



# **TotalGUARD**

**Group Benefits Plan**



## **Group Insurance Solutions**

### **Employee Benefits Exclusively Designed With Your Needs In Mind**

## **Group Insurance Benefits**

Employee Benefits are important, not only for the financial assistance they provide, but also for the security they provide for you and your family, especially in case of unforeseen needs.

This booklet has been specifically designed with your needs in mind, providing easy access to the information you need to know about the benefits made available to you. Your Certificate of Insurance confirms the benefit and the level/amount you are currently insured with.

The information contained in this booklet summarizes all possible benefits available under the TotalGUARD Program. Please refer to your Certificate of Insurance page to determine which benefits are applicable to you. In the event of a discrepancy between this booklet and the Group Insurance Contract, the terms of the Contract will apply.

At Western Financial Group Insurance Solutions we can answer any questions you may have about your benefits, or how to submit a claim. Please call us at 1-800-665-8990.

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# **TotalGUARD**

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# Definitions

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For the purposes of this booklet, the masculine pronoun and adjective include the feminine, unless a different meaning is plainly to be taken from the context. All words have their usual meaning, unless a special meaning is indicated.

## **Accidental Injury**

Any bodily lesion, sustained while your insurance is in force, directly and solely due to an external sudden, violent and unintentional cause, independent of any illness and requiring within 30 days of the event the care of a physician or an appropriate specialist.

## **Actively At Work**

The status of a participant who is physically and mentally capable of doing each and every personal job-related work function and who is actually working full-time and in a permanent manner on the basis of a minimum 20 hour work week at the policyholder's place of business or at any other place designated for the performance of a specific job-related task.

## **Associated Company**

A person, firm, corporation, partnership or proprietorship which is associated with the Policyholder as a member in good standing and which is in a classification of insurance risk approved by the company.

## **Benefit Percentage (Co-Insurance)**

The percentage of Covered Expenses which is payable as per the terms of the contract.

## **Deductible**

The amount of covered expenses that must be incurred and paid by you or your dependent before benefits are payable.

## **Dependents**

Your spouse or your children or your spouse's children, whether taken individually or collectively. If dependents are insured under this policy, the words spouse and child have the following meanings.

### **Spouse**

- Your legal spouse;
- A person whom you publicly acknowledge as your spouse, with whom you have been living in a permanent manner for over one year.

The person you have designated in writing to the insurer as your spouse is recognized as your dependent, until such time as you advise otherwise. Any dissolution of a marriage through divorce or annulment or, in the case of common-law marriage, actual separation for over three months, results in the loss of status of spouse.

## **Child**

All unmarried children of the participant, of the spouse or of both, including the legally adopted children or those for whom the participant or the spouse exercises or would exercise, in the case of a minor, parental authority and whom the participant or the spouse supports and who is:

- Under age 21;
- Over age 21 but under age 25, being a full-time student in an accredited educational institution, subject to evidence to the satisfaction of the Insurer;
- Regardless of age, suffering from a severe, incurable and chronic physical or mental disability while meeting the requirements indicated above of a dependent child, rendering such child unable to pursue a substantially gainful occupation, subject to adequate medical evidence.

## **Dispensing Fee**

Of the total prescription drug cost, that portion charged for the pharmacist's professional services for filling a prescription. The dispensing fee maximum is the maximum amount that will be reimbursed.

## **Drug**

Medications that have been approved for use by the Federal Government of Canada and have a Drug Identification Number (DIN).

## **Earnings**

Your regular rate of earnings from your employer, excluding bonuses, overtime, fees, lodging and meal allowances, amounts paid by the employer as fringe benefits, isolation allowances and any lump sum payment, but including the weekly equivalent of the amount of commissions received by you from your employer during the two calendar years ending on the immediately preceding December 31st, as reported on your T4 forms.

## **Elimination Period**

The continuous period during which you must be absent due to disability before you can begin to receive disability benefits.

## **Employee**

A person actively working in a permanent manner on a full-time basis for the employer and receiving regular income for services rendered.

## **Illness, Disease, Sickness**

Any pathological condition resulting from a deviation of health requiring both regular and continuous medical care actually given by a physician or an appropriate specialist and an appropriate therapy, considered satisfactory by the insurer.

## **Income**

Your remuneration as declared by your employer to the insurer.

**Net Income**

Your annual income, less the income tax deducted according to the tax tables established under the Canadian Income Tax Act and by any similar legislation of your province of residence.

**Non-Evidence Limit**

You must submit satisfactory medical evidence for benefit amounts greater than the non-evidence limit.

**Physician**

A person duly authorized by a provincial law to practice medicine and who is a member in good standing of a professional medical body.

**Provincial Plan**

Any plan which provides hospital, medical or dental benefits established by the government in the province where the insured person lives and which is governed by the Canada Health Act.

**Reasonable and Customary**

Within the usual range of charges being made by others of similar standing in the area in which the charge is incurred when providing the same or comparable service or supplies.

**Specialist**

A physician practicing a specialty of medicine for which he is certified by the Royal College of Physicians and Surgeons of Canada or by the Corporation professionnelle des médecins du Québec, or both.

**Waiting Period**

The period of continuous employment with your employer, which you must complete before you are eligible for Employee Benefits.

**Ward**

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

# General Insurance Provisions

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## Eligibility

You must complete an application form supplied by your employer for yourself and your dependents, if any. You are eligible for insurance on the date that you have satisfied the waiting period specified by your employer.

## Dependents Eligibility

Your dependents are eligible for insurance at the later of the day on which you become eligible, or, the day on which you have a dependent for the first time.

If your employer receives your application more than 31 days after your eligibility date, you must provide evidence of insurability at no expense to the insurer.

## Effective Date of Insurance

Your insurance and your dependents' insurance become effective on one of the following dates:

- The first day of the month following your eligibility date, if your application is received by your employer within 31 days after such date.
- The first day of the month following the date after which the insurer accepts your required evidence of insurability. Such evidence must be provided at no expense to the insurer.

However, for an employee who is a resident of Québec, the Health Insurance Benefit will take effect, without evidence of insurability, on the date your employer receives the application.

- If you were not actively at work on the date your insurance would have otherwise become effective, the insurance takes effect on the date you return to active work.

If your dependents are already insured, any person who subsequently becomes a dependent and meets the eligibility guidelines is immediately insured. Dependant children are eligible for coverage as of 24 hours of age. Please notify your customer service representative of any dependent additions.

## Change in Coverage

To ensure that your coverage is kept up to date for yourself and your dependents, it is vital that you immediately report any changes to Western Financial Group Insurance Solutions in writing within 31 days. Such changes could include:

- Name
- Beneficiary
- Dependent Coverage
- Salary
- Applying for coverage previously waived

To make such changes, forms can be downloaded from our web site at [www.westernfgis.ca](http://www.westernfgis.ca).

## **Beneficiary**

You may designate one or several beneficiaries, or if your beneficiary should predecease you, the benefit will be paid to your estate. You are the beneficiary of your dependents' life insurance, if your plan covers your dependents.

## **Subrogation**

The Insurer is subrogated in all the rights of the participant and the insured against the third party liable for the damage that has given rise to an entitlement to payment of benefits under this contract up to the limitation of amounts paid by the Insurer.

The Insurer may, in the exercise of its right of subrogation and if it deems that a third party is liable, require that the participant and the insured sign, if applicable, an act of subrogation in its favour at the time of paying any benefits.

## **Termination of Insurance**

Your insurance or your dependents' insurance terminates at the earliest of the following dates:

- On the date you cease to qualify as an eligible employee;
- On the date the benefit or contract is terminated;
- On the last day of the period for which your employer has paid the premium.

The termination date for each benefit and the reduction formula for the insurance amounts are specified in the Certificate of Insurance.

# Life Benefit

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## General Description

Your Life coverage provides a benefit for your beneficiary if you die while covered. The amount of your Life coverage shown on the Certificate of Insurance in effect on the date of your death will be paid when the Insurer receives due written proof of death.

## Beneficiary

If you die while covered, the Insurer will pay the full amount of your benefit to your last named beneficiary on file with Western Financial Group Insurance Solutions.

If you have not named a beneficiary, the benefit amount will be paid to your estate. Anyone can be your beneficiary. You can change your beneficiary at any time, unless a law prevents you from doing so or you indicate that the beneficiary is not to be changed by filing a new designation form. The change will be effective on the date the form is signed, but it will not apply to any payment made by the Insurer prior to the date the form is received by the Insurer.

## Benefit Amount

Please refer to your Certificate of Insurance page.

## Waiver of Premium

If you become totally disabled before you retire or reach age 65, whichever is earlier, coverage may continue without any premiums being required as long as you are totally disabled (see the Long Term Disability (LTD) benefit section for further information on the definition of disability).

Waiver of premium will begin after you have been disabled for at least the elimination period of the LTD Benefit, or the sixth month, whichever is earlier. This benefit will continue until you cease to be disabled or reach age 65, whichever is earlier.

## Submitting a Claim

To submit a claim, your beneficiary must complete the Life Claim form, which is available from Western Financial Group Insurance Solutions.

Upon completion of the form, a death certificate is required and both the form and certificate should be mailed to Western Financial Group Insurance Solutions. A completed claim form must be submitted within 90 days from the date of death.

## Restriction – Suicide

If a participant commits suicide, whether he is sane or insane, and has been protected for less than 12 months by the life insurance protection or the previous life insurance protection which was replaced by this policy, the Insurer will refund the premiums collected for this participant for the life insurance coverage in lieu of paying the amount of life insurance.

If a participant increases his amount of life insurance, the 12-month period mentioned above begins to run once again from the date the increased life insurance takes effect, but only for the increase of such amount.

**Conversion Privilege**

If your Employee Benefits terminate or reduce, you may be eligible to convert your Employee Life Insurance to an individual policy, without medical evidence. You must apply for the individual "whole-life" or "term-to-65" policy, and pay the first monthly premium within 31 days of the termination of your Employee Life Insurance. If you die during this 31-day period, the amount of Employee Life Insurance available for conversion will be paid to your beneficiary or estate, even if you didn't apply for conversion.

For more information on the Conversion Privilege, please call Western Financial Group Insurance Solutions at 1-800-665-8990.

**Reduction Schedule**

Your benefit amount reduces by 50% at age 65.

**Termination Age**

Benefit terminates at age 70 or retirement, whichever is earlier.

Please refer to your Certificate of Insurance to see if this benefit applies to you.

# Accidental Death and Dismemberment

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## General Description

If you sustain an accidental injury while insured and suffer a loss specified in the Schedule of Losses below, this benefit provides financial assistance to you or your beneficiary. In the event of your death, the benefit is payable to your beneficiary. If your beneficiary dies before you or if there is no designated beneficiary, this benefit is payable to your estate. For losses other than Loss of Life, the benefit is payable to you.

## Benefit

Please refer to your Certificate of Insurance page.

