Your group insurance plan

Group Health Centre

Policy No. 541256

ONA Local 12 Employees

Desjardins
Insurance
Life • Health • Retirement

Your Group Insurance Plan

Policy No. 541256-2

ONA Local 12 Employees

This document is an integral part of the Insurance certificate. It is a summary of your Group Insurance Policy effective August 1, 2023. Only the Group Insurance Policy may be used to settle legal matters.

This electronic version of the booklet has been updated on April 1, 2024. Please be advised that this electronic version is updated more frequently than the printed copy of your booklet. Therefore, there may be discrepancies between the paper and electronic copies.

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CONTACT US

HEALTH AND DENTAL INQUIRIES

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

By e-mail at: Groupservice@dfs.ca

By phone at: 1-877-324-5041

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

HEALTH ASSISTANCE

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

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

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

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

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

The Covered Person may contact HEALTH ASSISTANCE at any time.

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

TRAVEL ASSISTANCE SERVICE

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

1) 24 hour toll-free telephone assistance,

2) referral to Physicians or health-care facilities,

3) assistance for Hospital admission,

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

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

6) establishing and staying in contact with DFS,

7) handling arrangements in the event of death,

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

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

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

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

12) referral to lawyers if legal problems arise,

13) translation services for emergency calls,

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

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

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

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

GENERAL INQUIRIES

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

YOU SHOULD KNOW

WHAT HAPPENS WITH THE DRUGS COVERAGE AT AGE 65?

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

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

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

  or

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

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

TRAVELS ABROAD

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

ACCESS TO THE POLICY

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

HOW TO FILE A COMPLAINT

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

There are 3 ways to reach the Dispute Resolution Officer

In writing, at the following address:

Dispute Resolution Officer

Desjardins Financial Security

200, rue des Commandeurs

Lévis (Québec) G6V 6R2

By e-mail at: disputeofficer@dfs.ca

By phone at: 1 877 838-8185

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

DEFINITIONS

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

Accident

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

Actively at Work

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

Child

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

This Child must:

1) be under 21 years of age,

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

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

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

Continuing Medical Care
The treatment a Member receives. It must be: 1) accepted by the medical profession as an effective, appropriate and essential treatment in the diagnosis or care of the specific Illness or injury, 2) reasonable, considered as standard practice, and 3) provided or prescribed by a Physician or, when DFS deems necessary, by a specialist in the appropriate field. This is not limited to examinations and tests and must be provided at the frequency required for the specific Illness or injury.
Covered Person
The Member or their Dependent.
Day surgery
Outpatient surgery that allows an individual to return home on the same day as the surgical procedure is performed by a Physician. The procedure must require local or general anaesthesia. This does not include minor surgery performed in the office of a Physician.
Deductible
The amount of eligible expenses that a Covered Person must pay before reimbursement is made.
Dentist
A person licensed to practice dentistry by the appropriate authority in the jurisdiction where the services are provided.
Dependent
A Spouse or Child who resides in Canada. However, if a Dependent resides outside Canada he will be deemed to reside in Canada provided he is covered under a provincial medical plan 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 basis.
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 Member in line with any provincial or federal legislation, or an agreement between the Member 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
To be admitted to a Hospital as an inpatient, or any Hospital stay for Day Surgery.

Illness
Any health deterioration or bodily disorder verified by a Physician. Organ donations and related complications are also considered illnesses.
Immediate Family Member
Spouse, son, daughter, father, mother, brother, sister, step-father, step-mother, step-son, step-daughter, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, sister-in-law, of the Member.
Immediate Relative
The Covered Person's spouse, son, daughter, father, mother, brother or sister.
Insurer
Desjardins Financial Security Life Assurance Company, hereafter, DFS, with its head office at 200 rue des Commandeurs, Lévis (Quebec) G6V 6R2.
Loss
1) For an arm, the complete severance through or above the elbow. 2) For a finger, the complete severance of 2 entire phalanges of one finger. 3) For a foot, the complete severance through or above the ankle joint but below the knee joint. 4) For a hand, the complete severance through or above the wrist but below the elbow joint. 5) For hearing, the complete and irrecoverable loss of hearing in one ear diagnosed by a duly qualified otolaryngologist and corresponding to an auditory threshold of greater than 90 decibels. 6) For a leg, the complete severance through or above the knee joint. 7) For sight, the total and irrecoverable loss of sight of one eye diagnosed by a duly qualified ophthalmologist, corresponding to a corrected visual acuity of 20/200 or less, or to a field of vision of less than 20 degrees.

