www.medavie.bluecross.ca

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PARMALAT CANADA INC.

Permanent Full Time
Winnipeg – St. Joseph Union Plant Employees and Drivers

Group Number: 93378-035

Date of Issue: September 1, 2013

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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 understands 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 your Human Resources representative 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 your Human Resources representative who 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)
1-888-588-1212 (in Quebec)
1-888-873-9200 (elsewhere in Canada)

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

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

1. Log on to the Medavie Blue Cross Web site at www.medavie.bluecross.ca
2. Select “Plan Members”
3. Choose “Go to Secure Site” and select “First Time, Register Now”
4. Complete the online registration form
5. A temporary password will be e-mailed to the e-mail address entered during registration
6. Return to the Plan Member Website and enter the user ID and temporary password
7. You will be prompted to change the password. Click “Submit” to save the new password
8. Click “Done” once the changes are saved

Please ensure you make note of your user ID and 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., hereafter called the Company.

Medavie Blue Cross administers the following benefits on behalf of Parmalat Canada Inc.:
- Hospital Benefit
- Worldwide Travel Benefit
- Referrals for Services Outside Canada
- Extended Health Benefit
- Drug Benefit
- Dental Benefit

Blue Cross Life Insurance Company of Canada underwrites the following benefits:
- Group Life Benefit
- Long Term Disability Benefit

AIG Insurance Company of Canada underwrites Basic Accidental Death and Dismemberment Insurance and Business Travel Accident Insurance.

The Williamson Group underwrites Return to Health – Employee Short Term Disability (STD) Benefits.

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.

There will be reference in the booklet to “Licensed” or “Approved Provider”. The intent is to identify qualified providers that will optimize your care.

The Company approved provider is a provider of health care services and supplies recognized and approved by the Company for payment on a direct payment policy and/or reimbursement policy basis. The Company will make payment for eligible health care services and supplies provided to participants by such Company approved providers.

If you have any question about whether a provider is approved, please contact our call centre at 1-800-355-9133.

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
Group coverage is provided to all hourly permanent full-time employees who are actively at work, scheduled to regularly work the minimum hours per week as outlined in the Collective Bargaining Agreement in effect and has completed the appropriate waiting period. In addition, an employee must be a resident of Canada and covered under the provincial government plan. Coverage commences following 530 regular hours worked.

To participate in your group plan, you must complete the enrolment form that is provided to you upon your eligibility to the various plans.

The enrollment form must be completed and returned to your Human Resources representative within 31 days of your eligibility date to avoid the late applicant status. If you are a late applicant, you are required to submit proof of good health for the Group Life and LTD benefits. Depending on the status of your health, you may or may not be approved for the Group Life and LTD benefits. Therefore, it is imperative to ensure your enrollment form for group benefits is submitted to your Human Resources representative within 31 days of your eligibility date.

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 is defined as a person of the opposite or same sex who is legally married to you, or has continuously resided with you for not less than one full year having been represented as members of a conjugal relationship (common law). In the event of divorce, legal separation, or discontinuance of cohabitation ("common law" spouse), you may elect to continue membership of the former spouse or to provide notice to the Company to terminate coverage for the spouse. The Company will at no time provide coverage for more than one spouse under the same plan.

b) Unmarried dependent children who are financially dependent on you are eligible for benefits, if they are:
   - less than 22 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 22 (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.

Filing a Claim

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.

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

Reimbursement plan - complete the claim form, 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 on which expenses were incurred or within a time agreed upon by the Company when contract terminates.

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 are incurred or within a time agreed upon by the Company when contract terminates.

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 coordinate 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.

Filing a Claim

Referrals for Services Outside Canada

Please ensure to obtain detailed receipts in duplicate for any expenses incurred. Upon your return, the Company will require you to obtain and send one of the receipts to your provincial government health plan for their consideration and payment. When a reply has been received from them, send proof of their payment together with appropriate receipts to the Company for payment of the remaining eligible benefits. A letter from the referring physician is required as well as a description of the treatment rendered from the attending physician. Always 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.

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 your coinsurance, and excess expenses are 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.

Group Life Benefit

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 Benefit

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 three months of the onset of the disability.

Definition of Usual, Customary and Reasonable (U & C)

Usual, Customary and Reasonable (U & C) 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 the Company, or in accordance with a payment schedule established by 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.

MEDAVIE BLUE CROSS CONTACT INFORMATION

Please contact Medavie Blue Cross at the following location to answer any inquiries you may have relating to your group coverage or to submit claims.

Medavie Blue Cross
185 The West Mall
Suite 1200
P. O. Box 2000
Etobicoke, ON M9C 5P1

Toll Free: 1-800-355-9133
Local Tel.: 1-416-626-3788
E-Mail: *inquiry@medavie.bluecross.ca*

SUMMARY OF BENEFITS

COVERED EMPLOYEE'S BASIC LIFE BENEFIT

Benefit Formula	Flat amount
Maximum	$42,000*
Non-evidence Limit	$42,000**
Waiver of premiums	No
Termination	The earlier of retirement, termination of employment or age 72

* **Effective February 1, 2015** – Maximum Benefit is revised to $44,000.
** **Effective February 1, 2015** – Non-evidence Limit is revised to $44,000.

COVERED EMPLOYEE'S LONG TERM DISABILITY BENEFIT

Benefit Formula	66.67% of monthly salary
Elimination Period	364 days
Benefit Period	Lesser of 24 months or age 65
Taxable	Yes
Duration Own Occupation	24 months
Integration of Benefits	Direct
Waiver of premiums	Yes
Termination	Benefit payments cease the earlier of retirement, termination of employment or age 65. Benefit coverage ceases at age 65 less the elimination period.

SUMMARY OF BENEFITS

HOSPITAL BENEFIT
In Canada Only

	% Co-insurance	Accommodation	Maximum duration
Hospital Room	100% 80%	Semi-private Private	Unlimited
Convalescent Care/ Physical Rehabilitation	80%	Room and Board	$10 per day to a maximum of 120 days/lifetime
Addiction Facility	100%	Room and Board	U & C

GENERAL INFORMATION

Deductible	$10 single/$10 family in a calendar year in combination with Hospital, Extended Health and Vision.
Survivor Benefit	12 months, without dues
Termination	**Hospital Room and Addiction Facility** - The earlier of retirement or termination of employment. **Convalescent Care/Physical Rehabilitation** - The earlier of retirement, termination of employment or age 65.

