My BENEFIT PLAN

Design Group Staffing Inc.

Classification: All Employees

Billing Division: 100

Revised Effective Date: April 1, 2020

gsc green shield canada

WELCOME TO YOUR BENEFIT PLAN

This summary contains information about your group benefits with **Design Group Staffing Inc.**, your plan sponsor, available through the group contract with Green Shield Canada (GSC).

HEALTH SUMMARY

The health benefits are intended to supplement your provincial health insurance plan. The benefits shown below will be eligible if they are medically necessary for the treatment of an illness or injury, and reimbursement will be limited to reasonable and customary charges, in addition to any specific limitations and maximums stated below.

	Option 1	Option 2	Option 3
Calendar Year Deductible: (per person/per family)	No Deductible	No Deductible	No Deductible
Maximums Overall Health Maximum: Smoking cessation drugs: Medical Cannabis:	 Unlimited $300 per lifetime $5,000 every calendar year	 Unlimited $500 per lifetime $5,000 every calendar year	 Unlimited $500 per lifetime $5,000 every calendar year
Your Co-pay Prescription Drugs: **Medical Items and Services:** All Other Health Benefits:	 $12 plus 25% of the rendered cost minus $12, per prescription or refill 20% 0%	 $11 plus 15% of the rendered cost minus $11, per prescription or refill 15% 0%	 $10 per prescription or refill 10% 0%
Your Plan Covers	**Maximum Plan Pays**	**Maximum Plan Pays**	**Maximum Plan Pays**
Prescription Drugs	Unlimited	Unlimited	Unlimited
Hospital Accommodation	Semi-private room	Semi-private room	Semi-private or private room
Hearing Care	$700 every 5 benefit years	$750 every 5 benefit years	$1,000 every 5 benefit years
Orthotics/Orthopedic Footwear Custom boots or shoes or custom orthotics:	$300 every benefit year combined	$400 every benefit year combined	$500 every benefit year combined
Private Duty Nursing	$5,000 every benefit year	$7,500 every benefit year	$10,000 every benefit year
Paramedical Practitioners Chiropractor, Registered Massage Therapist, Physiotherapist	$200 every benefit year per type of practitioner	$75 per visit up to $300 every benefit year per type of practitioner	$85 per visit up to $500 every benefit year per type of practitioner
Naturopath, Osteopath, Chiropodist/Podiatrist, Acupuncturist, Audiologist, Occupational Therapist	$400 every benefit year per type of practitioner plus $50 every benefit year for X-rays by a Chiropractor, Osteopath and Podiatrist	$500 every benefit year per type of practitioner plus $50 every benefit year for X-rays by a Chiropractor, Osteopath and Podiatrist	$600 every benefit year per type of practitioner plus $50 every benefit year for X-rays by a Chiropractor, Osteopath and Podiatrist
Psychologist, Social Worker/Counsellor, or Master of Social Work	$500 every benefit year combined	$500 every benefit year combined	$700 every benefit year combined
Speech Therapist, Dietitian	$500 every benefit year per type of practitioner	$500 every benefit year per type of practitioner	$700 every benefit year per type of practitioner
Vision Eyeglasses or contact lenses or medically necessary contact lenses or laser eye surgery	Not Covered	$150 every 24 months based on date of first paid claim (every 12 months for dependent children 18 years of age and under)	$250 every 24 months based on date of first paid claim (every 12 months for dependent children 18 years of age and under
Optometric eye exams	$75 every 24 months based on date of first paid claim (every 12 months for dependent children 18 years of age and under)	$75 every 24 months based on date of first paid claim (every 12 months for dependent children 18 years of age and under)	$75 every 24 months based on date of first paid claim (every 12 months for dependent children 18 years of age and under)
Benefit Year: June 1st to May 31st			

TRAVEL SUMMARY

The travel benefits are intended to **supplement** provincial health insurance plans if you experience a medical emergency while travelling outside of your province of residence or Canada. If your provincial health insurance plan includes out-of-Canada benefits, hospital and medical services are eligible only if your provincial health insurance plan provides payment toward the cost of incurred services. The benefits shown below will be eligible if they are medically necessary for the emergency treatment of a sudden and unforeseen illness or injury and reimbursement will be limited to reasonable and customary charges for the area in which they are incurred.

