My group benefit plan

canada life™

the CUPE EWBT

All Plan Members

We are pleased to offer you our services. As we adhere to principles of inclusion, all genders are incorporated in the language used in our communications with you.

BENEFIT DETAILS

Canada Life™ is a leading Canadian life and health insurer. Canada Life's financial security advisors work with our clients from coast to coast to help them secure their financial future. We provide a wide range of retirement savings and income plans; as well as life, disability and critical illness insurance for individuals and families. As a leading provider of employee benefits in Canada, we offer effective benefit solutions for large and small employee groups.

Canada Life Online

Visit our website at www.canadalife.com for:

- information and details on Canada Life's corporate profile and our products and services
- investor information
- news releases
- contact information
- online claims submission

GroupNet for Plan Members

As a Canada Life plan member, you can register for GroupNet™ for Plan Members at http://www.otip.com/enrol. To access this service, click on My Claims. Follow the instructions to register. Make sure to have your plan and OTIP identification numbers available before accessing the website.

With GroupNet and GroupNet Mobile you can:

- Submit claims quickly
- Review your coverage and balances
- Find healthcare providers like chiropractors and massage therapists near you
- Save your benefits cards to your payment service application or program
- Get notified when your claims have been processed

Canada Life's Toll-Free Number

To contact a customer service representative at Canada Life for assistance with your medical and dental coverage, please call 1-866-800-8058.

If you would like service in a language other than English or French, please advise the customer service representative at the beginning of your call. A third-party translator with access to over 240 languages will be contacted for immediate assistance.

The information provided in the booklet is intended to summarize the principal features of the group benefit plan sponsored by the CUPE EWBT, but **Group Policy Nos. 172510** and **172511** and **Plan Document No. 50210** issued by Canada Life and **Policy Nos. AB10515801** and OE10515801 issued to the CUPE EWBT by Chubb Life Insurance Company of Canada are the governing documents. If there are variations between the information in the booklet and the provisions of the policies or plan document, the policies or plan document will prevail.

This booklet contains important information and should be kept in a safe place known to you and your family.

The Claim's Adjudicator is

and

Chubb Life Insurance Company of Canada

The plan is sponsored by

The CUPE EWBT

and the plan is administered by

The Ontario Teachers' Insurance Plan (OTIP)

This booklet was prepared on: January 29, 2020

Access to Documents

You have the right, upon request, to obtain a copy of the policy, your application and any written statements or other records you have provided to Canada Life as evidence of insurability, subject to certain limitations.

Legal Actions

Insured benefits

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the *Insurance Act* (for actions or proceedings governed by the laws of Alberta and British Columbia), *The Insurance Act* (for actions or proceedings governed by the laws of Manitoba), the *Limitations Act, 2002* (for actions or proceedings governed by the laws of Ontario), or other applicable legislation. For those actions or proceedings governed by the laws of Quebec, the prescriptive period is set out in the Quebec Civil Code.

Non-insured benefits

No legal action to recover non-insured benefits under this plan can be introduced for 60 days after notice of claim is submitted, or more than two years after a benefit has been denied.

Appeals

Insured benefits

You have the right to appeal a denial of all or part of the insurance or benefits described in the contract as long as you do so within one year of the initial denial of the insurance or a benefit. An appeal must be in writing and must include your reasons for believing the denial to be incorrect.

Non-insured benefits

You have the right to appeal a denial of all or part of the coverage or benefits described in this plan as long as you do so within two years after the denial. An appeal must be in writing and must include your reasons for believing the denial to be incorrect.

Benefit Limitation for Overpayment

Insured benefits

If benefits are paid that were not payable under the policy, you are responsible for repayment within 30 days after Canada Life sends you a notice of the overpayment, or within a longer period if agreed to in writing by Canada Life. If you fail to fulfil this responsibility, no further benefits are payable under the policy until the overpayment is recovered. This does not limit Canada Life's right to use other legal means to recover the overpayment.

Non-insured benefits

If benefits are overpaid you are responsible for repayment within six months, or within a longer period if agreed to by the CUPE EWBT. If you fail to fulfill this responsibility, further benefits will be withheld until the overpayment is recovered. This does not limit the CUPE EWBT's right to use other legal means to recover the overpayment.

Protecting Your Personal Information

At Canada Life, we recognize and respect the importance of privacy. Personal information about you is kept in a confidential file at the offices of Canada Life or the offices of an organization authorized by Canada Life. Canada Life may use service providers located within or outside Canada. We limit access to personal information in your file to Canada Life staff or persons authorized by Canada Life who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law. Your personal information may be subject to disclosure to those authorized under applicable law within or outside Canada.

We use the personal information to administer the group benefits plan under which you are covered. This includes many tasks, such as:

- determining your eligibility for coverage under the plan
- enrolling you for coverage
- investigating and assessing your claims and providing you with payment
- managing your claims
- verifying and auditing eligibility and claims
- creating and maintaining records concerning our relationship
- underwriting activities, such as determining the cost of the plan, and analyzing the design options of the plan
- Canada Life's and its affiliates' internal data management and analytics
- preparing regulatory reports, such as tax slips

The CUPE EWBT has an agreement with Canada Life in which your plan sponsor, the CUPE EWBT, has financial responsibility for some or all of the benefits in the plan and we process claims on the CUPE EWBT's behalf. We may exchange personal information with your health care providers, your plan administrator The Ontario Teachers' Insurance Plan (OTIP), any insurance or reinsurance companies, administrators of government benefits or other benefit programs, other organizations, or service providers working with us or the above when relevant and necessary to administer the plan.

As a plan member, you are responsible for the claims submitted. We may exchange personal information with you and a person acting on your behalf when relevant and necessary to confirm coverage and to manage the claims submitted.

You may request access or correction of the personal information in your file. A request for access or correction should be made in writing and may be sent to any of Canada Life's offices or to our head office.

For a copy of our Privacy Guidelines, or if you have questions about our personal information policies and practices (including with respect to service providers), write to Canada Life's Chief Compliance Officer or refer to www.canadalife.com.

Notice of Liability for Benefits

The CUPE EWBT has entered into an agreement with The Canada Life Assurance Company whereby the Healthcare (other than Global Medical Assistance) and Dentalcare benefits outlined in this booklet are uninsured and your plan sponsor has liability for them.

This means that the Healthcare (other than Global Medical Assistance) and Dentalcare benefits are:

- an unsecured financial obligation and are payable from your plan sponsor's net income, retained earnings or other financial resources; and
- not underwritten by a licensed insurer or regulated insurer.

All claims will, however, be processed by Canada Life.

If British Columbia law applies, the giving of this notice exempts the CUPE EWBT from the requirements under the Financial Institutions Act (British Columbia).

If Quebec law applies, any uninsured benefit is not under the supervision and control of the Autorité des marchés financiers.

TABLE OF CONTENTS

Benefit Summary

This summary must be read together with the benefits described in this booklet.

Member Basic Life Insurance	
	2 x annual earnings to a maximum of $400,000
Living Assistance Benefit	See benefit description for details
Member Supplementary Life Insurance	
	A plan member who transitioned into the CUPE EWBT plan on March 1, 2018 with more than 2 x annual earnings of basic life insurance will have the additional life volume as Supplementary Life Insurance
	The total amount of Basic Life and Supplemental Life Insurance is limited to a combined maximum of $400,000

Optional Life Insurance

Member and Spouse	Available in $10,000 units to a maximum of $300,000, for you or your spouse, subject to approval of evidence of insurability If you are covered under this plan as both a member and a spouse, you are limited to a maximum of $600,000
Child	Available in $5,000 units to a maximum of $25,000

Basic, Supplemental and Optional AD&D Insurance (Underwritten by Chubb Life Insurance Company of Canada)

See benefit description for details

Healthcare

Covered expenses will not exceed customary charges

A benefit year is from September 1st to August 31st.
Rolling months are consecutive months from the date of purchase.