## Schedule of Losses

The losses covered by this benefit must:

- Be caused directly and independently of any other cause, by bodily injuries resulting exclusively from external, violent and accidental means;
- Be a direct result of the accidental injury;
- Occur within 365 days from the date of the accidental injury;
- Be total and permanent or irrecoverable.

In the case of loss of speech or hearing, or loss of use of an arm, hand or leg, the loss must be continuous for 12 months and determined to be permanent, after which time the benefit is payable.

The amount payable for each loss is a percentage of your Employee Accidental Death and Dismemberment benefit amount, which was in effect as of the date of the injury.

<b>For Loss Of</b>	<b>Benefit Amount</b>
Life	100%
One Hand and One Foot	100%
Hearing in Both Ears and Speech	100%
Both Hands or Both Feet or Sight of Both Eyes	100%
One Hand or One Foot and Loss Sight of One Eye	100%
One Arm or One Leg	75%
One Hand or One Foot or Loss of Sight of One Eye or Speech or Hearing in Both Ears	66.67%
Thumb and Index Finger or at Least Four Fingers of the Same Hand	33.33%
Hearing in One Ear	25%
All Toes of One Foot	25%

<b>Paralysis</b>	<b>Benefit Amount</b>
All Four Limbs (Quadriplegia)	200%
Both Lower Limbs (Paraplegia)	200%
One Arm and One Leg on the Same Side of the Body (Hemiplegia)	200%

## **Definition**

The word “loss” means:

- For a hand or foot, total, permanent and irrecoverable loss of use of the limb or amputation at the wrist or ankle, or above;
- For a leg or arm, total, permanent and irrecoverable loss of use of the limb or amputation at the knee or elbow, or above;
- For the thumb and index finger, total, permanent and irrecoverable loss of use of the digit or amputation at the joint between the hand and the digit;
- For sight, hearing or speech, total, permanent and irrecoverable loss of sight, hearing in both ears or of speech.

## **Exposure and Disappearance**

If a loss occurs due to unavoidable exposure to the elements, after a conveyance in which you were travelling made a forced landing, or was lost, wrecked, stranded or sunk, a benefit will be payable for that loss. The amount payable will be determined in accordance with the Schedule of Losses.

If you disappear after a conveyance in which you were travelling made a forced landing, or was lost, wrecked, stranded or sunk, a benefit for loss of life will be payable if your body is not found within 365 days after the incident occurred.

## **Evidence and Examinations**

Evidence of the loss must be submitted to the Insurer within 90 days of the date of the loss, failing which no benefit is payable.

The Insurer is entitled to have the participant examined and, as the case may be, have an autopsy performed within the limits of the law.

## **Waiver of Premium**

If, while the Group Policy is in force, your Life premium is waived because you are totally disabled, the premium for this benefit will also be waived. Waiver of Premium for this benefit ceases if the benefit terminates.

## **Exclusions**

No benefit is payable for a loss attributable directly or indirectly, in whole or in part, to any of the following causes:

- Suicide, attempted suicide or self-inflicted injuries, whether the participant was sane or insane at the time;
- Perpetration or attempted perpetration by the participant of a crime or his participation in a crime;
- The participant’s active participation in a riot or insurrection;

- War or civil war, whether declared or undeclared;
- Active service in the armed forces of any country;
- A flight in any aircraft or flying machine when the participant is a member of the crew or carries out any duty in regard to such flight;
- Injuries which exhibit no visible wound or contusion on the outside of the body (except drowning and internal injuries revealed by surgery or autopsy), poisoning, intoxication or drug use.

**Reduction Schedule**

Your benefit amount reduces by 50% at age 65.

**Termination Age**

Benefit terminates at age 70 or retirement, whichever is earlier.

Please refer to your Certificate of Insurance to see if this benefit applies to you.

# Dependent Life Benefit

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## General Description

If one of your dependents dies while insured, the amount of this benefit will be paid to you.

## Benefit Amount

Please refer to your Certificate of Insurance page.

## Submitting a Claim

To submit a claim, you must complete the Life Claim form, which is available from Western Financial Group Insurance Solutions. A completed claim form must be submitted within 90 days from the date of loss, and also be accompanied by an original death certificate.

## Waiver of Premium

If your Life premium is waived because you are totally disabled, the premium for this benefit will also be waived.

## Restriction – Suicide

If a participant commits suicide, whether he is sane or insane, and has been protected for less than 12 months by the life insurance protection or the previous life insurance protection which was replaced by this policy, the Insurer will refund the premiums collected for this participant for the life insurance coverage in lieu of paying the amount of life insurance.

If a participant increases his amount of life insurance, the 12-month period mentioned above begins to run once again from the date the increase life insurance takes effect, but only for the increase of such amount.

## Conversion Privilege

If your spouse's life insurance terminates, he or she may be eligible to convert the terminated insurance to an individual policy, without medical evidence. Application for the individual "whole-life" or "term-to-65" policy must be made, and the first monthly premium paid, within 31 days of the termination date. If your spouse dies during this 31-day period, the amount of Dependent Life Insurance available for conversion will be paid to you, even if your spouse didn't apply for conversion.

For more information on the conversion privilege, please call Western Financial Group Insurance Solutions at 1-800-665-8990.

## Termination Age

Benefit terminates at age 70 or retirement, whichever is earlier.

Please refer to your Certificate of Insurance to see if this benefit applies to you.

# Short Term Disability Benefit

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## General Description

If you become Totally Disabled while insured and meet the Entitlement Criteria for this benefit, this benefit will be payable to you.

## Definition of Totally Disabled

Totally Disabled means a restriction or lack of ability due to an illness or injury which prevents you from performing the essential duties of your own occupation. The availability of work will not be considered in assessing your disability.

## Benefit Amount

Please refer to your Certificate of Insurance page.

## Benefit Period

Please refer to your Certificate of Insurance page.

## Elimination Period

You must be receiving regular, ongoing care and treatment from a physician during the Elimination Period in order for benefits to be payable at the end of the Elimination Period. Otherwise, benefits are not payable until the date you are first treated by your physician. Please refer to your Certificate of Insurance page for the Elimination Period.

## Entitlement Criteria

To be entitled to disability benefits, you must meet the following criteria:

- You must be continuously Totally Disabled throughout the Elimination Period;
- The Insurer must receive medical evidence documenting how your illness or injury causes restrictions or lack of ability, such that you are prevented from performing the essential duties of your own occupation;
- You must be receiving from a physician, regular, ongoing care and treatment appropriate for your disabling condition, as determined by the Insurer.

Where there is a dispute over the nature and extent of your disability and/or the appropriateness of the care and treatment being provided to you, the Insurer may require an examination by an independent expert.

## Payment of Disability Benefits

Disability benefit payments will be made weekly in arrears. Any payment for a period of less than one week will be made at a daily rate of one-seventh of your weekly benefit amount.

## Amount of Disability Benefit Payable

The amount of disability benefit payable to you is the Benefit Amount shown on your Certificate of Insurance page, reduced by any disability benefits you receive or are entitled to receive from the following sources for the same or related disability:

- Any government motor vehicle automobile insurance plan or policy which is considered an allowable exclusion under the Employment Insurance Premium Reduction Regulations, unless prohibited by law;
- If necessary, the amount of your benefit will be further reduced so that your total income from all sources does not exceed 85% of your pre-disability gross earnings (net earnings, if your benefit is non-taxable). All sources include those sources stated above and any benefit you are entitled to receive from:
  - Workers Compensation or similar coverage;
  - Canada or Québec Pension Plan, including dependent benefits;
  - Any group, association or franchise plan;
  - Any retirement or pension plan;
  - Earnings or payments from any employer, including severance payments and vacation pay;
  - Self-employment;
  - Any government plan, excluding Employment Insurance Benefits.

### **Periods for Which You Are Not Entitled to Benefits**

You are not entitled to benefit payments for any period that you are:

- Not receiving from a physician, regular, ongoing care and treatment appropriate for your disabling condition, as determined by the Insurer;
- Receiving Employment Insurance benefits;
- On lay-off during which you become Totally Disabled;
- On leave of absence during which you become Totally Disabled, unless your employer is required to pay benefits during this period as a result of legislation, regulation or case law;
- Receiving benefits under an employer-sponsored salary continuance or wage loss replacement plan, or receiving temporary disability benefits from Workers Compensation;
- Receiving earnings or payments from any employer, including severance payments and vacation pay;
- Incarcerated in a prison, correctional facility, or mental institution by order of authority of a criminal court.

### **Waiver of Premium**

If you become Totally Disabled before you retire or reach age 65, whichever is earlier, coverage may continue without any premiums being required as long as you are Totally Disabled (see the Long Term Disability (LTD) benefit section for further information on the definition of disability).

Waiver of premium will begin after you have been disabled for at least the elimination period of the LTD Benefit, or the sixth month, whichever is earlier. This benefit will continue until you cease to be disabled or reach age 65, whichever is earlier.

### **Subrogation**

If another person causes your disability and you have a legal right to recover damages, the Insurer will request that you complete a subrogation reimbursement agreement when you submit your Disability claim.

On settlement or judgement of your legal action, you will be required to reimburse the Insurer those amounts you recover which, when added to the disability benefits that the Insurer paid to you, exceed 100% of your lost income.

## **Tax Status of Benefits**

The tax position of any payments you receive under this benefit depends on whether you or your employer pays the cost of the benefit premium. If your employer pays a portion or all of the cost, then any disability benefit payments you receive will be taxable. If you pay the full cost of the benefit, then any disability benefit payments you receive will be non-taxable.

## **Termination of Benefit Payments**

Your disability benefit payments will cease on the earliest of:

- The date you cease to be Totally Disabled, as defined under this benefit;
- The date you work in any occupation for wage or profit;
- The date you do not supply the Insurer with appropriate medical evidence documenting how your illness or injury causes restrictions or lack of ability, such that you are prevented from performing the essential duties of your own occupation;
- The date you do not attend an examination by an independent expert chosen by the Insurer;
- The date on which benefits have been paid up to the Maximum Benefit Period for this benefit;
- The date you retire;
- The date of your death.

## **Recurrent Disability**

If you become Totally Disabled again from the same or related causes within 2 weeks from the end of the period for which Disability Income benefits were paid, the Insurer will treat the disability as a continuation of your previous disability.

You will not be required to satisfy any applicable Elimination Period. The benefit payable to you will be based on your earnings as at the date of your previous disability. Benefits for all such recurrent disabilities will not be paid for a combined period longer than the Maximum Benefit Period for this benefit.

If the same disability recurs more than 2 weeks after the end of the period for which benefits were paid, such disability will be considered a separate disability.

Two disabilities, which are due to unrelated causes, are considered separate disabilities if they are separated by a return to work of at least one day.

## **Exclusions**

No benefits are payable for any disability related to:

- Any illness or injury for which benefits are payable by Workers Compensation or similar coverage;
- Self-inflicted injuries or illnesses;
- War, insurrection, the hostile actions of any armed forces or participation in a riot or civil commotion;

- Medical or surgical care which is cosmetic;
- Any illness or injury that occurred or manifested itself while working for wage or profit for someone other than the Employer;
- The committing of or the attempt to commit an assault or criminal offense;
- Abuse of addictive substances, including drugs and alcohol, unless you are actively participating and co-operating in a medical treatment program for substance abuse which has been approved by the Insurer.