	Option 1	Option 2	Option 3
Calendar Year Deductible: (per person/per family)	No deductible	No deductible	No deductible
Your Co-pay:	Referral Services - 50% All Other Travel Benefits – 0%	Referral Services - 50% All Other Travel Benefits – 0%	Referral Services - 50% All Other Travel Benefits – 0%
Maximum Number of Days per Trip:	90 days	90 days	90 days
Your Plan Covers	**Maximum Plan Pays**	**Maximum Plan Pays**	**Maximum Plan Pays**
Emergency Services:	$5,000,000 per lifetime	$5,000,000 per lifetime	$5,000,000 per lifetime
Referral Services	$50,000 per lifetime	$50,000 per lifetime	$50,000 per lifetime

Before you travel, visit greenshield.ca for important information you will need to know if you experience a medical emergency while you are travelling.

DENTAL SUMMARY

The dental benefits shown below will be eligible if they are necessary for the prevention of dental disease or treatment of dental disease or injury and reimbursement will be limited to the amount stated in the Provincial Dental Association Fee Guide indicated below.

	Option 1	Option 2	Option 3
Calendar Year Deductible: (per person/per family)	No deductible	No deductible	No deductible
Dental Fee Guide: (General Practitioners)	Current province of residence	Current province of residence	Current province of residence
Your Co-pay Basic Services:	25%	15%	10%
Comprehensive Basic Services:	25%	20%	10%
Major Services:	30%	50%	50%
Orthodontics:	30%	50%	Not Covered
Your Plan Covers			
Basic Services	$3,000 every benefit year combined for all Basic, Comprehensive Basic and Major Services	$2,500 every benefit year combined for all Basic, Comprehensive Basic and Major Services	$2,000 every benefit year combined for all Basic, Comprehensive Basic and Major Services
Comprehensive Basic Services			
Major Services			
Orthodontics	$3,000 per lifetime per dependent child age 18 and under	$2,500 per lifetime per dependent child age 18 and under	Not Covered
Benefit Year: June 1st to May 31st			
Summary of Covered Benefits			
Basic Services include recall visits once every 9 months for Option 1 and once every 6 months for Option 2 & 3, fillings and extractions **Comprehensive Basic Services** include root canal therapy, periodontal scaling/root planing and denture relining/rebasing, repairs, or adjustments **Major Services** include crowns, dentures and/or bridgework (replacements of each limited to once every 5 years) **Orthodontics** includes treatment to straighten teeth/correct the bite.			

HEALTH CARE SPENDING ACCOUNT SUMMARY

This Health Care Spending Account (HCSA) is funded by your plan sponsor and administered by GSC. It can be used to pay for health and dental expenses that are not covered by your group benefit plan or your provincial health plan.

Lump sum per plan member	An amount as determined by your flex plan selection every benefit year
Benefit Year: June 1st to May 31st	

PERSONAL SPENDING ACCOUNT

This Personal Spending Account (PSA) is a spending account funded by your plan sponsor that you can use to pay for a range of personal wellness related expenses not covered by your group benefit plan or provincial health plan. Expenses claimed are subject to income tax as outlined by the Canada Revenue Agency

Lump sum per plan member	An amount as determined by your flex plan selection every benefit year
Benefit Year: June 1st to May 31st	

ABOUT THIS SUMMARY

This information is intended to provide an overview of the coverage available. Detailed benefit information about your coverage, including limitations and exclusions applicable to the benefits appearing in this summary, which will form part of your Benefit Plan Booklet, will be available online at greenshield.ca.

This summary describes the deductibles, co-pays and maximums that may be applicable to your coverage if you are included in the Billing Division shown on the cover of this summary. All dollar maximums stated in this summary are expressed in Canadian dollars.

You are covered for only those specific benefits for which you have applied and for which your plan sponsor has certified you are eligible. You must be covered in order for your dependents to be covered. Your coverage will terminate upon the earlier of the date you retirement or the date your plan sponsor advises GSC that you are no longer eligible for coverage. Coverage for your dependents will terminate upon the earlier of termination of your coverage or the date your dependent no longer satisfies the definition of a dependent.