Deductible	Nil
Reimbursement Level	100%

Basic Expense Maximums

Hospital	Semi-private room
Home Nursing Care	$25,000 every 36 rolling months
In-Canada Prescription Drugs	Included
Drugs Used To Treat Sexual Dysfunction	$300 each benefit year
Fertility Drugs	$12,000 lifetime or as otherwise required by law
Dispensing Fee Limits	The covered expense for the dispensing fee portion of a prescription drug charge is limited to $11.00. For maintenance drugs, a maximum of 6 dispensing fees are covered per drug with the same chemical, form and strength each benefit year
exception for Drugs Purchased in Saskatchewan	For maintenance drugs purchased in Saskatchewan, a maximum of 12 dispensing fees are covered per drug with the same chemical, form and strength each benefit year
exception for Drugs Purchased in Quebec	The dispensing fee frequency limit does not apply to drugs purchased in Quebec
Hearing Aids	$2,500 every 24 rolling months

Insulin Infusion Pumps	$2,000 per pump once every 60 rolling months
Incontinence Supplies	$1,000 every 12 rolling months
Custom-fitted Orthopedic Shoes	1 pair every 12 rolling months to a maximum of $500 per pair
Custom-made Foot Orthotics	1 pair every 24 rolling months to a maximum of $700
Myoelectric Arms	$10,000 per prosthesis
External Breast Prosthesis	1 every 12 rolling months
Surgical Brassieres	2 every 12 rolling months
Mechanical or Hydraulic Patient Lifters	$2,000 per lifter once every 60 rolling months
Outdoor Wheelchair Ramps	$2,000 lifetime
Blood-glucose Monitoring Machines	$150 every 12 rolling months
Continuous Glucose Monitoring Machines (including Sensors and Transmitters) and Flash Glucose Monitoring Systems	$4,000 combined every 12 rolling months
Transcutaneous Nerve Stimulators	$700 lifetime
Extremity Pumps for Lymphedema	$1,500 lifetime
Custom-made Compression Hose	2 pairs every 12 rolling months
Wigs	$1,000 lifetime
Continuous Positive Airway Pressure (CPAP) Machine and supplies	$2,500 each benefit year
Scoliosis Brace	Included

Paramedical Expense Maximums

Chiropractors	$750 each benefit year
Massage Therapists	$500 each benefit year
Naturopaths	$500 each benefit year
Osteopaths	$750 each benefit year
Physiotherapists/Athletic Therapists/Occupational Therapists	$1,750 combined each benefit year
Podiatrists/Chiropodists	$500 combined each benefit year
Psychologists/ Social Workers/ Marriage and Family Therapists and Psychotherapists	$1,500 combined each benefit year
Speech Therapists/Audiologists	$1,000 combined each benefit year

Visioncare Expense Maximums

Eye Examinations	1 every 24 rolling months
Glasses, Contact Lenses and Laser Eye Surgery	$450 every 24 rolling months

Out-of-Country Emergency Care Maximum	$1,000,000 per trip
Lifetime Healthcare Maximum	Unlimited

Dentalcare

Covered expenses will not exceed customary charges

Payment Basis	The dental fee guide in effect on the date treatment is rendered for the province in which treatment is rendered
Deductible	Nil
Reimbursement Levels	
Basic Coverage	100%
Major Coverage	70%
Orthodontic Coverage	50%
Plan Maximums	
Basic Coverage	Unlimited
Major Coverage	$2,500 each benefit year
Orthodontic Coverage	$3,000 lifetime

COMMENCEMENT AND TERMINATION OF COVERAGE

Permanent employees at an Ontario School Board are eligible to participate in the plan as of March 1, 2018.

New employees are eligible to participate in the plan on the date you begin a permanent position as a CUPE member at an Ontario school board.

- You and your dependents will be covered as soon as you become eligible.
- Temporary and casual members may not join the plan unless the local collective agreements as of the plan effective date of March 1, 2018 provides coverage for temporary or casual members.

Your coverage terminates when you are no longer a CUPE member, you are no longer eligible, you stop making the required contributions, the plan terminates or the end of the month in which you retire, whichever is earliest.

- Your dependents' coverage terminates when your coverage terminates or your dependent no longer qualifies, whichever is earlier.
- Your coverage may be extended if it would have normally been terminated because you are not actively at work due to disease or injury, temporary lay-off or leave of absence. See your plan administrator for details.

- When your coverage terminates or you go on leave, you may be entitled to an extension of benefits under the plan. See your plan administrator for details.

Survivor Benefits

If you die while your coverage is still in force, the health and dental benefits for your surviving spouse and dependents will be continued for a period of 12 months premium free. Then, benefits can continue for another 12 months with 100% premium contributions from your surviving spouse or dependents.

DEPENDENT COVERAGE

Dependent means:

- Your spouse, legal or common-law.
- Your unmarried children under age 21, or under age 26 if they are students.

  Children who are incapable of supporting themselves because of physical or mental disorder are covered without age limit if the disorder begins before they turn 21, or while they are students under 26, and the disorder has been continuous since that time.

BENEFICIARY DESIGNATION

You may make, alter, or revoke a designation of beneficiary as permitted by law. Any designation of beneficiary you made under your employer's previous policy prior to the effective date of this policy applies to this policy until you make a change to that designation. You should review your beneficiary designation from time to time to ensure that it reflects your current intentions. You may change the designation by logging into the OTIP My Benefits site.

MEMBER BASIC AND SUPPLEMENTARY LIFE INSURANCE

On your death, Canada Life will pay your life insurance benefits to your named beneficiary. If you have not named a beneficiary or there is no surviving beneficiary at the time of your death, payment will be made to your estate. Your plan administrator will explain the claim requirements to your beneficiary.

- Your life insurance and supplementary life insurance, if applicable, will not continue past the end of the day on the last day of the month in which you retire.

- If you become disabled while insured, Canada Life may waive the premiums on your life insurance after the waiting period, throughout the benefit period.

  If you are insured under the long term disability benefit, the waiting period is the same as the waiting period under the long term disability income benefit. A benefit period is the period of time after the waiting period during which you satisfy the disability definition under the long term disability income benefit. A benefit period will not continue past your 65th birthday.

  If you are not insured under the long term disability benefit and you are under age 65 and have been disabled for 6 months or more, you may be entitled to have your life insurance continued without premium payment until you reach age 65. You are considered disabled if injury or disease prevents you from being gainfully employed in any job. Canada Life will determine your qualification for waiver of premium benefits. If you believe you may be eligible, contact your plan administrator for claim forms. You must apply for waiver of premium benefits within 12 months of becoming eligible.

- Your life insurance may terminate if you are age 65 or over and you are not actively at work. However, if you are not actively at work because of disease or injury, your life insurance may be continued on a premium paying basis following the date you ceased to be actively at work.

- If any or all of your insurance terminates on or before your 65th birthday, you may be eligible to apply for an individual conversion policy without providing proof of your insurability. You must apply and pay the first premium no later than 45 days after your group insurance terminates. Contact your plan administrator for details.

Living Assistance Benefit

Canada Life may, at its discretion, pay a portion of your amount of insurance prior to your death. You may be eligible for a Living Assistance Benefit if:

- the prognosis of your illness is terminal and you are not expected to live longer than 24 months,

- your attending physician provides sufficient medical evidence, including the diagnosis and prognosis, to allow a thorough assessment of your life expectancy,

- the Group Policyholder authorizes the request for the payment of this benefit, and

- you have not named an irrevocable beneficiary.

The amount payable is equal to 50% of your amount of insurance or $50,000, whichever is less. You will be required to sign a valid release form for the amount paid in advance of your death. At the time of your death, the amount of the benefits payable will be reduced by the amount of the Living Assistance Benefit plus accumulated interest to the date of your death. Interest will be calculated at Canada Life's current one-year rate.

OPTIONAL LIFE INSURANCE

Optional life insurance allows you to choose additional coverage for yourself and your dependents. Check the **Benefit Summary** for the amount of optional life insurance available.

When you apply for optional life insurance for yourself or your spouse, you must provide proof of insurability, and the application must be approved by Canada Life. Canada Life may void the optional insurance if any statement or answer in your application misrepresents or fails to disclose any fact material to the insurance.

On your death, Canada Life will pay your life insurance to your named beneficiary. If you have not named a beneficiary or there is no surviving beneficiary at the time of your death, payment will be made to your estate. Your plan administrator will explain the claim requirements. If one of your dependents dies you will be paid the amount for which that person was insured.

- If you are approved for waiver of premium on your basic life insurance, any optional life insurance for yourself or your dependents will also continue without premium payment as long as your basic life insurance continues but not beyond the date your optional insurance would otherwise terminate.

- If you live in Quebec and your, your spouse's or your child’s optional life insurance terminates, you, your spouse or your child may be eligible for an individual conversion policy without providing proof of insurability.

  If you live elsewhere in Canada and your or your spouse's optional life insurance terminates, you or your spouse may be eligible for an individual conversion policy without providing proof of insurability.

  You must apply and pay the first premium no later than 45 days after the group insurance terminates. In the case of insurance for your spouse or child, you or your spouse may apply. See your plan administrator for details.

- Your and your children’s optional life insurance will not continue past the end of the day on the last day of the month in which you retire. Your spouse's coverage will terminate at the same time or the end of the day before the date they reach age 65 or are no longer your spouse, whichever comes first.

