

Your Group Benefits Booklet

lifemark

Core/Enhanced/Premium Health

Core/Enhanced/Premium Dental

Group Number: 91873

Updated Effective Date: January 1, 2021

MEDAVIE BLUE CROSS™

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Basic Accidental Death and Dismemberment Insurance
Policy No. AB10486201 underwritten by Chubb Life Insurance Company of Canada

PRIVACY PROTECTION PRACTICES

In the course of providing customers with quality health, life and travel coverage, the Company acquires and stores certain personal information about its clients and their dependents. The purpose of this document is to keep you informed about the Company's privacy protection practices.

Protecting personal information is not new to the Company. Ensuring the confidentiality of client information has always been fundamental to the way we do business and our staff understand that the privacy policies and procedures we have in place to ensure confidentiality are to be taken very seriously.

What is personal information?
Personal information includes details about an identifiable individual and may include name, age, identification numbers, income, employment data, marital and dependent status, medical records, and financial information.

How is your personal information used?
Your personal information is necessary to allow the Company to process your application for coverage under its health, life and travel plans. Your personal information is used:

- to provide the services outlined in your policy or the group policy of which you are an eligible member,
- to understand your needs so that we can recommend suitable products and services, and
- to manage our business.

To whom could this personal information be disclosed?
Depending on the type of coverage you carry with us, release of selected personal information to the following may be necessary in order to provide the services outlined in your policy:

- other Canadian Blue Cross organizations in order to administer your benefit plan if you reside outside the Atlantic Provinces, Quebec or Ontario,
- specialized health care professionals when necessary to assess benefit or product eligibility,
- government and regulatory authorities in an emergency situation or where required by law, other third parties, on a confidential basis, when required to administer the benefits outlined in your contract or your group's policy, and
- the plan member of any policy under which you are a participant.

We do not provide or sell personal information about you to any outside company for use in marketing and solicitation. Personal information about you or your dependents is not released to a third party without permission unless necessary to fulfill the services the Company is contracted to provide to you.

To ensure the Company is able to provide you with the best possible service, it is important that the personal information we use is accurate and up to date. You can help by keeping us informed of changes of address, marital status and the addition or deletion of dependents. Should you become aware of errors in our information about you, please contact our customer service personnel and we will ensure the data is corrected.

PRIVACY PROTECTION PRACTICES

By becoming a customer or filing a claim for benefits, you are agreeing to allow your personal information to be used and disclosed in the manner outlined above. If you prefer that we not use or disclose your personal information in those situations where it is not necessary to administer your benefit plan, please visit our website or write to us at the address provided.

Please note that not allowing the Company to use information about you may mean we may not be able to provide you with certain products or services that may be of use to you.

For more information on the Company's privacy policy, contact us using one of the following:

www.medavie.bluecross.ca

1-800-667-4511 (in Atlantic), 1-800-355-9133 (in Ontario) or 1-888-588-1212 (in Quebec)

Chief Privacy Officer
Medavie Blue Cross
Risk Management Group
644 Main Street
PO Box 220
Moncton, NB E1C 8L3

or

privacyofficer@medavie.bluecross.ca

If the issue is not resolved to your satisfaction, you may file a complaint in writing to:

Office of the Privacy
Commissioner of Canada
112 Kent Street
Ottawa, ON K1A 1H3

PLAN MEMBER WEBSITE

INSTRUCTION FOR MEMBERS

Medavie Blue Cross is continually developing its Web technology to respond to the needs of our customers. One such innovation, the Plan Member Website, will help you better understand, manage and co-ordinate your benefit plan.

The Plan Member Website is simple to use and is delivered in a secure environment. Now, when you want to access general information about your plan, view your claims and payment history, or print generic claim forms, you just have to click your mouse. The Plan Member Website is available 24 hours a day, seven days a week from home or work, all you need is an Internet connection. The Plan Member Website makes life easier for you.

ON THE PLAN MEMBER WEBSITE

There are a variety of options available to you on the Plan Member Website.

Coverage Inquiry: Detailed information about the Medavie Blue Cross benefit plan
Forms: Printable versions of generic Medavie Blue Cross claim forms

Member Information

- Members can view and/or update address information (where access is available)
- Request new identification cards
- Add/update banking information for direct deposit of claim payments (where applicable)

Member Statements

- Members can view claims history for member and dependents
- View record of payments issued to member and/or the service provider
- View Health Spending Account balances (where applicable)

FIRST-TIME ACCESS TO THE PLAN MEMBER WEBSITE

To register for the Plan Member Website, visit **www.medaviebc.ca** and log in.

Please ensure you make note of your password for future reference.

PLEASE NOTE

For security reasons, the Plan Member Website is for use of the plan member only.

We look forward to helping you take advantage of our online technology. For further information on the Plan Member Website, or for any questions about your Medavie Blue Cross benefit plan, please contact our Customer Information Center toll free at the number on the back of your identification card or e-mail *inquiry@medavie.bluecross.ca.*

AN OVERVIEW OF YOUR GROUP COVERAGE

A group coverage program covering your medical and financial security has been made available to you by your employer. This program is offered to you through Medavie Inc. and Blue Cross Life Insurance Company of Canada, hereafter called the Company.

The information contained in this booklet is an overview of the provisions of the policy between your employer and the Company. Included is a summary of your benefits and pertinent information that you will require to optimize the coverage available to you and your family.

This booklet together with your identification card contains important information and must therefore be kept in a safe place.

To access a wealth of savings on medical, vision care and many other products and services, visit www.blueadvantage.ca.

Where legislated, you have the right to request a copy of the group policy details pertaining to your insured coverage, a copy of your application for benefits, and any written statements or other records provided to the Company as evidence of your health. You may also request, with reasonable notice, a copy of the contract for insured benefits. The first copy will be provided at no cost to you. A fee may be charged for subsequent copies. All requests for copies of documents should be directed to Medavie Blue Cross.

Finally, please note that the masculine gender has been used indiscriminately throughout this document in order to facilitate its reading.

Group Insurance Eligibility

To be eligible for group coverage, you must be a permanent employee who is a resident of Canada, covered under your provincial government plan, actively at work and working a minimum of 30 hours per week on a regular basis and have completed the waiting period. The waiting period for your group plan is three months of continuous employment.

To participate in your group plan, you must complete the coverage forms that are provided to you upon your eligibility to the various plans.

Your dependents are covered on the date you become covered, or on the date they become your dependents.

If not actively at work when you would normally have become eligible, your coverage will commence when you return to work on a full-time basis.

Definition of Dependents
Your dependents are:

a) Your spouse, who is the person to whom you are married, or the person that you introduce as your spouse and with whom you have been living in a conjugal relationship for at least one year.

b) Your unmarried children who are your financial dependents and
   - are under 21 years of age, or
   - are under 26 years of age if full-time students attending an institution providing instruction at a secondary, college or university level, as a duly registered student, or
   - regardless of their age, if they live with you and have become totally and permanently disabled before age 21 (or age 26 if a student).

Proof of Health Requirement
You must submit proof of health if your application for coverage for yourself or your dependents is presented to the Company more than 31 days after the eligibility date.

If, at the effective date or any renewal date, participation in the group to which you belong falls below three covered employees, evidence of health will be required for all Employees and their dependents, regardless of the amount of coverage.

Conversion Privilege
If you should terminate employment, you may convert to an Individual plan currently issued by Blue Cross provided that application is made within 31 days following your date of termination. This conversion privilege is also available to the spouse, or where required by provincial legislation, dependent child.

Filing a Claim

Hospital Benefit

If you or one of your dependents are hospitalized, simply show your identification card at the time you are being admitted. The claim will be forwarded to our office by the hospital.

Drug Benefit

Pay direct plan - simply show your identification card and the provider will arrange to bill the Company.

Extended Health Benefit

Complete the claim form, if applicable, attach the original receipts and forward to the Company (See contact information).

The duly completed claim form must be sent to the Company no later than 24 months after the date expenses

Travel Benefit

Please call the toll free number on the back of your identification card for assistance when an unexpected illness or injury occurs while travelling outside your province of residence.

Every effort will be made by the Company to direct you towards the appropriate medical treatment and assist you in making payment to the providers of service and co-ordinate with your provincial government plan. However, under certain circumstances, the Company will require you to obtain and directly send original, detailed receipts for all expenses incurred outside your province of residence to your provincial government health plan for their consideration and payment. Please ensure you retain a copy of these receipts as you will need to submit them along with the provincial government health plan proof of payment statement directly to the Company (See contact information). This procedure should be followed when purchasing drugs, incurring medical services not pre-approved by the Company (some exceptions may apply) and when incurring medical services within Canada (that will be covered by your provincial health plan). Please provide your identification number when submitting a claim to the Company.

Claims for services outside of Canada are paid by the Company in Canadian currency based on the rate of exchange in effect at the conclusion of the services.

The duly completed claim form must be filed with the Company no later than six months after the date expenses are incurred.

Dental Benefit

Reimbursement can be made electronically through the CDA Net; you must present your identification card to your dentist at every visit. Two reimbursement options are possible depending on your dentist's preference:

a) You only have to pay for your deductible (if applicable) and the excess expenses not covered by coinsurance. The coinsurance amount is paid directly to the dentist by the Company; or
b) You pay the total amount requested by your dentist and you will receive in the next few days the portion of the expenses refundable by your plan.

If, however, your dentist cannot use the electronic transaction network, complete and submit a dental claim form with original receipts to the Company (See contact information). The duly completed claim form must be sent to the Company no later than 24 months after the date on which expenses were incurred or within a time agreed upon by the Company when contract terminates.

Note: For coverage purposes, you and your dependents are deemed covered under the Hospital and Health Insurance Act in your province of residence.

Hospital, Travel, Drug, Extended Health Benefit and Dental Benefits
Claims will be administered by the Blue Cross plan in the covered employee's province of residence.

Group Life, Optional Group Life and Dependent Life
Proof of claim must be submitted as soon as reasonably possible after the loss, and in no event later than one year from the date of the loss.

Long Term Disability Benefits
Written notice of proof of total disability, duly signed by the parties, must be provided to the Company within ninety (90) days immediately following the end of the Elimination Period.

If the contract terminates, proof of claim must be provided to the Company within six months of the onset of the disability.

Health Spending Account Benefit (HSA) and Personal Spending Account (PSA)
You must first submit expenses through any other benefits plan (government sponsored or private). You can submit any remaining expenses through your HSA account or your PSA account.

Manual - Available credits will be used to pay an HSA or PSA claim, as directed by you on the claim form.

Complete the claim form, attach the original receipts or explanation of benefits from previously remaining claim amounts, and forward them to the Company.

Limitation Periods for Legal Action
Every action or proceeding against an insurer (i.e. the Company) for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the Insurance Act.

Coordination of Benefits

If you or one of your dependents is covered under another health plan, the benefits payable under this plan and any other plan will be coordinated so that payments from all sources do not exceed the expenses actually incurred. Coordination of benefits will be done in accordance with the guidelines of the Canadian Life and Health Insurance Association (CLHIA).

With the exception of Worldwide Travel Benefit, the benefit payable to you or one of your dependents follows the order described below:

a) The benefits payable under a plan that does not include a co-ordination of benefits clause are payable before those which would otherwise be payable under this plan.

b) The benefits of any plan that includes a co-ordination of benefits clause are payable in the following order:
   - the plan where you qualify as an employee
   - the plan where you qualify as a dependent

If you or one of your dependents qualifies as an employee, benefits are payable in the following order:
- an active full-time employee,
- an active part-time employee,
- a retiree.

For the co-ordination of benefits for dependent children priority will go to the plan of:
- the parent with the earlier birth date in the calendar year,
- the parent whose first name begins with the letter that comes first in the alphabet, if both parents have the same birth date.

Dependent children whose parents are separated or divorced; priority will go to the plan of:
- the parent with custody of the child,
- the spouse of the parent with custody of the child,
- the parent who does not have custody of the child,
- the spouse of the parent who does not have custody of the child.

When the benefits due under this policy are payable after any other plan, the benefits payable are equal to the lesser of the following amount:

a) The total benefits that would have been payable in the absence of the Coordination of Benefits provision,
b) The total eligible expenses under your current plan less the benefits payable under any other plan. The benefits payable under any plan include those which you or one of your dependents would have been entitled had you duly submitted a claim.

“Plan” shall mean any coverage providing payment for medical treatment, services or supplies under any group, family, creditor or savings insurance coverage, and/or any government-sponsored plan providing coverage for similar care.

Payment for Worldwide Travel Benefit provided under this policy is limited to amounts that are in excess of coverage provided by any other plan, as specified under Exclusions and Limitations for Worldwide Travel Coverage.