You will receive Identification Cards showing your GSC Identification Number to be used on all claims and correspondence, and for identification purposes when speaking with our Customer Service Centre. Your number will appear on the front of the card and end in -00, while each of your dependents with their numbers will be shown on the back.

PLAN MEMBER ONLINE SERVICES–INFORMATION YOUR WAY

In addition to this summary, and our Customer Service Centre, we also provide you with access to our secure website. Self-service through the GSC website makes things quick, convenient and easy. Register with GSC to:

- View your Benefit Plan Booklet
- Access your personal claims information, including a breakdown of how your claims were processed
- Simulate a claim to instantly find out what portion of a claim will be covered
- Submit certain claims online
- Search for a drug to get information specific to your own coverage (or coverage for your family)
- Search for eligible dental, paramedical, and vision care providers in a particular location (within Canada)
- Search for vision and hearing care providers who offer discounts to GSC plan members through our Preferred Provider Network
- Arrange for claim payments to be deposited directly into your bank account
- Print personalized claim forms and replacement Identification Cards
- Print personal Explanation of Benefits statements for when you need to co-ordinate benefits

Register online at greenshield.ca and see what our website can do for you!

OUR COMMITMENT TO PRIVACY

The GSC Privacy Code balances the privacy rights of our group and benefit plan members and their dependents, and our employees, with the legitimate information requirements to provide customer service. To read our privacy policies and procedures, please visit us at **greenshield.ca**.

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MY BENEFIT PLAN

Green Shield Canada (GSC) is the provider for the following benefits:

Health Benefit Plan; Travel and Dental Benefit Plan

Green Shield Canada (GSC) is the administrator for the following spending accounts that are funded by the plan sponsor:

Health Care Spending Account (HCSA) and Personal Spending Account (PSA)

YOUR GROUP INSURANCE BOOKLET

Industrial Alliance Insurance and Financial Services Inc. is the insurer for the following benefits:

Participant's Life Insurance, Participant's Optional Life Insurance, Spouse's and Dependents' Optional Life Insurance and Long-Term Disability Income Insurance

DEFINITIONS

Unless specifically stated otherwise, the following definitions will apply throughout this booklet.

Allowed amount means**,** as determined by GSC:

a) Drugs – the GSC National Pricing Policy and/or the reasonable and customary charge;
b) Extended Health Services – the reasonable and customary charge for the service or supply but not more than the prevailing charge in the area in which the charge is made for a like service or supply;
c) Dental – the fee guide as specified in the Summary of Benefits.

Benefit year means the 12 consecutive months commencing on June 1st to May 31st of each year.

Biologic drug means a drug that is produced using living cells or microorganisms (e.g., bacteria) and are often manufactured using a specific process known as DNA technology.

Biosimilar drug means a biologic drug demonstrated to be similar to a reference biologic drug already authorized for sale by Health Canada.

Calendar year means the 12 consecutive months commencing on January 1st to December 31st of each year.

Co-pay means

a) for Prescription Drugs, the rendered amount that must be paid by you or your dependent before reimbursement of an expense will be made; and
b) for all other Health and Dental Benefits, the eligible allowed amount that must be paid by you or your dependent before reimbursement of an expense will be made.

Covered person means the plan member who has been enrolled in the plan or his or her enrolled dependents.

Custom made boots or shoes means footwear used by an individual whose condition cannot be accommodated by existing footwear products. The fabrication of the footwear involves making a unique cast of the covered person's feet and the use of 100% raw materials. (This footwear is used to accommodate the bony and structural abnormalities of the feet and lower legs resulting from trauma, disease or congenital deformities.)

Custom made foot orthotics means devices made from a 3-dimensional model of an individual's foot and made from raw materials. (These devices are used to relieve foot pain related to biomechanical misalignment to the feet and lower limbs.)

Deductible is the amount that must be paid by or on behalf of you and your dependent in any benefit year before reimbursement of an eligible expense will be made.