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

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

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

Loss of Use

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

Maternity Leave

Any leave of absence from work due to pregnancy:

1) as in agreement with any labour standards type legislation in effect in the Member's province of residence,
2) as in agreement between the Member and the Employer,
3) during which Employment Insurance benefits are paid.

Maximum Benefit Period

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

Medical Emergency

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

Member

An Employee covered under the policy.

Net Earnings

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

1) income tax,
2) contributions to the Canada/Quebec Pension Plan,
3) contributions to the Employment Insurance, and
4) any other contribution to a public income replacement plan.

Orthosis
A rigid orthopaedic appliance or apparatus used to maintain a part of the body in the correct position.
Paraplegia
The total and irrecoverable paralysis of both lower limbs.
Parental Leave
Any leave of absence from work taken by a Member to take care of his newborn or adopted child, as in agreement with any labour standards type legislation, or other period agreed to by the Member and the Employer.
Physician
A qualified medical practitioner who is legally licensed to practice medicine by the jurisdiction in which he operates.
Policyholder
The company or organization specified on the cover page of this 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 Member resides.

Spouse
A person residing in Canada who, at the time of the event that results in a claim: 1) is legally married to or living in a civil union with the Member, 2) is living with the Member in a conjugal relationship and has not been separated from the Member 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 Member last designated as such, subject to approval of any Evidence of Insurability required under the policy, or 2) the Spouse to whom the Member is legally married or with whom the Member 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 significant deterioration of the medical condition during the Trip.

Total Disability or Totally Disabled
1) During the Member Long Term Disability Benefit Qualifying Period and the next 24 months, a state of incapacity resulting from an Illness or Accident that entirely prevents the Member from performing the essential duties of his own occupation, 2) after the Member Long Term Disability Benefit Qualifying Period and the next 24 months, a state of incapacity, resulting from an Illness or Accident, that entirely prevents the Member from working in any occupation that he is suited for by education, Training and Experience. Training and experience means all of the knowledge and skills the Member acquired while in school, in the performance of his current or former professional activities or during his non-working hours. A Member is not considered disabled simply because an occupation that he is suited for by education, Training and Experience is not available in the area where he resides. A Member who needs a government issued driver's license to perform the duties of his occupation is not considered disabled simply because his license has been revoked or not renewed.
Travelling Companion
A person age 18 or older who is not a Dependent Child and who is sharing travel arrangements with the Covered Person.
Travel Service Supplier
A travel agency, a travel wholesaler, a travel package organizer, a cruise operator or an airline that has a valid license and operating certificate issued by the appropriate Canadian or foreign authorities.
Trip
Any fixed period of time that: 1) arrangements have been made with any Travel Service Supplier, or 2) reservations have been made by the Covered Person for ground travel usually included in a travel package.
Vehicle
A car, a motor home or a van with a maximum load of 1,000 kilograms.

GENERAL PROVISIONS

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 and words referring to any one gender include any other gender.

ELIGIBILITY

EMPLOYEE ELIGIBILITY

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

Number of hours worked per week	Waiting Period
25 hours	**For Member Long Term Disability Benefit:** 1950 hours of Continuous Service for the Employer **For all other Benefits:** 490 hours of Continuous Service for the Employer

DEPENDENT ELIGIBILITY

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

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

Dependents cannot be covered unless the Member 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 Member to designate persons to whom or for whose amounts are to be payable for some benefits.