### **Submitting a Claim**

To submit a claim, you must complete a Short-Term Disability Claim form, which is available from Western Financial Group Insurance Solutions. Your attending physician must also complete a portion of this form. Upon completion, please return the form to Western Financial Group Insurance Solutions for processing and submission to the Insurance company.

A completed claim form must be submitted to Western Financial Group Insurance Solutions within 90 days from the end of the Elimination Period.

### **Termination Age**

Benefit terminates at age 70 or retirement, whichever is earlier.

Please refer to your Certificate of Insurance to see if this benefit applies to you.

# Long Term Disability Benefit

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## General Description

If you become Totally Disabled while insured and meet the Entitlement Criteria for this benefit, this benefit will be payable to you.

## Definition of Totally Disabled

Totally Disabled means a restriction or lack of ability due to an illness or injury which prevents you from performing the essential duties of:

- Your own occupation, during the Elimination Period and the 2 years immediately following the Elimination Period;
- Any occupation for which you are qualified or may reasonably become qualified by training, education or experience after the 2 years specified above.

The availability of work will not be considered by the Insurer in assessing your disability.

If you must hold a government permit or license to perform the duties of your job, you will not be considered Totally Disabled solely because your permit or license has been withdrawn or not renewed.

## Benefit Amount

Please refer to your Certificate of Insurance page.

## Non Evidence Limit

Please refer to your Certificate of Insurance page.

## Benefit Period

Please refer to your Certificate of Insurance page.

## Elimination Period

You must be receiving regular, ongoing care and treatment from a physician during the Elimination Period in order for benefits to be payable at the end of the Elimination Period

## Entitlement Criteria

To be entitled to disability benefits, you must meet the following criteria:

- You must be continuously Totally Disabled throughout the Elimination Period. If you cease to be Totally Disabled during this period and then become disabled again within 3 weeks due to the same or related illness or injury, your Elimination Period will be extended by the number of days during which you ceased to be Totally Disabled;
- The Insurer must receive medical evidence documenting how your illness or injury causes restrictions or lack of ability, such that you are prevented from performing the essential duties of:
  - Your own occupation during the Elimination Period and the following 2 years, and;

- Any occupation for which you are qualified, or may reasonably become qualified, by training, education or experience after the 2 years specified above.
- You must be receiving from a physician, regular, ongoing care and treatment appropriate for your disabling condition, as determined by the Insurer.

At any time, the Insurer may require you to submit to a medical, psychiatric, psychological, educational and/or vocational examination or evaluation by an examiner selected by them.

### **Payment of Disability Benefits**

Disability benefit payments will be made monthly in arrears. Any payment for a period of less than one month will be made at a daily rate based on the number of days in the applicable month.

### **Amount of Disability Benefit Payable**

The amount of disability benefit payable to you is the amount shown on your Certificate of Insurance page.

If necessary, the amount of your benefit will be further reduced so that your total income from all sources does not exceed 85% of your pre-disability gross earnings (net earnings, if your benefit is non-taxable). All sources include any benefit you are entitled to receive from:

- Any group, association or franchise plan;
- Any retirement or pension plan;
- Earnings or payments from any employer, including severance payments and vacation pay;
- Self-employment;
- Any government plan, excluding Employment Insurance Benefits;
- Canada or Quebec Pension Plans' including dependent benefits;
- Workers Compensation or similar coverage.

Once benefits become payable, the amount of your benefit will not be affected by any subsequent cost of living increase in benefits you are receiving from other sources.

### **Periods for Which You Are Not Entitled to Benefits**

You are not entitled to benefit payments for any period that you are:

- Not receiving from a physician, regular, ongoing care and treatment appropriate for your disabling condition, as determined by the Insurer;
- Receiving Employment Insurance maternity or parental benefits;
- On lay-off during which you become Totally Disabled;
- On leave of absence during which you become Totally Disabled, unless your employer is required to pay benefits during this period as a result of legislation, regulation or case law;
- Receiving benefits under an employer-sponsored salary continuance or short-term wage loss replacement plan;

- Working in any occupation, except as provided for under the Rehabilitation Assistance provision;
- Incarcerated in a prison, correctional facility, or mental institution by order of authority of a criminal court.

### **Benefit Calculation Rules**

The Insurer will apply the following rules in determining your disability benefit:

- Benefits from other sources which began before the commencement of your current Disability will not be taken into account;
- Benefits payable from other sources will not be adjusted to take into account any difference between the tax status of those benefits and the benefit payable by the Insurer;
- Subsequent changes in benefits from other sources, other than cost of living increases, will be taken into consideration and a new benefit amount may be established;
- For benefits payable other than on a monthly basis, a monthly equivalent of such benefit will be estimated by the Insurer, and;
- If you do not apply for a benefit for which you are eligible, the amount of such benefit will be estimated by the Insurer and assumed to be paid.

### **Waiver of Premium**

The premium for your Long Term Disability benefit will be waived during any period you are entitled to receive Long Term Disability benefit payments.

### **Subrogation**

If your disability is caused by another person and you have a legal right to recover damages, the Insurer will request that you complete a subrogation reimbursement agreement when you submit your Long Term Disability claim.

On settlement or judgment of your legal action, you will be required to reimburse the Insurer those amounts you recover which, when added to the disability benefits that the Insurer paid to you, exceed 100% of your lost income.

### **Tax Status of Benefits**

The tax position of any payments you receive under this benefit depends on whether you or your employer pays the cost of the benefit. If your employer pays a portion or all of the cost, then any disability benefit payments you receive will be taxable. If you pay the full cost of the benefit, then any disability benefit payments you receive will be non-taxable.

### **Rehabilitation Assistance**

Once the Insurer determines that you are Totally Disabled, if appropriate, and at the Insurer's discretion, you will be offered rehabilitation to assist you in returning to gainful employment, either to your pre-disability occupation or to another occupation.

In considering whether Rehabilitation Assistance is appropriate for you, the Insurer will take into account:

- The nature, extent and expected duration of your disability;
- Your level of education, training or experience;
- The nature, scope, objectives and cost of a Vocational Plan.

### **Vocational Plan**

A Vocational Plan is a training or job placement program that is expected to facilitate your return to gainful employment.

If it is determined that Rehabilitation Assistance is appropriate for you, in partnership with you and your employer, the Insurer will provide a structured Vocational Plan that will prepare you for a return to work, either:

- With your employer;
- With an alternate employer, or;
- In a self-employed capacity.

### **Disability Benefits During Rehabilitation**

You will continue to be entitled to disability benefits while participating in the Vocational Plan. If you receive any earnings as part of the plan, your disability benefit will be reduced by 50% of the earnings you receive.

If you cease to participate in the Vocational Plan because of a change in your medical status, the Insurer will require medical evidence documenting how your current medical status prevents you from continuing with the Vocational Plan.

If you are not available or do not cooperate or participate in the Vocational Plan, you will no longer be entitled to disability benefits.

### **Termination of Benefit Payments**

Your disability benefit payments will cease on the earliest of:

- The date you cease to be Totally Disabled, as defined under this benefit;
- The date you do not supply the Insurer with appropriate medical evidence documenting how your illness or injury causes restrictions or lack of ability, such that you are prevented from performing the essential duties of;
  - Your own occupation, during the Elimination Period and the following two years, and;
  - Any occupation for which you are qualified, or may reasonably become qualified, by training, education or experience after the 2 years specified above;
- The date you do not attend an examination by an independent expert chosen by the Insurer;
- The date on which benefits have been paid up to the Maximum Benefit Period for this benefit;
- The date of your death.

## **Recurrent Disability**

If you become Totally Disabled again from the same or related causes within 6 months from the end of the period for which Long Term Disability benefits were paid, the Insurer will treat the disability as a continuation of your previous disability.

You will not be required to satisfy the Elimination Period again. The benefit payable to you will be based on your earnings as at the date of your previous disability. Benefits for all such recurrent disabilities will not be paid for a combined period longer than the Maximum Benefit Period for this benefit.

If the same disability recurs more than 6 months after the end of the period for which benefits were paid, such disability will be considered a separate disability.

Two disabilities, which are due to unrelated causes, are considered separate disabilities if they are separated by a return to work of at least one day.

## **Exclusions**

No benefits are payable for any disability related to:

- Self-inflicted injuries or illnesses;
- War, insurrection, the hostile actions of any armed forces or participation in a riot or civil commotion;
- Medical or surgical care which is cosmetic;
- Any illness or injury that occurred or manifested itself while working for wage or profit for someone other than the employer;
- The committing of or the attempt to commit an assault or criminal offense;
- Abuse of addictive substances, including drugs and alcohol, unless you are actively participating and cooperating in a medical treatment program for substance abuse which has been approved by the Insurer;
- This benefit does not cover disability beginning during the first 12 months following the effective date of the participant's coverage hereunder resulting from an injury or illness for which the symptoms have been the subject of consultations or have been treated during the 12 months preceding the effective date of the participant's coverage under this benefit. This provision does not apply when the participant was insured under a similar benefit stipulated in an earlier group contract that terminated during the 31 days preceding the effective date of the coverage under this benefit.

## **Submitting a Claim**

To submit a claim, you must complete a Long Term Disability Claim form, which is available from Western Financial Group Insurance Solutions. Your attending physician must also complete a portion of this form. A completed claim form must be submitted to Western Financial Group Insurance Solutions within 90 days from the end of the Elimination Period.

## **Termination Age**

Benefit terminates at age 65 or retirement, whichever is earlier.

Please refer to your Certificate of Insurance to see if this benefit applies to you.

# Extended Health Care

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## General Description

If you or your dependents incur charges for any of the Covered Expenses specified in this booklet, your Extended Health Care benefit can provide financial assistance.

Payment of Covered Expenses is subject to any maximum amounts and deductibles shown on the Certificate of Insurance.

## Covered Expenses

The expenses specified are covered to the extent that they are reasonable and customary:

- Medically necessary for the treatment of sickness or injury and recommended by a physician;
- Incurred for the care of a person while insured under this Group Benefit Program;
- Reasonable, taking all factors into account;
- Not covered under the Provincial Plan or any other government sponsored program;
- Legally insurable.

Payment of any Covered Expenses under this benefit, which may be purchased in large quantities, will be limited to the purchase of up to a 3-month supply at any one time.

## Hospital Care

Charges in excess of the hospital's public ward charge, for semi-private accommodation, provided:

- The person was confined to hospital on an in-patient basis;
- The accommodation was specifically elected by the patient.

Semi-private accommodation for confinement in a convalescent care facility.

## Prescription Drugs

Drugs or medicines dispensed by a licensed pharmacist, and which by law or convention require a written prescription of a physician or dentist:

- Oral contraceptives, intrauterine devices and diaphragms;
- Injectable medications;
- Life sustaining drugs;
- Preventive vaccines;
- Non-prescription drugs and supplies required for the treatment of diabetes (excluding automatic jet injectors or similar equipment).
- Ileostomy, colostomy and incontinence supplies.