BLUE CROSS CONTACT INFORMATION

For more information about your group benefits coverage or the plan member website, please contact our Customer Information Contact Centre toll free at:

Atlantic Provinces: 1-800-667-4511
Ontario: 1-800-355-9133
Quebec: 1-888-588-1212
From Anywhere in Canada: 1-888-873-9200

Have your group policy number and identification number ready when you call for questions regarding your coverage.

Alternatively, you can email your questions to **inquiry@medavie.bluecross.ca** or visit our website at **www.medaviebc.ca**.

Connect with Blue Cross
Like us on Facebook at **facebook.com/MedavieBlueCross**

Follow us on Twitter at @**MedavieBC**

My Good Health®
My Good Health is a secure, interactive web portal that provides valuable health information and tools for managing your health. You can create your own health profile and use it to map personal goals using My Good Health resources.

Blue Cross is proud to help point your way to healthier living. Go to medaviebc.mygoodhealth.ca and simply follow the instructions to register for your free account!

BLUE ADVANTAGE®

Savings are available to Blue Cross members across Canada. To take advantage of these savings, simply present your Blue Cross identification card to any participating provider and mention the **Blue Advantage®** program. A complete list of providers and discounts is available at **www.blueadvantage.ca.**

BLUE CROSS CONTACT INFORMATION

How to Obtain a Claim Form

Health benefit claim forms can be obtained from any one of the following sources:

- the plan member website;
- one of our Quick Pay® locations;
- your group benefits administrator; or
- our Customer Information Contact Centre at the toll-free number listed above.

All claim forms for Life, Accidental Death and Dismemberment, Disability or Critical Illness benefits can be obtained through your group benefits administrator.

How to Submit a Claim

Blue Cross offers several convenient options to quickly and efficiently submit your health benefit claims:

- eClaims through our secure plan member website;
- Mobile App (visit **www.medaviebc.ca/app** for more information or to download the app);
- Visit a Quick Pay® location or mail your completed claim form to the nearest Blue Cross office. To find the Blue Cross office or Quick Pay location nearest you, visit our website at www.medaviebc.ca.

You can submit your claims for Life, Accidental Death and Dismemberment, Disability or Critical Illness benefits by:

- Mail, fax, or scan to the address indicated on the applicable claim form;
- Drop the form off at one of our Quick Pay locations; or
- providing them to your group benefits administrator.

SUMMARY OF BENEFITS

COVERED EMPLOYEE'S BASIC LIFE BENEFIT	
Benefit Formula	1 x the annual salary
Maximum	$500,000
Non-evidence Limit	$500,000
Amount insured at age 65	50% of the amount of insurance
Waiver of premiums	Yes
Termination	The earlier of retirement, termination of employment or age 70

OPTIONAL LIFE BENEFIT	
Benefit Formula	Coverage is provided to the covered employee and/or spouse in units of $10,000 to a maximum of $500,000 per participant
Maximum	Combination of Basic Life and Optional Life must not exceed $500,000
Non-evidence Limit	Evidence of health is required for all amounts of coverage
Waiver of premiums	Yes
Termination	The earlier of retirement, termination of employment or age 65

DEPENDENT LIFE BENEFIT	
Coverage	Life insurance only
Spouse	$10,000
Child	$5,000 per child
Waiver of premiums	Yes
Termination	The earlier of retirement, termination of employment or age 70

COVERED EMPLOYEE'S LONG TERM DISABILITY BENEFIT	
Benefit Formula	67% of the first $4,000 of monthly salary plus 50% of the next $3,500 and 44% of the remainder
Elimination Period	16 weeks (112 days)
Maximum Benefit	$10,000 per month
Non-evidence Limit	$10,000
Benefit Period	To age 65
Taxable	No
Integration of Benefits (CPP or QPP and other social programs)	Direct
Pre-existing Conditions	3/6/12 months
Waiver of premiums	Yes
Termination	Benefit coverage ceases the earlier of retirement, termination of employment or age 65 less the elimination period.

SUMMARY OF BENEFITS

HOSPITAL BENEFIT Enhanced Health		
	% Co-insurance	**Benefit Maximum**
Convalescence	80%	Limited to $20 per day to a maximum of 180 days per calendar year
Physical Rehabilitation	80%	Limited to $20 per day to a maximum of 180 days per calendar year
Rehabilitation Facility (Substance Abuse – Drugs and Alcohol)	80%	Limited to semi-private accommodation

GENERAL INFORMATION Enhanced Health	
Deductible	Nil
Survivor Benefit	24 months, without premiums
Termination	The earlier of retirement, termination of employment or age 70

SUMMARY OF BENEFITS

HOSPITAL BENEFIT Premium Health		
	% Co-insurance	**Benefit Maximum**
Active Care	100%	Limited to semi-private accommodation
Convalescence	100%	Limited to $20 per day to a maximum of 180 days per calendar year
Physical Rehabilitation	100%	Limited to $20 per day to a maximum of 180 days per calendar year
Rehabilitation Facility (Substance Abuse – Drugs and Alcohol)	100%	Limited to semi-private accommodation

GENERAL INFORMATION Premium Health	
Deductible	Nil
Survivor Benefit	24 months, without premiums
Termination	The earlier of retirement, termination of employment or age 70

DRUG BENEFIT
Core Health

	Co-payment		Maximum
	Non-Quebec Residents	**Quebec Residents**	
Drug Benefit	Silver Fox pharmacies: Participant pays 0% All other pharmacies: Participant pays 50% plus dispensing fee	Participant pays 37% (0% when the out-of-pocket maximum is reached)*	Unlimited
Diabetic Supplies	Silver Fox pharmacies: Participant pays 0% All other pharmacies: Participant pays 50% plus dispensing fee	Participant pays 37% (0% when the out-of-pocket maximum is reached)*	Unlimited
Intrauterine Contraceptive Devices	Silver Fox pharmacies: Participant pays 0% All other pharmacies: Participant pays 50% plus dispensing fee	Participant pays 37% (0% when the out-of-pocket maximum is reached)*	Unlimited

*The out-of-pocket maximum for Quebec Participants meets the requirements of the Régie de l'assurance maladie du Québec (RAMQ).

GENERAL INFORMATION
Core Health

Deductible	Nil
Payment Type	Drug card - direct payment
Lowest Cost Substitution	Yes, even if the prescriber indicates no substitution
Survivor Benefit	24 months, without premiums
Termination	The earlier of retirement, termination of employment or age 70

DRUG BENEFIT Enhanced Health			
	Co-payment		Maximum
	Non-Quebec Residents	**Quebec Residents**	
Acute Medication	Silver Fox pharmacies: Participant pays 0% All other pharmacies: Participant pays 20% plus dispensing fee charges in excess of $5 per prescription	Participant pays 20% (0% when the out-of-pocket maximum is reached)*	Unlimited
Maintenance Medication	Silver Fox pharmacies: Participant pays 0% All other pharmacies: Participant pays 50% plus dispensing fee charges in excess of $5 per prescription	Participant pays 37% (0% when the out-of-pocket maximum is reached)*	Unlimited
Smoking Cessation Aids	Same as Maintenance Medication		$300/Lifetime
Diabetic Supplies	Same as Maintenance Medication		Unlimited
Contraceptive Devices	Same as Maintenance Medication		Unlimited
Vaccines	Same as Maintenance Medication		Unlimited

*The out-of-pocket maximum for Quebec Participants meets the requirements of the Régie de l'assurance maladie du Québec (RAMQ).

GENERAL INFORMATION Enhanced Health	
Deductible	Nil
Payment Type	Drug card - direct payment
Lowest Cost Substitution	Yes, even if the prescriber indicates no substitution
Survivor Benefit	24 months, without premiums
Termination	The earlier of retirement, termination of employment or age 70

DRUG BENEFIT **Premium Health**			
	Co-payment		**Maximum**
	Non-Quebec Residents	**Quebec Residents**	
Drug Benefit	Silver Fox pharmacies: Participant pays 0% All other pharmacies: Participant pays 20% plus dispensing fee charges in excess of $10 per prescription	Participant pays 20% (0% when the out-of-pocket maximum is reached)*	Unlimited
Smoking Cessation Aids	Silver Fox pharmacies: Participant pays 0% All other pharmacies: Participant pays 20% plus dispensing fee charges in excess of $10 per prescription	Participant pays 20% (0% when the out-of-pocket maximum is reached)*	$500/Lifetime
Fertility Benefits	Silver Fox pharmacies: Participant pays 0% All other pharmacies: Participant pays 20% plus dispensing fee charges in excess of $10 per prescription	Participant pays 20% (0% when the out-of-pocket maximum is reached)*	$10,000/Lifetime
Diabetic Supplies	Silver Fox pharmacies: Participant pays 0% All other pharmacies: Participant pays 20% plus dispensing fee charges in excess of $10 per prescription	Participant pays 20% (0% when the out-of-pocket maximum is reached)*	Unlimited

*The out-of-pocket maximum for Quebec Participants meets the requirements of the Régie de l'assurance maladie du Québec (RAMQ).

DRUG BENEFIT Premium Health			
	Co-payment		Maximum
	Non-Quebec Residents	**Quebec Residents**	
Contraceptive Devices	Silver Fox pharmacies: Participant pays 0% All other pharmacies: Participant pays 20% plus dispensing fee charges in excess of $10 per prescription	Participant pays 20%* (0% when the out-of-pocket maximum is reached)*	Unlimited
Vaccines	Silver Fox pharmacies: Participant pays 0% All other pharmacies: Participant pays 20% plus dispensing fee charges in excess of $10 per prescription	Participant pays 20%* (0% when the out-of-pocket maximum is reached)*	Unlimited

*The out-of-pocket maximum for Quebec Participants meets the requirements of the Régie de l'assurance maladie du Québec (RAMQ).

GENERAL INFORMATION Premium Health	
Deductible	Nil
Payment Type	Drug card - direct payment
Lowest Cost Substitution	Yes, even if the prescriber indicates no substitution
Survivor Benefit	24 months, without premiums
Termination	The earlier of retirement, termination of employment or age 70

EXTENDED HEALTH BENEFIT
MEDICAL EXPENSES
Core Health

	% Co-insurance	Maximum
Ambulance Transportation	50%	$1,000/calendar year
Compression Garments	50%	$200/calendar year
Prosthetics (limbs, eyes)	50%	Up to U & C (see Annex A)
Mobility Aids (cast, canes, crutches)	50%	Up to U & C
Medical Equipment	50%	Up to U & C (see Annex A)
Diabetic Equipment	50%	$200/calendar year
Ostomy Supplies	50%	Up to U & C
Hearing Aids	50%	$500/60 consecutive months
Intrauterine Contraceptive Device	50%	Unlimited
Other Medical Services and Supplies**	50%	Up to U & C (see Annex A)
TENS	50%	$300/5 calendar years
Diagnostic Tests***	50%	$1,000/calendar year
Accidental Dental Care*	50%	Subject to authorization

GENERAL INFORMATION
Core Health

Deductible	Nil
Survivor Benefit	24 months, without premiums
Termination	The earlier of retirement, termination of employment or age 70

*** Benefits subject to pre-authorization**
**** Other medical expenses are listed in Annex A**
***** Diagnostic imaging services coverage in Quebec only**

EXTENDED HEALTH BENEFIT PARAMEDICAL PRACTITIONERS Enhanced Health		
	Eligible maximum per visit	**Maximum per calendar year**
Psychologist	U & C	$250*
Chiropractor (including x-rays)	U & C	$250*
Naturopath (including x-rays)	U & C	$250*
Acupuncturist	U & C	$250*
Osteopath (including x-rays)	U & C	$250*
Chiropodist/Podiatrist (including x-rays)	U & C	$250*
Speech Therapist	U & C	$250*
Occupational Therapist	U & C	$250*
Physiotherapist	U & C	$250*
Massage Therapist	U & C	$250*

GENERAL INFORMATION Enhanced Health	
Co-Insurance	Lifemark Provider – 100% Non-Lifemark Provider – 80%
Deductible	Nil
Survivor Benefit	24 months, without premiums
Termination	The earlier of retirement, termination of employment or age 70

*** To a total combined maximum of $800 for all practitioners per calendar year.**

U & C - Usual, Customary and Reasonable: Usual, Customary and Reasonable means the normal charges for similar services made by other providers of the same standing in the locality or geographical area where the charge is incurred, as determined by Medavie Blue Cross, or in accordance with a payment schedule established by Medavie Blue Cross.