WORLDWIDE TRAVEL BENEFIT

	% Co-insurance	Maximum
Hospital and Medical Benefits	100%	$2,000,000 / Participant per incidence; limited to the first 60 days of a trip
Referrals for Services Outside Canada	100%	$500,000 per lifetime on pre-approval

GENERAL INFORMATION

Survivor Benefit	12 months, without dues
Travel Assistance	Provided by CanAssistance Inc.
Termination	The earlier of retirement or termination of employment

SUMMARY OF BENEFITS

EXTENDED HEALTH BENEFIT
In Canada Only

	% Co-insurance	Maximum
Physician Services	80%	U & C
Professional Ambulance	80%	U & C
Special Ambulance Attendant	80%	$500/calendar year
Private Duty Nursing	80%	U & C
Diagnostic and X-Ray Services	80%	U & C
Oxygen	80%	U & C

EXTENDED HEALTH BENEFIT

PARAMEDICAL PRACTITIONERS

	% Co-insurance	Eligible maximum per visit	Maximum per calendar year
Chiropractor	80%	U & C	$200
Podiatrist/Chiropodist	80%	U & C	$200
Osteopath	80%	U & C	$200
Massage Therapist	80%	U & C	$200
Clinical Psychologist	80%	U & C	$200
Speech Therapist	80%	U & C	$200
Physiotherapist	80%	U & C	$200
X-rays (Chiropractor, Osteopath, Chiropodist/Podiatrist)	80%	X-rays are combined with each practitioner maximum	

GENERAL INFORMATION

Deductible	$10 single/$10 family/calendar year in combination with Hospital, Extended Health and Vision Benefit
Survivor Benefit	12 months, without dues
Termination	The earlier of retirement or termination of employment

SUMMARY OF BENEFITS

EXTENDED HEALTH BENEFIT		
Accidental Dental	80%	$5,000 per accident
Diabetic Equipment	80%	$700 per lifetime
Ostomy Supplies	80%	U & C
Speech Aids	80%	$500 per lifetime
Molded Arch Supports/Orthopedic shoe(s) & Supplies	80%	2 pairs/calendar year
Prosthetic Appliances		
- Artificial Limbs	80%	U & C
- Breasts including Repairs and Adjustments	80%	$200/calendar year
- Eyes	80%	U & C
- Mastectomy Bra	80%	two/calendar year
- Hair Prosthetics (wigs)	80%	$300/calendar year
- Crutches, Canes, Splints, Casts, Trusses, Braces	80%	U & C
- Repairs and Adjustments	80%	$300/calendar year unless noted otherwise
Medical Supplies and Equipment		
- Stump Socks	80%	five pairs/calendar year
- Rental or Purchase of a Wheelchair or Hospital-type Bed	80%	U & C
- TENS Machine	80%	$300/five calendar years
- Burn Pressure Garments	80%	$500/calendar year
- Enuretic Devices (Mozes Detector)	80%	U & C
- Equipment for the Administration of Oxygen	80%	U & C
- Insulin Pump	80%	U & C
- Compression Pump	80%	U & C
- Accompanying Sleeves	80%	two/calendar year

GENERAL INFORMATION	
Deductible	$10 single/$10 family/calendar year in combination with Hospital, Extended Health and Vision Benefit
Survivor Benefit	12 months, without dues
Termination	The earlier of retirement or termination of employment

SUMMARY OF BENEFITS

EXTENDED HEALTH BENEFIT

VISION BENEFIT

	% Co-insurance	Maximum
Eye Examinations	80%	$50/24 consecutive months
Frames/Lenses/Contact Lenses due to Cataract Surgery	80%	One pair per lifetime
Intraocular Lenses due to Cataract Surgery	80%	One lens per eye per lifetime

GENERAL INFORMATION

Deductible	$10 single/$10 family/calendar year in combination with Hospital, Extended Health and Vision Benefit
Survivor Benefit	12 months, without dues
Termination	The earlier of retirement or termination of employment

SUMMARY OF BENEFITS

DRUG BENEFIT

	Co-payment	Maximum
Drugs	Any amount in excess of a $10 dispensing fee and 20% for each eligible drug on the prescription	Unlimited
Diabetic Supplies: insulin needles, syringes, lancets and test strips	Same as above	Unlimited
(IUD) Intrauterine Contraceptive Devices	Same as above	U & C
Fertility Drugs	Same as above	$3,000 per lifetime
Weight Loss Treatment	Same as above	$2,000 per lifetime
Erectile Dysfunction (impotence) Medications	Same as above	$1,000/calendar year
Smoking Cessation Products	Same as above	$500 per lifetime

GENERAL INFORMATION

Deductible	Nil
Method of Reimbursement	Drug card - pay direct plan
Survivor Benefit	12 months, without dues
Termination	The earlier of retirement or termination of employment

SUMMARY OF BENEFITS

DENTAL BENEFIT

	% Co-insurance	Maximum
Basic Services		
- Endodontic and Periodontic Services	50%	$2,000*/calendar year
- All Other Basic Services	100%	$2,000*/calendar year
Major Restorative Services	50%	$2,000*/calendar year
Payment Type	Reimbursement	
Fee Guide Schedule	2014 Dental Fee Guide for General Practitioners or specialist in effect in the province of Manitoba**	

*** Basic Services and Major Restorative Services subject to a combined maximum.**
**** Effective February 1, 2015 – The Fee Guide Schedule is revised to 2015.**

GENERAL INFORMATION

Deductible	Nil
Survivor Benefit	12 months, without dues
Termination	The earlier of retirement or termination of employment

SUMMARY OF BENEFITS

BASIC ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE
POLICY BSC 9026202A
ADMINISTERED BY AIG Insurance Company of Canada

Benefit Formula	An amount equal to that payable under the Policyholder's current group basic life policy
Termination	Terminates at age 72 or retirement

BUSINESS TRAVEL ACCIDENT INSURANCE
POLICY BSC 9026204
ADMINISTERED BY AIG Insurance Company of Canada

Benefit Formula	2 times the annual earnings
Rounding Method	To the next higher $1,000
Maximum	$1,000,000
Termination	Terminates at age 72 or retirement

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.

Coverage terminates when your employment terminates, at retirement or at age 72, whichever occurs first.

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

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.

This conversion option also applies to termination of coverage which becomes effective at specific ages.

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 66.67% of your pre-disability gross earnings,
   - 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.

Partial Disability
Where you are receiving Long Term Disability benefits for total disability and return to the work force, but in a reduced capacity, such that you are able to earn 80% or less of your pre-disability earnings, the following applies:

a) Monthly benefit payments will continue while you earn 80% or less of your pre-disability earnings. In no case, however, will monthly benefit payments continue past the earlier of:

   - the date that benefits would have ceased if you had remained totally disabled, or
   - the date the maximum benefit period specified in the Summary of Benefits is reached.

b) The Integration of Benefits provision shall apply, subject to the following special provisions:

   - Monthly benefits payable under this plan plus any income you receive from employment earnings and all other sources (including any increases due to cost of living escalations, merit increases or other increases in income) will not exceed 90% of your pre-disability gross earnings from the employer if Long Term Disability benefits are taxable under the Income Tax Act, Canada or 90% of your pre-disability net earnings from the employer if the Long Term Disability benefits are not taxable under the Income Tax Act, Canada.
   - For the purpose of partial disability benefits, your pre-disability gross or net earnings from the employer shall be increased by the lesser of 5% or the amount equal to the change in the Consumer Price Index for Canada for the period from the date of commencement of total disability to the following January 1st. In any year after that, your pre-disability gross or net earnings shall be increased by the lesser of 5% or the amount of increase allowed under the Canadian Pension Plan as a result of the escalation provisions of that plan related to the Consumer Price Index for Canada.