COVERAGE APPLICATION

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

1) Application within the time limit

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

2) Late application

a) All Benefits other than Dental Care Benefit

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

b) Dental Care Benefit

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

Evidence of Insurability

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

1) Member Custom Long Term Disability Benefit

2) Basic Life Insurance Benefit

EXEMPTION PRIVILEGE

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

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

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

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

COVERAGE TYPES

The coverage types available under the policy are:

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

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

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

A life event is defined as:

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

2) birth or adoption of a Child,

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

4) death of a Dependent,

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

6) a Dependent Child returns to school.

BENEFICIARY

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

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

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

COMMENCEMENT OF COVERAGE

COMMENCEMENT OF MEMBER COVERAGE

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

1) If application is made within the time limit

The coverage of any Employee is effective on the date he is eligible.

2) If late application

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

If an Employee is not Actively at Work due to Illness or injury on the date coverage would be effective, his coverage will start once he has been Actively at Work during:

1) 7 consecutive schedules working days following his return to work, for full-time Employees, or

2) all the consecutive working days scheduled in the 10 calendar days following his return to work, for part-time Employees.

COMMENCEMENT OF DEPENDENT COVERAGE

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

If a Member already has Dependent coverage on the date he acquires a new Dependent, the coverage of that Dependent is effective on the date he becomes a Dependent, except for benefits requiring Evidence of Insurability.

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

CHANGE IN AMOUNT OF COVERAGE AND BENEFIT

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 Member is Actively at Work on that date:

1) the date the Member 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 his eligibility for the change.

   Any increase in the Maximum without Evidence of Insurability does not apply to a Covered Person who was previously declined for an amount in excess of the Maximum without Evidence of Insurability.

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

CONTINUATION OF COVERAGE DURING ABSENCE FROM WORK

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

ILLNESS OR INJURY

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 Member is eligible for a premium waiver.

TEMPORARY LAY-OFF OR UNPAID LEAVE OF ABSENCE

The Member is allowed to keep all benefits that are in place immediately before the absence, except for Member Long Term Disability Benefit. Benefits can be continued for any predetermined period as long as premiums continue to be paid. However, the coverage can only be continued for a maximum of 12 months. DFS must be advised of the scheduled return to work date prior to the start of the absence.

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

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

   a) all benefits, or

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

2) discontinue all benefits.

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

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

STRIKE OR LOCK-OUT

The Member is allowed to keep all benefits that are in place immediately before the absence, except for Member Long Term Disability Benefit. 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 120 days.

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

TERMINATION OF BENEFITS AND COVERAGE

BENEFIT TERMINATION

Each Benefit terminates on the date specified below.

BENEFIT	TERMINATION DATE
Extended Health Care Benefit	The Member's 75th birthday or retirement, whichever comes first
Dental Care Benefit	The Member's 75th birthday or retirement, whichever comes first
Member Custom Long Term Disability Benefit	The Member's 65th birthday or retirement, whichever comes first
Life Insurance Benefit	The Member's 75th birthday or retirement, whichever comes first
Accidental Death and Dismemberment Benefit	The Member's 75th birthday or retirement, whichever comes first

TERMINATION OF MEMBER COVERAGE

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

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

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

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

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

5) the date he retires,

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

7) the date the policy terminates.

TERMINATION OF DEPENDENT COVERAGE

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

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

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

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

REINSTATEMENT OF COVERAGE

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

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

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

FRAUD

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

CLAIMS

NOTICE AND PROOF OF CLAIM

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

BENEFIT	TIME LIMIT
Extended Health Care Benefit	All claims, with receipts included, must be submitted to DFS within 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.
Member Custom 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.

If the policy terminates, no payment will be made:

1) under the Drug, Extended Health Care and Dental Care benefits for claims received by DFS after the date of termination of the policy, and
2) for any claim under all other benefits, unless the notice and proof of claim are 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 the Insurance Act or other legislation of the province where the Member resides.