Limitation

No benefit is paid for suicide within the first two years of initial or increased optional life coverage. In such a situation, Canada Life refunds the premiums that have been received. This limitation does not apply to coverage for a dependent child.

HEALTHCARE

All expenses will be reimbursed at the level shown in the **Benefit Summary**. Benefits may be subject to plan maximums and frequency limits. Check the **Benefit Summary** for this information.

Except for scoliosis braces and Continuous Positive Airway Pressure (CPAP) machines and related supplies, the plan covers customary charges for the following services and supplies. All covered services and supplies must represent reasonable treatment. Treatment is considered reasonable if it is accepted by the Canadian medical profession, it is proven to be effective, and it is of a form, intensity, frequency and duration essential to diagnosis or management of the disease or injury.

Your healthcare coverage will not continue past the end of the day on the last day of the month in which you retire, unless otherwise required by law.

Covered Expenses

- Ambulance transportation to the nearest centre where adequate treatment is available
- Hospital or nursing home confinement or home nursing care if it represents acute, convalescent, or palliative care.

  Acute care is active intervention required to diagnose or manage a condition that would otherwise deteriorate.

  Convalescent care is active treatment or rehabilitation for a condition that will significantly improve as a result of the care and follows a 3-day confinement for acute care.

  Palliative care is treatment for the relief of pain in the final stages of a terminal condition.

  - Preferred accommodation in a hospital or accommodation in a nursing home is covered when provided in Canada.

For hospital accommodation, the plan covers the difference between the hospital's semi-private and standard ward rates. For out-of-province hospital accommodation, any difference between the hospital's standard ward rate and the government authorized allowance in the person's home province is also covered.

The plan also covers the hospital facility fee related to dental surgery and any out-of-province hospital out-patient charges not covered by the government health plan in the person’s home province.

For accommodation in a nursing home, the plan covers the government authorized co-payment.

Limitation

Residences established primarily for senior citizens or which provide personal rather than medical care are not covered.

- The plan covers home nursing services, including chronic care, of a registered nurse, a registered practical nurse if the person is a resident of Ontario or a licensed practical nurse if the person is a resident of any other province, when services are provided in Canada.

  Nursing care is care that requires the skills and training of a professional nurse, and is provided by a professional nurse who is not a member of the patient's family.

  You should apply for a pre-care assessment before home nursing begins.

- Drugs and drug supplies described below when prescribed by a person entitled by law to prescribe them, dispensed by a person entitled by law to dispense them, and provided in Canada. Benefits for drugs and drug supplies provided outside Canada are payable only as provided under the out-of-country emergency care provision.

  - Drugs which require a written prescription according to the Food and Drugs Act, Canada or provincial legislation in effect where the drug is dispensed, including contraceptive drugs and products containing a contraceptive drug

  - Injectable drugs including vitamins, insulins and allergy extracts. Syringes for self-administered injections are also covered

  - Disposable needles for use with non-disposable insulin injection devices, lancets and test strips

  - Extemporaneous preparations or compounds if one of the ingredients is a covered drug

  - Certain other drugs that do not require a prescription by law may be covered. If you have any questions, contact your plan administrator before incurring the expense.

  The plan will also pay for preventative immunization vaccines and toxoids.

  Unless medical evidence is provided to Canada Life that indicates why a drug is not to be substituted, Canada Life can limit the covered expense to the cost of the lowest priced interchangeable drug.

  For drugs eligible under a provincial drug plan, coverage is limited to the deductible amount and coinsurance you are required to pay under that plan.

- Rental or, at the plan's discretion, purchase of certain medical supplies, appliances and prosthetic devices prescribed by a physician
- Custom-made foot orthotics, custom-fitted orthopedic shoes and Portofino Shoes, including sandals and modifications to orthopedic footwear, when prescribed by a physician
- Hearing aids, including batteries, tubing and ear molds provided at the time of purchase, when prescribed by a physician
- Diabetic supplies prescribed by a physician: Novolin-pens or similar insulin injection devices using a needle, blood-letting devices including platforms but not lancets. Lancets are covered under prescription drugs
- Blood-glucose monitoring machines prescribed by a physician
- Flash glucose monitoring machines prescribed by a physician, including sensors
- Continuous glucose monitoring machines prescribed by a physician, including receivers, sensors and transmitters
- External insulin infusion pumps prescribed by a physician
- Diagnostic laboratory and imaging procedures performed in the person's province of residence are covered when that type of procedure is not listed as an insured procedure under their provincial government plan. For greater certainty, a procedure is not eligible for coverage if a person can choose to pay for it, in whole or in part, instead of having the procedure covered under their provincial government plan

- Treatment of injury to sound natural teeth.

  A sound tooth is any tooth that did not require restorative treatment immediately before the accident. A natural tooth is any tooth that has not been artificially replaced.

  No benefits are paid for:

  - accidental damage to dentures
  - dental treatment completed more than 12 months after the accident
  - orthodontic diagnostic services or treatment

- Out-of-hospital treatment of muscle and bone disorders, including diagnostic x-rays, by a licensed chiropractor
- Out-of-hospital services of a qualified massage therapist
- Out-of-hospital services of a licensed naturopath
- Out-of-hospital services of a licensed osteopath, including diagnostic x-rays
- Out-of-hospital treatment of movement disorders by a licensed physiotherapist, a licensed athletic therapist or a qualified occupational therapist
- Out-of-hospital treatment of foot disorders (including diagnostic x-rays) by a licensed podiatrist or out-of-hospital services of a licensed chiropodist

- Out-of-hospital treatment by a registered psychologist or qualified social worker, including registered family and marriage therapists and registered and/or licensed psychotherapists

- Out-of-hospital treatment of speech impairments by a qualified speech therapist, or out-of-hospital treatment by a qualified audiologist

Visioncare

- Eye examinations, including refractions, when they are performed by a licensed ophthalmologist or optometrist, and coverage is not available under your provincial government plan

- Glasses and contact lenses required to correct vision when provided by a licensed ophthalmologist, optometrist or optician

- Laser eye surgery required to correct vision when performed by a licensed ophthalmologist

Global Medical Assistance Program

This program provides medical assistance through a worldwide communications network which operates 24 hours a day. The network locates medical services and obtains Canada Life's approval of covered services, when required as a result of a medical emergency arising while you or your dependent is travelling for vacation, business or education. Coverage for travel within Canada is limited to emergencies arising more than 500 kilometres from home. You must be covered by the government health plan in your home province to be eligible for global medical assistance benefits. The following services are covered, subject to Canada Life's prior approval:

- On-site hospital payment when required for admission, to a maximum of $1,000

- If suitable local care is not available, medical evacuation to the nearest suitable hospital while travelling in Canada. If travel is outside Canada, transportation will be provided to a hospital in Canada or to the nearest hospital outside Canada equipped to provide treatment

  When services are covered under this provision, they are not covered under other provisions described in this booklet

- Transportation and lodging for one family member joining a patient hospitalized for more than 7 days while travelling alone. Benefits will be paid for moderate quality lodgings up to $1,500 and for a round trip economy class ticket

- If you or a dependent is hospitalized while travelling with a companion, extra costs for moderate quality lodgings for the companion when the return trip is delayed due to your or your dependent’s medical condition, to a maximum of $1,500

- The cost of comparable return transportation home for you or a dependent and one travelling companion if prearranged, prepaid return transportation is missed because you or your dependent is hospitalized. Coverage is provided only when the return fare is not refundable. A rental vehicle is not considered prearranged, prepaid return transportation

- In case of death, preparation and transportation of the deceased home

- Return transportation home for minor children travelling with you or a dependent who are left unaccompanied because of your or your dependent's hospitalization or death. Return or round trip transportation for an escort for the children is also covered when considered necessary

- Costs of returning your or your dependent's vehicle home or to the nearest rental agency when illness or injury prevents you or your dependent from driving, to a maximum of $1,000.

  Limitation

  Benefits will not be paid for vehicle return if transportation reimbursement benefits are paid for the cost of comparable return transportation home

Benefits payable for moderate quality accommodation include telephone expenses as well as taxicab and car rental charges.

Limitation

Meal expenses are not covered.

Out-Of-Country Emergency Care

The plan covers medical expenses incurred as a result of a medical emergency arising while you or your dependent is outside Canada for vacation, business or education purposes. To qualify for benefits, you must be covered by the government health plan in your home province.

A medical emergency is a sudden, unexpected injury or an acute episode of disease.