Partial Disability (Cont'd)

- In no case will the amount of partial monthly benefits payable under this section exceed the amount of monthly disability benefits that would have been payable if you had remained totally disabled.
- The waiver of premium provision in this plan does not apply if you are receiving benefits for partial disability.
- You are required to provide proof of employment income satisfactory to the Company on a monthly basis for partial disability.

Recurrence

Successive periods of total disability separated by less than three 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 earnings.

Integration of Benefits

The amount of monthly Long Term Disability Benefit to which the covered employee is entitled as of the date of disability will be coordinated with other income payments to which he becomes entitled as a result of the current disability. The benefit co-ordination shall be applied as follows:

1. The amount of monthly income otherwise payable is first reduced directly by any disability benefits available under the Workers' Compensation Act or similar law, excluding automatic cost-of-living increases that occur after benefits begin, income replacement benefits payable under any plan of automobile insurance, where such reduction is not prohibited by law, and "income from all other sources". "Income from all other sources" includes:

   - disability benefits available under any government program, excluding employment insurance benefits and automatic cost-of-living increases under any government sponsored plan that occur after benefits begin that are payable to the disabled Employee,
   - retirement or pension benefits provided by any employer, as a result of the insured Employee's disability or medical condition
   - income from any disability under any Workers' Compensation Act or similar law, excluding automatic cost-of-living increases that occur after benefits begin,
   - income or benefits payable under a plan sponsored by an association, union or fraternal organization of which the insured Employee is a member, and
   - disability benefits available under any Criminal Injuries Compensation Act or similar law, where allowed by law.

2. The amount determined in 1. above is further reduced if necessary, so that the amount of monthly income, including all amounts of benefits mentioned in 1. above, does not exceed 85% of the covered employee's pre-disability earnings. If the insured Employee's benefit is non-taxable, the maximum will be 80% of Pre-Disability Earnings after income tax.

During the period of an approved rehabilitation program, the amount of monthly benefits as defined above, will be further reduced if necessary, so that the amount of monthly benefits together with all amounts of income mentioned in 1. above, including 100% of the remuneration received from an approved rehabilitation program, does not exceed 100% of the pre-disability salary.

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 self-inflicted injury or sickness, while sane or insane,

e) 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,

f) 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 – IN CANADA ONLY

This benefit covers eligible expenses incurred by you or your dependents for any usual and necessary expenses from a medical point of view and recommended by a physician. The Company will pay the usual, customary and reasonable charges based on any deductible, co-insurance or 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, providing eligible expenses are incurred in Canada. Benefit maximums are applied on a per person basis.

Eligible Expenses

Hospital Room Benefit
Hospitalization charges for a participant admitted as an inpatient in a hospital for active care after the effective date of his coverage and for as long as he is 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/Physical Rehabilitation
Charges for convalescent care/physical rehabilitation if the participant is admitted within 14 days following a hospital stay and is due to the same illness or condition which was the reason for the hospital stay, subject to the maximum reimbursement specified in the Summary of Benefits.

Addiction Facility
Charges for addiction facility, when approved in writing by a legally licensed physician, subject to the maximum reimbursement specified in the Summary of Benefits.

Termination of Coverage

The Hospital 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 Hospital Benefit terminates or on the date they no longer meet the definition of dependent, whichever occurs first.

WORLDWIDE TRAVEL BENEFIT

This coverage benefit covers emergency expenses occurring when you and your dependents are travelling outside of your province of residence. These benefits are subject to the trip limitation mentioned in the Summary of Benefits.

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, the Company will reimburse the cost of the call.

Eligible Expenses for Worldwide Travel Coverage

Accidental Dental

Charges for dental treatment to a maximum of $1,000 as a result of an accidental injury (direct accidental blow to the mouth) where 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 details of the accident.

Ambulance

Normal charges for 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 participant 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, the benefit covers:

- two economy seats by most direct route to the patient's home city in Canada, one for the participant and one round trip fare for a medical attendant;
- the number of economy seats required to accommodate the participant if on a stretcher and one round trip fare for a medical attendant.

Diagnostic Services

Charges for laboratory services for diagnostics and X-rays when ordered by the attending physician.

Drug Benefit

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.

Emergency and Payment Assistance

The services of a 24-hour emergency hotline are available to 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 participant 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 participant's condition and communication with the employee and family,
- return home or transfer of participant if medically permissible,
- transport a family member to the participant's bedside or to identify the deceased.

Non Medical Assistance - the participant may call to obtain:

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

Hospital Accommodation

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

Meals and Accommodation

Charges up to $700 ($100 per day for seven days) per trip for extra costs of commercial accommodation and meals incurred by a participant, remaining with a travelling companion when the trip is delayed due to illness or accident to a travelling companion or a participant. This must be verified by the attending physician and supported with receipts from commercial organizations.

Nurse

Charges for private duty nursing (not a relative of the patient or an employee of the hospital) when ordered by an attending physician.

Paramedical Services

Charges made by a licensed chiropractor, osteopath, chiropodist/podiatrist or physiotherapist (not a relative), in excess of payment by the provincial government health plan, excluding charges for X-rays.

Physicians and Surgeons

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

Return of Deceased

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

Transportation to Visit the Participant
Charges for one return economy fare by the most direct route for transportation costs (air, bus, train) when the participant has been confined to hospital for seven (7) days or more or has died, and the attending physician has advised of the necessity of the attendance of a family member or close friend of the participant.

Vehicle Return
Charges up to $500 per trip for the cost of driving the participant's vehicle, either private or rental, by commercial agency to the participant's residence or nearest appropriate vehicle rental agency when the participant is unable to return it due to sickness or accident.

Medical Appliances
The cost of temporary rental of wheelchairs, crutches, canes when required due to an accident or sudden illness that occurs outside the province of residence and when ordered by a physician.

Limitations and Exclusions

1. No benefits are available under the policy for the participant 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 the 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 of 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 the policy will not be paid if the participant receives the same from a third party.

4. No benefits will be paid for expenses incurred as the result of abuse of medications, drugs or alcohol; suicide or attempted suicide; criminal acts, war or other hostilities.

5. The Company, in consultation with the attending physician, reserves the right to return the patient to Canada. If any participant, based on medical evidence is able to return to Canada following the diagnosis of, or the emergency treatment for, a medical condition that requires continuing medical services, treatment or surgery, and the patient elects to have such treatment or 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 deterioration of the participant's medical condition during or after the transfer back to Canada.

Limitations and Exclusions (Cont'd)

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 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. The Company will not cover expenses in excess of $2 million Canadian per 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.

Termination

Travel benefit ceases at the earlier of retirement, termination of employment or the age noted in the Summary of Benefits.

REFERRALS FOR SERVICES OUTSIDE CANADA

When a participant is referred outside Canada by the attending physician for medical services not available in Canada, this benefit will pay the usual, customary and reasonable charges for the services listed below, in excess of provincial government health care allowances up to a lifetime maximum as mentioned in the Summary of Benefits.