SUBMISSION OF CLAIMS

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

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

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

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

CO-ORDINATION OF BENEFITS

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

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

Travel Insurance Expenses

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

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

MEDICAL EXAMINATIONS

From time to time, DFS is entitled to have a claimant examined by a health professional 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 Member. DFS may bring action in the name of the Member to enforce these rights.

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

RIGHT OF RECOVERY

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

WAIVER OF PREMIUM

This provision applies to the following Benefits:

- Member Custom Long Term Disability Benefit
- Basic Life Insurance Benefit
- Basic Accidental Death and Dismemberment Benefit

1) Beginning of the Waiver of Premium

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

2) Termination of the Waiver of Premium

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

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

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

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

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

e) the date the Member retires,

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

3) Recurrent Total Disability

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

4) Notice and Proof of Total Disability

For the Member to be eligible for Waiver of Premium, DFS must receive 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 Member became Totally Disabled.

EXTENDED HEALTH CARE BENEFIT

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

SUMMARY OF BENEFITS

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

Deductible	
Eligible Expenses	**Amount**
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 If a drug payment card is used when filling a prescription at a preferred pharmacy network that was selected by the Employer, the Dispensing Fee is reimbursed at 100%.
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 Member's province of residence, and

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

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

DRUGS

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

   a) by law require a prescription, or

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

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

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

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

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

4) Prior Authorization Drugs

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

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

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

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

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

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**
Smoking cessation aids (products only)	$200 per calendar year
Fertility treatment	Drugs and treatment, $5,000 combined lifetime

HEALTH PROFESSIONALS	
Eligible Expenses	**Maximum Payable Amount per Covered Person**
<u>Paramedical Services</u> Services of the following professionals if they are practicing within their recognized field and are members in good standing of their professional governing body that is recognized by DFS. Medical recommendation is not required unless specified.	For each type of professional, the maximum is limited to one visit per day
• chiropractor • massage therapist, orthotherapist or kinesiotherapist • podiatrist or chiropodist	Combined amount of $750 per calendar year for all these services combined, including x-rays ordered by a chiropractor, a chiropodist or a podiatrist
• physiotherapist, physiotherapy technologist, sports therapist or kinesiologist	Combined amount of $400 per calendar year
• psychologist, social worker, guidance counsellor, psychotherapist, psychoeducator, registered clinical counsellor or Canadian certified counsellor	Combined amount of $600 per calendar year

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 12 months after the date of the Accident. Reimbursement of Eligible Expenses is governed by the current year Dental Association Fee Guide for General Practitioners where the Member resides.

VISION CARE	
Eligible Expenses	**Limitations and/or Maximum Payable Amount per Covered Person**
Eye exam	One in any period of 24 months Reasonable and Customary Charges
Eyeglasses or contact lenses	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. $650 in any period of 24 months

Eyeglasses, contact lenses following a non refractive surgery (including cataract)	Purchase and replacement $300 lifetime
Intraocular lenses	Purchase, as a replacement for natural crystalline in case of cataracts $300 lifetime
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, up to: $300 lifetime

REFERRAL TREATMENT

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

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

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

3) DFS must give prior written approval, and

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

Eligible Expenses	Limitations and/or Maximum Payable Amount
Health Care Expenses	
Hospital room and board charges	In Canada: The difference between the cost of a ward and a semi-private room Outside Canada: semi-private room
Other hospital services	
Physician, surgeon or anaesthetist's fees	
Transportation Expenses	