- The following services and supplies are covered when related to the initial medical treatment:

    - treatment by a physician
    - diagnostic x-ray and laboratory services
    - hospital accommodation in a standard or semi-private ward or intensive care unit, if the confinement begins while you or your dependent is covered
    - medical supplies provided during a covered hospital confinement
    - paramedical services provided during a covered hospital confinement
    - hospital out-patient services and supplies
    - medical supplies provided out-of-hospital if they would have been covered in Canada
    - drugs
    - out-of-hospital services of a professional nurse
    - ambulance services by a licensed ambulance company to the nearest centre where essential treatment is available
    - dental accident treatment if it would have been covered in Canada

If your medical condition permits you to return to Canada, benefits will be limited to the amount payable under this plan for continued treatment outside Canada or the amount payable under this plan for comparable treatment in Canada, plus return transportation, whichever is less. No benefits are paid for expenses incurred more than 60 days after the date of departure from Canada. If you or your dependent is hospital confined at the end of the 60-day period, benefits will be extended to the end of the confinement.

Other Services and Supplies

Services or supplies that represent reasonable treatment but are not otherwise covered under this plan may be covered by the plan on such terms as the plan administrator determines.

Limitations

A claim for a service or supply that was purchased from a provider that is not approved by the plan administrator may be declined.

The covered expense for a service or supply may be limited to that of a lower cost alternative service or supply that represents reasonable treatment.

Except to the extent otherwise required by law, no benefits are paid for:

- Expenses private benefit plans are not permitted to cover by law
- Services or supplies for which a charge is made only because you have coverage
- The portion of the expense for services or supplies that is payable by the government health plan in your home province, whether or not you are actually covered under the government health plan
- Any portion of services or supplies which you are entitled to receive, or for which you are entitled to a benefit or reimbursement, by law or under a plan that is legislated, funded, or administered in whole or in part by a government ("government plan"), without regard to whether coverage would have otherwise been available under this plan

  In this limitation, government plan does not include a group plan for government employees
- Services or supplies that do not represent reasonable treatment

- Services or supplies associated with:
  - treatment performed only for cosmetic purposes
  - recreation or sports rather than with other daily living activities
  - the diagnosis or treatment of infertility, other than drugs
  - contraception, other than contraceptive drugs and products containing a contraceptive drug
- Services or supplies associated with a covered service or supply, unless specifically listed as a covered service or supply or determined by the plan administrator to be a covered service or supply
- Extra medical supplies that are spares or alternates
- Services or supplies received out-of-province in Canada unless you are covered by the government health plan in your home province and benefits would have been paid under this plan for the same services or supplies if they had been received in your home province

  This limitation does not apply to Global Medical Assistance
- Expenses arising from war, insurrection, or voluntary participation in a riot
- Chronic care, except as listed under Home Nursing Care
- Podiatric treatments for which a portion of the cost is payable under the Ontario Health Insurance Plan (OHIP). Benefits for these services are payable only after the maximum annual OHIP benefit has been paid
- Visioncare services and supplies required by an employer as a condition of employment

- Services or supplies that the plan administrator has determined are not proportionate to the disease or injury or, where applicable, the stage or progression of the disease or injury. In determining whether a service or supply is proportionate, the plan administrator may take any factor into consideration including, but not limited to, the following:

    - clinical practice guidelines;
    - assessments of the clinical effectiveness of the service or supply, including by professional advisory bodies or government agencies;
    - information provided by a manufacturer or provider of the service or supply; and
    - assessments of the cost effectiveness of the service or supply, including by professional advisory bodies or government agencies.

In addition and except to the extent otherwise required by law, under the prescription drug coverage, no benefits are paid for:

- Drugs or drug supplies that appear on an exclusion list maintained by Canada Life. Canada Life may exclude coverage for all expenses for a drug or drug supply, or only those expenses that relate to the treatment of specific diseases or injuries or the stages or progressions of specific diseases or injuries. Canada Life may add or remove a drug or drug supply from an exclusion list at any time.

    For greater certainty, a drug or drug supply may be added to an exclusion list for any reason including, but not limited to, the following:

    - Canada Life determining that further information from professional advisory bodies, government agencies or the manufacturer of the drug or drug supply is necessary to assess the drug or drug supply; or

    - Canada Life determining that the drug or drug supply is not proportionate to the disease or injury or, where applicable, the stage or progression of the disease or injury.

- Atomizers, appliances, prosthetic devices, colostomy supplies, first aid supplies, diagnostic supplies or testing equipment
- Non-disposable insulin delivery devices or spring loaded devices used to hold blood letting devices
- Delivery or extension devices for inhaled medications
- Oral vitamins, minerals, dietary supplements, homeopathic preparations, infant formulas or injectable total parenteral nutrition solutions
- Diaphragms, condoms, contraceptive jellies, foams, sponges, suppositories, contraceptive implants or appliances
- Smoking cessation products
- Any drug that does not have a drug identification number as defined by the Food and Drugs Act, Canada
- Any single purchase of drugs which would not reasonably be used within 34 days. In the case of certain maintenance drugs, a 100-day supply will be covered
- Drugs administered during treatment in an emergency room of a hospital, or as an in-patient in a hospital
- Non-injectable allergy extracts
- Drugs that are considered cosmetic, such as topical minoxidil or sunscreens, whether or not prescribed for a medical reason

Note: If you are age 65 or older and reside in Quebec, you cease to be covered under this plan for basic prescription drug coverage and are covered under the basic plan provided by the *Régie de l'assurance-maladie du Québec,* unless you elect to be covered under this plan as set out below.

A one-time election may be made to be covered under this plan. You must make this election and communicate it to the CUPE EWBT by the end of the 60-day period immediately following:

- the date you reach age 65; or
- the date you become a resident of Quebec, within the meaning of the Health Insurance Act, Quebec, if you are age 65 or over.

While your election to be covered under this plan is in effect, you will be deemed not to be entitled to the basic plan provided by the *Régie de l'assurance-maladie du Québec*.

"Basic prescription drug coverage" means the portion of drug expenses that is reimbursed by the *Régie de l'assurance-maladie du Québec*.

Prior Authorization

In order to determine whether coverage is provided for certain services or supplies, Canada Life maintains a limited list of services and supplies that require prior authorization.

For services and supplies, including a listing of the prior authorization drugs, go to www.canadalife.com.

Prior authorization is intended to help ensure that a service or supply represents a reasonable treatment.

If the use of a lower cost alternative service or supply represents reasonable treatment, you or your dependent may be required to provide medical evidence to Canada Life why the lower cost alternative service or supply cannot be used before coverage may be provided for the service or supply.

Health Case Management

Canada Life may contact you to participate in health case management. Health case management is a program recommended or approved by Canada Life that may include but is not limited to:

- consultation with you or your dependent and the attending physician to gain understanding of the treatment plan recommended by the attending physician;
- comparison, with the attending physician, of the recommended treatment plan with alternatives, if any, that represent reasonable treatment;
- identification to the attending physician of opportunities for education and support; and
- monitoring your or your dependent's adherence to the treatment plan recommended by the person's attending physician.

In determining whether to implement health case management, Canada Life may assess such factors as the service or supply, the medical condition, and the existence of generally accepted medical guidelines for objectively measuring medical effectiveness of the treatment plan recommended by the attending physician.

Health Case Management Limitation

The payment of benefits for a service or supply may be limited, on such terms as Canada Life determines, where:

- Canada Life has implemented health case management and you or your dependent do not participate or cooperate; or
- you or your dependent have not adhered to the treatment plan recommended by the attending physician with respect to the use of the service or supply.

Designated Provider Limitation

For a service or supply to which prior authorization applies or where Canada Life has recommended or approved health case management, Canada Life can require that a service or supply be purchased from or administered by a provider designated by Canada Life, and:

- limit the covered expense for a service or supply that was not purchased from or administered by a provider designated by Canada Life to the cost of the service or supply had it been purchased from or administered by the provider designated by Canada Life; or
- decline a claim for a service or supply that was not purchased from or administered by a provider designated by Canada Life.

Patient Assistance Program

A patient assistance program may provide financial, educational or other assistance to you or your dependents with respect to certain services or supplies.

If you or your dependents are eligible for a patient assistance program, Canada Life can require you or your dependent to apply to and participate in such a program. Where financial assistance is available from a patient assistance program in which Canada Life requires participation, Canada Life can reduce the amount of a covered expense for a service or supply by the amount of financial assistance you or your dependent is entitled to receive for that service or supply.

How to Make a Claim

- **Out-of-country claims (including those for Global Medical Assistance expenses)** should be submitted to Canada Life as soon as possible after the expense is incurred. It is very important that you send your claims to the Canada Life Out-of-Country Claims Department immediately as your Provincial or Territorial Medical Plan has very strict time limitations.