Charges for the following expenses are not covered, even when prescribed:

- The administration of serums, vaccines or injectable drugs;

- Charges for drugs, biological and related preparations which are intended to be administered in hospital on an in-patient or out-patient basis and are not intended for a patient's use at home;
- Fertility drugs;
- Anti-smoking drugs;
- Anti-obesity drugs;
- Erectile dysfunction drugs;
- Hair growth stimulants;
- Coagulotherapy or Radiotherapy.

### **Drug Maximum**

Please refer to your Certificate of Insurance.

### **Benefit Percentage**

Please refer to your Certificate of Insurance.

### **Payment of Covered Expenses**

- Payment will be subject to the Drug Dispensing Fee Maximum and benefit percentage as shown on the Certificate of Insurance;
- Covered expenses for any prescribed drug or medicine will not exceed the price of the lowest cost generic equivalent product that can legally be used to fill the prescription;
- If there is no generic equivalent product for the prescribed drug or medicine, the amount covered is the cost of the prescribed product.

### **No Substitution Prescriptions**

- If your prescription contains a written direction from your physician or dentist that the prescribed drug or medicine is not to be substituted with another product and the drug or medicine is a covered expense under this benefit, the full cost of the prescribed product will be considered;
- The amount payable subject to the Drug Dispensing Fee Maximum and benefit percentage as shown on your Certificate of Insurance.

### **Payment of Drug Claims**

Your Pay Direct Drug Card provides your pharmacist with immediate confirmation of covered drug expenses. This means that when you present your Pay Direct Drug Card to your pharmacist at the time of purchase, you and your eligible dependents will not incur out-of-pocket expenses for the full cost of the prescription. The Pay Direct Drug Card is honoured by participating pharmacists displaying the appropriate Pay Direct decal. To fill a prescription for covered drug expenses:

- Present your Pay Direct Drug Card to the pharmacist at the time of purchase, and;
- Pay any amounts that are not covered under this benefit.

You will be required to pay the full cost of the prescription at the time of purchase if:

- You cannot locate a participating Pay Direct Drug Pharmacy;
- You do not have your Pay Direct Drug Card with you at that time;
- The prescription is not payable through the Pay Direct Drug Card system.

## Drug Dispensing Fee Maximum

Please refer to your Certificate of Insurance.

## Professional Services

Services provided by the following licensed practitioners:

- Chiropractor
- Osteopath
- Massage Therapist\* (A written doctor's referral is required.)
- Podiatrist
- Naturopath
- Physiotherapist
- Psychologist
- Speech Therapist
- Psychiatrist - if treatment is rendered in the province of Quebec and the treatment is not covered under Quebec's Provincial Plan.

**\*Note: Massage therapy is not covered if you have bronze coverage.**

For dollar amount per visit and maximum per calendar year, please refer to your Certificate of Insurance.

Expenses for some of these Professional Services may be payable in part by Provincial Plans. Coverage for the balance of such expenses prior to reaching the Provincial Plan maximum may be prohibited by provincial legislation. In those provinces, expenses under this Benefit Program are payable after the Provincial Plan's maximum for the benefit year has been paid.

## Medical Services and Supplies

For all medical equipment and supplies covered under this provision, Covered Expenses will be limited to the cost of the device or item that adequately meets the patient's fundamental medical needs.

## Private Duty Nursing

Services which are deemed to be within the practice of nursing and which are provided in the patient's home by:

- A registered nurse, or;
- A registered nursing assistant (or equivalent designation) that has completed an approved medications training program.

Covered Expenses are subject to a maximum of \$10,000 per calendar year.

Charges for the following services are not covered:

- Service provided primarily for custodial care, homemaking duties or supervision;
- Service performed by a nursing practitioner who is related to or lives with the patient;
- Service performed while the patient is confined in a hospital, nursing home, or similar institution; due to biting or chewing, to a maximum of \$3,000 per accident.

- Service, which can be performed by a person of lesser qualification, a relative, friend or a member of the patient's household.

**The insurer suggests that a detailed treatment plan be submitted with cost estimates before Private Duty Nursing Services begin. You will then be advised of any benefit that will be provided.**

## **Ambulance**

Licensed ambulance service provided in the patient's province of residence, including air ambulance, to and from the nearest hospital where adequate treatment is available.

## **Medical Services and Equipment**

Rental or, when approved by the insurer, purchase of:

- Laboratory tests, up to a maximum of \$250 per eligible test;
- Ultrasound, up to a maximum of \$250 per eligible test;
- Mobility Equipment: crutches, canes, walkers and wheelchairs;
- Durable Medical Equipment: manual hospital beds, respiratory and oxygen equipment, and other durable equipment usually found only in hospitals;
- Artificial eyes, limbs;
- Contact lenses or Intraocular lenses following cataract surgery, limited to one lens per eye to a maximum of \$500 — if not covered by provincial plan;
- Surgical stockings, up to a maximum of 4 pairs per calendar year;
- Stump socks, up to a maximum of 12 every 12 months;
- Mastectomy bra, up to a maximum of 4 per calendar year;
- Braces (other than foot braces), trusses, collars, leg orthosis, casts and splints;
- Stock-item orthopedic shoes and modifications or adjustments to stock-item orthopedic shoes or regular footwear, up to a maximum of \$150 per calendar year for shoes which are attached to and form part of a brace and \$75 per calendar year for shoes which are not attached to and do not form part of a brace (recommendation of either a physician or a podiatrist is required);
- Custom-made shoes which are constructed by a Certified Orthopedic Footwear Specialist (C.F.S.O.) and are required because of a medical abnormality, up to a maximum of \$150 per calendar year;
- Casted, custom-made orthotics, up to a maximum of \$400 per 3 calendar years (recommendation of either a physician or podiatrist is required);
- Cost and installation of initial hearing aids (including charges for batteries) to a maximum of \$500 per 5 calendar years;
- Initial pair of glasses or contact lenses, which are required as a result of an accidental injury.
- Breast Prostheses, up to a maximum of \$385 in a benefit year

## **Other Supplies and Services**

- Ileostomy, colostomy and incontinence supplies;
- Medicated dressings and burn garments;
- Wigs and hairpieces for patients with temporary hair loss as a result of medical treatment, up to a maximum of \$250 per lifetime;

- Oxygen and diagnostic services;
- Glucometers prescribed by a specialist, up to a lifetime maximum of \$700;
- Charges for the treatment of accidental injuries to natural teeth or jaw, provided the treatment is rendered within 12 months of the accident, excluding injuries due to biting or chewing, to a maximum of \$3,000 per accident.

### **Travel Medical Emergency Insurance**

Emergency medical treatment of a sickness or injury which occurs while temporarily outside the province of residence, provided the insured person who receives the treatment is also covered by the Provincial Plan during the absence from the province of residence. A medical emergency is a sudden, unexpected injury, which occurs, or an unforeseen illness, which begins while an insured person is travelling outside their province of residence and requires immediate medical attention. Such emergency no longer exists when, in the opinion of the attending physician, the insured person is able to return to his province of residence.

- Emergency services are payable up to a maximum of \$5,000,000 per calendar year;
- Termination Age is 70 or retirement, if earlier;
- Period is 90 days per trip;
- Patient must contact insurance provider within 48 hours of commencement of treatment.

Complete details are given in the Travel Plan brochure. It is important that you understand your plan before you travel.

### **Referral**

Referral services paid to a maximum of \$50,000 per calendar year.

If, while outside Canada on referral for medical treatment, the insured person requires treatment for a medical condition which is related directly or indirectly to the referral treatment, the total expenses payable for all treatments are subject to the maximum.

For all non-emergency medical treatment outside of Canada, the insurance provider requires:

- That it be recommended by a physician practicing in Canada, and;
- Prior to the commencement of any referral treatment, written pre-authorization must be obtained from your provincial health plan and the claims provider. You will then be advised of any benefit that will be provided.

Charges for the following are payable under this expense:

- Physician's services;
- Hospital room and board at semi-private rates;
- The cost of special hospital services;
- Hospital charges for out-patient treatment.

The amount payable for these expenses will be the reasonable and customary charges less the amount payable by the Provincial Plan or which would have been payable had proper application been made. Charges incurred outside the province of residence for all other Covered Extended Health Care Expenses are payable on the same basis as if they were incurred in the province of residence.

## Submitting a Claim

To submit a claim, you must complete an Extended Health Care Claim form, except when claiming for physician or hospital expenses incurred outside your province of residence. For these expenses, you must complete an Out-of-Province/Out-of-Canada claim form. Claim forms are available from Western Financial Group Insurance Solutions' web site ([www.westernfgis.ca](http://www.westernfgis.ca)). All applicable receipts must be attached to the completed claim form when submitting to the claims provider.

All claims must be submitted within 12 months after the date the expense was incurred. However, upon termination of your insurance, all claims must be submitted no later than 90 days from the termination date.

Claims for Out-of-Canada expenses must first be submitted to the Provincial Plan for payment. Any outstanding balance should be submitted to the claims provider, along with the explanation of payment from the Provincial Plan.

## Payment of Claims

Once the claim has been processed, you will be sent an Explanation of Benefits statement. This statement provides the information that may be required for tax purposes (the information provided on a receipt) as well as any deductibles, maximums, or co-payments applied to the payment of your claim. This statement can also be used to submit Co-ordination of Benefit (COB) claims.

## Co-ordination of Benefits

If you or your dependents are insured for similar benefits under another Plan, Western Financial Group Insurance Solutions will take this into account when determining the amount of expenses payable under this program.

This process is known as Co-ordination of Benefits. It allows for reimbursement of insured health expenses from all plans, up to a total of 100% of the actual expenses incurred.

Plan means:

- Other Group Benefit Programs;
- Any other arrangement of coverage for individuals in a group;
- Individual travel insurance plans.

Plan does not include school insurance or Provincial Plans.

## Order of Benefit Payment

A variety of circumstances will affect which Plan is considered as the "Primary Carrier" (i.e. responsible for making the initial payment toward the eligible expense), and which Plan is considered as the "Secondary Carrier" (i.e. responsible for making the payment to cover the remaining eligible expense).

- If the other Plan does not provide for Co-ordination of Benefits, it will be considered as the Primary Carrier, and will be responsible for making the initial payment toward the eligible expense;
- If the other Plan does provide for Co-ordination of Benefits, the following rules are applied to determine which Plan is the Primary Carrier.

**For claims incurred by you or your Dependent Spouse:**

- The Plan insuring you or your Dependent Spouse as an employee/member pays benefits before the Plan insuring you or your Spouse as a dependent.

In situations where you or your Spouse has coverage as an employee/member under more than one Plan, the order of benefits payable will be determined as follows:

- The Plan where the person is covered as an active full time employee, then;
- The Plan where the person is covered as an active part time employee, then;
- The Plan where the person is covered as a retiree.