Dependent means

a) your spouse, if you are legally married or if not legally married, you have lived in a common-law relationship for more than 1 year. Only one spouse will be considered at any time as being covered under the group contract;
b) your unmarried child under age 21;
c) your unmarried child under age 26, if enrolled and in full-time attendance at an accredited college, university or educational institute;

d) your unmarried child (regardless of age) who became totally disabled while eligible under b) or c) above, and has been continuously so disabled since that time and is considered a dependent as defined under the Income Tax Act, also qualify as a dependent; and
e) for Health Care Spending Account, in addition to your dependents above, your relative who is a Canadian resident and dependent on you for support and for whom you are claiming a tax deduction on your federal tax return, as outlined in the rules and regulations of the Canadian Income Tax Act.

Your child (your or your spouse's natural, legally adopted or stepchildren) must reside with you in a parent-child relationship or be dependent upon you (or both) and not regularly employed.

Children who are in full-time attendance at an accredited school do not have to reside with you or attend school in your province. If the school is in another province or country, you must apply to your provincial health insurance plan for an extension of coverage to ensure your child continues to be covered under a provincial health insurance plan.

Fee guide means the list of dental procedure codes developed by and maintained by the Canadian Dental Association, adopted by the provincial or territorial dental association of the province or territory in which the service is provided (or your province of residence if any dental service is provided outside Canada) and in effect at the time the service is provided.

Injury means an unexpected or unforeseen event that occurs as a direct result of a violent, sudden and unexpected action from an outside source.

Off-label use means using a drug for a purpose or to treat a condition other than what Health Canada has approved that drug to be used.

Orthopedic shoes means off-the-shelf, ready-made footwear prescribed for covered persons diagnosed with a specific medical condition that affects their feet and who require specialized footwear to treat their condition and assist with mobility. The footwear may be modified or adjusted to fit the covered person's feet.

Plan member means you, when you are enrolled for coverage.

Private room for hospital accommodation means a room having only one treatment bed.

Reasonable and customary means in the opinion of GSC, the usual charge of the provider for the service or supply, in the absence of insurance, but not more than the prevailing charge in the area for a like service or supply.

Reference biologic drug means a biologic drug that is first authorized for sale by Health Canada.

Rendered amount means the amount charged by a provider for a service and submitted for payment of a claim.

Semi-private room for hospital accommodation means a room having only two treatment beds.

ELIGIBILITY

For You

To be eligible for coverage, you must be a plan member who is:

a) a resident of Canada;
b) covered under your provincial health insurance plan; and
c) actively at work and working a minimum of 20 hours per week on a regular basis (except for retired plan members).

For Your Dependents

To be eligible for coverage you must be:

a) covered under this plan; and
b) each dependent must be covered under a provincial health insurance plan.

Coverage Effective Date

Your coverage begins on the date you become eligible for coverage, have satisfied the eligibility requirements and you are enrolled under the plan.

You will be eligible for coverage on the first day following 3 months of continuous active employment.

Your dependent coverage will begin on the same date as your coverage.

Your plan sponsor is solely responsible for submitting all required forms to GSC as of the Effective Date of this plan or as of the first date that you become eligible.

Enrolment

To enroll, you must request coverage by supplying the appropriate enrolment information to your administrator within 31 days of becoming eligible for the benefits plan. There are 3 options available for each of the following 4 categories: Prescription Drugs, Medical Items & Services, Paramedical Services and Vision and Dental. If you opt out of the Medical Items & Services category, this also opts you out of the Travel Benefit and the corresponding flex dollars will be forfeited.

You may choose different coverage options for both the Health Benefit Plan and Dental Benefit Plan.

Coverage Lock-In Period

Once you have elected your coverage Option, you will be permitted to increase or decrease your coverage:

a) on the benefit enrollment date following 12 months of coverage; or
b) within 31 days of experiencing a qualifying life event.

Default Coverage

If you do not enrol within 31 days of becoming eligible you will receive Option 1 - single coverage only for Health and Dental.

Re-enrolment

Re-enrolment occurs every 12 months with your choices effective June 1st. You may elect to change your coverage selection or continue your current coverage selection for the next benefit period (subject to the locked-in restrictions). If you do not re-elect coverage, your existing coverage choices will apply.