  Access GroupNet for Plan Members to obtain a personalized claim form or obtain form M5432 (Statement of Claim Out-of-Country Expenses form) from your plan administrator. You must also obtain the Government Assignment form, and residents of British Columbia, Quebec and Newfoundland & Labrador must also obtain the Special Government Claim form. The Canada Life Out-of-Country Claims Department will forward the appropriate government forms to your attention when required.

  You should complete all applicable forms, making sure all required information is included. Attach all original receipts and forward the claim to the Canada Life Out-of-Country Claims Department. Be sure to keep a copy for your own records. The plan will pay all eligible claims including your Provincial or Territorial Medical Plan portion. Your Provincial or Territorial Medical Plan will then reimburse the plan for the government's share of the expenses.

  Out-of-country claims must be submitted within a certain time period that varies by province or territory. For the claims submission period applicable in your province or territory or for any other questions or for assistance in completing any of the forms, please contact Canada Life's Out-of-Country Claims Department at 1-866-800-8058.

- **Claims for expenses incurred in Canada, for paramedical services and visioncare**, may be submitted online. To use this online service you will need to be registered for GroupNet for Plan Members and signed up for direct deposit of claim payments with eDetails. For online claim submissions, your Explanation of Benefits will only be available online.

  Online claims must be submitted to Canada Life as soon as possible, but no later than 6 months after you incur the expense.

  You must retain your receipt for 12 months from the date you submit your claim to Canada Life as a record of the transaction, and you must submit it to Canada Life on request.

- **For all other Healthcare claims**, access GroupNet for Plan Members to obtain a personalized claim form or obtain form M635D from your plan administrator. Complete this form making sure it shows all required information.

  Attach your receipts to the claim form and return it to the Canada Life Benefit Payment Office as soon as possible, but no later than 15 months after you incur the expense and no later than 180 days after the date of termination of your coverage.

- **For drug claims**, your plan administrator will provide you with a prescription drug identification card. Present your card to the pharmacist with your prescription.

  Before your prescription is filled, an Assure Claims check will be done. Assure Claims is a series of seven checks that are electronically done on your drug claim history for increased safety and compliance monitoring. This has been designed to improve the health and quality of life for you and your dependents. Checks done include drug interaction, therapeutic duplication and duration of therapy, allowing the pharmacist to react prior to the drug being dispensed. Depending on the outcome of the checks, the pharmacist may refuse to dispense the prescribed drug.

  When your coverage ends, return your direct pay drug identification card to your plan administrator.

DENTALCARE

All expenses will be reimbursed at the level shown in the **Benefit Summary**. Benefits may be subject to plan maximums and frequency limits. Check the **Benefit Summary** for this information.

The plan covers customary charges to the extent they do not exceed the dental fee guide level shown in the **Benefit Summary**. Denturist fee guides are applicable when services are provided by a denturist. Dental hygienist fee guides are applicable when services are provided by a dental hygienist practising independently.

All covered services and supplies must represent reasonable treatment. Treatment is considered reasonable if it is recognized by the Canadian Dental Association, it is proven to be effective, and it is of a form, frequency, and duration essential to the management of the person's dental health. To be considered reasonable, treatment must also be performed by a dentist or under a dentist’s supervision, performed by a dental hygienist entitled by law to practise independently, or performed by a denturist.

Your dentalcare coverage will not continue past the end of the day on the last day of the month in which you retire.

Treatment Plan

- Before incurring any large dental expenses, or beginning any orthodontic treatment, ask your dental service provider to complete a treatment plan and submit it to the plan. The benefits payable for the proposed treatment will be calculated, so you will know in advance the approximate portion of the cost you will have to pay.

Basic Coverage

The following expenses will be covered:

- Diagnostic services including:
  - one complete oral examination once every 24 rolling months
  - limited oral examinations once every 9 rolling months (once every 6 rolling months for dependent children under age 19), except that only one limited oral examination is covered in any 12-month period that a complete oral examination is also performed
  - limited periodontal examinations once every 9 rolling months (once every 6 rolling months for dependent children under age 19)
  - complete series of x-rays every 24 rolling months
  - intra-oral x-rays to a maximum of 15 films every 24 rolling months and a panoramic x-ray every 24 rolling months. Services provided in the same 12 months as a complete series are not covered
- Preventive services including:
  - polishing and topical application of fluoride each once every 9 rolling months (once every 6 rolling months for dependent children under age 19)
  - scaling, limited to a maximum combined with periodontal root planing of 12 time units every 12 rolling months

    A time unit is considered to be a 15-minute interval or any portion of a 15-minute interval
  - oral hygiene instruction once in a person's lifetime

- pit and fissure sealants on bicuspids and permanent molars every 60 rolling months
- space maintainers including appliances for the control of harmful habits
- finishing restorations
- interproximal disking
- recontouring of teeth

- Minor restorative services including:
  - caries, trauma, and pain control
  - amalgam and tooth-coloured fillings. Replacement fillings are covered only if the existing filling is at least 2 years old or the existing filling was not covered under this plan
  - retentive pins and prefabricated posts for fillings
  - prefabricated crowns for primary teeth
- Endodontics. Root canal therapy for permanent teeth will be limited to one course of treatment per tooth. Repeat treatment is covered only if the original treatment fails after the first 18 rolling months
- Periodontal services including:
  - root planing, limited to a maximum combined with preventive scaling of 12 time units every 12 rolling months
  - occlusal adjustment and equilibration, limited to a combined maximum of 4 time units every 12 rolling months

    A time unit is considered to be a 15-minute interval or any portion of a 15-minute interval

- Denture maintenance, including:
    - denture relines for dentures at least 6 months old, once every 36 rolling months
    - denture rebases for dentures at least 2 years old, once every 36 rolling months
    - resilient liner in relined or rebased dentures after the 3-month post-insertion care period has elapsed, once every 36 rolling months
    - denture repairs and additions and resetting of denture teeth after the 3-month post-insertion care period has elapsed
    - denture adjustments after the 3-month post-insertion care period has elapsed, once every 12 rolling months
- Oral surgery
- Adjunctive services

Major Coverage

- Crowns. Coverage for complicated crowns is limited to the cost of standard crowns
- Onlays

  Replacement crowns and onlays are covered when the existing restoration is at least 5 years old and cannot be made serviceable

- Standard complete dentures, standard cast or acrylic partial dentures or complete overdentures or bridgework when standard complete or partial dentures are not viable treatment options. Coverage for tooth-coloured retainers and pontics on molars is limited to the cost of metal retainers and pontics. Replacement appliances are covered only when:

  - the existing appliance is a covered temporary appliance

  - the existing appliance is at least 5 years old and cannot be made serviceable. If the existing appliance is less than 5 years old, a replacement will still be covered if the existing appliance becomes unserviceable as a result of the placement of an initial opposing appliance or the extraction of additional teeth.

    If additional teeth are extracted but the existing appliance can be made serviceable, coverage is limited to the replacement of the additional teeth

- Denture-related surgical services for remodelling and recontouring oral tissues

- Appliance maintenance following the 3-month post-insertion period including:

  - denture remakes, once every 36 rolling months

  - tissue conditioning

  - repairs to covered bridgework

  - removal and recementation of bridgework

Orthodontic Coverage

- Orthodontics are covered for persons age 6 or over when treatment starts

Limitations

If you do not apply for dentalcare coverage within one month after you become eligible, benefits are limited to $200 during the first 12 months of your coverage.

No benefits are paid for:

- Duplicate x-rays, custom fluoride appliances, audio-visual oral hygiene instruction and nutritional counselling
- The following endodontic services - root canal therapy for primary teeth, isolation of teeth, enlargement of pulp chambers and endosseous intra coronal implants
- The following periodontal services - desensitization, topical application of antimicrobial agents, subgingival periodontal irrigation, charges for post surgical treatment and periodontal re-evaluations
- The following oral surgery services - implantology, surgical movement of teeth, services performed to remodel or recontour oral tissues (other than minor alveoloplasty, gingivoplasty and stomatoplasty) and alveoloplasty or gingivoplasty performed in conjunction with extractions. Services for remodelling and recontouring oral tissues will be covered under Major Coverage
- Hypnosis or acupuncture
- Veneers, recontouring existing crowns, and staining porcelain

- Crowns or onlays if the tooth could have been restored using other procedures. If crowns, onlays or inlays are provided, benefits will be based on coverage for fillings

- No benefits are paid for overdentures or initial bridgework if standard complete or partial dentures would have been a viable treatment option.

  If overdentures are provided, coverage will be limited to the cost of standard complete dentures.