Ambulance
Charges for licensed ambulance services required to transport a stretcher patient to and from the nearest hospital able to provide essential care. Charges for air transport are included to a maximum of up to three economy seats on a regularly scheduled flight.

Ambulance Attendant
Charges for travel expenses of an accompanying Registered Nurse or qualified medical attendant (not a relative) when medically necessary and approved by Medavie Blue Cross.

Hospital
All hospital charges for medically necessary services, less the amount allowed under the provincial government health care plan, such as:

- hospital room accommodation
- intensive care rooms
- nursing services
- operating and recovery rooms
- diagnostic and laboratory services including X-rays
- oxygen and blood
- prescription drugs including intravenous solutions
- physiotherapy

Physicians and Surgeons
Customary charges of physicians and surgeons for services rendered, less the amount allowed under the provincial government health care plan.

Limitations and Exclusions

1. The referral outside Canada must be medically necessary and must not be for services available in Canada, as determined by Medavie Blue Cross.

2. The claim must have prior approval for payment from Medavie Blue Cross.

3. Payment will be made for the reasonable and customary charges of the provider of the services or supplies in the area in which the services are rendered.

4. Payment will only be made for services and supplies rendered while the patient was under the active treatment of a licensed physician.

5. Payment will not be made for treatment of any illness commencing within 12 months after the participant's effective date of group coverage for which the participant has received medical treatment or has been prescribed drugs 12 months prior to the effective date of this coverage.

6. The services to be provided outside Canada must not be experimental or investigative in nature.

7. Referrals outside of Canada exclude, but are not limited to, services not available due to waiting lists and/or treatment which has been refused by a physician in Canada.

Termination

Referrals for Services Outside Canada benefit ceases at the earlier of retirement, termination of employment or the age noted in the Summary of Benefits.

This benefit covers eligible expenses incurred by you or your dependents for any usual and necessary expenses from a medical point of view and recommended by a physician. The Company will pay the usual, customary and reasonable charges based on any deductible, co-insurance or 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, providing eligible expenses are incurred in Canada. Benefit maximums are applied on a per person basis.

Eligible Expenses

Physician Services
Charges outside the province of residence in excess of the allowance under a government health plan.

Professional Ambulance
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.

Special Ambulance Attendant
Travel expenses of a Registered Nurse (not a relative) when medically necessary and approved by the Company. The maximum payable amount is mentioned in the Summary of Benefits.

Private Duty Nursing
Provided you do not reside in a convalescent nursing home and the nurse is not a relative, charges for medically necessary home nursing care performed by a registered nurse.

All nursing services must be pre-approved by the Company in order to be considered for reimbursement. Payment for eligible expenses will be based upon the payment schedule for private duty nurses established by the Company for the Participant's province of residence.

Diagnostic and X-ray Services
Charges for laboratory services and x-ray examinations.

Oxygen
Charges for oxygen on the written authorization of the attending physician.

EXTENDED HEALTH BENEFIT

This benefit covers eligible expenses incurred by you or your dependents for any usual and necessary expenses from a medical point of view and recommended by a physician. The Company will pay the usual, customary and reasonable charges based on any deductible, co-insurance or 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. Benefit maximums are applied on a per person basis.

Eligible Expenses

Accidental Dental
Charges for dental treatment when natural teeth have been damaged by a direct accidental blow to the mouth or jaw. Services must be rendered or approved for payment by the Company within 12 months of the accident. Benefits will be paid up to the current dental association fee guide for general practitioners in the participant's province of residence.

Diabetic Equipment
Charges for the following equipment on the written authorization of the attending physician for the treatment and control of diabetes: pressurized insulin injector, glucometer or equipment approved by the Company that performs similar functions. The overall maximum payable for this equipment is noted in the Summary of Benefits.

Ostomy Supplies
Charges for essential ostomy supplies on the written authorization of the attending physician.

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. The maximum payable amount is mentioned in the Summary of Benefits

Paramedical Services
Charges for treatment, including X-rays, 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.

Prosthetic Appliances
Charges for the following remedial prosthetic appliances or supplies, when authorized by the attending physician. The maximum payable amount is mentioned in the Summary of Benefits:

- artificial limbs,
- breasts (including repairs and adjustments),
- eyes,
- mastectomy bra, and
- crutches, canes, splints, casts, trusses and braces.

Replacement of these items will not be a benefit unless replacement is required due to pathological or physiological change. Repairs and/or adjustments are provided to a maximum amount payable as mentioned in the Summary of Benefits unless noted otherwise.

Hair, 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).

Medical Supplies and Equipment

Charges for the following medical supplies and equipment, when prescribed by an authorized physician. The maximum payable amount is mentioned in the Summary of Benefits:

- stump socks,
- rental (or purchase, if approved by Medavie Blue Cross) of a wheelchair or hospital-type bed,
- TENS machine,
- burn pressure garments,
- enuretic devices (mozes detector)
- equipment for the administration of oxygen,
- insulin pump,
- compression pump, and
- accompanying sleeves.

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. Not all eligible medical supplies and equipment are listed above. Please contact our call centre for more specific information and all claiming requirements.

Molded Arch Supports

Charges for molded arch supports to accommodate, relieve, or remedy some mechanical foot defect or abnormality, excluding their replacement (except for pathological change), on the written authorization of an orthopedic surgeon, physiatrist, rheumatologist, podiatrists/chiropodists or the attending physician. The maximum amount payable is mentioned in the Summary of Benefits.

Orthopedic Shoe(s) & Supplies

Charges for orthopedic footwear when the footwear are customized with special features to accommodate, relieve or remedy some mechanical foot defect or abnormality and is prescribed by an orthopedic surgeon, physiatrist, rheumatologist or the attending physician. Also, charges for footwear modification and adjustment 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 mentioned in the Summary of Benefits.

Vision Care

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

Frames/Lenses/Contact Lenses due to Cataract Surgery
Charges for frames, lenses or contact lenses when medically necessary on the written authorization of the attending physician following cataract surgery. Subject to the maximum amount payable mentioned in the Summary of Benefits.

Intraocular Lenses due to Cataract Surgery
Charges for intraocular lenses when medically necessary on the written authorization of the attending physician following cataract surgery. Subject to the maximum amount payable mentioned in the Summary of Benefits.

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.

DRUG BENEFIT

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. Benefit maximums are applied on a per person basis.

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.

When an eligible interchangeable drug has been prescribed, the Company adheres to the mandatory substitution legislation in each province.

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

Eligible Expenses

The plan refunds expenses for drugs which require a prescription by law, approved by the Company, and prescribed by a doctor or dentist, according to the percentage of reimbursement specified in the Summary of Benefits. 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.

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.

DENTAL BENEFIT

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. Benefit maximums are applied on a per person basis.

Dental benefits are based on the usual and customary charges up to the Dental Fee Guide as specified in the Summary of Benefits for general practitioners or specialist in effect in the province of Manitoba.

Eligible Expenses
The following expenses are reimbursed, according to the percentage of reimbursement and maximum specified in the Summary of Benefits.