EXTENDED HEALTH BENEFIT MEDICAL EXPENSES Enhanced Health		
	% Co-insurance	**Maximum**
Nursing Care	80%	$10,000/calendar year
Ambulance Transportation	80%	$1,000/calendar year
Orthopedic Shoes/Molded Arch Orthotics	80%	$300/3 calendar years
Orthopedic Supplies	80%	$200/calendar year
Compression Garments	80%	$200/calendar year
Prosthetics (limbs, eyes)	80%	Up to U & C (see Annex A)
Mobility Aids (cast, canes, crutches)	80%	Up to U & C
Medical Equipment	80%	Up to U & C (see Annex A)
Diabetic Equipment	80%	$200/calendar year
Ostomy Supplies	80%	Up to U & C
Hearing Aids	80%	$500/60 consecutive months
Intrauterine Contraceptive Device	80%	Unlimited
Other Medical Services and Supplies**	80%	Up to U & C (see Annex A)
TENS	80%	$300/5 calendar years
Diagnostic Tests***	80%	$1,000/calendar year
Accidental Dental Care*	80%	Subject to authorization

GENERAL INFORMATION Enhanced Health	
Deductible	Nil
Survivor Benefit	24 months, without premiums
Termination	The earlier of retirement, termination of employment or age 70

*** Benefits subject to pre-authorization**
**** Other medical expenses are listed in Annex A**
***** Diagnostic imaging services coverage in Quebec only**

EXTENDED HEALTH BENEFIT VISION CARE Enhanced Health		
	% Co-insurance	**Maximum**
Eye Examination	80%	One eye examination (up to U & C)/24 consecutive months
Contact Lenses Due to Disease	80%	$200/24 Consecutive months
Lenses/Frames/Contact Lenses/Laser Eye Surgery	80%	$200/24 Consecutive months
Visual Training	80%	$150/Lifetime

GENERAL INFORMATION Enhanced Health	
Deductible	Nil
Termination	The earlier of retirement, termination of employment or age 70

EXTENDED HEALTH BENEFIT
PARAMEDICAL PRACTITIONERS
Premium Health

	Eligible maximum per visit	Maximum per calendar year
Psychologist	U & C	$400*
Chiropractor (including x-rays)	U & C	$400*
Naturopath (including x-rays)	U & C	$400*
Acupuncturist	U & C	$400*
Osteopath (including x-rays)	U & C	$400*
Chiropodist/Podiatrist (including x-rays)	U & C	$400*
Speech Therapist	U & C	$400*
Occupational Therapist	U & C	$400*
Physiotherapist	U & C	$400*
Massage Therapist	U & C	$400*

GENERAL INFORMATION
Premium Health

Co-Insurance	Lifemark Provider – 100% Non-Lifemark Provider – 80%
Deductible	Nil
Survivor Benefit	24 months, without premiums
Termination	The earlier of retirement, termination of employment or age 70

*** To a total combined maximum of $1,200 for all practitioners per calendar year.**

U & C - Usual, Customary and Reasonable: Usual, Customary and Reasonable means the normal charges for similar services made by other providers of the same standing in the locality or geographical area where the charge is incurred, as determined by Medavie Blue Cross, or in accordance with a payment schedule established by Medavie Blue Cross.

EXTENDED HEALTH BENEFIT MEDICAL EXPENSES Premium Health		
	% Co-insurance	**Maximum**
Nursing Care	100%	$10,000/calendar year
Ambulance Transportation	100%	$1,000/calendar year
Orthopedic Shoes/ Molded Arch Orthotics	100%	$300/calendar year
Orthopedic Supplies	100%	$200/calendar year
Compression Garments	100%	$200/calendar year
Prosthetics (limbs, eyes)	100%	Up to U & C (see Annex A)
Mobility Aids (cast, canes, crutches)	100%	Up to U & C
Medical Equipment	100%	Up to U & C (see Annex A)
Diabetic Equipment	100%	$200/calendar year
Ostomy Supplies	100%	Up to U & C
Hearing Aids	100%	$500/60 consecutive months
Intrauterine Contraceptive Device	100%	Unlimited
Other Medical Services and Supplies**	100%	Up to U & C (see Annex A)
TENS	100%	$300/5 calendar years
Diagnostic Tests***	100%	$1,000/calendar year
Accidental Dental Care*	100%	Subject to authorization

GENERAL INFORMATION Premium Health	
Deductible	Nil
Survivor Benefit	24 months, without premiums
Termination	The earlier of retirement, termination of employment or age 70

*** Benefits subject to pre-authorization**
**** Other medical expenses are listed in Annex A**
***** Diagnostic imaging services coverage in Quebec only**

EXTENDED HEALTH BENEFIT VISION CARE Premium Health		
	% Co-insurance	**Maximum**
Eye Examination	100%	One eye examination (up to U & C)/24 consecutive months
Contact Lenses Due to Disease	100%	$200/24 Consecutive months
Lenses/Frames/Contact Lenses/Laser Eye Surgery	100%	$300/24 Consecutive months
Visual Training	100%	$150/Lifetime

GENERAL INFORMATION Premium Health	
Deductible	Nil
Termination	The earlier of retirement, termination of employment or age 70

SUMMARY OF BENEFITS

WORLDWIDE TRAVEL BENEFIT		
	% Co-insurance	**Maximum**
Emergency Hospital and Medical Travel	100%	$2,000,000 / Participant per Incident*; limited to the first 60 days of a Trip

GENERAL INFORMATION	
Survivor Benefit	24 months, without premiums
Travel Assistance	Provided by CanAssistance Inc.
Termination	The earlier of retirement, termination of employment or age 70

***Incident: An individual occurrence of Emergency Illness or injury.**

DENTAL BENEFIT – In Canada Only
Core Dental

	% Co-insurance	Maximum per calendar year
Preventive Care	50%	$1,000*
Basic Plan	50%	$1,000*
Fee Guide Schedule	Current year	
Number of Recall Examinations, Polishing and Topical Application of Fluoride	1 per 12 consecutive months	

GENERAL INFORMATION
Core Dental

Deductible	Nil
Payment Type	Reimbursement
Survivor Benefit	24 months, without premiums
Termination	The earlier of retirement, termination of employment or age 70

*** Preventive Care and Basic Plan subject to a combined maximum**

DENTAL BENEFIT – In Canada Only Enhanced Dental		
	% Co-insurance	**Maximum per calendar year**
Preventive Care	80%	$1,500*
Basic Plan	80%	$1,500*
Major Plan	50%	$1,500*
Fee Guide Schedule	Current year	
Number of Recall Examinations, Polishing and Topical Application of Fluoride	1 per 9 consecutive months	

GENERAL INFORMATION Enhanced Dental	
Deductible	Nil
Payment Type	Reimbursement
Survivor Benefit	25 months, without premiums
Termination	The earlier of retirement, termination of employment or age 70

*** Preventive Care, Basic Plan and Major Plan subject to a combined maximum**

DENTAL BENEFIT – In Canada Only Premium Dental		
	% Co-insurance	**Maximum per calendar year**
Preventive Care	90%	$2,250*
Basic Plan	90%	$2,250*
Major Plan	50%	$2,250*
Orthodontic Plan	50%	$2,250/lifetime
Fee Guide Schedule	Current year	
Number of Recall Examinations, Polishing and Topical Application of Fluoride	1 per 6 consecutive months	

GENERAL INFORMATION Premium Dental	
Deductible	Nil
Payment Type	Reimbursement
Survivor Benefit	26 months, without premiums
Termination	The earlier of retirement, termination of employment or age 70

*** Preventive Care, Basic Plan and Major Plan subject to a combined maximum**

HEALTH SPENDING ACCOUNT	
Policy Year	January 1st to December 31st
Account Type	Credit Carry Forward
Grace Period for Active Employees	60 days
Grace Period for Terminated Employees	60 days

GENERAL INFORMATION	
Deductible	Nil
Payment Type	Manual Reimbursement (credits will be used to pay an HSA claim as directed by you on the claim form)
Credit Allocation Frequency	Annually
Termination	The earlier of retirement, termination of employment or age 70

PERSONAL SPENDING ACCOUNT (PSA)	
Policy Year	January 1st to December 31st
Account Type	No Carry Forward
Covered Benefit Categories	Health and Wellness Support Alternative Health Treatments Fitness and Sports Activities and Equipment Personal Development Family Care Recreation and Leisure Supplements and Meal Replacement Other Eligible Medical Expenses
CRA Dependent Coverage	Yes
Grace Period for Active Covered Employees	60 days
Grace Period for Terminated Employees	60 days

GENERAL INFORMATION	
Payment Type	Reimbursement Upon Request (credits will be used to pay a Personal Spending Account (PSA) claim as directed by the Covered Employee)
Credit Allocation Frequency	Annually
Termination	The earlier of retirement, termination of employment or age 70

ANNEX A – EXTENDED HEALTH BENEFITS

Applicable in Canada

Prosthetics are subject to a frequency of one per lifetime. If due to physiological/pathological change to the residual limb, medical documentation of such will be considered.

Repairs and/or adjustments are provided to a maximum of $300 per calendar year.

Wigs: $300 per lifetime

Durable medical equipment is subject to pre-authorization and purchase at the discretion of Medavie Blue Cross.

Other medical services and supplies as prescribed:

- Oxygen and rental of equipment for the administration thereof are subject to pre-authorization and purchase at the discretion of Medavie Blue Cross,
- Wheelchair/scooter cushions and inserts (as approved up to usual, customary and reasonable charges),
- Ostomy supplies and incontinence supplies up to usual, customary and reasonable charges,
- Artificial larynx subject to a frequency of one per lifetime up to usual, customary and reasonable charges,
- Charges for the repair of artificial larynx: $300 per calendar year,
- Burn pressure garments: $500 per calendar year,
- Surgical brassieres: limited to two per calendar year,
- Speech aids: $500 per lifetime,
- Spacing devices up to usual, customary and reasonable charges,
- Allergy testing materials: $50 per calendar year,
- Sleeves for lymphedema: two per calendar year.

LIFE BENEFIT

The Life Benefit plan offers, at a reasonable cost, the amounts of Life Benefit protection required to meet your needs as well as those of your dependents.

Basic Life Benefit
Your Basic Life Benefit amount is as specified in the Summary of Benefits.

The Basic Life Benefit is reduced by 50% when you reach age 65. Coverage terminates when your employment terminates, at retirement or at age 70, whichever occurs first.

Optional Life Benefit
Please refer to the Summary of Benefits to know if the Optional Life Benefit is offered in your group.

In the affirmative, you may subscribe to the Optional Life Benefit in $10,000 increments, as stipulated in the Summary of Benefits.

The Optional Life Benefit coverage terminates when your employment terminates, at retirement or upon reaching age 65, whichever occurs first.

Dependent's Basic Life Benefit
Your dependents are also covered if you have chosen family coverage. Their amount of coverage is specified in the Summary of Benefits.

The dependent's coverage terminates concurrently with your coverage termination, or when they are no longer eligible as dependents, whichever occurs first.

Advance Payment Due to Terminal Illness
If you are diagnosed with a terminal illness that is expected to result in your death within 12 months, a lump sum advance equivalent of up to 50% of your amount of coverage or $50,000, whichever is less, may be deducted from your death benefit and paid to you. This sum may be used at your discretion.

Payment of Benefits
Upon your death, the Company will pay, to your named beneficiary, the amount of your Basic Life Benefit.

Waiver of Premiums

If you become totally disabled before your 65th birthday, your life benefit premiums are waived, beginning on the date six consecutive months of total disability have expired, provided satisfactory evidence of total disability is submitted to the Company.

The amount of coverage that is subject to waiver of premiums is the amount in force on the date the disability began.

The waiver terminates on the earliest of the following dates:

a) The date you return to remunerative employment,
b) The date you are no longer disabled,
c) The date you refuse to undergo a medical examination requested by the Company,
d) The date you reach age 65.

Conversion Privilege

If your employment terminates on or before you reach age 65, you may request, within 31 days of such termination, to convert your coverage to an individual coverage policy, up to $200,000 or higher where required by applicable provincial legislation without having to submit evidence of health. The individual coverage premium is determined according to the Company's rate schedule in force at the time of conversion, taking into consideration the amount of coverage, your age and the risk category to which you will belong at the time.

LONG TERM DISABILITY BENEFIT

If your total disability continues beyond the elimination period specified in the Summary of Benefits, you may become eligible for Long Term Disability benefits. Payments begin following the elimination period, with payments being made on the last day of each month. The benefit is equal to 1/30 of the month for each day of total disability.

Total Disability
For the purpose of the Long Term Disability Benefit, total disability means:

a) During the elimination period and the following 24 months, you are totally and continuously unable, as the result of an illness or accident, to perform the regular duties of your own occupation; and

b) Subsequently, you are totally and continuously unable, as the result of an illness or accident, from performing the regular duties of any occupation,

- that would enable you to earn at least 60% of your pre-disability salary,
- for which you are reasonably qualified, or may so become, by training, education or experience.

Regular duties are defined as those work-related activities which are considered essential to your performance in the occupation and which proportionately take the majority of time to complete.