**For claims incurred by your Dependent Child:**

The Plan covering the parent whose birthday (month/day) is earlier in the calendar year pays benefits first. If both parents have the same birth date, the Plan covering the parent whose first name begins with the earlier letter in the alphabet pays first.

However, if you and your Spouse are separated or divorced, the following order applies:

- The Plan of the parent with custody of the child, then;
- The Plan of the spouse of the parent with custody of the child (i.e. if the parent with custody of the child remarries or has a common-law spouse, the new spouse's Plan will pay benefits for the Dependent Child), then;
- The Plan of the parent not having custody of the child, then;
- The Plan of the spouse of the parent not having custody of the child (i.e. if the parent without custody of the child remarries or has a common-law spouse, the new spouse's Plan will pay benefits for the Dependent Child);
- A claim for accidental injury to natural teeth will be determined under Extended Health Care Plans with accidental dental coverage before it is considered under Dental Plans;
- If the order of benefit payment cannot be determined from the above, the benefits payable under each Plan will be in proportion to the amount that would have been payable if Co-ordination of Benefits did not exist;
- If the insured person is also covered under an individual travel insurance plan, benefits will be coordinated in accordance with the guidelines provided by the Canadian Life and Health Insurance Association.

**Submitting a Claim for Co-ordination of Benefits**

To submit a claim when Co-ordination of Benefits applies, refer to the following guidelines:

- As per the Order of Benefit Payment section, determine which Plan is the Primary Carrier and which is the Secondary Carrier;
- Submit all necessary claim forms and original receipts to the Primary Carrier;
- Keep a photocopy of each receipt or ask the Primary Carrier to return the original receipts to you once your claim has been settled;
- Once the Primary Carrier has settled your claim, you will receive a statement outlining how your claim has been handled. Submit this statement along with all necessary claim forms and receipts to the Secondary Carrier for further consideration of payment, if applicable.

## Drug Benefit For Quebec Residents

If you and your dependents reside in Québec, the following provisions apply to your drug benefit coverage. The following expenses are covered:

- Drugs that are on the List of Insured Drugs that is published by the Régis de l'assurance-maladie du Québec (RAMQ List), provided such drugs are on the list at the time the expense is incurred; and;
- Drugs that are listed as a covered expense in this Benefit Booklet, but are not on the RAMQ List.

The following provisions apply only to the coverage of drugs that are on the RAMQ List.

Coverage for all other drugs will be subject to the regular provisions included in this Booklet.

### Benefit Percentage

Prior to the annual out-of-pocket maximum being reached, the percentage of covered drug expenses payable under this benefit will be as follows:

- For any drug on the RAMQ List which is not otherwise covered under the terms of this Benefit, the percentage payable at the time of claim, and;
- For any drug on the RAMQ List, which is covered under the terms of this Benefit, the percentage is the greater of: the benefit percentage stated under The Benefit; and the percentage at the time of claim.

After the annual out-of-pocket maximum has been reached, the percentage of covered drug expenses payable under this Benefit will be 100%.

### Annual Out-of-Pocket Maximum

The annual out-of-pocket maximum is the portion of covered drug expenses, which must be paid by you and your spouse in a calendar year, before the percentage payable under this benefit will be 100%. Amounts that will be applied to the annual out-of-pocket maximum are:

- Deductible amounts, and;
- The portion of covered expenses that are paid by an insured person, when the percentage of covered expenses payable under this benefit is less than 100%.

The annual out-of-pocket maximum for you and your spouse is that determined by the RAMQ, including those portions of covered expenses paid for your dependent children.

For the purposes of calculating the out-of-pocket maximum for you and your spouse, dependent children are combined with the plan member.

### Deductible

Deductible amounts, if any, for the drug benefit will apply, until the annual out-of-pocket maximum is reached. Thereafter, the deductible will not apply.

## **Lifetime Maximums**

Lifetime maximums, if any, for the drug benefit will not apply. Drug coverage provided after the lifetime maximum stated under The Benefit is reached is subject to the following conditions:

- Only drugs that are on the RAMQ List are covered, and;
- The percentage payable by the insurer for covered expenses at time of claim.

## **Dependent Children**

All unmarried children of the participant, of the spouse or of both, including the legally adopted children or those for whom the participant or the spouse exercises or would exercise, in the case of a minor, parental authority and whom the participant or the spouse supports and who is:

- Under age 21;
- Over age 21 but under age 25, being a full-time student in an accredited educational institution, subject to evidence to the satisfaction of the Insurer;
- Regardless of age, suffering from a severe, incurable and chronic physical or mental disability while meeting the requirements indicated above of a dependent child, rendering such child unable to pursue a substantially gainful occupation, subject to adequate medical evidence.

## **Subrogation (Third Party Liability)**

The insurer retains the right to subrogation if benefits have or should have been paid or provided by a third party. In cases of third party liability, you must advise your lawyer of these rights.

## **Exclusions & Limitations**

- Any Eligible Service, which is or would in the absence of benefits, have been provided gratuitously to a Participant or for which payment is made on behalf of the Participant by a not-for-profit prepayment association, insurance carrier, third party administrator, like agency or a party other than the current claims provider, the Group or the Participant;
- Any Eligible Service which:
  - a) is not provided by a health practitioner legally qualified to provide such Service; or
  - b) is provided by a health practitioner whose license by the relevant provincial regulatory and/or professional association has been suspended or revoked; or
  - c) is not provided by a designated Provider of Service in response to a prescription issued by a legally qualified health practitioner;
- Any Eligible Service prior to its provision to a Participant;
- Any service which is not an Eligible Service or that is otherwise excluded by the covered expenses;
- Any Eligible Service rendered in connection with a condition due to or arising out of any act of war, riot, or insurrection, including, but not limited to, any war declared or undeclared and armed aggression resisted by the armed forces of any country, combination of countries or international organizations, nor for any

Eligible Service rendered while the Participant serves in the armed forces of any country;

- Any Eligible Service which arises out of, or is occasioned by, a criminal act of a Participant;
- Any Eligible Service provided or paid for by any governmental body, or agency, which is identical or similar to the Eligible Services set forth in the covered expenses:
  - a) any workers' compensation board or tribunal; or
  - b) any provincial health insurance plan; or
  - c) any other governmental body or agency;
- Any service or supply that is identical or similar to any of the Eligible Services set forth in the covered expenses, which were previously provided or paid for by any governmental body or agency, but which have been modified, suspended or discontinued as result of changes in provincial health plan legislation or de-listing of any provincial health plan services or supplies;
- Any Eligible Service, including but not limited to, drugs, laboratory services, diagnostic testing or any other service which is identical or similar to any of the Eligible Services set forth in the covered expenses, which is provided by and/ or administered in any public or private health care clinic or like facility, medical practitioner's office or residence, where the treatment or drug does not meet the accepted standards or is not considered to be effective (either medically or from a cost perspective, based on Health Canada's approved indication for use);
- Any Eligible Service which is identical or similar to any of the Eligible Services set forth in the covered expenses, which is provided by a medical practitioner who has opted out of any provincial health insurance plan and the provincial health insurance plan would have otherwise paid for such Eligible Service;
- Any part of the cost of an Eligible Service which is in excess of the lower of:
  - a) the reasonable and customary charge for such Eligible Services; or
  - b) the maximum with respect thereto as established in the covered expenses;
- Any Eligible Service for the treatment of congenital malformations or which are primarily for cosmetic or aesthetic purposes;
- Any Eligible Service rendered to a Participant in treatment of a self-inflicted injury whether or not the Participant is mentally incompetent;
- Any Eligible Service which is deemed to be experimental;
- Any Eligible Service rendered by a Provider of Service employed or engaged by an employer, mutual benefit association, fraternal or cooperative association, trustee, or similar person or group, other than services from a Provider of Service employed or engaged by a group under an employee assistance plan;
- Any drug or medicine which is not legally available for sale in Canada;
- Any Eligible Service that relates to treatment of injuries arising out of a motor vehicle accident;
- Any Eligible Service rendered to any Participant who has been removed from enrollment or any Eligible Service, for which the Participant has been deemed ineligible, by reason of practices in respect of claims or Eligible Services in

which the Participant has in the opinion of the claims payment provider, been engaged that, in the opinion of the claims payment provider, are inappropriate or abusive;

- Any Eligible Service which, by law, the claims payment provider is prohibited from paying;
- Any specific treatment or drug or medicine which:
  - a) does not meet accepted standards of medical, dental or ophthalmic practice or is not considered to be effective (either medically or from a cost perspective, based on Health Canada's approved indication for use);
  - b) is an adjunctive drug prescribed in connection with any treatment or drug that is not an Eligible Service;
  - c) will be administered in a hospital;
  - d) is not dispensed by the pharmacist in accordance with the Benefit Plan;
  - e) is not being used and/or administered in accordance with Health Canada's approved indication for use, even though such drug or procedure may customarily be used in the treatment of other illnesses or injuries; and
- Any cognitive or administrative services or other fees charged by a Provider of Service for services other than those directly relating to the delivery of the service or supply.

### **Survivor Benefit**

If you die while your dependents are insured under this Group Benefit Program, the insurer will continue the benefits without payment of premium, until the earliest of:

- The date your dependent is no longer a dependent, according to the definition of dependent;
- The date similar coverage is obtained elsewhere;
- The date which is 2 years from your death, or;
- The date the Group Plan terminates.

This benefit terminates at age 70.

### **Termination Age**

At age 70 or retirement, whichever is earlier.

Please refer to your Certificate of Insurance to see if this benefit applies to you.

# Vision Care

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## **Benefit**

- Eye exams as per your Certificate of Insurance;
- Purchase and fitting of prescription glasses or elective contact lenses, as well as repairs, to a maximum per your Certificate of Insurance;
- If contact lenses are required to treat a severe condition, or if vision in the better eye can be improved to a 20/40 level with contact lenses but not with glasses, the maximum payable as per your Certificate of Insurance;
- Visual training, to a maximum of \$200 per lifetime.

## **Benefit Maximum**

Please refer to your Certificate of Insurance.

## **Termination Age**

At age 70 or retirement, whichever is earlier.

Please refer to your Certificate of Insurance to see if this benefit applies to you.

# Dental Care

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## General Description

Dental care coverage pays for eligible expenses that are incurred for dental procedures provided by a licensed dentist, denturist, dental hygienist and anaesthetist while you are covered by this group plan.

For each dental procedure, reasonable and customary charges will be covered. Payments will be based on the Dental Association Fee Guide for general practitioners in the province where the employee lives at the time treatment is received. If you reside in Alberta, the current Fee Guide is considered to be the 1997 Alberta Dental Association Fee Guide for General Practitioners plus an inflationary adjustment.