Opting Out

Participation in this plan is compulsory. However, if you have waived eligibility due to having coverage through your spouse's benefit plan, you must request coverage from your plan sponsor within 31 days after termination of the coverage under your spouse's plan.

Life Events

If you experience a qualifying life event, you may elect to increase as many levels as you wish or decrease by one level only within 31 days of your life event change. Qualifying life events include:

a) the birth or adoption of a child;
b) a change in dependent child eligibility;
c) the death of a spouse or dependent child;
d) a change in your marital status;
e) the loss of spouse's coverage under another plan;
f) a change in work status (ie. move from Full Time to Part Time); or
g) a move to another province.

Termination

Your coverage will end on the earliest of the following dates:

a) the date your employment ends;
b) the date you are no longer actively working;
c) the date you retire;
d) the end of the period for which rates have been paid to GSC for your coverage;
e) the date the group contract terminates.

Dependent coverage will end on the earliest of the following dates:

a) the date your coverage terminates;
b) the date your dependent is no longer an eligible dependent;
c) the date on which your dependent child attains the specified age limit;
d) the end of the period for which rates have been paid for dependent coverage;
e) the date the group contract terminates.

Dependent Children Continuation of Coverage

Any child whose coverage would end because they have reached the specified age limit may qualify for continued coverage, subject to the following conditions:

a) your child became dependent upon you by reason of a mental or physical disability prior to reaching this age; and
b) your child has been continuously so disabled since that time.

Survivor Continuation of Coverage

(not applicable to Health Care Spending Account and Personal Spending Account)

In the event of your death while covered by this plan, coverage will continue for your eligible covered dependents until the earliest of the following dates:

a) 12 months after the date of your death;
b) the date the covered person would no longer be considered a dependent under the plan if you were still alive; or
c) the date the benefit under which your dependent is covered, terminates.

Losing your Group Benefits?

If your coverage terminates under your Plan Sponsor's benefit plan, you may apply for one of GSC's individual Health and Dental plans. Acceptance for these plans is guaranteed as long as GSC receives your application within 90 days of your employee benefits termination date, provided GSC receives the initial payment. There are no health questions and no medical when you apply. These plans offer coverage for medications that treat pre-existing conditions. Best of all, they provide life-time coverage.

SureHealth™ LINK Plans– Buying directly from GSC

Visit SureHealth.ca where you'll find details about the SureHealth™ LINK plan options available. You can request an information package, you can get quotes online, and you can buy completely online. It is quick and easy. You can give us a call at 1.844.753.SURE (7873) –we can answer any questions you have or we can take your application over the phone.

PRISM CONTINUUM® – Buying from an Advisor

Special Benefits Insurance Services (SBIS) can help. Call 416.601.0429 or 1.800.667.0429 to speak with a specialist about the Prism Continuum program. They can review the options available to you and advise you on the coverage that best suits your needs.

DESCRIPTION OF BENEFITS

HEALTH BENEFIT PLAN

The benefits described in this section will be eligible, up to the amount shown in the Summary of Benefits, if they are medically necessary for the treatment of an illness or injury. Reimbursement will be limited to reasonable and customary charges in addition to any specific limitations and maximums stated in the Summary of Benefits and as stated in this Description of Benefits.

Prescription Drugs

Prescription drug benefits, up to the amount shown in the Summary of Benefits, that:

a) are prescribed by a legally qualified medical practitioner or dental practitioner as permitted by law; and
b) legally require a prescription and have a Drug Identification Number (DIN); and
c) are approved under GSC's drug review process; and
d) are paid on a Pay Direct basis.

GSC reserves the right to manage its drug formularies through an evidence-based review process in which drugs are evaluated based on overall value taking into account clinical efficacy, safety, unmet need and plan affordability. Formulary management includes the right to:

- add a drug to GSC's formularies;
- exclude or remove a drug from GSC's formularies regardless of Health Canada approval and/or the existence of provincial coverage;
- place restrictions on a formulary drug as determined by GSC. Restrictions may include, but are not limited to, GSC's pre-approval of the drug before the claim can be reimbursed, requirement to obtain the drug through an approved provider, and requirement to obtain a lower cost alternative of the same treatment such as a generic or a biosimilar drug.