The availability of such occupations, jobs or work will not be considered while assessing your disability.

The loss of a professional or occupational license or certification does not, in itself, constitute disability.

Recurrence
Successive periods of total disability separated by less than six months of continuous active employment are considered one period of disability, unless the new disability is due to an illness or accident totally unrelated to the cause of the previous disability and commences only after your return to work.

When successive periods are considered one period of total disability, the elimination period is not applied a second time and the same amount as for the initial total disability is payable less any payments already made, for the remainder of the maximum period originally set.

Rehabilitation Program
If, while receiving monthly benefits, you participate in a rehabilitation program approved by the Company:

a) The total disability will not be considered as having ended for the sole reason that you participate in such a program,

b) The monthly benefits payable hereunder will be reduced by 50% of the remuneration you receive from such a rehabilitation program,

c) If, while participating in such a rehabilitation program, you again become totally disabled, your benefits will revert back to the amount you received before the start of the rehabilitative employment program.

d) During the rehabilitation program, the monthly benefits payable hereunder will be reduced as necessary so that the total income from all sources does not exceed 100% of your pre-disability salary.

Pre-existing Condition

A pre-existing condition is an injury or an illness for which you have consulted a physician or received medical treatment, care or services (including diagnostic measures) or have been prescribed medication, during the same three month period immediately preceding the effective date of your coverage (under this policy or a previous policy).

Long Term Disability Benefits are not payable for any disability caused by or resulting from a pre-existing condition unless:

- you have not consulted a physician, received medical treatment, care or services (including diagnostic measures) or have not been prescribed medication for any six consecutive months within the 15 month time period beginning three months before and ending 12 months after the effective date of your Long Term Disability coverage, or
- the disability begins after 12 consecutive months of employment from the effective date of your coverage.

Integration of Benefits

The amount of monthly Long Term Disability Benefit to which you are entitled as of the date of disability will be co-ordinated with other income payments to which you become entitled as a result of the current disability. The benefit co-ordination shall be applied as follows:

1. The amount of monthly Long Term Disability benefit will be reduced by any income or benefits payable to you, as a result of the current or subsequent disability by:
   - any disability benefits available from the Canada or Quebec Pension Plan (Primary Benefits only),
   - any disability benefits payable under the Worker's Compensation Act,
   - any Canada or Quebec Pension Plan retirement benefits, if applied for by you after the date you meet the definition of disability,
   - any retirement income, or benefits payable under any group program provided by or through the employer,
   - any income or benefits payable under a plan sponsored by an association, union or fraternal organization of which you are a member,
   - any income or benefits payable under any plan of automobile insurance, where such reduction is not prohibited by law or is not required to be reimbursed to the auto insurer, and
   - any wage or remuneration payable from any employer or from self-employment, other than those received under an approved rehabilitation program.

2. The amount of monthly Long Term Disability benefit will be further reduced so that income and benefits received by you from all sources does not exceed 85% of your pre-disability salary.

During an approved rehabilitation program, the amount of monthly Long Term Disability benefit will be reduced by 50% of the remuneration received by you from such rehabilitation program and if necessary, will further be reduced so that the total amount of income and benefits received does not exceed 100% of pre-disability salary.

<u>Canada/Quebec Pension plan freeze</u>

Once the initial CPP/QPP offset has been established on a Long Term Disability claim, it will not be changed due to cost-of-living adjustments to the CPP/QPP payments.

Limitations and Exclusions

Long Term Disability Benefits will not be payable if disability, illness, injury or accident occurs while participating in or while engaged in any criminal activity, regardless of whether charges are laid or a conviction obtained.

Long Term Disability Benefits are not payable for any of the following:

a) Any period of disability during which you are not under the appropriate treatment and care of a physician who is a registered medical specialist or health care practitioner in the field of medicine that is applicable to your condition,

b) Any period during which you are not undergoing a course of medical treatment or participating in a program of rehabilitation that is deemed appropriate in the opinion of the Company

c) Any period during which you are imprisoned,

d) Any disability due to or resulting from insurrection, war (declared or not) or the hostile actions of the armed forces of any country, or the participation in any riot or civil commotion,

e) Any disability during the period:

- of formal maternity leave taken by you pursuant to provincial or federal law, or pursuant to mutual agreement between you and the employer, or
- in which employment insurance maternity benefits are being paid or would be paid if you were eligible, whichever is longer.

Termination of the Right to Benefits

Even when totally disabled, the right to receive benefits may be revoked, if:

a) You refuse to undergo a medical examination requested by the Company.

b) You refuse to participate in a medical or rehabilitative employment program judged reasonable and appropriate by both the Company and your attending physician.

c) You fail to produce proof satisfying the Company of the persistence of disability.

d) You engage in remunerative work, unless it is part of a rehabilitative employment program.

e) You move or live temporarily outside Canada, unless you have notified the Company in writing and the Company has given his prior approval.

f) Your disability no longer meets the policy definition.

In any event, benefits terminate at your retirement, when you reach age 65 or when the benefit period specified in the Summary of Benefits expires.

Waiver of Premium

If you are totally disabled, any premium due under this benefit will be waived commencing with the first full calendar month following the expiration of the elimination period until such time as you return to active full-time employment.

Termination of Benefit

The Long Term Disability Benefit ends upon termination of your employment, at retirement or when you reach age 65.

HOSPITAL BENEFIT

This benefit covers eligible expenses incurred by you or your dependents subject to the deductible (if applicable) and the percentage of reimbursement specified in the Summary of Benefits.

Deductible
The deductible, if applicable, is the portion of eligible expenses that you must pay for you and your dependents before the Company begins to reimburse expenses eligible under this policy. The deductible applies only once per calendar year.

The eligible expenses incurred during the last three months of a calendar year and which were insufficient to meet the deductible for that year may be used to reduce the deductible for the following calendar year.

Eligible Expenses
The usual and necessary expenses from a medical point of view and recommended by a physician are reimbursed at the percentages and up to the maximums specified in the Summary of Benefits. Reimbursement will be considered only when the services are provided by an approved provider as identified by the Company.

HOSPITALIZATION

Hospital Room Benefit
Hospitalization charges when you are admitted as an inpatient in a hospital for active care after the effective date of your coverage and for as long as you are entitled to covered services, subject to the maximum reimbursement specified in the Summary of Benefits. The preferred accommodation is specified in the Summary of Benefits.

Convalescent Care
Charges for convalescent care, if you have been admitted less than 14 days after obtaining your discharge from a hospital where you have been receiving active treatment, subject to the daily maximum and maximum number of days specified in the Summary of Benefits.

Rehabilitation
Charges for rehabilitative care after the effective date of your coverage, subject to the daily maximum and maximum number of days specified in the Summary of Benefits.

Termination of Benefit
The Hospital Benefit ends at your retirement, the termination of employment or the age noted in the Summary of Benefits, whichever occurs first. The dependent's coverage ends either on the date you cease to be covered or on the date they no longer meet the definition of dependent, whichever occurs first.

Survivor Benefit
After your death, your dependents continue to be covered without cost and up to the earliest of the following dates:

a) 24 months after the date of your death,
b) The date they cease to be eligible dependents,
c) The effective date of any similar coverage with another insurer, or
d) The termination date of the group policy.

DRUG BENEFIT – IN CANADA ONLY

This benefit covers expenses for eligible drugs as defined by the Company and is subject to any deductible, co-pay, co-insurance or maximum listed in the Summary of Benefits.

The Company may, on an ongoing basis, add, delete or amend the list of eligible drugs on any list hereinafter mentioned. Certain drugs may require prior authorization to be eligible for payment as identified by the Company.

Drugs must be dispensed by a provider approved by the Company.

If the Summary of Benefits specifies Lowest Cost Substitution applies, and an interchangeable drug has been prescribed, the Company will reimburse to the lowest ingredient cost interchangeable drug.

You may request a higher cost interchangeable drug; however, you will be responsible for paying the difference in cost between the interchangeable drugs.

Regardless of whether your physician indicates the prescribed interchangeable drug cannot be substituted, the Company will only reimburse to the lowest ingredient cost interchangeable drug.

For participants with an adverse reaction to the interchangeable drug dispensed, the Company will consider reimbursement to another interchangeable drug on a case by case basis only, through the defined exception process.

Certain prescription-requiring drugs on the eligible drug benefit list are eligible benefits on an individual participant basis based on specific medical needs and when approved by the Company under the special authorization process.

Eligible expenses are considered to have been incurred on the date the services are rendered or the product is supplied.

Deductible
The deductible is the portion of eligible expenses that you must pay before the Company begins to reimburse expenses eligible under this policy, if applicable.

Eligible Expenses
The plan refunds the following expenses, according to the percentage of reimbursement specified in the Summary of Benefits:

Expenses for drugs which require a prescription by law, approved by the Company, and prescribed by a doctor or dentist are eligible. In addition, certain drugs prescribed by other qualified health professionals will be considered if the applicable provincial legislations permit the professional to prescribe those drugs.

Acute Medications are eligible drugs prescribed to treat a condition that is typically short in duration and requires urgent care.

Acute Medication includes drugs which due to pharmacy regulations cannot be mailed, including:

- narcotics;
- controlled substances and stimulants; or
- drugs not available for purchase in a retail pharmacy.

Maintenance Medications are eligible drugs prescribed to treat a chronic, long-term condition. Maintenance Medications are taken on a regular, recurring basis and include drugs that do not fall under the definition of an Acute Medication.

Expenses not Reimbursed by the Plan
Incurred expenses for the following products or drugs are excluded, unless specified in the Summary of Benefits:

- products not approved by the Company,
- products for the care of contact lenses,
- proteins or dietary supplements, amino acids, essential fatty acids,
- processed food for infants,
- hygiene products, including soaps and emollients,
- softeners and protective substances for the skin,
- minerals, vitamins,
- homeopathic/naturopathic products,
- drugs or drug formats or preparations with no therapeutic indication,
- herbal remedies,
- traditional medicines,
- probiotics,
- weight loss treatments,
- erectile dysfunction drugs,
- fertility drugs,
- any drugs generally administered in a hospital setting.

Applicable to Quebec Residents

Act Respecting Prescription Drug Insurance
This policy must be administered in accordance with the Act Respecting Prescription Drug Insurance ("the Act") in relation to Quebec participants, including the Act's provisions with respect to maximum coinsurance, out-of-pocket maximums, eligible drugs and exception drugs.

Under no circumstances will the expenses not reimbursed by the plan provision of this benefit render Drug Benefits for Quebec participants less generous than the basic prescription drug insurance plan established by the Act.

Out-of-pocket Maximum per Calendar Year
If, in any calendar year, a Quebec participant spends more on eligible drugs than the maximum contribution amount established by the RAMQ, the amounts in excess of the maximum contribution amount will be reimbursed by the Company at a rate of 100%. The Quebec participant's contribution amount includes the deductible and co-payment, if applicable, for you and your dependents.

Participants Age 65 Years and Over
When you and your spouse reach the age of sixty-five (65), you have a decision to make regarding your drug coverage.

Decision to join the RAMQ plan at age 65

When you or your spouse reaches the age of sixty-five (65) you may choose to be insured under the basic prescription drug insurance plan provided by the Act Respecting Prescription Drug Insurance (RAMQ's plan) rather than to maintain complete drug coverage under the group insurance plan. Such choice is then irrevocable.

If, at age sixty-five (65), you choose to be insured under the RAMQ's plan, you and your dependents, regardless of their age, will no longer be eligible for coverage under the group insurance plan (except for supplementary coverage, as mentioned in items a) and b) below).

If, at age sixty-five (65), your spouse chooses to be covered under the RAMQ's plan, then he will no longer be eligible for coverage under the group insurance plan (except for supplementary coverage, as mentioned in items a) and b) below).

However, you and your dependents who have joined the RAMQ's plan remain covered under the group insurance plan for the expenses indicated below (by paying the increase in premium, if applicable, according to the premium rates schedule of the contract):

a) the deductible and the coinsurance paid by the insured under the RAMQ's plan; and
b) subject to the deductible and the percentage of reimbursement mentioned in the benefit summary for drug coverage: the reimbursement of any prescription drug which does not appear on the list provided by the RAMQ, but which is covered under the insurer's list of drugs.

Decision to cancel registration with the RAMQ at age 65

When a Quebec resident reaches the age of sixty-five (65), he is automatically registered by the RAMQ as a beneficiary of its prescription drug coverage. When you or your spouse reaches the age of sixty-five (65) you must therefore cancel your automatic registration with the RAMQ plan in order to continue full drug coverage under the group insurance plan. Provisions relating to the increase in premium (if applicable) are mentioned in the premium schedule of the contract or, after the effective date of the contract, in the contract renewal provisions issued by the Insurer.

