim that:

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

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

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

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

BASIC ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

Participant
Amount of Insurance
Equal to the Basic Life Benefit
Reduction
The Amount of Insurance is reduced by 50% on the Participant's 65th birthday.

SCHEDULE OF LOSSES

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

Loss of	Percentage
Life	100%
Sight of Both Eyes	100%
Both Hands or Both Feet	100%
Both Arms or Both Legs	100%
One Hand and Sight of One Eye	100%
One Foot and Sight of One Eye	100%

Loss of	Percentage
Hearing in Both Ears and Speech	100%
One Hand and One Foot	100%
One Arm or One Leg	75%
One Hand or One Foot	67%
Sight of One Eye	67%
Hearing in Both Ears or Speech	67%
Thumb and Index Finger of the Same Hand	33%
At least Four Fingers of the Same Hand	33%
All Toes of One Foot	25%
Hearing in One Ear	25%

Loss of Use of	Percentage
Both Arms or Both Hands	100%
Both Legs or Both Feet	100%
One Hand and One Foot	100%
One Arm or One Leg	75%
One Hand or One Foot	67%
Thumb and Index Finger of the Same Hand	33%
Hemiplegia, Paraplegia, Quadriplegia	200%

DISAPPEARANCE

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

EXPOSURE TO THE ELEMENTS (FORCES OF NATURE)

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

REHABILITATION

If a Participant requires training because of an eligible loss, DFS reimburses the reasonable and necessary training expenses actually incurred, up to a maximum of $10,000, provided that:

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

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

FAMILY TRANSPORTATION AND HOTEL ACCOMMODATION

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

1) they are confined as an inpatient,

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

3) they are under the regular care of a Physician.

REPATRIATION

If a Covered Person dies due to an Accident, DFS reimburses the reasonable and customary expenses incurred for preparation of the body for burial or cremation and transportation of the body from the place of the Accident to the Covered Person's place of residence in Canada, up to a maximum of $10,000, provided that:

1) the Accident occurs 100 kilometres or more from their normal place of residence, and

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

HOME OR VEHICLE CONVERSION

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

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

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

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

Reimbursement is only made if:

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

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

EDUCATION COSTS

If a Participant dies due to an Accident DFS reimburses an Education Costs benefit for each Child who was covered under the policy on the date of the Accident and the date the Participant dies, if:

1) on the date of the Accident the Child is:

   a) enrolled as a full-time student in an institution of higher learning above the secondary school level, or

   b) in a secondary school, but then enrolls as a full-time student in an institution of higher learning within 365 days of the death of the Participant, and

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

The Education Costs Benefit includes all reasonable and necessary expenses incurred for tuition and related costs, up to

1) 2% of the amount that the Participant is covered for under this Benefit on the date of their death, and

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

The Child must continue their education on a full-time basis in an institution of higher learning without any interruption longer than the normal school vacation.

SPOUSAL RETRAINING

If the Spouse is covered under the policy on the date the Participant dies due to an Accident, DFS reimburses the reasonable and necessary expenses actually incurred by the Spouse to take part in a formal occupational training program. Reimbursement is limited to a maximum of $10,000 provided that:

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

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

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

LIMITATIONS AND EXCLUSIONS

Limitations

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

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

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

Exclusions

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

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

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

3) dental or medical treatment, a surgical procedure or the administration of anaesthesia,

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

5) travel or flight aboard any aircraft as a pilot or crew member, and not solely as a passenger in an aircraft that:

    a) is certified airworthy or has a flight permit issued under the appropriate authorities in Canada or under the laws of the country where the aircraft is registered, and all the conditions under which the certificate or permit is issued have been complied with, and

    b) is used for the sole purpose of transportation and not for aviation training or practice, or for experimental or test purposes,

6) committing or attempting to commit a criminal offence, including operation while impaired, as set out under the Criminal Code of Canada.

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

SECOND MEDICAL OPINION SERVICES

The services offered by the Service Provider allow the Covered Person to get a complete second medical opinion report, based on the evaluation of their medical file, to confirm the diagnosis and identify the best treatment options, in the case of a serious or potentially life-threatening medical condition.

The Service Provider offers the Covered Person leading support, applies the best medical practices and collaborates with the Covered Person's own physician to obtain the best results for the Covered Person within the Canadian health care system. The Service Provider leverages a Canadian direct network of medical specialists to obtain the best medical diagnostic and treatment opinions and when needed, leverages its worldwide Preferred Provider Organisations.

The eligible serious or potentially life-threatening medical conditions include, without limitation:

Cancer, all types
Benign brain tumors
AIDS
Neurodegenerative diseases such as Multiple Sclerosis, Parkinson's, ALS and Alzheimer's Disease
Blindness
Deafness
Prolonged Coma
Respiratory, Kidney or Liver Failure
Autoimmune Diseases such as Rheumatoid Arthritis and Lupus
Cardiovascular Conditions such as Stroke, Coronary Artery Disease and Valvular Heart Disease
Venous Thromboembolic Disease

SERVICES

The following services are provided if they are determined to be appropriate.

Locate Canadian Medical Specialists

- Find treating physician and medical specialists for a specific medical condition.

Obtain Second Medical Opinion

Receive a second medical opinion report for one of the critical medical conditions. Identification of appropriate specialist or subspecialist for comprehensive review of the Covered Person's medical file is made from an existing network of expert medical consultants across Canada. The second medical opinion report includes:

- Summary of the clinical history and the questions being asked
- Summary of the investigations completed
- Recommendation of further avenues of treatment and/or further investigations required
- Appropriate literature references in support of the above.

Accessibility To Medical Treatments

- Evaluate the treatment options for a health condition
- Identify programs or treatment available in the Covered Person's area
- Understand the terms and sometimes the risks that can be associated with treatment options

Assuris protection

Desjardins Insurance is a member of Assuris, a not for profit corporation, funded by the life insurance industry. It protects Canadian policyholders against loss of benefits due to the financial failure of a member company.

Details about the extent of Assuris' protection are available at **www.assuris.ca** or in their brochure, which you can get by writing to **info@assuris.ca** or calling 1-866-878-1225.

Our commitment to you

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

desjardinslifeinsurance.com/planmember

Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company. Desjardins®, Desjardins Insurance® and related trademarks are trademarks of the Fédération des caisses Desjardins du Québec used under licence by Desjardins Financial Security Life Assurance Company.

200 Rue des Commandeurs, Lévis QC G6V 6R2 / 1-866-647-5013
desjardinslifeinsurance.com

03074E (2023-10)
100%