If approved by GSC, this plan includes drugs with a Drug Identification Number (DIN) that do not legally require a prescription, including, but not limited to nitroglycerin, insulin and all other approved injectables, as well as related supplies such as diabetic syringes, needles, lancets, and testing agents.

Certain drugs require prior approval from GSC before your drug claim can be reimbursed. You can find out if your drug requires prior approval either by using the online drug search tool available to you through GSC's Plan Member Online Services, or by contacting GSC's Customer Service Centre.

For Quebec:
In no event will the amount dispensed exceed a 3-month supply (6 months if a vacation supply is required) of a prescription at any one time and not more than a 13-month supply in any 12 consecutive months.

For All Other Provinces:
Maintenance drugs required to treat lifelong chronic conditions may be required to be purchased in a 90-day supply of a prescription at any one time. Non-maintenance drugs may be purchased in a supply not exceeding 3-months (90-day) supply of a prescription at any one time. However, for all drugs, 6 months for a vacation supply may be purchased and not more than a 13-month supply in any 12 consecutive months.

Generic drug substitution
Reimbursement will be made for the cost of the lowest priced equivalent drug based on specific provincial regulations, unless your medical or dental practitioner has written that there is to be no substitution of the prescribed drug or medicine.

NOTE:

Drug Benefit over age 65: The Drug Benefit co-pay and the deductible (where applicable) in your province of residence are eligible benefits.

Quebec residents only: Legislation requires GSC to follow the RAMQ (The Regie de l'assurance maladie du Quebec) reimbursement guidelines for all residents of Quebec. If you are younger than age 65, you must enroll for the GSC Prescription Drugs benefit plan and GSC will be the only payer. If you are age 65 or older, enrolment in RAMQ is automatic, enrolment in the GSC Prescription Drugs benefit plan is optional, and RAMQ would be first payer.

If any provisions of this plan do not meet the minimum requirements of the RAMQ plan, adjustments are automatically made to meet RAMQ requirements.

Eligible benefits do not include and no amount will be paid for:

a) Drugs for the treatment of obesity, erectile dysfunction and infertility;
b) Reference biologic drugs that have an approved biosimilar;
c) Vitamins that do not legally require a prescription;
d) Vaccines;
e) Nicotine replacement products, such as patches, gum, lozenges, and inhalers;
f) Products which may lawfully be sold or offered for sale other than through retail pharmacies, and which are not normally considered by practitioners as medicines for which a prescription is necessary or required;
g) Ingredients or products which have not been approved by Health Canada for the treatment of a medical condition or disease and are deemed to be experimental in nature and/or may be in the testing stage.

Medical Cannabis

Medical cannabis, up to the amount shown in the Summary of Benefits when use is authorized by a legally authorized physician (M.D.) or nurse practitioner for covered persons at least 25 years of age for the treatment of medical conditions approved for coverage, as determined by GSC. All claims for medical cannabis are subject to GSC's pre-authorization process.

Reimbursement for medical cannabis (including tax and shipping charges) will be considered as a treatment of last resort when all other standard medications and treatment options, including commercially available cannabinoids that have been issued a DIN by Health Canada, have failed or deemed inappropriate, and the medical cannabis is:

- a form that is considered legal for medical purposes as defined by the *Access to Cannabis for Medical Purposes Regulations*; and
- dispensed by a producer licensed by Health Canada.

Reimbursement will not be made for any equipment or supplies required to grow or harvest any plants, or produce any form of medical cannabis or cannabinoid, regardless if such form is approved for use by Health Canada, or any devices required to administer the product such as, but not limited to, pipes or vapourizers.