If a Quebec resident decides to maintain coverage under this benefit, the Company reserves the right to modify the premium rates applicable to this benefit for any Quebec resident age 65 and over.

Termination of Coverage

The Drug Benefit ends at your retirement, termination of employment or the age noted in the Summary of Benefits, whichever occurs first. The coverage for eligible dependents ends when your Drug Benefit terminates or on the date they no longer meet the definition of dependent, whichever occurs first.

EXTENDED HEALTH BENEFIT – IN CANADA ONLY

This benefit covers eligible expenses incurred by you or your dependents subject to the deductible (if applicable) and the percentage of reimbursement specified in the Summary of Benefits, providing eligible expenses are incurred in Canada.

Deductible

The deductible, if applicable, is the portion of eligible expenses that you must pay for you and your dependents before the Company begins to reimburse expenses eligible under this policy. The deductible applies only once per calendar year.

The eligible expenses incurred during the last three months of a calendar year and which were insufficient to meet the deductible for that year may be used to reduce the deductible for the following calendar year.

Eligible Expenses

The usual and necessary expenses from a medical point of view and recommended by a physician are reimbursed at the percentages and up to the maximums specified in the Summary of Benefits. Reimbursement will be considered only when the services are provided by an approved provider as identified by the Company.

MEDICAL SERVICES AND SUPPLIES

Ambulance Transportation

Transportation in a licensed ambulance, including air ambulance, when medically necessary and when incurred in Canada, to and from the nearest hospital able to provide the necessary medical services, subject to a maximum amount payable noted in the Summary of Benefits.

Orthopedic Shoes/Custom Made Orthotic Shoe Inserts

Charges for orthopedic shoes when the shoes have been customized with special features to accommodate relieve or remedy some mechanical foot defect or abnormality. A prescription from an orthopedic surgeon, physiatrist, rheumatologist, chiropodist/podiatrist or the attending Physician is required along with a copy of the biomechanical or gait analysis from the health care professional.

Charges for custom made orthotic shoe inserts when required to accommodate, relieve, or remedy some mechanical foot defect or abnormality, excluding their replacement (except for pathological change), on written authorization of an orthopedic surgeon, physiatrist, rheumatologist, podiatrist or the attending physician.

The combined maximum amount payable is noted in the Summary of Benefits.

Orthopedic Supplies

Charges for shoe modifications, adjustments and supplies when prescribed by one of the health care professionals noted above to accommodate, relieve or remedy some mechanical foot defect or abnormality. The maximum amount payable is noted in the Summary of Benefits.

Compression Garments

Charges, including elastic support garments and gradient compression garments, (made to measure) on written authorization of the attending physician, to a maximum combined amount payable as noted in the Summary of Benefits.

Prostheses

Charges for the following remedial prosthetic appliances:

- artificial limbs (limited to one prosthetic appliance for each limb per lifetime),
- myoelectric limbs ($10,000 for each limb per lifetime),
- residual limb socks up to the usual, reasonable and customary amount,
- breasts (limited to a left and a right prosthesis every two (2) consecutive calendar years),
- artificial nose (limited to one (1) per lifetime),
- eyes (limited to one left and one right prosthesis per lifetime),
- casts and splints up to the usual, customary and reasonable amount,
- trusses (limited to one truss per five (5) consecutive calendar years),
- braces (limited to one (1) cervical collar per calendar year. All other braces are limited to one (1) per lifetime),
- canes and crutches (limited to a combined maximum of two (2) per lifetime).

Replacement of these items will not be a benefit unless replacement is required due to pathological or physiological change.

Wigs, when loss is due to an underlying pathology or its treatment (i.e. chemotherapy), to a maximum amount payable as noted in the Summary of Benefits. Hair prosthetics, replacement therapy and other procedures for physiological hair loss are not eligible (i.e. male pattern baldness).

Prosthetic repairs and/or adjustments are provided to a maximum amount payable as noted in the Summary of Benefits.

Hearing Aids

Charges for hearing aids (excluding batteries and exams), when prescribed by an otolaryngologist, otologist and/or recommended by a registered audiologist. The maximum amount payable for both ears combined is noted in the Summary of Benefits.

TENS

Charges for the rental or purchase of a neuromuscular stimulation device (TENS) to the maximum amount payable noted in the Summary of Benefits.

Diabetic Equipment

Charges for the following equipment used for the treatment and control of diabetes: glucometer, pressurized insulin injector, blood glucose monitoring and insulin dosing systems, or equipment approved by the Company that performs similar functions. The overall maximum payable for this equipment is noted in the Summary of Benefits.

Medical Equipment

Charges for rental of a wheelchair, hospital-type bed (including mattress and safety side rails), and equipment for the administration of oxygen, when prescribed by a licensed physician. If, due to extended illness or disability, it is felt that the need for these items will be long-term, the Company, at its sole discretion, may approve the purchase of these items.

Once the original equipment purchase is approved, the rental or approved purchase of another piece of similar equipment will be limited to once every five consecutive calendar years.

Charges for the repair of a manual or electric wheelchair up to the usual, customary and reasonable amount.

You or your dependent must obtain the prior approval from the Company before any purchase, rental or repair otherwise the claim may be rejected.

Diagnostic Test

Charges for diagnostic laboratory and X-ray services, when carried out by an approved laboratory which, in the opinion of the Company, is qualified to render such services. These services will include:

- laboratory analyses, X-rays, electrocardiograms, CT scans, ultrasounds, and magnetic resonance imagery (MRI).

Services will be provided to a maximum combined amount payable as noted in the Summary of Benefits. Diagnostic imaging services coverage in Quebec only.

Paramedical Services

Charges for treatment, except when performed in a hospital, by a licensed practitioner. The maximum payable amount for each eligible practitioner is mentioned in the Summary of Benefits. In addition the maximum payable amount for X-rays is mentioned in the Summary of Benefits.

Other Medical Services and Supplies

a) Charges for the purchase of wheelchair/scooter cushions and inserts, limited to the usual, customary and reasonable amount.
b) Charges for artificial larynx, limited to one purchase per lifetime.
c) Charges for the repair of artificial larynx, subject to the maximum amount payable noted in the Summary of Benefits.
d) Charges for the purchase of burn pressure garments, subject to the maximum amount payable noted in the Summary of Benefits.
e) Charges for the purchase of surgical brassieres, limited to two (2) per calendar year.
f) Charges for the purchase of spacing devices up to the usual, customary and reasonable amount.
g) Charges for allergy testing materials, subject to the maximum amount payable noted in the Summary of Benefits.
h) Charges for sleeves for lymphedema, limited to two (2) per calendar year.

Ostomy Supplies

Charges for essential ostomy supplies, up to the usual, customary and reasonable amount.

Speech Aids

Charges for speech aid equipment, when approved by a qualified speech therapist and authorized by the attending physician, for persons who do not have oral communication ability, to a maximum payable amount noted in the Summary of Benefits.

Intrauterine Contraceptive Device (IUD)

Purchase of an intrauterine contraceptive device (IUD), to the maximum amount payable noted in the Summary of Benefits.

Accidental Dental
Charges for dental treatment, when sound, natural teeth have been damaged by a direct accidental blow to the mouth, or a fractured or dislocated jaw required setting.

This dental treatment must be rendered or reported and approved for payment by the Company within 180 days of the accident and dental work must be completed within 24 months from the date of the accident. Eligible expense will be the dentists' usual and customary fee up to the "dental fee guide" for general practitioners in effect where services are rendered.

All deferred dental treatment must be completed and approved for payment by the Company no later than the last day of the month in which the person turns 21 years of age unless otherwise prescribed by statute, in which case the statutory provision applicable in the province where the participant resides shall apply.

When such dental treatment must be deferred because of the age of the patient, or other factors which are justified, in the opinion of the Company, the claim may be approved for later payment. To meet our payment criteria, the participant must have been covered by the Company for accidental dental at the time the accident occurred, and must still be covered by the Company at the time the services are rendered. The only exception to this criterion is when the participant is uninsured for dental benefits at the time the service is rendered, in which case the claim may be approved. The subscriber must submit to the Company within 180 days of the accident complete details of the required services from the dentist and reason for deferment.

VISION CARE

Eye Examination
Charge of a registered, licensed optometrist or ophthalmologist for eye examinations. Subject to the maximum amount payable mentioned in the Summary of Benefits.

Contact Lenses Due to Disease
Charges for contact lenses when prescribed by a licensed ophthalmologist for ulcerated keratitis; severe corneal scarring, keratoconus (conical cornea) or aphakia, provided sight can be improved to at least 20/40 level by contact lenses but cannot be improved to that level by spectacle lenses. The total maximum payable amount is stated in the Summary of Benefits.

Visual Training
Charge of a registered, licensed optometrist or ophthalmologist for visual training and remedial eye exercises limited to the maximum payable amount stated in the Summary of Benefits.

Lenses/Frames/Contact Lenses/Laser Eye Surgery
Charges incurred for corrective lenses/frames or contact lenses or intraocular lenses used in cataract surgery or the cost of laser eye surgery when prescribed by an optometrist or ophthalmologist, up to the maximum amount payable stated in the Summary of Benefits.

Specific Exclusion
Expenses incurred for non-corrective sunglasses and safety glasses are excluded.

Expenses not Reimbursed by the Plan

The following expenses are not reimbursed under the plan:

a) Medical examinations or routine general check-ups required for use by a third party,

b) Charges for rest cures, convalescent care, custodial care, rehabilitation services in a hospital for the chronically ill or a chronic care unit of a general hospital, or charges incurred by the participant when, in the opinion of the Company, proper treatment should be in a chronic care unit of an institution for the chronically ill,

c) Charges relating to elective services obtained by a participant outside his province of residence when his provincial government health care programs have not accepted liability for those items normally covered in the participant's province of residence,

d) Any services and supplies to which the participant is entitled under any workers compensation statute or any other legislation,

e) Charges which normally would not be made if the participant were not covered by this policy,

f) Services for cosmetic purposes or condition not detrimental to one's health,

g) Any services and supplies normally available without cost, or at nominal cost, under any government statute on the effective date of this policy, whether or not such services or supplies continue to be eligible under a government program,

h) Mileage and/or delivery charges to or from a hospital or health care professional,

i) Services in connection with an injury or disease resulting from riot, insurrection or war whether war be declared or not. This includes any condition caused directly or indirectly by any armed forces,

j) Medications restricted under federal or provincial legislation that are prescribed and/or dispensed despite such regulations,

k) Registration charges or non-residents surcharges in any hospital,

l) Services required as a result of attempting to commit a criminal act,

m) Service performed by an unqualified practitioner,

n) Charges for missed appointments or the completion of forms,

o) Services which are normally paid for directly or indirectly by the employer,

p) Any health care services and supplies which are not provided by a company approved provider,

q) Charges for experimental or investigative health care services or supplies,

r) Any health care service or supply that are not medically necessary nor proven effective,

s) Charges for health care planning assessments including, but not limited to physiotherapy assessments. Health care planning assessments will be excluded as eligible benefits, unless otherwise specified in this policy,

t) Any health care services and supplies administered in a hospital or by any agency or provider controlled by a hospital or by any agency or provider funded, in whole or in part, by government of any level, are not eligible for reimbursement under this policy, unless otherwise specified in this policy.

EXTENDED HEALTH BENEFIT – IN CANADA ONLY

Limitation

For the purpose of the present benefit, all participants shall be deemed covered under the hospital and health insurance acts of their province of residence in Canada.

Termination of Benefit

The Extended Health Benefit ends at your retirement, the termination of employment or the age noted in the Summary of Benefits, whichever occurs first. The dependent's coverage ends either on the date you cease to be covered or on the date they no longer meet the definition of dependent, whichever occurs first.

WORLDWIDE TRAVEL BENEFIT

This benefit covers emergency expenses occurring when you and your dependents are travelling outside of your province of residence.

WORLDWIDE TRAVEL COVERAGE

Travel Assistance Lines

In the event of a medical emergency outside your province of residence, you or your representative must call CanAssistance as soon as possible at one of the following numbers:

From Canada or the United States: 1-800-563-4444

From anywhere else: 1-506-854-2222 (collect)

For better service, be sure to give your name, the number of the phone from which you are calling and your Blue Cross group and certificate numbers.

If calling collect is not possible, Medavie Blue Cross will reimburse the cost of the call.

Eligible Expenses for Worldwide Travel Coverage

The plan reimburses all usual and reasonable expenses incurred following an emergency situation resulting from an accident or an illness, up to a maximum amount payable of $2,000,000 per incident, per participant.

Eligible treatments are those declared necessary to stabilize the medical condition, and benefits are additional to those provided for by government plans.