BASIC SERVICES

Diagnostic Services
- complete examinations once every 24 consecutive months
- recall examinations once every six consecutive months
- bitewing once every six consecutive months
- full series X-rays or panorex X-rays once every 24 consecutive months
- test/analysis/laboratory procedures

Preventive Services
- polishing once every six consecutive months
- fluoride treatment once every six consecutive months
- scaling limited to 8 units in a calendar year in combination with root planing
- Oral hygiene instruction/plaque control once every six consecutive months
- pit and fissure sealants
- space maintainers (Dependents under 18 years of age)
- periodontal appliances (bruxism) once every two consecutive calendar years **- 50%**

Restorative Services
- amalgam (metal) and tooth coloured (white) fillings

Endodontic Services - 50%
- root canal therapy

Periodontic Services
- occlusal equilibration **- 50%**
- scaling and/or root planing limited to 8 units in a calendar year in combination with scaling
- periodontal surgery (grafts) **- 50%**

BASIC SERVICES (Cont'd)

Prosthodontic Services - 50%

- denture adjustment and repairs
- denture reline or rebase once every two consecutive calendar years
- tissue conditioning

Surgical Services

- extraction of teeth and roots
- surgical movement of teeth
- removal of benign tumors, cysts

General Services

- general anaesthesia and intravenous sedation in conjunction with oral surgery

MAJOR RESTORATIVE SERVICES

Extensive Restoratives

- inlays/onlays once every 60 consecutive months
- crowns once every 60 consecutive months

Prosthodontic Services

- complete and partial dentures once every 60 consecutive months
- bridgework once every 60 consecutive months

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.

Note: Implant related codes such as crown over implants or dentures over implants are not a benefit.

Dental Exclusions and Limitations

The dental plan does not cover the following expenses:

1. Splinting for periodontal reasons, where cast, crowns or inlays are used for this purpose, with or without onlays.
2. Veneers for cosmetic purposes.
3. Accidental dental services do not form part of the Dental Benefits being offered
4. Services rendered by a dental hygienist but not administered under the supervision of a dentist.
5. Treatment or appliance, related directly or indirectly to full mouth reconstruction, to correct vertical dimension.

Laboratory Charges

Reimbursement of laboratory fees will be limited to the reasonable and customary charges for such services. However, in no event will the total reimbursement of eligible laboratory fees exceed 60% of the suggested dental fee in the appropriate fee guide for the particular dental treatment.

Predetermination of Benefits

If the cost of the proposed dental treatment exceeds $500, have your dentist complete the predetermination section of the claim form and forward it to the Company before the start of treatment. You will thus know, beforehand, the exact amount of the reimbursement. If you change dentist in the course of treatment, you will be required to submit a new treatment plan to the Company.

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.

GENERAL EXCLUSIONS AND LIMITATIONS FOR HEALTH AND DENTAL BENEFITS

The following expenses are not reimbursed under the plan:

1. Medical examinations or routine general checkups required for use by a third party.
2. Elective services obtained outside the participant's province of residence.
3. Charges which normally would not be made if the participant was not covered under the plan.
4. Any item or service not listed as a benefit in this plan.
5. Medications restricted under federal or provincial legislation.
6. Registration charges or non-resident surcharges in any hospital.
7. Services performed by an unqualified practitioner.
8. Charges for missed appointments or the completion of forms.
9. Charges for health care planning assessments.
10. Any health care services and supplies that are not provided by an approved provider.
11. Convalescent, custodial or rehabilitation services, unless otherwise specified.
12. Conditions not detrimental to health.
13. Services that are not medically required, that are given for cosmetic purposes or that exceed the ordinary services given in accordance with current therapeutic practice.
14. Benefits the participant receives or is entitled to receive from Workers' Compensation.
15. Mileage or delivery charges.
16. Any injury or illness resulting from the participant's active participation in or related to civil unrest, riot, insurrection or war.
17. Participation in the commission of a criminal offence.
18. A service or supply that is experimental or investigative in nature.
19. A service or supply that is not medically necessary or proven effective.
20. Services for which the government prohibits the payment of benefit.
21. Services provided without charge or normally paid for directly or indirectly by the employer.
22. Services for which the employee or dependent is entitled to indemnity from any government plan, or any plan or arrangement.
23. Services as a result of self-inflicted injuries or any suicide attempt, whether the participant is sane or not.

Co-ordination of Benefits

In the event that benefits may be claimed under more than one section of the health care plan, the claim will be assessed in a manner that provides the greatest benefit.

If you are eligible for similar benefits under another group benefit plan the amount payable through this plan shall be co-ordinated with all benefit plans and will not exceed 100% of the eligible expense. Where both spouses of a family have coverage through their own employer benefit plans, the first payer of each spouse's claim is their own employer's plan. Any amount not paid by the first payer can then be submitted for consideration to the other spouse's benefit plan (the second-payer).

Claims for dependent children should be submitted first to the benefit plan of the spouse who has the earlier birth month in the calendar year, and then to the other spouse's benefit plan. When submitting a claim to a second payer, be sure to include payment details provided by the first payer.

Benefit payments will be co-ordinated with any other plan or arrangement, in accordance with the Canadian Life and Health Insurance Association (CLHIA) guidelines.

Alternative Benefit

Where more than one form or alternative form of 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 or supply with a lower cost, when deemed appropriate and consistent with good health management.

Conversion Privilege

If you should terminate employment, you may convert to an Individual Health and Dental 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 surviving spouse and/or dependents in the event of your death.

Survivor Benefit

In the event of your death, eligible dependents will continue to be covered for Health and Dental benefits on a non-premium basis, however, coverage will end on the earliest of the following dates:

- the contract termination date;
- twelve (12) months after the employee's death;
- the effective date of any similar coverage with another insurer;
- whenever they cease to be eligible dependents.

Policy No.: BSC 9026202A Div 35
Administred by AIG Insurance Company of Canada.

Why You Need Accident Insurance
A serious accidental injury or death can have tremendous consequences. A serious injury may prevent you from meeting your financial obligations and your loss of life may leave your spouse with insufficient financial resources to fulfill their financial responsibilities.

Your Employer has provided you with Accident Insurance coverage underwritten by AIG Insurance Company of Canada. The policy provides a lump sum benefit to help ease the financial impact and assure your family's needs are met if you loss of life as a result of an accident. Your accident coverage also provides you with 'living benefits' should an accident leave you paralyzed or should you lose through severance, or loss of use of a limb, sight, speech or hearing.

How It Works
You are automatically covered for a Principal Sum amount equal to your group life benefit.

Here's What You Get
Broad Accident Insurance Coverage - Your plan provides generous Accidental Death & Dismemberment benefits for injuries as a result of covered accidents.

Guaranteed Acceptance - Coverage is provided regardless of your health history.

24/7 Worldwide Coverage - Your coverage is in force around-the-clock—at work, at home or at play, anywhere in the world.