Extended Health Services

Hospital Accommodation: Provided your provincial health insurance plan has accepted or agreed to pay the ward or standard rate, reimbursement for hospital accommodation shown in the Summary of Benefits will be limited to:

a) reasonable and customary charges in the area where received, for accommodation in a public general hospital; and
b) for accommodation in a convalescent or rehabilitation hospital or a convalescent or rehabilitation wing in a public general hospital or a public chronic hospital or chronic care in a public general hospital (when admitted within 14 days of discharge from a public general hospital), limited to the following:
   - Option 1 - $20 per day, limited to 180 days every benefit year
   - Option 2 - $30 per day, limited to 180 days every benefit year
   - Option 3 - $40 per day, limited to 180 days every benefit year

Hearing Care: Reimbursement for hearing aids, repairs or replacement parts, if recommended or approved by the attending legally qualified medical practitioner, up to the amount shown in the Summary of Benefits. No amount will be paid for batteries.

Medical Items and Services: When prescribed by a legally qualified medical practitioner, unless specified otherwise below, reimbursement for reasonable and customary charges, up to the amount, where applicable, as shown in the Summary of Benefits for:
a) Aids for daily living: such as hospital style beds, including rails and mattresses; bedpans; standard commodes; decubitus (bedridden) supplies; I.V. stands; trapezes; urinals;
b) Footwear, when prescribed by your attending physician, nurse practitioner, podiatrist or chiropodist, and dispensed by your podiatrist, chiropodist, chiropractor, orthotist, or pedorthist:
   i) custom-made foot orthotics or repairs to custom made foot orthotics;
   ii) custom-made boots or shoes, , modifications and repairs to orthopedic shoes, or footwear as an integral part of a brace, (subject to a medical pre-authorization);
c) Braces, casts;
d) Diabetic equipment, such as:
   i) blood glucose meters;
   ii) insulin pumps;
   iii) insulin pump supplies;
   iv) diabetic supplies; and
   v) glucose monitoring systems (GMS) such as continuous and flash type monitors subject to medical pre-authorization and reimbursed to the cost of a blood glucose meter. Disposable GMS supplies (used with the monitor), such as, but not limited to sensors and transmitters, are included and subject to any overall annual maximum applicable to diabetic testing and monitoring equipment and supplies;
e) Medical services, such as diagnostic tests, X-rays and laboratory tests;
f) Incontinence/Ostomy equipment, such as catheter supplies and ostomy supplies;
g) Mobility aids such as canes, crutches, walkers and wheelchairs (including batteries);
h) Standard prosthetics, such as:
   i) arm, hand, leg, foot, eye, larynx,
   ii) external breast prosthesis limited to $150 every 24 months;
   iii) post-mastectomy bra;
   iv) cataract eyewear, limited to $200 per lifetime for covered persons 65 years of age and under;
i) Respiratory/Cardiology equipment, such as compressors, inhalant devices, tracheotomy supplies and oxygen;
j) Compression stockings with a pressure measurement of 15 mmhg or higher, limited to $100 every benefit year;
k) Wigs, for temporary or permanent hair loss as a result of a medical condition, limited to $150 every benefit year;

Some items may require pre-authorization. To confirm eligibility prior to purchasing or renting equipment, submit a Pre-Authorization Form to GSC.

Limitations

a) The rental price of durable medical equipment will not exceed the purchase price. GSC's decision to purchase or rent will be based on the legally qualified medical practitioner's estimate of the duration of need as established by the original prescription. Rental authorization may be granted for the prescribed duration. Equipment that has been refurbished by the supplier for resale is not an eligible benefit;

b) Durable medical equipment must be appropriate for use in the home, able to withstand repeated use and generally not useful in the absence of illness or injury;

c) When deluxe medical equipment is a covered benefit, reimbursement will be made only when deluxe features are required in order for the covered person to effectively operate the equipment. Items that are not primarily medical in nature or that are for comfort and convenience are not eligible.

Emergency Transportation: Reimbursement for reasonable and customary charges for professional land or air ambulance to the nearest hospital equipped to provide the required treatment, when medically required as the result of an injury, illness or acute physical disability.

Private Duty Nursing in the Home: Reimbursement for the services of a Registered Nurse (R.N.) or Registered Practical Nurse/Licensed Practical Nurse (R.P.N./L.P.N.) in the home on a visit or shift basis, up to the amount shown in the Summary of Benefits. No amount will be paid for services which are custodial and/or services which do not require the skill level of a Registered Nurse (R.N.) or Registered Practical Nurse/Licensed Practical Nurse (R.P.N./L.P.N.).