## Benefits

### Level I - Basic Services

- One complete oral exam during any 3 calendar years;
- Full-mouth X-rays during any 2 calendar years;
- One unit of light scaling and one unit of polishing, or prophylaxis (light scaling and polishing), when the service is performed in Quebec; recall frequency as per your Certificate of Insurance;
- Recall exams, bitewing X-rays, and fluoride treatments; recall frequency as per your Certificate of Insurance;
- Routine diagnostic and laboratory procedures;
- Initial oral hygiene instruction, plus one recall;
- Fillings, retentive pins and pit and fissure sealants;
- Pre-fabricated full coverage restorations (stainless steel crowns) for primary teeth only, excluding crowns of porcelain fused to metal, acrylic, plastic, gold, porcelain and other substances;
- Space maintainers (appliances placed for orthodontic purposes are not covered);
- Minor surgical procedures and post surgical care;
- Extractions (including impacted and residual roots);
- Consultations and conscious sedation;
- Denture repairs, relines and rebases;
- Injection of antibiotic drugs when administered by a Dentist in conjunction with dental surgery.

### Level II - Supplementary Services

- Surgical procedures not included in Level I (excluding implant surgery);
- Periodontal scaling not covered under Level I, and root planing, up to a combined maximum per your Certificate of Insurance;
  - Provisional splinting;
  - Occlusal equilibration, up to a maximum of 8 units per calendar year;

- Endodontic services, which include root canals and therapy, root amputation, apexifications and periapical services.

### **Level III - Dentures**

- Initial provision of full or partial removable dentures;
- Replacement of removable standard dentures, provided the dentures are required because:
  - A natural tooth is extracted and the existing appliance cannot be made serviceable;
  - The existing appliance is at least 60 months old; or
  - The existing appliance is temporary and is replaced with the permanent dentures within 12 months of its installation.
- Dentures required solely to replace a natural tooth, which was missing prior to becoming insured for this covered expense are not covered.

### **Level IV - Major Restorative Services**

- Crowns and onlays when the function of a tooth is impaired due to cuspal or incisal angle damage caused by trauma or decay;
- Initial provision of fixed bridgework;
- Replacement of bridgework, provided the new bridgework is required because:
  - A natural tooth is extracted and the existing appliance cannot be made serviceable;
  - The existing appliance is at least 60 months old, or;
  - The existing appliance is temporary and is replaced with the permanent bridge within 12 months of its installation;
  - Bridgework required solely to replace a natural tooth, which was missing prior to becoming insured for this covered expense is not covered.

**For breakdown of co-insurance, or to see if this applies to you, please refer to your Certificate of Insurance.**

### **Level V - Orthodontics**

- Orthodontic services, for dependent children only, provided treatment commences prior to reaching age 19.

**For breakdown of co-insurance, or to see if this applies to you, please refer to your Certificate of Insurance.**

### **Deductible**

Nil.

### **Benefit Percentage**

Please refer to your Certificate of Insurance.

### **Benefit Maximums**

Please refer to your Certificate of Insurance.

## **Late Applicant Limitation**

If you or your dependents become insured for dental benefits more than 31 days after you first become eligible to apply, the amount payable in the first 12 months of coverage will be limited to \$250 for each insured person.

## **Submitting a Claim**

This program gives you the ability to submit your claim electronically, as long as you present your dentist with your wallet card.

To submit a paper claim, you and your dentist must complete a Dental Claim form, which is available from Western Financial Group Insurance Solutions' web site ([www.westernfgis.ca](http://www.westernfgis.ca)). Once the form has been completed, submit it to claims provider.

All claims must be received within 12 months after the date the expense was incurred. However, upon termination of your insurance, all claims must be received no later than 90 days from the termination date.

## **Pre-Determination**

If the cost of any proposed dental treatment is expected to exceed \$300, Western Financial Group Insurance Solutions suggests that you submit a detailed Pre-Authorization, available from your dentist, before the treatment begins. You can then be advised of the amount you are entitled to receive under this benefit.

## **Dental Fee Guide**

Current Fee Guide for General Practitioners for your Province of Residence, unless you reside in Alberta.

## **Alternate Treatment**

Where any two or more courses of treatment covered under this benefit would produce professionally adequate results for a given condition, the insurer will pay benefits as if the least expensive course of treatment were used. The insurer will determine the adequacy of the various courses of treatment available, through a professional dental consultant.

## **Co-ordination of Benefits**

If you or your dependents are insured for similar benefits under another Plan, Western Financial Group Insurance Solutions will take this into account when determining the amount of expenses payable under this program.

This process is known as Co-ordination of Benefits. It allows for reimbursement of insured dental expenses from all plans, up to a total of 100% of the actual expenses incurred.

Plan means:

- Other Group Benefit Programs;
- Any other arrangement of coverage for individuals in a group;
- Individual travel insurance plans.

Plan does not include school insurance or Provincial Plans.

## Order of Benefit Payment

A variety of circumstances will affect which Plan is considered as the “Primary Carrier” (i.e. responsible for making the initial payment toward the eligible expense), and which Plan is considered as the “Secondary Carrier” (i.e. responsible for making the payment to cover the remaining eligible expense):

- If the other Plan does not provide for Co-ordination of Benefits, it will be considered as the Primary Carrier, and will be responsible for making the initial payment toward the eligible expense;
- If the other Plan does provide for Co-ordination of Benefits, the following rules are applied to determine which Plan is the Primary Carrier.

### For Claims Incurred by You or Your Dependent Spouse:

- The Plan insuring you or your Dependent Spouse as an employee/member pays benefits before the Plan insuring you or your Spouse as a dependent.

In situations where you or your Spouse has coverage as an employee/member under more than one Plan, the order of benefit payable will be determined as follows:

- The Plan where the person is covered as an active full time employee, then;
- The Plan where the person is covered as an active part time employee, then;
- The Plan where the person is covered as a retiree.

### For Claims Incurred by Your Dependent Child:

The Plan covering the parent whose birthday (month/day) is earlier in the calendar year pays benefits first. If both parents have the same birth date, the Plan covering the parent whose first name begins with the earlier letter in the alphabet pays first. However, if you and your Spouse are separated or divorced, the following order applies:

- The Plan of the parent with custody of the child, then;
- The Plan of the spouse of the parent with custody of the child (i.e. if the parent with custody of the child remarries or has a common-law spouse, the new spouse’s Plan will pay benefits for the Dependent Child), then;
- The Plan of the parent not having custody of the child, then;
- The Plan of the spouse of the parent not having custody of the child (i.e. if the parent without custody of the child remarries or has a common-law spouse, the new spouse’s Plan will pay benefits for the Dependent Child);
- A claim for accidental injury to natural teeth will be determined under Extended Health Care Plans with accidental dental coverage before it is considered under Dental Plans;
- If the order of benefit payment cannot be determined from the above, the benefits payable under each Plan will be in proportion to the amount that would have been payable if Co-ordination of Benefits did not exist;
- If the insured person is also covered under an individual travel insurance plan, benefits will be co-ordinated in accordance with the guidelines provided by the Canadian Life and Health Insurance Association.

## Submitting a Claim for Co-ordination of Benefits

To submit a claim when Co-ordination of Benefits applies, refer to the following guidelines:

- As per the Order of Benefit Payment section, determine which Plan is the Primary Carrier and which is the Secondary Carrier;
- Submit all necessary claim forms and original receipts to the Primary Carrier;
- Keep a photocopy of each receipt or ask the Primary Carrier to return the original receipts to you once your claim has been settled;
- Once the Primary Carrier has settled your claim, you will receive a statement outlining how your claim has been handled. Submit this statement along with all necessary claim forms and receipts to the Secondary Carrier for further consideration of payment, if applicable.

## Payment of Claims

Once the claim has been processed, you will be sent an Explanation of Benefits. This statement provides the information that may be required for tax purposes (the information provided on a receipt) as well as any deductibles, maximums, or co-payments applied to the payment of your claim. This statement can also be used to submit Co-ordination of Benefit (COB) claims.

## Subrogation (Third Party Liability)

If your expenses result from an injury caused by another person and you have the legal right to recover damages, the insurer may request that you complete a subrogation reimbursement agreement when you submit a claim for such expenses.

On settlement or judgement of your legal action, you will be required to reimburse the insurer those amounts you recover which, when added to the payments you received from the insurer, do not exceed 100% of your incurred expenses.

## Exclusions & Limitations

- Any Eligible Service, which is or would in the absence of benefits, have been provided gratuitously to a Participant or for which payment is made on behalf of the Participant by a not-for-profit prepayment association, insurance carrier, third party administrator, like agency or a party other than the current claims provider, the Group or the Participant;
- Any Eligible Service which:
  - a) is not provided by a health practitioner legally qualified to provide such Service; or
  - b) is provided by a health practitioner whose license by the relevant provincial regulatory and/or professional association has been suspended or revoked; or
  - c) is not provided by a designated Provider of Service in response to a prescription issued by a legally qualified health practitioner;
- Any Eligible Service prior to its provision to a Participant;
- Any service which is not an Eligible Service or that is otherwise excluded by the covered expenses;

- Any Eligible Service rendered in connection with a condition due to or arising out of any act of war, riot, or insurrection, including, but not limited to, any war declared or undeclared and armed aggression resisted by the armed forces of any country, combination of countries or international organizations, nor for any Eligible Service rendered while the Participant serves in the armed forces of any country;
- Any Eligible Service which arises out of, or is occasioned by, a criminal act of a Participant;
- Any Eligible Service provided or paid for by any governmental body, or agency, which is identical or similar to the Eligible Services set forth in the covered expenses:
  - a) any workers' compensation board or tribunal; or
  - b) any provincial health insurance plan; or
  - c) any other governmental body or agency;
- Any service or supply that is identical or similar to any of the Eligible Services set forth in the covered expenses, which were previously provided or paid for by any governmental body or agency, but which have been modified, suspended or discontinued as result of changes in provincial health plan legislation or de-listing of any provincial health plan services or supplies;
- Any Eligible Service, including but not limited to, drugs, laboratory services, diagnostic testing or any other service which is identical or similar to any of the Eligible Services set forth in the covered expenses, which is provided by and/ or administered in any public or private health care clinic or like facility, medical practitioner's office or residence, where the treatment or drug does not meet the accepted standards or is not considered to be effective (either medically or from a cost perspective, based on Health Canada's approved indication for use);
- Any Eligible Service which is identical or similar to any of the Eligible Services set forth in the covered expenses, which is provided by a medical practitioner who has opted out of any provincial health insurance plan and the provincial health insurance plan would have otherwise paid for such Eligible Service;
- Any part of the cost of an Eligible Service which is in excess of the lower of:
  - a) the reasonable and customary charge for such Eligible Services; or
  - b) the maximum with respect thereto as established in the covered expenses;
- Any Eligible Service for the treatment of congenital malformations or which are primarily for cosmetic or aesthetic purposes;
- Any Eligible Service rendered to a Participant in treatment of a self-inflicted injury whether or not the Participant is mentally incompetent;
- Any Eligible Service which is deemed to be experimental;
- Any Eligible Service rendered by a Provider of Service employed or engaged by an employer, mutual benefit association, fraternal or cooperative association, trustee, or similar person or group, other than services from a Provider of Service employed or engaged by a group under an employee assistance plan;
- Any Eligible Service that is a dental service and is not contained within one

of the procedure codes developed and maintained from time to time by the Canadian Dental Association and adopted by the provincial or territorial dental association of the province or territory in which the service is provided and in effect at the time of providing such service (where a dental service has been provided outside Canada, the applicable procedure code shall be that one developed by the Canadian Dental Association and adopted and in effect at the time by the provincial or territorial dental association of the province or territory in which the Participant resides at the time the service is provided);

- Any Eligible Service that relates to treatment of injuries arising out of a motor vehicle accident;
- Any Eligible Service rendered to any Participant who has been removed from enrollment or any Eligible Service, for which the Participant has been deemed ineligible, by reason of practices in respect of claims or Eligible Services in which the Participant has in the opinion of the claims payment provider, been engaged that, in the opinion of the claims payment provider, are inappropriate or abusive;
- Any Eligible Service which, by law, the claims payment provider is prohibited from paying;
- Any cognitive or administrative services or other fees charged by a Provider of Service for services other than those directly relating to the delivery of the service or supply.