  If initial bridgework is provided, coverage will be limited to the cost of a standard cast partial denture and restoration of abutment teeth when required for purposes other than bridgework

  If additional bridgework is performed in the same arch within 60 months, coverage will be limited to the cost of the addition of teeth to a denture and restoration of abutment teeth when required for purposes other than bridgework

  Benefits will be limited to the cost of standard dentures or bridgework when any of the following are provided:
  - equilibrated and gnathological dentures;
  - dentures with stress breaker;
  - precision and semi-precision attachments;
  - dentures with swing lock connectors;
  - partial overdentures; and
  - dentures and bridgework related to implants.

- Expenses covered under another group plan's extension of benefits provision

- Services or supplies covered under Healthcare. If the amount payable would be greater under this Dentalcare benefit, then benefits will be paid under Dentalcare and not Healthcare

- Expenses private benefit plans are not permitted to cover by law
- Services and supplies you are entitled to without charge by law or for which a charge is made only because you have coverage
- Services or supplies that do not represent reasonable treatment
- Treatment performed for cosmetic purposes only
- Congenital defects or developmental malformations in people 19 years of age or over, except orthodontics
- Temporomandibular joint disorders, vertical dimension correction or myofacial pain
- Expenses arising from war, insurrection, or voluntary participation in a riot

How to Make a Claim

- **Claims for expenses incurred in Canada** may be submitted online. Access GroupNet for Plan Members to obtain a personalized claim form or obtain form M445D from your plan administrator and have your dental service provider complete the form. The completed claim form will contain the information necessary to enter the claim online. To use the online service you will need to be registered for GroupNet for Plan Members and signed up for direct deposit of claim payments with eDetails. For online claim submissions, your Explanation of Benefits will only be available online.

  Your dental service provider may be able to submit your online claim directly to Canada Life for you.

  Online claims must be submitted to Canada Life as soon as possible, but no later than 6 months after the dental treatment.

  You must retain your receipt for 12 months from the date you submit your claim to Canada Life as a record of the transaction, and you must submit it to Canada Life on request.

- **For all other Dentalcare claims**, access GroupNet for Plan Members to obtain a personalized claim form or obtain form M445D from your plan administrator. Have your dental service provider complete the form and return it to the Canada Life Benefit Payment Office as soon as possible, but no later than 15 months after the dental treatment and no later than 180 days after the date of termination of your coverage.

COORDINATION OF BENEFITS

- Benefits for you or a dependent will be directly reduced by any amount payable under a government plan. If you or a dependent are entitled to benefits for the same expenses under another group plan or as both a member and dependent under this plan or as a dependent of both parents under this plan, benefits will be co-ordinated so that the total benefits from all plans will not exceed expenses.

- You and your spouse should first submit your own claims through your own group plan. Claims for dependent children should be submitted to the plan of the parent who has the earlier birth date in the calendar year (the year of birth is not considered). If you are separated or divorced, the plan which will pay benefits for your children will be determined in the following order:

  1. the plan of the parent with custody of the child;
  2. the plan of the spouse of the parent with custody of the child;
  3. the plan of the parent without custody of the child;
  4. the plan of the spouse of the parent without custody of the child

  You may submit a claim to the plan of the other spouse for any amount which is not paid by the first plan.

CHUBB

Basic, Supplemental & Optional Accidental Death & Dismemberment Insurance

For the Members of:
CUPE EDUCATION WORKERS' BENEFITS TRUST

Policy Number:
AB10515801
OE10515801

Underwritten by:
Chubb Life Insurance Company of Canada

Effective Date:
March 1, 2018

This brochure has been prepared in connection with a group plan underwritten by Chubb Life Insurance Company of Canada (“Chubb Life”). For ease of reference it contains a brief description only and does not mention every provision of the contract issued. Please remember that rights and obligations are determined in accordance with the contract and not this brochure. For the exact provisions applicable, please consult your Administrator.

BASIC AND SUPPLEMENTAL ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

COVERAGE

The plan offers you full 24-hour protection against accidents, on or off the job, on business, on vacation, at home, regardless of your health history.

ELIGIBILITY

A. All active, eligible members of the CUPE EWBT.
B. Members who have been approved for life waiver of premium prior to the establishment of the Trust

BENEFIT AMOUNT

A & B. Two (2) times annual earnings rounded to the next higher $1,000 (if not already a multiple thereof) to a maximum of $400,000 (**combined with Supplemental AD&D, if applicable*).**

***Supplemental AD&D – grandparented amount equal to the amount of lost AD&D coverage prior to EWBT effective date of March 1, 2018**

*The term "annual earnings" for Class A as used herein shall be based on an Insured's income as defined under the life insurance contract. For Class B, at implementation, annual earnings will be assumed to be $50,000 until the Administrator is able to confirm the amount of earnings applicable to the life insurance for which premium has been waived.

Benefit terminates at the end of the month in which the member retires.

In the event of your death, the benefit amount is payable to the beneficiary you have named under your Group Life Insurance Plan or in the absence of such designation, to your Estate.

Benefits payable under the following section will be limited to only one policy in the event the benefits are contained in two or more policies issued to the Policyholder by Chubb Life (not applicable to the Schedule of Losses, Exposure and Disappearance, Conversion and Cosmetic Disfigurement).

OPTIONAL ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

COVERAGE

The plan offers you full 24-hour protection against accidents, on or off the job, on business, on vacation, at home, regardless of your health history.

ELIGIBILITY

All active, eligible members of the CUPE EWBT.

Your spouse, (legally married or domestic partner).

BENEFIT AMOUNT – MEMBER AND/OR SPOUSE

You or your spouse may choose any amount of insurance from $10,000 to $300,000 in units of $10,000.

THE FOLLOWING BENEFITS ARE APPLICABLE TO BOTH THE BASIC AND OPTIONAL INSURANCE

SCHEDULE OF LOSSES

Accidental Death & Dismemberment

If such injuries shall result in any one of the following specific losses within one year from the date of the accident, Chubb Life will pay the percentage of the benefit amount, based on the amount stated under the benefit amount section, however, that not more than one (the largest) of such benefits shall be paid with respect to injuries resulting from one accident.

	Percentage of Benefit Amount
Loss of Life	100
Loss of Entire Sight of Both Eyes	100%
Loss of One Hand and One Foot	100%
Loss of Use of One Hand and One Foot	100%
Loss of One Hand and Entire Sight of One Eye	100%
Loss of One Foot and Entire Sight of One Eye	100%
Loss of Speech and Hearing in Both Ears	100%
Brain Death	100%
Coma	100%
Loss of Both Arms, Both Hands, Both Legs or Both Feet	200%

Loss of Use of Both Arms, Both Hands, Both Legs or Both Feet 200%
Quadriplegia 200%
Paraplegia 200%
Hemiplegia 200%
Loss of One Arm or One Leg 75%
Loss of Use of One Arm or One Leg..... 75%
Loss of One Hand or One Foot 75%
Loss of Use of one Hand or One Foot..... 75%
Loss of Entire Sight of One Eye 75%
Loss of Speech or Hearing in Both Ears 75%
Loss of Thumb and Index Finger of Same Hand 33 1/3%
Loss of Use of Thumb and Index Finger of Same Hand 33 1/3%
Loss of Four Fingers of Same Hand 33 1/3%
Loss of Hearing One Ear 33 1/3%
Loss of All Toes of Same Foot 25%

"Loss" shall mean with respect to hand or foot, the actual severance through or above the wrist or ankle joint; with respect to arm or leg, the actual severance through or above the elbow or knee joint; with respect to eye, the total and irrecoverable loss of sight; with respect to speech, the total and irrecoverable loss of speech which does not allow audible communication in any degree; with respect to hearing, the total and irrecoverable loss of hearing which cannot be corrected by any hearing aid or device; with respect to thumb and index finger or four fingers, the actual severance through or above the metacarpophalangeal joints of the same hand (the joints between the fingers and the hand); with regard to toes, the actual severance through or above the metatarsophalangeal joints (the joints between the toes and the foot) of the same foot. If an Insured Person suffers complete severance of a hand, foot, arm or leg as described above, then Chubb Life will pay the amount specified in the Schedule of Losses even if the severed limb is surgically reattached, whether successful or not.

"Loss" as used with reference to quadriplegia (paralysis of both upper and lower limbs), paraplegia (paralysis of both lower limbs), and hemiplegia (total paralysis of upper and lower limbs of one side of the body), means the complete and irrecoverable paralysis of such limbs, provided such loss of function is continuous for 180 consecutive days and such loss of function is thereafter determined on evidence satisfactory to Chubb Life to be permanent.