Hospital Accommodation

Charges of a public general hospital, less the amount allowed under the provincial government health plan, for (a) room accommodation (not a suite of rooms), and (b) medically necessary inpatient and outpatient services.

Physicians and Surgeons

Customary charges of physicians and surgeons for service rendered, less the amount allowed under the provincial government health plan.

Medical Appliances

The cost of casts, crutches, canes, slings, splints, trusses, braces and/or temporary rental of wheelchair when required as a result of sickness or accident. This benefit will be payable only when the sickness or accident occurs outside the participant's province of residence and when ordered by a physician.

Nurse

Private duty nursing, including registered nurse, registered nursing assistant or certified nursing assistant, when ordered by a physician at the usual, customary and reasonable fee. Nurses providing the service must not be a relative of the patient or an employee of the hospital.

Ambulance

Normal charges for licensed ambulance service, including air ambulance and evacuation, to and from the nearest qualified medical facility.

Coming Home

Extra costs of return economy fare by the most direct route (air, bus, train) when an illness is such that the patient must return home and be accompanied by a qualified medical attendant (not a relative). Written authorization is required from the attending physician. If returning on a commercial aircraft, this coverage is included:

a) Two economy seats by most direct route to the patient's home city in Canada, one for the covered patient and one round trip fare for a medical attendant,
b) The number of economy seats required to accommodate the covered person if on a stretcher and one round trip for a medical attendant.

Diagnostic Services

The cost of diagnostic laboratory and X-ray services, less the amount allowed under the provincial government health plan, when ordered by the attending physician.

Paramedical Services

The cost of services made by chiropractors, osteopaths, chiropodist/podiatrists and physiotherapists (not a relative), in excess of payment by a provincial government health plan, excluding charges for X-rays.

Drug Benefits

Charges for Drug Benefits in a quantity sufficient for the period of travel. Payment of eligible drugs will be made only when proof of purchase and payment is supplied in the form of an account from a Company approved provider located outside the participant's province of residence and showing the name of the preparation, date of purchase, quantity, strength and total cost.

Accidental Dental

Charges for dental treatment to a maximum amount of $1,000 Canadian when, as the result of accidental injury (direct accidental blow to the mouth), natural teeth have been damaged, or a fractured or dislocated jaw requires setting. Such dental treatment must be rendered or reported and approved for payment by the Company within 180 days of the accident and be supported by proper certification.

When such dental treatment must be deferred because of the age of the patient, or other factors which are justified, in the opinion of the Company, the claim may be approved for later payment. To meet our payment criteria, the participant must have been covered by the Company for accidental dental at the time the accident occurred, and must still be covered by the Company at the time the services are rendered. The only exception to this criteria is when the participant is uninsured for Dental benefits at the time the service is rendered, in which case the claim may be approved. The participant must submit to the Company within 180 days of the accident complete details of the required services of the dentist and reason for deferment.

Vehicle Return

An allowance of up to $500 Canadian for the cost of driving the patient's vehicle, either private or rental, by commercial agency to the patient's residence or nearest appropriate vehicle rental agency when the patient is unable to return it due to sickness or accident.

Return of Deceased

Up to $3,000 Canadian towards the cost of preparation (including cremation) and homeward transportation of a deceased participant (excluding the cost of a coffin) to the point of departure in Canada by the most direct route.

Meals and Accommodations
Up to $1,200 Canadian ($150 per day for eight days) per trip for extra costs of commercial accommodation and meals incurred by the covered employee, or by a covered dependent remaining with a travelling companion when the trip is delayed due to illness or accident to either a travelling companion or a participant. Must be verified by the attending physician and supported with receipts from commercial organizations.

Transportation to Visit the Participant
One return economy fare by the most direct route for transportation costs (air, bus, train), when the covered person has been confined to the hospital or has died and the attending physician has advised the necessary attendance of an immediate family member or a close friend of the participant.

Emergency and Payment Assistance
The services of a 24 hour emergency hotline are available to the participants who need assistance while travelling. By telephoning the appropriate number on your "World Assistance Card" when a medical emergency occurs, coverage will be confirmed to the hospital or physician. Payment of medical expenses will be arranged or co-ordinated on behalf of the participant. In addition, the following services are offered:

Medical Assistance
The patient may call for a list of hospitals or medical facilities and arrangements will be made for:

- advice from a qualified physician,
- medical follow-up of the patient's condition and communication with the covered employee and family,
- return home or transfer of patient if medically permissible,
- transport of a family member to the patient's bedside or to identify the deceased.

Non-medical Assistance
The patient may call to obtain:

- an emergency response in any major language,
- emergency assistance in contacting the family or business,
- referral to legal counsel.

Exclusions and Limitations for Worldwide Travel Coverage
No benefits are paid in the following cases:

1. No benefits are available under this policy for residents travelling outside their province of residence primarily or incidentally to seek medical advice or treatment, even if such a trip is on the recommendation of a physician.

2. No benefits are available under this policy for elective (non-emergency) treatment or surgery. This is defined as treatment or surgery (a) not required for the immediate relief of acute pain and suffering, or (b) which reasonably could be delayed until the participant has returned to Canada or (c) which the participant elects to have rendered or performed outside Canada following emergency treatment for, or diagnosis of, a medical condition which (on medical evidence) would not prevent the participant from returning to Canada prior to such treatment or surgery.

3. Benefits under this policy shall not be paid if the participant received the same from a third party.

Exclusions and Limitations for Worldwide Travel Coverage (Cont'd)

4. No benefits will be paid for expenses incurred as the result of abuse of medications; suicide or attempted suicide; criminal acts, or injuries suffered as a result of operating a motor vehicle while alcohol levels are in excess of the legal limit in the jurisdiction where the accident occurred.

5. The Company, in consultation with the attending physician, reserves the right to return the patient to Canada. If any participant is (on medical evidence) able to return to Canada following the diagnosis of, the emergency treatment for, a medical condition which requires continuing medical services, treatment or surgery, and the participant elects to have such treatment of such services rendered or surgery performed outside Canada, the expense of such continuing medical services, treatment or surgery will not be covered by this plan. The Company accepts no responsibility in the event of the deterioration of the participant's medical condition during or after the transfer back to Canada.

6. Coverage is limited to expenses incurred as a result of a sudden illness or accident which occurs outside the participant's province of residence. Pre-existing conditions will be covered as a benefit, provided the condition is stable prior to travel, and when medical attention is not anticipated during the travel period.

   A pre-existing condition is considered stable if you, in the 90 days before the departure date have not:

   a) been treated or evaluated for new symptoms or related conditions;
   b) had symptoms that increased in frequency or severity, or examination findings indicating the condition has worsened;
   c) been prescribed a new treatment or change in treatment for the condition (generally does not include reductions in medication due to improvement in the condition, or regular changes in medication as part of an established treatment plan);
   d) been admitted to or treated in a hospital for the condition; or
   e) been awaiting new treatments or tests regarding the medical condition (does not include routine tests).

   The above criteria will be considered collectively in relation to the overall medical condition.

7. This policy excludes loss, damage, cost or expense of whatsoever nature directly or indirectly caused by, resulting from or in connection with any of the following regardless of any other cause or event contributing concurrently or in any other sequence to the loss:

   a) expenses incurred while travelling in a country (or a specific region of a country) for which there is a Government of Canada travel warning, when such travel warning was issued before the departure date and the loss or expense is related to the reason for which the travel warning was issued; and
   b) insurrection, war (declared or not), the hostile action of the armed forces of any country or participation in any riot or civil commotion.

8. Coverage is limited to amounts that are in excess of coverage provided by any other plan. If a participant has other travel benefits in respect of a loss covered by this policy, the Company shall be liable only for the part of the claim which is in excess of the amount recoverable or recovered from such other travel benefit. Where it is determined by a court that the policy and any other plan(s) provide primary coverage, the benefit will be co-ordinated with the other plan, as described under the Co-ordination of Benefits provision.

Exclusions and Limitations for Worldwide Travel Coverage (Cont'd)

9. The Company will not cover expenses in excess of $2 million Canadian per covered participant, per incidence outside the province of residence.

   All claims and required government forms must be submitted within four (4) months of the date of service.

Restrictions on the Duration of Trips

All customary and reasonable expenses and services described in the Worldwide Travel Benefit are eligible if they are incurred following an emergency resulting from an accident or sudden illness which occurs during the first 60 days of a trip outside the participant's province of residence, provided the participant is covered under the hospital and health government programs of his province of residence when the emergency occurs.

Termination of Travel Benefit

The Travel Benefit coverage ends at your retirement, the termination of employment, upon death or when you reach age 70, whichever occurs first. Coverage for your dependents ends either on the date you cease to be covered or on the date they no longer meet the definition of dependent, whichever occurs first. Coverage for any participant ceases when he is no longer covered under the government health program in his province of residence.

Survivor Benefit

After your death, your dependents continue to be covered without cost and up to the earliest of the following dates:

a) 24 months after the date of your death,
b) The date they cease to be eligible dependents,
c) The effective date of any similar coverage with another insurer, or
d) The termination date of the group policy.

DENTAL BENEFIT – IN CANADA ONLY

This benefit covers eligible expenses incurred by you or one of your dependents for dental services recommended by a dentist and performed by:

- a dentist, or
- a dental hygienist under the supervision of a dentist, or
- a denturist.

Expenses are subject to the deductible (if applicable), percentages of reimbursement and maximums specified in the Summary of Benefits.

However, if you or your dependents become covered more than 31 days after your date of eligibility, the maximum amount reimbursed under this benefit for all eligible services is limited to $250 during the first 12 months of coverage.

Calculation of Eligible Expenses
The eligible amount for covered benefits is the amount indicated in the suggested fee guide for dental services approved by the province of provider (current year edition).

Deductible
The deductible, if applicable, is the portion of eligible expenses that you must pay for you and your dependents before the Company begins to reimburse expenses eligible under this policy. The deductible applies only once per calendar year.

The eligible expenses incurred during the last three months of a calendar year and which were insufficient to meet the deductible for that year may be used to reduce the deductible for the following calendar year.

Eligible Expenses
After payment of the deductible (if applicable), the following expenses are reimbursed, according to the percentage of reimbursement and maximum specified in the Summary of Benefits.

<u>Preventive Care</u>

a) Oral examinations and diagnosis
   - Complete oral examination (once per calendar year)
   - Recall oral examination (as mentioned in the Summary of Benefits)
   - Emergency oral examination
   - Specific oral examination (once per calendar year)

b) X-rays
   - Complete series films or panoramic film (one per two consecutive calendar years, combined)
   - Intra-oral films – periapical
   - Intra-oral films – occlusal (once per calendar year)
   - Intra-oral films – bitewings (once per calendar year)
   - Extra-oral films
   - Sialography
   - Radiopaque dyes

Preventive Care (Cont'd)

c) Laboratory tests and examinations
- Bacterial culture
- Biopsy of soft oral tissue
- Biopsy of hard oral tissue
- Cytological examination

d) Preventive treatment
- Polishing of coronal portion of teeth (as mentioned in the Summary of Benefits)
- Topical application of fluoride (as mentioned in the Summary of Benefits)
- Oral hygiene instruction (lifetime maximum of one instruction)
- Pit and fissure sealants (for participants under age 18)
- Scaling
  Core Dental - (6 units* every 12 consecutive months in combination with root planing)
  Enhanced Dental - (8 units* every 12 consecutive months in combination with root planing)
  Premium Dental - (10 units* every 12 consecutive months in combination with root planing)

e) Space maintainers(for participants under age 18)

Basic Care

a) Restorations
- Amalgam, acrylic, silicate or composite on posterior and anterior teeth
- Retentive pins
- Full coverage prefabricated restorations

b) Endodontic services
- Pulp capping
- Pulpotomy
- Emergency pulpectomy
- Root-canal therapy
- Endodontic surgery
- Bleaching (endodontically treated teeth)
- Apexification

c) Periodontics
- Periodontal surgery
- Provisional splinting
- Management of acute infections
- Desensitizations
- Other adjunctive periodontal services
- Root planing
  Core Dental - (6 units* every 12 consecutive months in combination with scaling)
  Enhanced Dental - (8 units* every 12 consecutive months in combination with scaling)
  Premium Dental - (10 units* every 12 consecutive months in combination with scaling)
- Periodontal curettage
- Occlusal adjustments (three units* per calendar year)
- Periodontal appliances (one per two calendar years)
- Adjustments to appliances (three units* per calendar year)

Basic Care (Cont'd)

d) Removable denture adjustments
- Minor adjustments
- Rebasing and relining (one per two calendar years)

* A unit of time is equal to 15 minutes of service

e) Oral surgery
- Removal of erupted teeth
- Surgical exposure and movement of teeth
- Surgical excision of cysts and neoplasms

f) General adjunctive services
- Anaesthesia (related to surgery)

Major Restoration The following charges are eligible if major restorations are included in the Summary of Benefits:

a) Extensive Restorations
- Inlays/onlays/crowns (once per tooth every five consecutive calendar years)

b) Prosthodontic Services
- Complete and partial dentures (once every five consecutive calendar years)
- Bridgework (once every five consecutive calendar years)
- Implants (once per tooth every 10 consecutive calendar years)
- Restorations over implants (i.e. crowns, bridgework and dentures) (once per tooth every 10 consecutive calendar years)

This program excludes replacement of the denture unless it is at least 5 years old and cannot be made serviceable, and the replacement of dentures that may have been lost, mislaid or stolen.