### **Survivor Benefit**

If you die while your dependents are insured under this Group Benefit Program, the insurer will continue the Dental Care benefits without payment of premium, until the earliest of:

- The date your dependent is no longer a dependent, according to the definition of dependent;
- The date similar coverage is obtained elsewhere;
- The date which is 2 years from your death, or;
- The date the Group Plan terminates.

This benefit terminates at age 70.

### **Termination Age**

At age 70 or retirement, whichever is earlier.

Please refer to your Certificate of Insurance to see if this benefit applies to you.

# Employee Optional Life Insurance

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## General Description

Your Life coverage provides a benefit for your beneficiary if you die while covered. The amount of your Life coverage shown on the Certificate of Insurance in effect on the date of your death will be paid when the Insurer receives due written proof of death.

## Beneficiary

If you die while covered, the Insurer will pay the full amount of your benefit to your last named beneficiary on file with Western Financial Group Insurance Solutions.

If you have not named a beneficiary, the benefit amount will be paid to your estate. Anyone can be your beneficiary. You can change your beneficiary at any time, unless a law prevents you from doing so or you indicate that the beneficiary is not to be changed by filing a new designation form. The change will be effective on the date the form is signed, but it will not apply to any payment made by the Insurer prior to the date the form is received by the Insurer.

## Benefit Amount

Increments of \$25,000, to a maximum of \$250,000.

## Non-Evidence Limit

All amounts are subject to Evidence of Insurability.

## Waiver of Premium

If you become Totally Disabled while insured prior to age 65 and meet the Entitlement Criteria outlined below, your Insurance will continue without payment of premium, after the elimination period of 180 days.

## Definition of Totally Disabled

Totally Disabled means a restriction or lack of ability due to an illness or injury which prevents you from performing the essential duties of any occupation for which you are qualified or may reasonably become qualified by training, education or experience.

The availability of work will not be considered by the insurer in assessing your disability.

If you must hold a government permit or license to perform the essential duties of your job, you will not be considered Totally Disabled solely because your permit or license has been withdrawn or not renewed.

## Entitlement Criteria

To be entitled to Waiver of Premium, you must meet the following criteria:

- You must be continuously Totally Disabled throughout the Elimination Period. If you cease to be Totally Disabled during this period and then become disabled again within 3 weeks due to the same or related illness or injury, your Elimination Period will be extended by the number of days during which you ceased to be Totally Disabled;

- The insurer must receive medical evidence documenting how your illness or injury causes restrictions or lack of ability, such that you are prevented from performing the essential duties of any occupation for which you are qualified, or may reasonably become qualified by training, education or experience;
- You must be receiving from a physician, regular, ongoing care and treatment appropriate for your disabling condition, as determined by the insurer.

At any time, the insurer may require you to submit to a medical, psychiatric, psychological, educational and/or vocational examination or evaluation by an examiner selected by them.

### **Termination of Waiver of Premium**

Your Waiver of Premium will cease on the earliest of:

- The date you cease to be Totally Disabled, as defined under this benefit;
- The date you do not supply the insurance carrier with appropriate medical evidence documenting how your illness or injury causes restrictions or lack of ability, such that you are prevented from performing the essential duties of any occupation for which you are qualified, or may reasonably become qualified, by training, education or experience;
- The date you are no longer receiving from a physician, regular, ongoing care and treatment appropriate for the disabling condition, as determined by the insurer;
- The date you do not attend an examination by an independent expert chosen by the insurer;
- The end of the month following the date of your 65th birthday;
- The date of your death.

### **Recurrent Disability**

If you become Totally Disabled again from the same or related causes as those for which premiums were previously waived and such disability recurs within 6 months of cessation of the Waiver of Premium benefit, the insurer will waive the Elimination Period.

Your amount of insurance on which premiums were previously waived will be reinstated.

If the same disability recurs more than 6 months after cessation of the Waiver of Premium benefit, such disability will be considered a separate disability.

Two disabilities, which are due to unrelated causes, are considered separate disabilities if they are separated by a return to work of at least one day.

### **Submitting A Claim**

To submit a claim, your beneficiary must complete the Life Claim form, and upon completion of the form, proof of death documents should be attached and the form returned to Western Financial Group Insurance Solutions.

A completed claim form must be submitted within 90 days from the date of the loss.

To submit a claim for the Waiver of Premium you must complete a Waiver of Premium claim form, which is available from Western Financial Group Insurance Solutions. Your attending physician must also complete a portion of this form.

A completed claim form must be submitted within 90 days from the end of the Elimination period.

## **Conversion Privilege**

If your Employee Benefits terminate or reduce, you may be eligible to convert your Employee Optional Life Insurance to an individual policy, without medical evidence. You must apply for the individual policy, and pay the first monthly premium within 31 days of the termination of your Employee Optional Life Insurance. If you die during this 31 day period, the amount of Employee Optional Life Insurance available for conversion will be paid to your beneficiary estate, even if you didn't apply for conversion.

For more information on the Conversion Privilege, please call Western Financial Group Insurance Solutions at 1-800-665-8990.

## **Exclusions**

If death results from suicide any amount of Optional Life Insurance that has been in effect for less than one year will not be payable.

## **Termination Age**

At age 70 or retirement, whichever is earlier.

Please refer to your Certificate of Insurance to see if this benefit applies to you.

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# Spousal Optional Life Insurance

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## General Description

If your Spouse dies while insured, the amount of this benefit will be paid to you. The amount of Life coverage shown on the Certificate of Insurance in effect on the date of death will be paid when the Insurer receives due written proof of death.

## Beneficiary

You are the beneficiary of your Spouse's benefit.

## Benefit Amount

Increments of \$25,000, to a maximum of \$250,000.

## Non-Evidence Limit

All amounts are subject to Evidence of Insurability.

## Waiver of Premium

If you become Totally Disabled while insured prior to age 65 and meet the Entitlement Criteria outlined below, the Insurance will continue without payment of premium, after the elimination period of 180 days.

## Definition of Totally Disabled

Totally Disabled means a restriction or lack of ability due to an illness or injury which prevents you from performing the essential duties of any occupation for which you are qualified or may reasonably become qualified by training, education or experience.

The availability of work will not be considered by the insurer in assessing your disability.

If you must hold a government permit or license to perform the essential duties of your job, you will not be considered Totally Disabled solely because your permit or license has been withdrawn or not renewed.

## Entitlement Criteria

To be entitled to Waiver of Premium, you must meet the following criteria:

- You must be continuously Totally Disabled throughout the Elimination Period. If you cease to be Totally Disabled during this period and then become disabled again within 3 weeks due to the same or related illness or injury, your Elimination Period will be extended by the number of days during which you ceased to be Totally Disabled;
- The insurer must receive medical evidence documenting how your illness or injury causes restrictions or lack of ability, such that you are prevented from performing the essential duties of any occupation for which you are qualified, or may reasonably become qualified by training, education or experience;
- You must be receiving from a physician, regular, ongoing care and treatment appropriate for your disabling condition, as determined by the insurer.

At any time, the insurer may require you to submit to a medical, psychiatric, psychological, educational and/or vocational examination or evaluation by an examiner selected by them.

### **Termination of Waiver of Premium**

Your Waiver of Premium will cease on the earliest of:

- The date you cease to be Totally Disabled, as defined under this benefit;
- The date you do not supply the insurer with appropriate medical evidence documenting how your illness or injury causes restrictions or lack of ability, such that you are prevented from performing the essential duties of any occupation for which you are qualified, or may reasonably become qualified, by training, education or experience;
- The date you are no longer receiving from a physician, regular, ongoing care and treatment appropriate for the disabling condition, as determined by the insurer;
- The date you do not attend an examination by an independent expert chosen by the insurer;
- The end of the month following the date of your 65th birthday;
- The date of your death.

### **Recurrent Disability**

If you become Totally Disabled again from the same or related causes as those for which premiums were previously waived and such disability recurs within 6 months of cessation of the Waiver of Premium benefit, the insurer will waive the Elimination Period.

Your amount of insurance on which premiums were previously waived will be reinstated.

If the same disability recurs more than 6 months after cessation of the Waiver of Premium benefit, such disability will be considered a separate disability.

Two disabilities, which are due to unrelated causes, are considered separate disabilities if they are separated by a return to work of at least one day.

### **Submitting A Claim**

To submit a claim, you must complete the Life Claim form, and upon completion of the form, proof of death documents should be attached and the form returned to Western Financial Group Insurance Solutions.

A completed claim form must be submitted within 90 days from the date of the loss.

To submit a claim for the Waiver of Premium you must complete a Waiver of Premium claim form, which is available from Western Financial Group Insurance Solutions. Your attending physician must also complete a portion of this form.

A completed claim form must be submitted within 90 days from the end of the Elimination period.

## **Conversion Privilege**

If your Employee Benefits terminate or reduce, you may be eligible to convert Spousal Optional Life Insurance to an individual policy, without medical evidence. You must apply for the individual policy, and pay the first monthly premium within 31 days of the termination. If your spouse dies during this 31 day period, the amount of Spousal Optional Life Insurance available for conversion will be paid to you, even if you didn't apply for conversion.

For more information on the Conversion Privilege, please call: 1-800-665-8990.

## **Exclusions**

If death results from suicide any amount of Optional Life Insurance that has been in effect for less than one year will not be payable.

## **Termination Age**

At age 70 or retirement, whichever is earlier.

Please refer to your Certificate of Insurance to see if this benefit applies to you.

# Employee Optional Accidental Death and Dismemberment

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## General Description

If you sustain an accidental injury while insured and suffer a loss specified in the Schedule of Losses below, this benefit provides financial assistance to you or your beneficiary. In the event of your death, the benefit is payable to your beneficiary. If your beneficiary dies before you or if there is no designated beneficiary, this benefit is payable to your estate. For losses other than Loss of Life, the benefit is payable to you.

## Benefit Amount

Increments of \$25,000 to a maximum of \$250,000.