Expenses to transport the Covered Person by a suitable means to a place of treatment competent to provide appropriate care.	
Expenses for an Immediate Family Member to be transported with the Covered Person to the place of treatment.	
Round-trip economy transportation for a qualified medical attendant when ordered by the attending Physician.	The attendant cannot be an Immediate Family Member, friend or Travelling Companion
Round-trip economy air, bus or train transportation by the most direct route for one Immediate Family Member to visit the Covered Person who must be confined for at least 7 days.	• The Covered Person must not be accompanied by an Immediate Family Member age 18 or over • The Living Expenses for the Immediate Family Member up to a maximum of $1,500 • The visit must be considered as beneficial to the patient by the attending Physician
On the death of a Covered Person, one round-trip economy air, bus or train transportation by the most direct route for one Immediate Family Member to the place of death for identification of the remains prior to repatriation.	The Covered Person must not be accompanied by an Immediate Family Member age 18 or over
On the death of a Covered Person, the cost to prepare and return the body or cremains to the place of residence by the most direct route (plane, bus or train).	$5,000 The cost of the casket or urn is not covered
Living Expenses	
The Covered Person's cost of meals and accommodation for the duration of his treatment. Additional child care expenses for Children not accompanying the Covered Person.	$200 per day per Covered Person for a maximum of 10 days. This maximum is for all these expenses combined

Long-distance Telephone Charges	
Long-distance telephone charges to reach an Immediate Family Member if the Covered Person is hospitalized.	• $50 per day up to an overall maximum of $200 per Period of Hospitalization • The Covered Person must not be accompanied by an Immediate Family Member age 18 or over • These expenses are eligible if no reimbursement has been made for Transportation Expenses for one Immediate Family Member to the Hospital
Overall Maximum Benefit	
Expenses incurred outside the province of residence, but within Canada	No maximum
Expenses incurred outside Canada	$50,000 per calendar year per Covered Person

TRAVEL INSURANCE

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

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

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

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

The Member must contact DFS if the duration of the stay outside Canada is or may be longer than 180 days, otherwise, 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	
Transportation Expenses To be eligible, all the expenses listed below must be approved and arranged by "Travel Assistance"	
Expenses to repatriate the Covered Person, as soon as his health allows it, by a suitable means of Public Transportation to his place of residence to receive appropriate care.	These expenses are eligible if the means of transportation originally arranged for the return Trip cannot be used.
Expenses for another person also covered under this Benefit to be repatriated at the same time as the Covered Person.	These expenses are eligible if the means of transportation originally arranged for the return Trip cannot be used.
Expenses for a suitable means of Public Transportation to repatriate the children accompanying and under the care of the Covered Person during the Trip if: • the Covered Person must be repatriated or hospitalized for more than 24 hours, and • nobody else can bring the children back to their home.	

Additional transportation to repatriate the cat or dog accompanying the Covered Person if: • the Covered Person must be repatriated, and • nobody else can bring the animal back to the Covered Person's place of residence.	$500 per Trip
The following fees for the transportation of the luggage of the Covered Person who must be repatriated: • excess luggage if brought back by another person, or • shipment of luggage to the Covered Person's place of residence if nobody else can bring it back.	$300 per Trip
Round-trip economy transportation for a qualified medical attendant when ordered by the attending Physician.	The attendant cannot be an Immediate Family Member, friend or Travelling Companion.
Round-trip economy air, bus or train transportation by the most direct route for one Immediate Family Member to visit the Covered Person who must be confined for at least 7 days.	• The Covered Person must not be accompanied by an Immediate Family Member age 18 or over. • The Living Expenses for the Immediate Family Member is limited to $1,500. • The visit must be considered as beneficial to the patient by the attending Physician.

<table>
<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>
<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>
</table>

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

RESTRICTIONS, LIMITATIONS AND EXCLUSIONS

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

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

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

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

Additional Restrictions Applicable to Drugs

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 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,

8) confinement in a Chronic Care Establishment,

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

10) robotic walking aid apparatus,

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

12) charges for any surgically implanted item,

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

14) physical exercise class or program of any kind,

15) therapeutic bath of any kind,

16) fasting therapy and related charges,

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

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

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

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

21) incontinence supplies,

22) expenses incurred for detoxification,

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

24) 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) 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 Member's province of residence requires services. Failure to contact "Travel Assistance" may result in limited reimbursement of any costs incurred or denial of the claim. DFS is not responsible for the availability or quality of the medical services even after repatriation.