"Loss of Use" shall mean the total and irrecoverable loss of function of an arm, hand, foot, leg or thumb and index finger of the same hand provided such loss of function is continuous for 12 consecutive months and such loss of function is thereafter determined on evidence satisfactory to Chubb Life to be permanent.

"Brain Death" means irreversible unconsciousness with total loss of brain function; and complete absence of electrical activity of the brain, even though the heart is still beating.

"Coma" means the Insured has been in a state of unconsciousness for a continuous period of at least 96 hours, during which external stimulation produced no more than primitive avoidance reflexes. A Physician who is certified as a neurologist must confirm diagnosis in writing.

All benefits that are payable at 200% of the Principal Sum are subject to an all policies combined maximum benefit amount of $1,000,000.

Repatriation Benefit

When injuries result in loss of life of an Insured outside 150 kilometers from their city of permanent residence or outside Canada and the loss of life occurs within 365 days from the date of the accident, Chubb Life will pay the actual expense incurred for preparing the deceased for burial and shipment of the body to the city of residence of the deceased, but not to exceed $15,000.

Rehabilitation Benefit

When injuries result in a payment being made by Chubb Life under any benefit excluding the Loss of Life Benefit, Chubb Life will also pay the reasonable and necessary expenses actually incurred up to a limit of $15,000 for special training of an Insured provided:

a. such training is required because of such injuries and in order for an Insured to become qualified to engage in an occupation in which he or she would not have been engaged except for such injuries;
b. expenses are to be incurred within two years from the date of the accident;
c. no payment will be made for ordinary living, travelling, or clothing expenses.

Family Transportation Benefit

When injuries result in an Insured's confinement as an in-patient in a hospital outside 150 kilometers from an Insured's city of permanent residence or outside Canada and requires personal attendance of a "Family Member" as recommended by the attending physician, in writing, Chubb Life will pay for the expense incurred by the member of the family, for the transportation by the most direct route by a licensed common carrier to the Insured, while confined, but not to exceed $15,000.

"Family Member" means spouse, parent or stepparent, child or stepchild or brother or sister, stepbrother or stepsister, brother-in-law or sister-in-law, mother-in-law or father-in-law, and son-in-law or daughter-in-law.

Spousal Occupational Training Benefit

When injuries result in a payment being made by Chubb Life under the Loss of Life Benefit, Chubb Life will pay in addition the expenses actually incurred, within 365 days from the date of the accident, by the spouse of an Insured for a formal occupation training program for the purpose of specifically qualifying such spouse to gain active employment in an occupation for which the spouse would otherwise not have sufficient qualifications. The maximum payable hereunder is $15,000.

Home Alteration and Vehicle Modification Benefit

In the event an Insured sustains an injury which results in a payment being made under the Schedule of Losses, excluding the Loss of Life Benefit, and such injury subsequently requires the use of a wheelchair to be ambulatory, Chubb Life will pay the reasonable and necessary expenses actually incurred within 365 days from the date of the accident for:

1. the one-time cost of alterations to an Insured's principal residence to make it wheelchair accessible and habitable; and
2. the one-time cost of modifications necessary to a motor vehicle utilized by an Insured to make the vehicle accessible or operable for an Insured.

Benefit payments herein will not be paid unless:

i. home alterations are made by a person or persons experienced in such alterations and recommended by a recognized organization, providing support and assistance to wheelchair users; and
ii. vehicle modifications are carried out by a person or persons with experience in such matters and modifications are approved by the Provincial vehicle licensing authorities.

The maximum payable under both items 1 and 2 shall be 10% of an Insured's Principal Sum amount to a maximum of $50,000.

Day Care Benefit

If an Insured suffers a loss of life in a covered accident while the policy is in force, Chubb Life will pay, in addition to all other benefits payable under the policy a Day Care Benefit equal to the reasonable and necessary expenses actually incurred, subject to the lesser of 5% of an Insured's Principal Sum amount or a maximum of $5,000 per year, on behalf of any dependent child who is enrolled in a legally licensed day care centre on the date of the accident or who enrolls in a legally licensed day care centre within 365 days following the date of the accident.

The "Day Care Benefit" will be paid each year for four consecutive years, but only upon receipt of satisfactory proof that a child is enrolled in a legally licensed day care centre.

"Dependent Child" means the Member's eligible unmarried, dependent children, including natural, legitimate, illegitimate, adopted, step child or common law child, who are under age 21, or under age 26, if the child is a full-time student and dependent on you or your spouse for financial support, or over age 21 if the child is dependent by reason of mental or physical infirmity and incapable of self-sustaining employment and dependent upon you or your spouse for financial support.

Special Education Benefit

If an Insured suffers a loss of life in a covered accident while the policy is in force, Chubb Life will pay, in addition to all other benefits payable under the policy, a Special Education Benefit up to 5% of an Insured's Principal Sum amount, (subject to a maximum of $5,000 per year), on behalf of any dependent child who, on the date of the accident, is enrolled as a full-time student in any post-secondary institution of higher learning or was at the 12th grade level and subsequently enrolls as a full-time student in any post-secondary institution of higher learning within 365 days following the date of the accident.

The "Special Education Benefit" is payable annually for a maximum of four consecutive annual payments but only if the dependent child continues his or her education as a full-time student in an institution of higher learning.

Bereavement Benefit

When injuries covered by the policy result in loss of life of an Insured within 365 days from the date of the accident, Chubb Life will pay the reasonable and necessary expenses actually incurred by the spouse and dependent children of an Insured for up to six sessions of grief counseling, by a "Professional Counsellor", subject to a maximum of $1,000.
"Professional Counsellor" means a therapist or counsellor who is licensed, registered or certified to provide such treatment.

In-Hospital Confinement Monthly Income

In the event an Insured sustains an injury which results in a payment being made under the Schedule of Losses, excluding the Loss of Life Benefit, and the Insured is hospital confined as an in-patient and is under the care of a legally qualified and registered physician or surgeon other than himself or herself, Chubb Life will pay for each full month, 1% of an Insured's Principal Sum amount, subject to a maximum amount of $2,500, or 1/30 of such monthly benefit for each day of partial month, retroactive to the 1st full day of such confinement but not to exceed 365 days in the aggregate for each period of hospital confinement.

"Hospital" as used herein means a legally constituted establishment which meets all of the following requirements: (1) operates primarily for the reception, care and treatment of sick, ailing or injured persons as in-patients; (2) provides 24 hour a day nursing service by registered or graduate nurses; (3) has a staff of one or more licensed physicians available at all times; (4) provides organized facilities for diagnosis and surgical facilities; and (5) is not primarily a clinic, nursing home or convalescent home or similar establishment nor, other than incidentally, a place for alcoholics or drug addicts.

"In-Patient" means a person admitted to a hospital as a resident or bed-patient and who is provided at least one day's room and board by the hospital.

Cosmetic Disfigurement

If an Insured suffers a third degree burn due to an accident, Chubb Life will pay a percentage of the Principal Sum depending on the area of the body which was burned according to the following table, subject to a maximum benefit payable of $25,000:

Body Part	**% of Principal Sum Payable**
Face, Neck, Head	100%
Hand & Forearm	25%
Either Upper Arm	15%
Torso (Front or Back)	35%
Either Thigh	10%
Either Lower Leg (below knee)	25%

In the event of a 50% surface burn, the % of benefit is reduced by 50%. This table only represents the maximum percent of the Principal Sum payable for any one accident. If the Insured suffers burns in more than one area as a result of any one accident, benefits will not exceed a maximum of $25,000.

Seat Belt Benefit

In the event an Insured sustains an injury which results in a payment being made under the Schedule of Losses, an Insured's Principal Sum amount will be increased by 10% to a maximum of $25,000 if, at the time of the accident, the Insured was driving or riding in a vehicle and wearing a properly fastened seat belt. Due proof of seat belt use must be provided as part of the written proof of loss.

"Vehicle" means a private passenger car, station wagon, van, or jeep-type automobile. **"Seat Belt"** means those belts that form a restraint system.

Identification Benefit

In the event accidental loss of life is sustained by an Insured not less than 150 kilometers from an Insured's normal place of residence and identification of the body by a "Family Member" has been requested by the police or a similar governmental authority, Chubb Life will reimburse the reasonable expenses actually incurred by such member for:

a. transportation by the most direct route to the city or town where the body is located; and
b. hotel accommodation in such city or town, subject to a maximum duration of three days.

The reimbursement of such expenses incurred is subject to the accidental Loss of Life Benefit being subsequently payable in accordance with the terms of the policy following the identification of the body as an Insured. The maximum amount payable will not exceed $15,000 for all such expenses.
Payment will not be made for board or other ordinary living, travelling or clothing expenses, and transportation must occur in a vehicle or device operated under a license for the conveyance of passengers for hire.