Orthodontic Services The following charges are eligible if orthodontic services are included in the Summary of Benefits:

- Orthodontic examinations and records
- Removable or cemented appliances for active treatment or retention
- Fixed appliances (braces)

Reasonable expenses incurred for orthodontic services given by an orthodontist to correct dental irregularities. Eligible treatments are those provided after the tenth (10^{th}) and before the nineteenth (19th) birthday of the participant.

Payment of Orthodontic Services

The payment of orthodontic claims will be made according to one of the following methods:

a) If a single charge is estimated for the entire course of treatment and you pay this charge to the orthodontist in pre-arranged instalments over an estimated period of treatment, the Company will reimburse you each time you submit a bill or receipt for any pre-arranged instalment.

b) If a single charge is estimated for the entire course of treatment and you pay this charge to the orthodontist in one lump sum, the Company will reimburse up to 1/2 of the total cost initially and equal instalments thereafter over the entire treatment period.

If instead of a single charge, each treatment is charged as it is performed; the Company will reimburse you as each charge is incurred.

Expenses not Covered by the Plan

The following expenses are not covered:

a) Treatment or appliance, related directly or indirectly to full mouth reconstruction, or to correct vertical dimension and temporomandibular joint dysfunction, unless specified otherwise in your Summary of Benefits.

b) Services rendered by a dental hygienist but not administered under the supervision of a dentist, except in those provinces where it is no longer a legal requirement.

c) Services and supplies relating to any appliance worn in the practice of a sport.

d) Expenses that are payable or reimbursable under a public or private plan or that would normally be so if a claim had been submitted.

e) Charges payable under an occupational health and safety board or by an automobile insurance bureau, or any other similar law or public plan, if applicable.

f) Expenses resulting from any suicide attempt or self-inflicted injury, whether the participant is sane or not.

g) Expenses due to any injury or illness resulting from the participant's active participation in civil unrest, riot or insurrection, unless while performing work related functions, or injury sustained in a war.

h) Services that are not medically required, that are given for cosmetic purposes (this exclusion does not apply to composite restoration).

i) Services that exceed the ordinary services given in accordance with current therapeutic practice.

j) Care or services rendered free of charge, or that would be if there were no benefit coverage, or that are not chargeable to the participant.

k) Expenses incurred for veneers.

l) Splinting for periodontal reasons, where cast crowns or inlays are used for this purpose, with or without onlays.

DENTAL BENEFIT – IN CANADA ONLY

Restriction

No reimbursement will be made for any portion of the charge that is over the suggested fee in the appropriate fee guide for the least expensive treatment that will provide a professionally adequate result.

Reimbursement of laboratory fees will be limited to the reasonable and customary charges for such services in the area where the services are provided.

Alternate Benefits

When one or more form of alternative treatment exists, the Company, in consultation with its health care consultants, reserves the right to make payment for eligible services and supplies based on an alternate procedure with a lower cost, when deemed appropriate and consistent with good health management.

Termination of Benefit

The Dental Care benefit ends at your retirement, the termination of employment or the age noted in the Summary of Benefits, whichever occurs first. The dependent's coverage ends either on the date you cease to be covered (but not upon your death) or on the date they no longer meet the definition of dependent, whichever occurs first.

HEALTH SPENDING ACCOUNT BENEFIT

A Health Spending Account (HSA) provides additional flexibility within your group benefit plan, and allows you to cover medical expenses with pre-tax dollars (except in the province of Quebec).

Under an HSA, you have access to a pre-determined amount of HSA credits. Credits represent the value allocated to the HSA in any particular policy year (specified in the Summary of Benefits).

The HSA credits will be available to you according to the Credit Allocation Frequency specified in the Summary of Benefits.

Under no circumstances will unused HSA credits be paid out as cash.

These credits are intended to pay for medical and dental expenses, and can also be used to supplement existing benefits. For example, they can be used cover deductibles, co-payments, or amounts above plan maximums.

Dependent Coverage
Your dependents can also be covered if you have chosen family coverage.

CRA dependents are eligible for coverage, according to the Canada Revenue Agency definition. This could include members of your extended family, such as parents, grandparents or grandchildren.

HEALTH SPENDING ACCOUNT BENEFIT

Eligible Expenses

Eligible expenses will be assessed and reimbursed by the Company based upon the Canada Revenue Agency guidelines, and must be deemed reasonable and medically necessary by the Company. Eligible expenses include deductible amounts, co-payment amounts, amounts exceeding plan maximums, as well as expenses which are not covered by any applicable group policy, individual policy, government health care program, or any other private program.

Common Eligible Expenses			
Attendant Care (requires certification of need from physician)	• Services provided in Home, Retirement Home, Nursing Home or Group Home	• Includes Fees from: - Personal Care Worker - Registered Nurse - Respite Care	• Includes Fees for: - Food Preparation - Housekeeping - Laundry Services
Dental Services (excluding teeth whitening and cosmetic veneers)	• Diagnostic Services (x-rays) • Dentures • Orthodontics	• Preventive Services, such as: - Recall Examinations, - Polishing, and - Application of Fluoride	
Diagnostic Services*	• Diagnostic laboratory, radiological tests and scans		
Drugs	• Drugs requiring a prescription and/or dispensed by a pharmacist, physician or practitioner*	• Fertility Treatments • Flu Shots • Insulin* • Liver Extract Injections*	• Smoking Cessation Drugs* • Vaccines • Vitamin B12 Injections*
Facility Care (excluding television rentals and phone fees)	• Convalescent care home • Hospital	• Nursing home • Psychiatric facility • Substance abuse facility	
Medical Devices and Services*	• Air Conditioners (required for severe chronic ailment, disease or disorder) • Artificial Eyes and Limbs • Blood Transfusion Fees • Breast Prosthesis • Cochlear Implants • Crutches • Diabetic Supplies	• Electronic Bone Healing Devices • Electronic Speech • Synthesisers • Hearing Aids • Heart Monitoring Devices • Needles and Syringes • Ostomy Supplies • Oxygen Equipment • Physician Fees	• Prosthetics • Repairs to Eligible • HSA Devices • Respirators • Scooters • Trusses • Walkers • Wheelchairs (excluding accessories)
Medical Practitioner Services	• Acupuncturist • Athletic Therapist • Audiologist • Chiropodist/Podiatrist • Chiropractor • Dental Hygienist • Dentist	• Dietician • Homeopath • Massage Therapist** • Naturopath • Occupational Therapist • Osteopath	• Personal Care Worker* • Physiotherapist • Psychiatrist • Psychologist • Registered Nurse • Social Worker • Speech Therapist
Medical Transportation Services	• Ambulance Services • Bone Marrow Transplant Charges (patient and donor), such as transportation charges and meals and expenses	• Meals and Transportation Expenses, when patient transportation is required (plus one attending person - if required)	• Organ Donor Charges (patient and donor), such as transportation charges and meals and expenses
Miscellaneous	• Health and Dental Plan Premiums (private insurance)	• Home or Vehicle Modifications, when required for disabled persons	• Seeing Eye Dog Miscellaneous Charges
Rehabilitative Training	• Lip Reading	• Sign Language	
Vision Care	• Contact Lenses • Eye Examinations	• Laser Eye Surgery	• Prescription Lenses and Frames

***Prescription Required**
****For therapeutic massage services only**

Expenses not Reimbursed by the Plan
The following are examples of expenses which are not covered:

Common Ineligible Expenses			
Adoption Fees	• Adoption Fees		
Cosmetic Procedures (aimed at purely enhancing appearance)	• Augmentations • Botox Injections • Liposuction	• Hair Replacement Procedures and Supplies (ex. hair plugs, hair extensions)	• Laser Hair Removal • Tattoo Removal • Teeth Whitening
Cosmetics and Hygiene Products	• Contact Lens Solution • Lotions and Creams	• Make-up • Sunscreen	• Toothpaste
Dietary Supplements	• Food (except when required for enteral feeding)	• Minerals and Supplements	• Meal Replacements
Esthetic Massage Therapy	Such as:	• Aromatherapy Massage	• Body Wraps
Fees for missed appointments	• Fees for missed appointments		
Health Programs	• Weight loss program fees		
Home Appliances	• Air Conditioners • Air Purifiers	• Dehumidifiers • Fans	• Humidifiers (except when required for CPAP machines)
Hot Tubs and Saunas	• Hot Tubs	• Saunas	
Life and Disability Plan Premiums	• Life and Disability Plan Premiums		
Over the counter medications	Such as: • Acid Controllers • Allergy Medications • Cough and Cold Items	• Creams and Lotions Digestive Aids • Herbal Remedies • Pain Relievers	• Smoking Cessation Products • Vitamins
Personal Response Systems	• Lifeline Services • Health Line Services		
Shoes	• Off the shelf	• Athletic	
Sports Equipment	• Treadmills		

***Prescription Required**

Further to this list, please refer to the Summary of Benefits for Specific Benefit Exclusions or Specific Expense Exclusions (if any).

About your Health Spending Account
Credits may be used to reimburse eligible expenses incurred in the same policy year the credits were allocated.

Unused credits can also be carried forward into the following policy year. Credits cannot be carried forward more than one year. At the end of the second policy year, unused credits from the first are forfeited.

Claims must be applied to any carry forward credits before current Policy Year credits are used.

Claims must be submitted in the policy year they were incurred. However, there is a grace period specified in the Summary of Benefits, within which claims may be submitted after the policy year end.

Termination of Benefit

The Health Spending Account Benefit ends at your retirement, the termination of employment or the age noted in the Summary of Benefits, whichever occurs first. The dependent's coverage ends either on the date you cease to be covered or on the date they no longer meet the definition of dependent, whichever occurs first.

If your employment ends, or your group terminates coverage with the Company, you will have the grace period for terminated employees (specified in the Summary of Benefits) within which to use the remaining balance. Only eligible expenses incurred prior to the termination of coverage are eligible.

PERSONAL SPENDING ACCOUNT BENEFIT

A Personal Spending Account (PSA) provides additional flexibility within your group benefit plan and allows you to cover expenses that were not covered under your other group benefits.

Under a PSA, you have access to a pre-determined amount of PSA credits. Credits represent the value allocated to the PSA in any particular policy year (specified in the Summary of Benefits).

The credits will be allocated to the PSA at the credit allocation frequency specified in the Summary of Benefits.

Under no circumstances will unused PSA credits be paid out as cash.

Dependent Coverage
Your dependents can also be covered if you have chosen family coverage.

CRA dependents are eligible for coverage, according to the Canada Revenue Agency definition. This could include members of your extended family, such as parents, grandparents or grandchildren.

Covered Expenses
The Company will pay expenses that meet the eligibility requirements of the covered benefit categories specified in the Summary of Benefits. All expenses that are submitted for reimbursement must have a valid receipt as proof that services have been paid in full.

The expenses listed below are examples only and should not be considered an exhaustive list. The Company reserves the right to make exceptions for expenses not explicitly listed but which fall into one of the following categories.

1. **Health and Wellness Support**

a) **Nutritional Counselling**
Charges for nutritional counselling for eating disorders and weight management, including educational courses, workshops and seminars.

b) **Stress Management**
Charges for stress management counselling, including educational courses, workshops and seminars.

c) **Smoking Cessation**
Charges for over-the-counter smoking cessation products such as gum, patches and lozenges, as well as hypnotherapy, support programs and educational courses, workshops and seminars.

This coverage excludes purchase of electronic cigarettes.

d) **Weight Management**
Charges for:
- weight management programs, including registration fees, day planners and meal guides;
- weight loss surgery, including gastric banding and gastric bypass;
- hypnotherapy; and
- colon hydrotherapy and cleansing kits.

Expenses (Cont'd)

e) **Health Assessment**
Charges for online personal health assessments and personal health assessment workshops.

f) **Prenatal Class**
Charges for prenatal classes, birth plan counselling services and educational courses, workshops and seminars.

This coverage excludes birth pool rentals and postpartum services such as birth trauma counselling.

g) Home/Personal Aids
Charges for home and personal aids.