No reimbursement is made:

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

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

3) if the Covered Person did not agree to:

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

   b) change hospital or clinic,

   c) be examined for diagnostic purposes,

   d) repatriation as recommended by "Travel Assistance";

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

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

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

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

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

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

9) 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.

DENTAL CARE BENEFIT

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

SUMMARY OF BENEFITS

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

Deductible	
Eligible Expenses	**Amount**
All Eligible Expenses	None
Percentage of Reimbursement	
Eligible Expenses	**Percentage**
Preventive Services	100%
Basic Services	100%
Major Restorative Services	50%
Orthodontics	50%
Maximum Benefit	
Eligible Expenses	**Amount**
Preventive and Basic Services	Unlimited
Major Restorative Services	Combined maximum of $1,500 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 his license, or

3) a licensed denturist.

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

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

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

PREDETERMINATION OF BENEFIT

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

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

FEE GUIDE

Reimbursement of Eligible Expenses incurred in Canada is governed by the Provincial Dental Association Fee Guide for General Practitioners, dental hygienists or denturists of the province where the services are provided, and recognized by DFS, for the calendar year during which expenses are incurred minus 2 years.

Reimbursement of Eligible Expenses incurred outside Canada is governed by the Provincial Dental Association Fee Guide for General Practitioners of the province where the Member resides and recognized by DFS, for the calendar year during which expenses are incurred minus 2 years.

In the absence of a fee guide recognized by DFS or if the fee guide is not recognized by DFS for the 2 years preceding the one during which expenses are incurred, Eligible Expenses are limited to the Reasonable and Customary Charges for that year. Additional expenses related to Eligible Expenses for which no amount is set in the fee guide are limited to the Reasonable and Customary Charges. The Eligible Expenses for lab fees are limited to 60% of the amount for the corresponding procedure in the applicable Fee Guide.

ELIGIBLE EXPENSES

IN CANADA

PREVENTIVE SERVICES	
Eligible Expenses	**Limitations and/or Maximum per Covered Person**
Examinations	
• Complete oral examination	One every 2 calendar years
• Preventive or recall oral examination	One in any 9-month period
• Emergency oral examination	
• Specific oral examination	
Radiographs (X-rays)	
• Complete series of radiographs or panoramic radiographs	One every 2 calendar years
• Intraoral radiographs (except bitewing films)	
• Bitewing films	One in any 9-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	One in any 9-month period
• Fluoride treatment	One in any 9-month period
• Finishing restorations, including disking and recontouring of natural teeth to improve function	
• Pit and fissure sealants	
• Interproximal disking	
• Space maintainer	2 in any 12-month period For persons under age 18
• Scaling and root planing	12 units per calendar year

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

Implantology	
• Implant	One implant per tooth in a lifetime
• Oral surgery related to an implant	Each surgery is limited to one in a lifetime per eligible implant
• Periodontal surgery related to an implant	
• Radiographic guide	Once in a lifetime per eligible implant
Other Restorations	
• Veneer, gold foil, inlay, onlay, crown	
• Repair	
• Retentive pins, posts and cores	
• Recementation	
• Removal	

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

OUTSIDE CANADA

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

1) for emergency treatment only, and

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

RESTRICTIONS, LIMITATIONS AND EXCLUSIONS

Restrictions

Late Application

If the Member's application for the Dental Care Benefit is late, for either himself or his Dependents, reimbursement is limited to $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) patient motivation (psychological evaluation),

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

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

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

15) semi-precision or precision attachments,

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

MEMBER CUSTOM LONG TERM DISABILITY BENEFIT

SUMMARY OF BENEFITS

When DFS receives satisfactory Proof of Claim that the Member:

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

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

DFS pays benefits according to policy provisions.