"Family Member" means spouse, parent or stepparent, child or stepchild or brother or sister, stepbrother or stepsister, brother-in-law or sister-in-law, mother-in-law or father-in-law, and son-in-law or daughter-in-law.

Conversion Privilege

On the date of termination of employment or during the 31-day period following termination of employment, an Insured Person may convert his or her insurance to an individual ACCIDENTAL DEATH and DISMEMBERMENT only insurance policy of Chubb Life. The individual policy will be effective either as of the date that the application is received by Chubb Life or on the date that coverage under the group policy ceases, whichever occurs later. The premium will be the same, as a person would ordinarily pay when applying for an individual policy at that time.

Exposure and Disappearance

Loss resulting from unavoidable exposure to the elements shall be covered to the extent of the benefits afforded an Insured.

If the body of an Insured Member has not been found within one year of disappearance, stranding, sinking or wrecking of the conveyance in which an Insured was riding at the time of the accident, it shall be presumed, subject to all other conditions of the policy, that an Insured Member suffered a loss of life resulting from bodily injuries sustained in the accident covered under the policy.

Waiver of Premium

If an Insured Member, under age 65, becomes totally disabled for six consecutive months and an Insured Member provides evidence of total disability satisfactory to Chubb Life Insurance, Chubb Life Insurance will then waive the payment of each premium which falls due with respect to an Insured Member and any Insured Dependents. Subject to all the terms and conditions of the policy, waiver of any premium as herein provided will continue with respect to an Insured Member until age 65 or earlier termination of the policy. If an Insured Member ceases to be disabled and an Insured Member returns to employment and is a member of an eligible class, insurance with respect to an Insured Member may be continued upon resumption of premium payments by an Insured Member or the Policyholder.
If after 120 days, an Insured receives approval of any long term disability claim provided under a policy of group insurance through the Policyholder, Chubb Life will then waive the payment of each Accidental Death and Dismemberment insurance premium subject to the terms stated above.

Recurrent Disabilities

When an Insured Member becomes totally disabled again from the same or related causes within six months of cessation of the Waiver of Premiums, then all such recurrences will be considered a continuation of the same disability and Chubb Life will waive the six month qualification period.

If the same disability recurs more than six months after cessation of the Waiver of Premiums, such disability will be considered a separate disability. Two disabilities which are due to unrelated causes are considered separate disabilities if they were separated by a return to work of at least one day.

Termination of Waiver of Premium

Waiver of Premiums will cease on the earliest of:

a. the date an Insured Member ceases to meet the policy's definition of totally disabled;
b. the date an Insured Member does not supply Chubb Life with appropriate medical evidence as deemed necessary by Chubb Life;
c. the date an Insured Member is no longer receiving regular, ongoing care and treatment of a Physician appropriate for the disabling condition, as determined by Chubb Life;
d. the date an Insured Member does not attend a medical, psychiatric, psychological, functional, educational and/or vocational examination evaluation by an examiner selected by Chubb Life;
e. the date the policy terminates;
f. the date an Insured Member turns 65; or
g. the date an Insured Member dies.

Coverage During Waiver of Premium

While premiums are being waived, Basic Accidental Death and Dismemberment Insurance under the policy on an Insured Member will continue to be in force. The amount of such insurance will be the amount of insurance that was in effect on the date of commencement of the disability, subject to any age reduction or termination shown in the policy.

"Totally Disabled or Total Disability" with respect to Waiver of Premium means disability resulting from injury or sickness which prevents engagement in an Insured Member's own occupation for twenty-four (24) consecutive months.

Continuance of Coverage

If an Insured Member is: (1) laid off on a temporary basis; (2) temporarily absent from work due to short-term disability; (3) on leave of absence; or (4) on maternity leave, coverage shall be extended for 12 months, subject to the payment of premiums. If an Insured Member assumes other occupational duties during the leave or lay-off period, no benefits shall be payable for a loss occurring during the performance of such other occupation.

Benefits payable under this section will be limited to only one (1) policy in the event the benefits are contained in two (2) or more policies issued to the Policyholder by the Company *(not applicable to Common Disaster).*

THE FOLLOWING BENEFITS ARE APPLICABLE TO THE OPTIONAL INSURANCE ONLY

Common Disaster Benefit
(only applicable in the case of member and spouse coverage being elected)

If as a result of a "common accident" you and your spouse should both lose your lives within one (1) year of such "common accident", your spouse's loss of life benefit shall be increased to equal 100% of your (employee) benefit amount. The benefit will be payable to and equally divided among your "surviving children", or, in the case of any "surviving child" who is a minor or otherwise not competent to give valid release, Chubb Life may pay such benefit to the guardian, trustee or other person deemed by Chubb Life to be equitably entitled to receive such benefit. Any payment made by Chubb Life in good faith pursuant to this provision shall fully discharge Chubb Life to the extent of such payment.

"Common accident" means the same accident or separate accidents occurring within the same 24 hour period.

"Surviving Children" means your dependent children as defined in the definition of "Dependent Child" applicable to the policy provided such children survive both you and your spouse by at least 24 hours.

Extended Family Benefit
(only applicable in the case of member and spouse coverage being elected)

If an Insured Member, who had insured his spouse, suffers loss of life in a covered accident, coverage may be extended for the spouse for a maximum of twenty-four (24) months if premiums are paid.

THE FOLLOWING PROVISIONS ARE APPLICABLE TO BOTH THE BASIC AND OPTIONAL INSURANCE

EXCLUSIONS

The plan does not cover any loss, which is the result of:

a. Intentionally self-inflicted injury, suicide or any attempt thereat;
b. Declared or undeclared war, or any act of war, terrorism, riot or insurrection, or service in the armed forces of any country, government or international organization;

c. Travel or flying in an aircraft owned or leased by the Policyholder, an Insured or a member of an Insured's household, or aircraft being used for any test or experimental purpose, firefighting, power line inspection, pipeline inspection, aerial photography or exploration except to the extent such travel or flight is provided in the "Hazards Insured Against" section of this policy, if applicable);
d. Losses occurring while the Insured is serving on full-time active duty in the Armed Forces of any country or international authority (any premium paid to be returned by the Company pro-rata for any such period of full-time active duty.
e. This insurance does not apply to the extent that trade or economic sanctions or other laws or regulations prohibit us from providing insurance, including, but not limited to, the payment of claims. All other terms and conditions of the policy remain unchanged.

GENERAL PROVISIONS

Beneficiary

A member has the right to name a beneficiary when he applies for insurance. It is understood that the beneficiary designation made under the Policyholder's Group Life Insurance Policy shall be recognized as the beneficiary under the policy, unless a further designation has been made that specifically identifies the policy. Failing such designation, all benefits will be paid to the estate of the insured person.

All other indemnities of the policy will be payable to the insured person.
An insured person can change his beneficiary at any time, where permitted by law. The Company assumes no responsibility for the validity of such designation or change of beneficiary.

The policy contains a provision removing or restricting the right of the insured person to designate persons to whom or for whose benefit insurance money is to be payable.

Legal Actions

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the Insurance Act, Limitations Act, 2002 or other applicable legislation in the Insured's province of residence.

Change of Insurer

An insured member under a former policy may not be excluded from the new policy or be denied benefits solely because of a pre-existing condition limitation that was not applicable or that did not exist in the former policy, or because the person is not at work on the date of coming into force of the new policy.
The insured and any claimant under the policy has the right, as determined by law applicable in the insured's province of residence, to obtain a copy of his/her application, any written evidence of insurability (as applicable) and the Policy, on request, subject to certain access limitations.

HOW TO CLAIM

In the event of a claim, claim forms can be obtained from the Plan Administrator.

Notice of claim must be given to Chubb Life within 30 days from the date of the accident, the beginning of the disability or after the survival period, and

subsequent proof of claim must be submitted to Chubb Life within 90 days from the date of the accident or after survival period.

Failure to give notice of claim or furnish proof of claim within the time prescribed in the policy condition will not invalidate the claim if the notice or proof is given or furnished as soon as reasonably possible and if it is shown that it was not reasonably possible to give notice or furnish proof within the time so prescribed. In no event, will Chubb Life accept notice of claim beyond one year.

02/18

CHUBB

Chubb Life is part of the Chubb group of insurance companies, with operations in 54 countries, Chubb provides commercial and personal property and casualty insurance, personal accident and supplemental health insurance, reinsurance and life insurance to a diverse group of clients.

Chubb Limited, the parent company of Chubb Life, is listed on the New York Stock Exchange (NYSE: CB) and is a component of the S&P 500 index.