Definitions
"Insured Employee" means you, if you are an Employee of the policyholder under age 72

Eligible Dependents:
"Spouse" means a person who is under the age of 72 and who is either legally married to you, or if there is no such person, is a person who, although not legally married to you, is cohabitating with you for a period of at least one year and is publicly represented as your domestic partner in the community in which you reside.

"Dependent Child" means a person who is either your natural child, adopted child or step-child or a child to whom you are *in loco parentis* and who is (i) under 23 years of age, unmarried and dependent upon you for maintenance and support and not employed for more than 25 hours per week; or (ii) under 26 years of age, unmarried and enrolled in post-secondary education and dependent upon you for maintenance and support and not employed for more than 25 hours per week; or (iii) by reason of mental or physical infirmity is incapable of self-sustaining employment and who is considered your Dependent Child within the terms of the Income Tax Act (Canada).

Beneficiary Designation
You may designate a beneficiary to receive the amount payable hereunder for your Loss of Life. In the absence of such a beneficiary designation, the benefit for Loss of Life shall be payable to your estate.

All other benefits will be payable to you.

Benefits and Coverages

Accidental Death, Dismemberment, Paralysis and Loss of Use

If a covered loss occurs within 365 days after the date of the covered accident causing the loss, the Company will pay in one installment the indicated percentage of the Principal Sum as set out in the following Table of Losses. If more than one loss is sustained, only one benefit shall be payable, the largest.

Table of Losses

Loss of Life .... The Principal Sum
Loss of Both Hands or Both Feet .... The Principal Sum
Loss of Entire Sight of Both Eyes .... The Principal Sum
Loss of One Hand and One Foot .... The Principal Sum
Loss of One Hand and the Entire Sight of One Eye .... The Principal Sum
Loss of One Foot and the Entire Sight of One Eye .... The Principal Sum
Loss of One Arm or One Leg .... Four-Fifths of The Principal Sum
Loss of One Hand or One Foot .... Three-Quarters of The Principal Sum
Loss of The Entire Sight of One Eye .... Three-Quarters of The Principal Sum
Loss of Thumb and Index Finger of the Same Hand .... One-Third of The Principal Sum
Loss of Speech and Hearing .... The Principal Sum
Loss of Speech or Hearing .... Three-Quarters of The Principal Sum
Loss of Hearing in One Ear .... Two-Thirds of The Principal Sum
Loss of Four Fingers of One Hand .... One-Third of The Principal Sum
Loss of All Toes of One Foot .... One-Quarter of The Principal Sum

Loss of Use

Loss of Use of Both Arms or Both Hands .... The Principal Sum
Loss of Use of One Hand or One Foot .... Three-Quarters of The Principal Sum
Loss of Use of One Arm or One Leg .... Four-Fifths of The Principal Sum

Paralysis

Quadriplegia (total paralysis of both upper and lower limbs) .... Two Times The Principal Sum up to a maximum of One Million Dollars
Paraplegia (total paralysis of both lower limbs) .... Two Times The Principal Sum up to a maximum of One Million Dollars
Hemiplegia (total paralysis of upper and lower limbs of one side of the body) .... Two Times The Principal Sum up to a maximum of One Million Dollars

If you sustain more than one loss as a result of the same accident, only one amount, the largest, will be paid.

"Loss" when used with reference to “Quadriplegia”, “Paraplegia”, and “Hemiplegia” means the complete and irreversible paralysis of such limbs; “Hand” or “Foot” means the complete severance through or above the wrist or ankle joint, but below the elbow or knee joint; “Arm” or “Leg” means the complete severance through or above the elbow or knee joint; “Thumb and Index Finger” means the complete severance through or above the first phalange; “Fingers” means the complete severance through or above the first phalange of all Four Fingers of One Hand; “Toes” means the complete severance of both phalanges of all the Toes of One Foot; “The Entire Sight of One Eye” means the total and irrecoverable Loss of Sight such that corrected visual acuity must be 20/200 or less in such eye; “The Entire Sight of Both Eyes”

means the total and irrecoverable Loss of Sight in Both Eyes such that corrected visual acuity must be 20/200 or less and the field of vision must be less than 20 degrees in both eyes. A Physician certified in Ophthalmology must clinically confirm the diagnosis in writing; “Hearing in One Ear” means the diagnosis of permanent Loss of Hearing in One Ear, with an auditory threshold of more than 90 decibels. A Physician certified in Otolaryngology must confirm the diagnosis in writing; “Hearing” means the diagnosis of permanent Loss of Hearing in Both Ears, with an auditory threshold of more than 90 decibels in each ear. A Physician certified in Otolaryngology must confirm the diagnosis in writing; “Speech” means complete and irrecoverable Loss of the ability to utter intelligible sounds; and "Loss of Use" means the total and irrecoverable Loss of Use provided the Loss is continuous for 12 consecutive months and such Loss of Use is determined to be permanent. “Loss” when used herein may also include “Loss of Life”.

Home Alteration and Vehicle Modification Benefit
Pays a one-time benefit of up to $15,000 for modification to your home or vehicle if you suffer an injury for which you receive a benefit under the Plan and require a wheelchair to be ambulatory.

Workplace Modification and Accommodation Benefit
Pays a benefit of up to $5,000 to your Employer if you suffer an injury for which you receive a benefit under the Plan and require special adaptive equipment or workplace modification in order for you to return to work full-time.

Psychological Therapy
Pays a benefit of up to $5,000 if you suffer an injury for which you receive a benefit under the Plan and require psychological therapy within 2 years of the injury.

In-Hospital Benefit
Pays a benefit of (i) 1% of the Principal Sum to a maximum of $2,500 per month for hospital confinements of more than 30 nights, or (ii) 1/30th of the amount determined under (i) for hospital confinements of more than 5 but less than 30 nights, if you suffer an injury for which you receive a benefit under the Plan and are confined to hospital as a result of such injury, for a maximum of twelve months.

Family Transportation
Pays a benefit of up to $15,000 for the expenses incurred for the transportation of an immediate family member to your hospital if you suffer an injury for which you receive a benefit under the Plan and as a result are confined to a hospital more than 100 kilometres from home.

Repatriation Benefit
Pays a benefit of up to $15,000 to cover the expenses to return your body to your city of residence if you suffer a covered accidental death while at least 50 kilometres from home.

Identification Benefit
Pays a benefit of up to $5,000 for the transportation and commercial lodging of an immediate family member to identify your body if you suffer a covered accidental death at least 150 kilometres from home and a law enforcement agency requests such identification.

Seat Belt Benefit
Pays an additional benefit of 10% of the Principal Sum to a maximum of $50,000 if you suffer a covered accidental death while operating or riding as a passenger in a private passenger automobile in which your seat belt was properly fastened.

Day Care Benefit
Pays an annual benefit of up to 5% of the Principal Sum to a maximum of $5,000 per year for the day care costs of each Dependent Child under age 13 who is enrolled, or who enrolls within 90 days, in a day care facility if you suffer a covered accidental death. The benefit is payable for up to four consecutive years.

Dependent Child Educational Benefit
Pays an annual benefit of up to 5% of the Principal Sum to a maximum of $5,000 per school year for the tuition costs of each Dependent Child who is enrolled in post-secondary education if you suffer a covered accidental death. The benefit is payable for up to four consecutive years.