## Schedule of Losses

The losses covered by this benefit must:

- be caused directly and independently of any other cause, by bodily injuries resulting exclusively from external, violent and accidental means;
- be a direct result of the accidental injury;
- occur within 365 days from the date of the accidental injury;
- be total and irreversible or irrecoverable.

In the case of loss of speech or hearing, or loss of use of an arm, hand or leg, the loss must be continuous for 12 months and determined to be permanent, after which time the benefit is payable.

The amount payable for each loss is a percentage of your Accidental Death and Dismemberment benefit amount, which was in effect as of the date of the injury.

- Loss of Life - 100%
- Loss of Both Hands or Both Feet or Sight of Both Eyes - 100%
- Loss of Sight of Both Eyes - 100%
- Loss of One Hand and One Foot - 100%
- Loss of One Hand or One Foot and Loss Sight of One Eye - 100%
- Loss of Hearing in Both Ears and Speech - 100%
- Loss of One Arm or One Leg - 75%
- One Hand or One Foot or Loss of Sight of One Eye or Speech or Hearing in Both Ears - 66.67%
- Loss of Thumb and Index Finger or at least Four Fingers of the Same Hand - 33.33%
- Loss of All Toes of One Foot - 25%
- Loss of Hearing in One Ear - 25%
- Hemiplegia, Paraplegia, or Quadriplegia - 200%

The word “loss” means:

- For a hand or foot, total, permanent and irrecoverable loss of use of the limb or amputation at the wrist or ankle, or above;
- For a leg or arm, total, permanent and irrecoverable loss of use of the limb or amputation at the knee or elbow, or above;
- For the thumb and index finger, total, permanent and irrecoverable loss of use of the digit or amputation at the joint between the hand and the digit;
- For sight, hearing or speech, total, permanent and irrecoverable loss of sight, hearing in both ears or of speech.

### **Exposure and Disappearance**

If a loss occurs due to unavoidable exposure to the elements, after a conveyance in which you were travelling made a forced landing, or was lost, wrecked, stranded or sunk, a benefit will be payable for that loss. The amount payable will be determined in accordance with the Schedule of Losses. If you disappear after a conveyance in which you were travelling made a forced landing, or was lost, wrecked, stranded or sunk, a benefit for loss of life will be payable if your body is not found within 365 days after the incident occurred.

### **Evidence and Examinations**

Evidence of the loss must be submitted to the Insurer within 90 days of the date of the loss, failing which no benefit is payable. The Insurer is entitled to have the participant examined and, as the case may be, have an autopsy performed within the limits of the law.

### **Waiver of Premium**

If you become Totally Disabled while insured prior to age 65 and meet the Entitlement Criteria outlined below, your Insurance will continue without payment of premium, after the elimination period of 180 days.

### **Exclusions**

No benefit is payable for a loss attributable directly or indirectly, in whole or in part, to any of the following causes:

- Suicide, attempted suicide or self-inflicted injuries, whether the participant was sane or insane at the time;
- Perpetration or attempted perpetration by the participant of a crime or his participation in a crime;
- The participant’s active participation in a riot or insurrection;
- War or civil war, whether declared or undeclared;
- Active service in the armed forces of any country;
- A flight in any aircraft or flying machine when the participant is a member of the crew or carries out any duty in regard to such flight;
- Injuries which exhibit no visible wound or contusion on the outside of the body (except drowning and internal injuries revealed by surgery or autopsy), poisoning, intoxication or drug use.

### **Termination Age**

The earlier of attained age 70, or retirement.

Please refer to your Certificate of Insurance to see if this benefit applies to you.

# Family Optional Accidental Death and Dismemberment

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## General Description

If one of your dependents sustains an accidental injury while insured and suffer a loss specified in the Schedule of Losses below, this benefit provides financial assistance to you or your beneficiary. In the event of your death, the benefit is payable to your beneficiary. If your beneficiary dies before you or if there is no designated beneficiary, this benefit is payable to your estate. For losses other than Loss of Life, the benefit is payable to you.

## Benefit Amount

Increments of \$25,000 to a maximum of \$250,000.

## Schedule of Losses

The losses covered by this benefit must:

- be caused directly and independently of any other cause, by bodily injuries resulting exclusively from external, violent and accidental means;
- be a direct result of the accidental injury;
- occur within 365 days from the date of the accidental injury;
- be total and irreversible or irrecoverable.

In the case of loss of speech or hearing, or loss of use of an arm, hand or leg, the loss must be continuous for 12 months and determined to be permanent, after which time the benefit is payable.

The amount payable for each loss is a percentage of your Accidental Death and Dismemberment benefit amount, which was in effect as of the date of the injury.

- Loss of Life - 100%
- Loss of Both Hands or Both Feet or Sight of Both Eyes - 100%
- Loss of Sight of Both Eyes - 100%
- Loss of One Hand and One Foot - 100%
- Loss of One Hand or One Foot and Loss Sight of One Eye - 100%
- Loss of Hearing in Both Ears and Speech - 100%
- Loss of One Arm or One Leg - 75%
- One Hand or One Foot or Loss of Sight of One Eye or Speech or Hearing in Both Ears - 66.67%
- Loss of Thumb and Index Finger or at least Four Fingers of the Same Hand - 33.33%
- Loss of All Toes of One Foot - 25%
- Loss of Hearing in One Ear - 25%
- Hemiplegia, Paraplegia, or Quadriplegia - 200%

The word “loss” means:

- For a hand or foot, total, permanent and irrecoverable loss of use of the limb or amputation at the wrist or ankle, or above;
- For a leg or arm, total, permanent and irrecoverable loss of use of the limb or amputation at the knee or elbow, or above;
- For the thumb and index finger, total, permanent and irrecoverable loss of use of the digit or amputation at the joint between the hand and the digit;
- For sight, hearing or speech, total, permanent and irrecoverable loss of sight, hearing in both ears or of speech.

### **Exposure and Disappearance**

If a loss occurs due to unavoidable exposure to the elements, after a conveyance in which you or one of your dependents were travelling made a forced landing, or was lost, wrecked, stranded or sunk, a benefit will be payable for that loss. The amount payable will be determined in accordance with the Schedule of Losses. If you or one of your dependents disappear after a conveyance in which you were travelling made a forced landing, or was lost, wrecked, stranded or sunk, a benefit for loss of life will be payable if your body is not found within 365 days after the incident occurred.

### **Evidence and Examinations**

Evidence of the loss must be submitted to the Insurer within 90 days of the date of the loss, failing which no benefit is payable. The Insurer is entitled to have the participant examined and, as the case may be, have an autopsy performed within the limits of the law.

### **Waiver of Premium**

If you become Totally Disabled while insured prior to age 65 and meet the Entitlement Criteria outlined below, your Insurance will continue without payment of premium, after the elimination period of 180 days.

### **Exclusions**

No benefit is payable for a loss attributable directly or indirectly, in whole or in part, to any of the following causes:

- Suicide, attempted suicide or self-inflicted injuries, whether the participant was sane or insane at the time;
- Perpetration or attempted perpetration by the participant of a crime or his participation in a crime;
- The participant's active participation in a riot or insurrection;
- War or civil war, whether declared or undeclared;
- Active service in the armed forces of any country;
- A flight in any aircraft or flying machine when the participant is a member of the crew or carries out any duty in regard to such flight;
- Injuries which exhibit no visible wound or contusion on the outside of the body (except drowning and internal injuries revealed by surgery or autopsy), poisoning, intoxication or drug use.

### **Termination Age**

The earlier of attained age 70, or employee's retirement.

Please refer to your Certificate of Insurance to see if this benefit applies to you.

# Privacy Act

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## PIPEDA

By Act of Parliament, the Federal Government of Canada passed the Personal Information Protection and Electronic Documents Act (PIPEDA), commonly referred to as Bill C-6, to deal with the issue of protecting personal information. Initially the Act applied to federally regulated private sector businesses (e.g. federal corporations, banking and telecommunications). Effective January 1, 2004 the Act applied more broadly (other than where provinces and territories have passed substantially similar legislation), to every private sector organization engaged in commercial activities in respect to how personal information is collected, used and disclosed in the course of its regular business activities.

### What Does This Mean?

An organization must comply with a series of obligations and be accountable for compliance to ten principles set out in Schedule 1 of the Act ([www.privcom.gc.ca](http://www.privcom.gc.ca)). The office of the Privacy Commissioner is empowered to receive, investigate and remedy complaints where warranted.

### Western Financial Group Insurance Solutions' Commitment to Privacy Protection

Protecting the privacy and confidentiality of personal information has always been fundamental to the way we do business and is the responsibility of every employee of Western Financial Group Insurance Solutions during the course of providing products and services to our clients. The range of products and services we offer our groups and benefit plan participants continues to expand along with the technology we use for their delivery and storage. No matter how our business changes, we remain committed to protecting and respecting your right to privacy and confidentiality.

With particular reference to PIPEDA, we have reviewed and where needed, revised our current privacy policies and information handling procedures, having developed a Privacy Code which appears below. This to further safeguard the use and handling of essential personal information obtained with the express consent of our clients and only for the purpose for which consent was granted when this information was collected.

The Personal Information Protection and Electronic Documents Act (PIPEDA), came into effect for insurers on January 1, 2004.

You are assured that Western Financial Group Insurance Solutions is focused on respecting your privacy and maintaining confidentiality of information to the extent we have safeguards in place to protect your personal, business, and financial information which adheres to the Ten Privacy Principles as covered by the PIPEDA ([www.privcom.gc.ca](http://www.privcom.gc.ca)).

- Principle 1 - Accountability
- Principle 2 - Identifying Purposes
- Principle 3 - Consent
- Principle 4 - Limiting Collection
- Principle 5 - Limiting Use, Disclosure and Retention
- Principle 6 - Accuracy
- Principle 7 - Safeguarding Customer Information
- Principle 8 - Openness
- Principle 9 - Customer Access
- Principle 10 - Handling Customer Complaints and Suggestions

The collection of personal information is important; it is limited to the details that are needed to provide our programs and services that best meet your needs and to assess your future needs. Most of that information is obtained from you, but it might also come from other third parties. By example, information about you may be used:

- For ongoing customer service and other contact matters;
- In connection with our offering and delivery of products and services;
- To obtain claims history;
- To prevent fraud;
- To share or exchange reports and information with any corporation or enterprise with whom you have a financial relationship;
- For billing and accounting services related to your business activity with Western Financial Group Insurance Solutions;
- To comply with legal and regulatory requirements.

Personal information is collected only for its intended purpose and is not disclosed to any other parties without consent of the individual.

If you would like further information about privacy and security, please contact us at [privacy@westernfgis.ca](mailto:privacy@westernfgis.ca). In addition you may request this information by writing to our corporate office at the following address:

Western Financial Group Insurance Solutions  
777 Portage Avenue  
Winnipeg, Manitoba R3G 0N3  
Attention: Privacy Officer

There is no charge to access your information unless you request copies of records, in which case you will be advised in advance. If you find that your information is inaccurate or incomplete, we will make changes to our records accordingly.



**Group Insurance Solutions**  
Western Financial Group (Network) Inc.  
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