MEMBER CUSTOM LONG TERM DISABILITY BENEFIT

Percentage and Maximum of Benefit
60% of monthly gross Earnings, rounded to the next $1, if not already a multiple Maximum $3,800 Maximum without Evidence of Insurability: no evidence required if application is completed within the time limit
Qualifying Period
120 days
Maximum Age to be Eligible
64 years and 245 days
Maximum Benefit Period
To age 65
Taxability Status
Taxable

QUALIFYING PERIOD

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

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

2) the date the Member consults a Physician.

If Total Disability begins during an absence from work, the Qualifying 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 Member is scheduled to return to work, for any other absence or leave,

provided the Member can and does continue his coverage under this Benefit throughout the leave.

BENEFIT PAYMENT

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

Benefits are 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 Qualifying Period, or

2) the scheduled return to work date.

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

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

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

RECURRENT DISABILITY

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

1) less than 3 consecutive weeks during the Qualifying Period, or

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

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

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

REHABILITATION

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

The Member 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 Member is eligible to receive under any Workers' Compensation Act or similar legislation,

b) benefits the Member 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 Member 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

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

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

a) any amounts payable under this Benefit,

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

c) any benefits the Member 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 Member 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 any 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

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 as part of a rehabilitative program, the benefits payable by DFS are reduced by any income earned from any rehabilitative program.

Benefits are reduced so that his total income from all sources does not exceed 100% of his monthly gross 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 Member is required to apply for all benefits available to him under any of the above plans or legislations. If he fails to apply, DFS may estimate the income that is otherwise payable under any government plan. The Member’s benefits are reduced by this estimated amount. Any adjustments are made once the notice of the actual award is received.

5) Lump-sum payment

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

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

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

9) while benefits are paid under the Employment Insurance Act, other than those paid during the "health related portion" of the Maternity leave.

Pre-existing condition exclusion

No benefits are payable for any Total Disability that:

1) began during the first 12 months of the Member'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 Member 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 Member 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 or indirectly from any one of the following causes:

1) war, whether declared or not, or service in the armed forces of any country, or participation in a riot, insurrection or civil commotion,
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 Member 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 Member 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 Member retires, or
4) this Benefit terminates.

LIFE INSURANCE BENEFIT

SUMMARY OF BENEFITS

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

BASIC LIFE INSURANCE BENEFIT

Member
Amount of Insurance
2 times annual Earnings, rounded to the next higher $1,000, if not already a multiple Minimum $10,000 Maximum $350,000 Maximum without Evidence of Insurability: no evidence required if application is completed within the time limit
Reduction
The Amount of Insurance is reduced by 50% on the Member's 65th birthday.

EARLY PAYMENT

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

1) approval is obtained from DFS,

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

3) the Member is competent to act, and

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

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

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

The value of the Early Payment is:

1) the total amount of Early Payment paid, plus

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

EARLY PAYMENT EXCLUSION

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

CONVERSION PRIVILEGE

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

1) $200,000, or

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

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

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

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

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

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

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

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

Member
Amount of Insurance
Equal to the Basic Life Benefit
Reduction
The Member's Amount of Insurance is reduced by 50% on the Member'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%

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

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

DISAPPEARANCE

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

EXPOSURE TO THE ELEMENTS (FORCES OF NATURE)

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

REHABILITATION

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

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

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

FAMILY TRANSPORTATION AND HOTEL ACCOMMODATION

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

1) he is confined as an inpatient,

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

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

REPATRIATION

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

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

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

HOME OR VEHICLE CONVERSION

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

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

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

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

Reimbursement is only made if:

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

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

DAY CARE BENEFIT

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

1) the dependent child is under age 13,

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

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

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

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

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

LIMITATIONS AND EXCLUSIONS

Limitations

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

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

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

Exclusions

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

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

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

3) service in the armed forces of any country,

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

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

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

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

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

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

CONVERSION PRIVILEGE

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

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

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.

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