Spousal Educational Benefit
Pays a benefit of up to $15,000 for your Spouse's expenses in enrolling in a professional or trades training program for the purpose of obtaining an independent source of income, if you suffer a covered accidental death and such expenses are incurred within 30 months of your death.

Funeral Expense
Pays a benefit of up to $5,000 to reimburse funeral expenses if you suffer a covered accidental death.

Bereavement Benefit
Pays a benefit of up to $1,000 if you suffer loss of life in a covered accident and your eligible dependents require counselling within one year of the accident.

Waiver of Premium
In the event that you become totally and permanently disabled and your waiver of premium claim is accepted and approved under the Policyholder's current group life policy, then the premiums payable under this policy are waived 30 weeks from the date the claim is accepted and approved by the Group Life Plan Underwriter until one of the following occurs, whichever is earlier:

(a) The date you attain the age of 65,
(b) The date of your death or recovery,
(c) The date the Master Policy is terminated.

Continuance of Coverage
It is hereby declared and agreed that coverage may be continued by payment of premium during periods of approved leave of absence, lay-offs, while on pregnancy leave, parental leave, or special maternity leave. This continuation of coverage will be granted for a period equal to the Policyholder's current Group Life policy, to a maximum of 70 weeks. Coverage for all applicable benefits outlined in the Policy will be continued until the maximum period of time outlined by labour law as long as premiums continue to be paid by the Policyholder. The choice of continuing coverage must be made by the Policyholder at the start of the absence and it is non-revocable. In the event of total disability, coverage may be continued by payment of premium, until the earlier of age 65, death, retirement, or termination of the master policy.

Conversion Privilege Benefit
If you leave your job for any reason, you have 90 days to convert your coverage under the Plan to an individual insurance policy providing comparable coverage and with a coverage amount not greater than the Principal Sum at individual rates in force at that time.

Policy Exclusions

The Plan will not cover any losses caused in whole or in part by, or resulting in whole or in part from, the following:

(a) suicide or any attempt thereat by you while sane;
(b) self inflicted injury or any attempt thereat by you while sane or insane;
(c) declared or undeclared war or any act thereof;
(d) sickness, disease, or bodily infirmity whether the Loss or claim results directly or indirectly from any of these;
(e) mental incapacity whether the Loss or claim results directly or indirectly from any mental incapacity;
(f) injury sustained while you are undergoing the medical or surgical treatment of sickness, disease, or bodily or mental infirmity;
(g) stroke or cerebrovascular accident or event; cardiovascular accident or event; myocardial infarction or heart attack; coronary thrombosis; aneurysm;
(h) travel or flight in or on (including getting in or out of, or on or off of) any vehicle used for aerial navigation, if you are:
    (i) riding as a passenger in any aircraft not intended or licensed for the transportation of passengers;
    (ii) performing, learning to perform or instructing others to perform as a pilot or crew member of any aircraft; or
    (iii) riding as a passenger in an aircraft owned or leased by the Policyholder;
(i) infections of any kind regardless of how contracted, except bacterial infections that are directly caused by botulism, ptomaine poisoning or an accidental cut or wound independent and in the absence of any underlying sickness, disease or condition including but not limited to diabetes;
(j) injury or Loss sustained if you are on full-time active duty in the armed forces or organized reserve corps of any country or international authority. (Unearned premium for any period for which you are on full-time active duty shall, upon application to the Company by the Policyholder, be refunded);
(k) injury or Loss sustained while you are under the influence of alcohol and operating any vehicle or means of transportation or conveyance while your blood alcohol is over 80 milligrams in 100 millilitres of blood;
(l) injury or Loss sustained while you are under the influence of a drug or substance which is controlled as specified under the Controlled Drug and Substances Act (Canada) unless taken pursuant to the advice of and in strict accordance with the instructions of a duly licensed physician;
(m) the commission or attempted commission by you or injury incurred while you are in the course of committing or attempting to commit any act which if adjudicated by a court would be an indictable offence under the laws of the jurisdiction where the act was committed; and
(n) an act, attempted act or omission taken or made by you, or an act, attempted act or omission taken or made with your consent, for the purposes of interrupting the blood flow to your brain or to cause asphyxiation to you whether with intent to cause harm or not; and
(o) natural causes.

Aggregate Limit Per Accident
The maximum amount the Company will pay for two or more Insured Employees injured in one accident is the amount of the Aggregate Limit Per Accident set out in the policy, if any. If the total of the benefits which would be paid by the Company would exceed the Aggregate Limit Per Accident, each Insured Employee shall receive their proportionate share of the amount of the Aggregate Limit Per Accident paid by the Company.

Effective Date
Your coverage begins on the date you satisfy the definition of "Insured Employee".

Termination Date
Coverage ends on the earliest of:

1. the date the policy is terminated;
2. the premium due date if premiums are not paid when due;
3. the date you no longer satisfy the definition of an Insured Employee; or
4. the first day of the month following the date you no longer belong to an Eligible Class of Employees as set out in the Policy.

This brochure provides only brief descriptions of the coverage available. The full details of the coverage are contained in the Policy including limitations, exclusions and termination provisions. If there are any conflicts between this document and the Policy, the Policy shall govern. Insurance is underwritten by AIG Insurance Company of Canada.

Document printed in March 15

Administered by AIG Insurance Company of Canada
Policy BSC 9026204

Business Travel Accident Insurance covers only losses resulting from an accident that occurs while you are travelling on company business. It does not cover regular travel to and from work, nor does it apply to vacation travel.

Amount of Coverage
Your Business Travel Accident Insurance is equal to 2 times your annual earnings (rounded to the next higher $1,000) to a maximum benefit of $1,000,000. When applicable, it is payable in addition your Basic Life and AD&D Insurance. Business Travel Accident Insurance is subject to adjustment when your salary rate changes.

Annual Earnings
Are your current base income.

Termination
The Business Travel Accident Insurance terminates at age 72 or retirement whichever is earlier.

Exclusion
Business Travel Accident Insurance benefits will not be paid for any losses resulting from: suicide or self-inflicted injury; or flying as a pilot or crew member of any aircraft.

Who Will Be Paid
In the event of your accidental death, Business Travel Accident benefits will be paid to the beneficiary you have designated. Certain benefits are also payable in the event of dismemberment, disability and/or loss of use resulting from an accident while you are travelling on business. In these situations accident benefits are payable to you, the insured.

Administered by The Williamson Group

Division 35 – Permanent Full-Time Winnipeg,
St. Joseph Union Plant Employees and Drivers

Employees may apply for a STD income benefit if they're totally disabled due to a non-work related illness or injury.

Qualification period: To qualify for an STD benefit, an Employee must be absent from work for 3 working days. The Employee must provide confirmation from a treating physician that they have been totally disabled and that they have been seen by a physician during the 3 working day qualification period. Benefits are payable on the 4th day of illness or hospitalization or 1st day in the case of accident. In no event will payment be approved prior to the date of the initial visit to the treating physician.