2. **Alternative Health Treatments**

a) **Mind/Body Therapy**
Charges for herbalists, homeopaths, athletic therapists, traditional Chinese medical practitioners, Shiatsu therapists, hypnotherapy, meditation, electrotherapy, reflexology and mind/body therapy retreats and renewal centres.

3. **Fitness and Sports Activities and Equipment**

a) **Fitness and Sports Fees**
Charges for fitness centre memberships and drop-in fees, sports leagues and team registration fees, registration fees for marathons, triathlons and other race events, golfing fees, ski-lift passes and locker fees.

b) **Instructed Fitness or Sports Class**
Charges for fitness and sports-related classes and clinics, such as dance, swimming, gymnastics, rock climbing, yoga, martial arts, golf, tennis, hockey and skiing.

c) **Personal Trainer**
Charges for the services of a certified personal fitness trainer.

d) Fitness and Sports Equipment
Charges for purchase or rental of:

- stationary exercise equipment, including treadmills, ellipticals, rowers and weight machines;
- other fitness-related equipment, including bicycles, rollerblades, trampolines, weights, yoga mats and fitness balls and bands;
- sporting equipment and protective gear, including hockey sticks, golf clubs, rackets, balls, helmets, pads and goggles;
- equipment bags, gloves and footwear (including cleats) for a specific sport activity;
- active footwear; and
- human-powered boats, including canoes and kayaks.

This coverage excludes athletic apparel.

4. **Professional Development**

a) Professional Development

Charges for:

- courses and seminars;
- conference and classes;
- exam fees and required textbooks for professional interest courses; and
- travel costs associated with eligible professional development.

5. **Family Care**

a) Family Care Services

Charges for child care and elder care services including daycare, nanny services, before and after school programs and in-home personal support workers.

6. **Recreation and Leisure**

a) Recreational Fees and Equipment: Charges for fees and equipment for recreational activities such as camping, fishing and hunting, as well as zoo and heritage park fees, science centre fees and survival equipment.

This coverage excludes purchase or rental of firearms or ammunition and admission fees for movies, plays, concerts or sporting events.

7. **Supplements and Meal Replacement**

a) **Supplements and Over-the-Counter Medications**

Charges for vitamins, minerals, extracts, herbs, oils and over-the-counter medications.

b) **Nutritional Products**

Charges for purchase of nutritional drinks or shakes, protein powder and energy bars.

8. **Other Eligible Medical Expenses**

a) **Health and Dental Medical Expenses**

Charges for health and dental medical expenses that have been partially covered or otherwise not covered by an existing health or dental plan or Health Spending Account (if applicable).

Account Type – No Carry Forward

Credits may be used to reimburse eligible expenses incurred in the same policy year in which the credits were allocated. At the end of a policy year, any unused credits are forfeited.

Unused credits cannot be carried forward into further subsequent policy years.

Claims must be submitted in the policy year they were incurred or within the grace period specified in the Summary of Benefits.

PERSONAL SPENDING ACCOUNT BENEFIT

General Provisions

Credits allocated to the PSA are irrevocable, except where their allocation is based on the Covered Employee's employment status.

In the event a Covered Employee's coverage is terminated, the Policyholder may adjust the credits allocated to the PSA for that policy year. The Policyholder must promptly notify the Company of the adjusted amount of credits.

If the terminated Covered Employee has outstanding claims which were incurred prior to the termination date, they may be submitted within the grace period for terminated Covered Employees specified in the Summary of Benefits. These claims will be applied against any remaining credits.

Exclusions and Limitations

The following exclusions and limitations apply:

a) Covered Employees must meet eligibility requirements to have incurred expenses payable by the PSA benefit.
b) If an eligible claim amount exceeds the Covered Employee's current credit balance, the claim will be reimbursed up to the credit balance.
c) No claim will be eligible for reimbursement exceeding 100% of the credit balance.
d) Claims submitted for expenses incurred prior to the effective date of this policy will not be reimbursed, nor will claims submitted for expenses incurred after the termination date of this policy.
e) Expenses for services which have already been paid by any other private health care plans or any government health care program.
f) Interest charges.
g) Services, treatments or supplies that do not fall within the categories of eligible expenses listed in this benefit.
h) Print and media purchases such as books and magazines.
i) Pre-owned equipment or supplies.
j) Purchase of food, including meals associated with weight management programs, unless otherwise specified as a covered expense in this benefit.
k) Any expenses specifically noted as excluded within the PSA benefit categories.

EMPLOYEE ASSISTANCE PROGRAM – LIFEWORKS®

LifeWorks is a confidential, full-service Employee Assistance Program (EAP) and work-life/wellness resource designed to help you and your dependents with a variety of issues, concerns, or questions related to work and life. The program is an employee benefit and provided at no additional cost to you by your employer.

LifeWorks offers confidential consultations; online information and tools; counselling by phone, video, chat, and in-person; community referrals; and personalized research.

You can access the program 24 hours a day, seven days a week, 365 days a year, by toll-free number or online for support related to:

- **LIFE:** Stress/Overload, Anxiety, Depression, Grief/Loss, Community Resources
- **FAMILY:** Parenting, Separation/Divorce, Blended Families, Caring for Older Adults, Education
- **MONEY:** Saving/Investing, Debt Management, Estate Planning/Wills, Home Buying/Renting
- **WORK:** Work Relationships, Job Stress/Burnout, Managing People
- **HEALTH:** Fitness/Nutrition, Sleep, Addiction/Recovery, Smoking Cessation

Contact LifeWorks toll-free, 24/7: 1.877.207.8833
Service en Français : 1 877 307-1080 TTY: 1.877.371.9978
www.login.lifeworks.com

CHUBB

Basic Accidental Death & Dismemberment Insurance

For the Executives and Full-Time Employees of:
Lifemark Health Corp.

Policy Number:
AB10486201

Underwritten by:
Chubb Life Insurance Company of Canada

Effective Date:
January 01, 2019

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

COVERAGE

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

ELIGIBILITY

All active, permanent full-time employees of the policyholder, working a minimum of 20 hours per week, under age 70.

BENEFIT AMOUNT

You are covered for a Principal Sum that is equal to one times your annual earnings* rounded to the next $1,000 (if not already a multiple thereof) to a maximum of $500,000.

*The term "annual earnings" as used herein shall mean an Insured Person's basic annual salary excluding overtime, bonus or commission.

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

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

SCHEDULE OF LOSSES

Accidental Death & Dismemberment

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

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

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

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

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

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

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

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

Repatriation Benefit

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

Rehabilitation Benefit

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

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

Family Transportation Benefit

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

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

Spousal Occupational Training Benefit

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

Home Alteration and Vehicle Modification Benefit

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

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

Benefit payments herein will not be paid unless:

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

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

Day Care Benefit

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

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

"Dependent Child" means the Employee's eligible unmarried natural, adopted, step child or common law child under 12 years of age who is principally dependent on the Employee or the Employee's spouse for financial support.

Special Education Benefit

If an Insured Person suffers a loss of life in a covered accident while the policy is in force, Chubb Life will pay, in addition to all other benefits payable under the policy, a Special Education Benefit up to 5% of an Insured Person's Principal Sum amount, (subject to a maximum of $5,000 per year), on behalf of any dependent

child who, on the date of the accident, is enrolled as a full-time student in any post-secondary institution of higher learning or was at the 12th grade level and subsequently enrolls as a full-time student in any post-secondary institution of higher learning within 365 days following the date of the accident.

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

Bereavement Benefit

When injuries covered by the policy result in loss of life of an Insured Person within 365 days from the date of the accident, Chubb Life will pay the reasonable and necessary expenses actually incurred by the spouse and dependent children of an Insured Person for up to six sessions of grief counseling, by a "Professional Counsellor", subject to a maximum of $1,000.

"Professional Counsellor" means a therapist or counsellor who is licensed, registered or certified to provide such treatment.

In-Hospital Confinement Monthly Income

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

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

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

Cosmetic Disfigurement

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

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

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

Seat Belt Benefit

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

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

Identification Benefit

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

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

The reimbursement of such expenses incurred is subject to the accidental Loss of Life Benefit being subsequently payable in accordance with the terms of the policy following the identification of the body as an Insured Person. The maximum amount payable will not exceed $15,000 for all such expenses.

Payment will not be made for board or other ordinary living, travelling or clothing expenses, and transportation must occur in a vehicle or device operated under a license for the conveyance of passengers for hire.

"Family Member" means spouse, parent or stepparent, child or stepchild or brother or sister, stepbrother or stepsister, brother-in-law or sister-in-law,

mother-in-law or father-in-law, and son-in-law or daughter-in-law.

Conversion Privilege

On the date of termination of employment or during the 31-day period following termination of employment, an Insured Person may convert his or her insurance to an individual ACCIDENTAL DEATH and DISMEMBERMENT only insurance policy of Chubb Life. The individual policy will be effective either as of the date that the application is received by Chubb Life or on the date that coverage under the group policy ceases, whichever occurs later. The premium will be the same, as a person would ordinarily pay when applying for an individual policy at that time. Application for an individual policy may be made at any office of Chubb Life. The amount of insurance benefit converted to shall not exceed that amount issued during employment up to an all policies combined maximum of $200,000. The individual policy will cover ACCIDENTAL DEATH and DISMEMBERMENT only.

Exposure and Disappearance

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

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

Waiver of Premium

If an Insured Employee, under age 65, becomes totally disabled for six consecutive months and an Insured Employee provides evidence of total disability satisfactory to Chubb Life Insurance, Chubb Life Insurance will then waive the payment of each premium which falls due with respect to an Insured Employee and any Insured Dependents. Subject to all the terms and conditions of the policy, waiver of any premium as herein provided will continue with respect to an Insured Employee until age 65 or earlier termination of the policy. If an Insured Employee ceases to be disabled and an Insured Employee returns to employment with the Policyholder and is a member of an eligible class, insurance with respect to an Insured Employee may be continued upon resumption of premium payments by an Insured Employee or the Policyholder.

If after 120 days, an Insured Employee receives approval of any long term disability claim provided under a policy of group insurance through the Policyholder, Chubb Life will then waive the payment of each Accidental Death and Dismemberment insurance premium subject to the terms stated above.

Recurrent Disabilities

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

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

Termination of Waiver of Premium

Waiver of Premiums will cease on the earliest of:

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

Coverage During Waiver of Premium

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

"Totally Disabled or Total Disability" with respect to Waiver of Premium means disability resulting from injury or sickness which prevents engagement in an Insured Person's regular occupation for six consecutive months.

Continuance of Coverage

In the case of a Primary Insured who is (1) laid-off on a temporary basis, (2) temporarily absent from work due to short-term disability, or (3) on leave of absence, coverage shall be extended for a period of 12 months following the beginning of any such event subject to payment of premiums.

In the case of a Primary Insured who is on maternity or parental leave coverage shall be extended for a period of up to 18 months following the beginning of any such event subject to payment of premiums.

If an Insured assumes other occupational duties during the leave or lay-off period, no benefits shall be payable for a loss occurring during the performance of such other occupation.

EXCLUSIONS

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

a. Intentionally self-inflicted injury, suicide or any attempt thereat;
b. Declared or undeclared war, or any act thereof
c. Travel or flying in an aircraft owned or leased by the Policyholder, an Insured or a member of an Insured's household, or aircraft being used for any test or experimental purpose, firefighting, power line inspection, pipeline inspection, aerial photography or exploration
d. Losses occurring while the Insured is serving on full-time active duty in the Armed Forces of any country or international authority (any premium paid to be returned by the Company pro-rata for any such period of full-time active duty.)
e. Travel or flight in any vehicle or device for aerial navigation; except to the extent such travel or flight is provided in the "Hazards Insured Against" section of the Accidental Death & Dismemberment portion of this policy

GENERAL PROVISIONS

Beneficiary

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

All other indemnities of the policy will be payable to the insured person.

An insured person can change his beneficiary at any time, where permitted by law. The Company assumes no responsibility for the validity of such designation or change of beneficiary.

The beneficiary designation made by the insured person (if any) under the replaced policy has been retained. The insured person should review the existing designation to ensure it reflects his/her current intention.

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

Legal Actions

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

Change of Insurer

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

HOW TO CLAIM

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

Notice of claim must be given to Chubb Life within 30 days from the date of the accident, the beginning of the disability or after the survival period, and subsequent proof of claim must be submitted to Chubb Life within 90 days from the date of the accident or after survival period.

Failure to give notice of claim or furnish proof of claim within the time prescribed in the policy condition will not invalidate the claim if the notice or proof is given or furnished as soon as reasonably possible and if it is shown that it was not reasonably possible to give notice or furnish proof within the time so prescribed.

In no event, will Chubb Life accept notice of claim beyond one year.

04/19

CHUBB

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

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