Parmalat, through their payroll pays the first 3 days @ 66 2/3% to the STD maximum for both illness and hospitalization

Maximum benefit period: 52 weeks

Approved Short Term Disability leave ends on the earlier of the following dates:

- Return to work
- Your maximum benefit period has expired
- Your employment ends, retirement or you are no longer eligible, or the policy terminates, whichever is earliest.

Amount of Benefit: Benefits are paid as a percentage of your regular earnings on the last active working day as follows:

The amount of the benefit is calculated according to the following schedule:

- Weeks 1 – 2: 66 2/3% of your regular weekly earnings per week to the EI maximum as of February 1, 2013
- Weeks 3 – 17: Employment Insurance Sickness Benefits, Parmalat through the RTH STD Program provides a top-up to 66 2/3% to STD to EI maximum
- Weeks 18 – 52:66 2/3% of your regular weekly earnings per week to the EI maximum as of February 1, 2013

Benefits are paid only for the scheduled working days that you are totally disabled. If you are Totally disabled for part of a week, you will receive 1/7th of the weekly benefit.

The STD benefit is taxable.

RETURN TO HEALTH - EMPLOYEE SHORT TERM DISABILITY (STD) BENEFITS

Definition of Disability:

Eligible Employees will be entitled to receive STD benefits as replacement for lost income, if, as a result of a non-work related illness or injury they are unable to perform a substantial portion of the duties of their own occupation. Benefits begin after the qualification period is over and continue until you are no longer eligible for benefits.

If you have not seen a physician before the end of the qualification period, benefits will not be payable until the date you were seen by the treating physician in consultation.

Interrupted periods of total disability are considered to be a single period of disability if the Employee returns to work for a period of less than:

1. Two (2) weeks, if total disability is due to the same or related cause, or
2. One day, if total disability is due to an entirely unrelated cause

In such cases, a new qualifying period is not applied. The amount that will be paid to the Employee will be the same as for the initial period of total disability and the combined period that will be paid will not exceed 30 weeks.

Proof of Claim:

An Attending Physician Statement (APS) form supplied by Human Resources is to be completed by a doctor for an absence greater than 3 working days. The medical information furnished must medically support total disability.

Rehabilitation Program:

It is recognized that some Employees either no longer meet the criteria for being "totally disabled" or will require work modifications for an early return to work. These individuals can often be accommodated through graduated return to work programs, work hardening programs, or with limitations and restrictions in job requirements. The rehabilitation program provides a work modification arrangement (by temporarily reducing work hours or activities) to a disabled person who is not yet fully recovered but can work at some job. In order to qualify for a Rehabilitation Program an Employee must:

- Be unable to perform substantially all of the essential duties of his/her own occupation or similar occupation
- Be capable of productive and useful work.

In addition, the expected modified work period must be progressive and assist the Employee in becoming capable of regular full-time work and should not exceed 8 weeks (12 weeks maximum for specific cases or return to STD/LTD). It is required that an Employee will participate in all aspects of a return to work and rehabilitation efforts/programs.

When the Employee is enrolled in an authorized Rehabilitation Program, the Employee will receive his/her basic earnings for the hours worked at Parmalat Canada Inc. The hours not worked that are considered to be part of the remaining STD benefits will be paid under this plan.

Exclusions and Limitations:

No benefit shall be payable if a Disability, illness, injury or accident occurs while participating in or engaged in any criminal activity, regardless of whether charges are laid or a conviction obtained.

Also, Weekly Indemnity benefits are not payable for any of the following:

A. any disability for which the Employee does not provide proof of a claim;
B any disability occurring prior to the Employee becoming eligible to participate in **THE RETURN TO HEALTH SHORT TERM DISABILITY PROGRAM**
C. any period of disability during which the Employee is not under appropriate treatment and care of a Physician/Doctor for the mental or physical impairment causing the disability. In the case of treatment by a chiropractor, medical documentation from a Physician and/or Specialist will be required to justify an absence recommended by a chiropractor exceeding a period of 4 weeks;
D. any period of disability during which the Employee refuses to follow an active treatment program as approved by a Doctor/ Specialist;
E. any period of disability during which the Employee refuses to attend an IME;
F. any period of disability during which the Employee is not undergoing a course of medical treatment or participation in a program of rehabilitation which, in the opinion of the Case Manager is deemed appropriate;
G. any period of disability during which the Employee is serving a prison sentence or are confined in a similar institution;
H. any disability due to or resulting from self-inflicted injury or Sickness or Attempted Suicide, while sane or insane;
I. 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;
J. any disability occurring while the Employee is on a leave of absence, strike, disciplinary suspension or lay-off as stated under leave of absence. If an Employee becomes totally disabled during a lay-off, disciplinary suspension or approved leave and his coverage continues during this time, he will be eligible for benefit payments following his recall or scheduled return to full-time work with Parmalat Canada Inc. The Employee must have been totally disabled for the waiting period in the case of illness and still be totally disabled on the
    a. date recalled or scheduled to return to full-time work with the employer. In the case of an accident, the Employee must be totally disabled on the date recalled or scheduled to return to full-time work. However, if the Employee becomes totally disabled before a notice of separation is given, payments continue while the Employee is totally disabled, but not beyond the end of the maximum benefit period;
K. the Employee is absent from Canada longer than 4 weeks due to any reason, unless the Case Manager and your Employer have agreed in writing in advance to pay benefits during this period;
L. any disability due to drug and/or alcohol abuse unless the Employee is receiving continued treatment from a licensed physician who specializes in the treatment of drug and/or alcohol abuse;
M. any disability, due to or resulting from any cause, for which the Employee is eligible, or in receipt of Workers Compensation or similar benefit

Exclusions and Limitations: (Cont.)

N. any disability due to elective, cosmetic or experimental surgery unless the treatment is for accidental injuries;
O. any period the Employee is engaged in any occupation or employment for wage or profit and,
P. any Disability during the period:
   a. of maternity leave taken by the Employee pursuant to provincial or federal law, or pursuant to mutual agreement between the person and the employer, or
   b. in which the employment insurance maternity benefits are being paid or would be paid if the Employee were eligible, whichever is the longer.

THE RETURN TO HEALTH SHORT TERM DISABILITY PROGRAM will determine any portion of a pregnancy leave, which is voluntary, and any portion, which is health-related. The health-related portion of the leave is the period in which a woman can establish, through appropriate medical documentation that she is unable to work for health reasons related to childbirth or recovery from childbirth. STD benefits will be payable for health-related portions of the leave.

Benefits may be suspended if:

a) Medical documentation, which has been requested, has not been submitted.
b) Work related issues or conditions resulting in a Workers Compensation Claim which has been approved and paid.
c) The Employee has not returned to work on the date specified and agreed to by the treating physician.
d) There are conflicting opinions, diagnosis or prognoses which are not resolved by an Independent Medical Evaluation conducted by a physician specialized in the specific medical field which is applicable to the Employee’s physical or mental impairment.

Obtain your Short Term Disability forms from Human Resources

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