A Pre-Authorization Form for Private Duty Nursing must be completed by the attending physician and submitted to GSC.

Paramedical Practitioners: Reimbursement for the services of the practitioners included, up to the amount shown in the Summary of Benefits, when the practitioner rendering the service is licensed by their provincial regulatory agency or a registered member of a professional association and that association is recognized by GSC. Please contact the GSC Customer Service Centre to confirm practitioner eligibility.

NOTE:

- Podiatry services are eligible in coordination with your provincial health insurance plan

Accidental Dental: Reimbursement for the services of a licensed dental practitioner for dental care to natural teeth when necessitated by a direct blow to the mouth and not by an object wittingly or unwittingly placed in the mouth. The accident must occur while the coverage is in force. When natural teeth have been damaged eligible services are limited to one set of artificial teeth. You must notify GSC immediately following the accident and the treatment must commence within 180 days of the accident.

GSC will not be liable for any services performed after the earlier of a) 365 days following the accident, or b) the date you or your dependent cease to be covered under this plan.

No amount will be paid for periodontia or orthodontia treatments or the repair or replacement of artificial teeth.

Charges will be based on the current Provincial Dental Association Fee Guide for General Practitioners in the province where services are rendered. Approval will be based on the current status and/or benefit level of the covered person at the time that we are notified of the accident. Any change in coverage will alter GSC's liability.

In the event of a dental accident, claims should be submitted under the health benefit plan before submitting them under the dental plan.

Vision (Option 1):
Reimbursement up to the amounts shown in the Summary of Benefits, for optometric eye examinations for visual acuity performed by a licensed optometrist, ophthalmologist or physician. This benefit is available only in those provinces where eye examinations are not covered by the provincial health insurance plan.

This benefit does not include and no amount will be paid for prescription eyeglasses or contact lenses, medically necessary contact lenses or any other related services.

Vision (Option 2 & 3):
Reimbursement for the services performed by a licensed Optometrist, Optician or Ophthalmologist, up to the amounts shown in the Summary of Benefits, for:

a) Prescription eyeglasses or contact lenses;
b) Optometric eye examinations for visual acuity performed by a licensed optometrist, ophthalmologist or physician. This benefit is available only in those provinces where eye examinations are not covered by the provincial health insurance plan;
c) Medically necessary contact lenses when visual acuity cannot otherwise be corrected to at least 20/40 in the better eye or when medically necessary due to keratoconus, irregular astigmatism, irregular corneal curvature or physical deformity resulting in an inability to wear normal frames;
d) Replacement parts for prescription eyeglasses;
e) Laser eye surgery;
f) Plano sunglasses prescribed by a legally qualified medical practitioner for the treatment of specific ophthalmic diseases or conditions.

Eligible benefits do not include and no amount will be paid for:

a) Medical or surgical treatment, except for laser eye surgery;
b) Special or unusual procedures such as, but not limited to, orthoptics, vision training, subnormal vision aids and aniseikonic lenses;
c) Follow-up visits associated with the dispensing and fitting of contact lenses;
d) Charges for eyeglass cases.

Health Exclusions

Eligible benefits do not include and reimbursement will not be made for:

1. Services or supplies received as a result of disease, illness or injury due to:
   a) an act of war, declared or undeclared;
   b) participation in a riot or civil commotion; or
   c) committing a criminal offence;

2. Services or supplies provided while serving in the armed forces of any country;

3. Failure to keep a scheduled appointment with a legally qualified medical or dental practitioner;

4. The completion of any claim forms and/or insurance reports;

5. Any specific treatment or drug which:
   a) does not meet accepted standards of medical, dental or ophthalmic practice, including charges for services or supplies which are experimental in nature;
   b) is not considered to be effective (either medically or from a cost perspective) as determined by GSC's drug review process regardless if Health Canada's approved the drug;
   c) is an adjunctive drug prescribed in connection with any treatment or drug that is not an eligible service;
   d) is administered in a hospital or is required to be administered in a hospital in accordance with Health Canada's approved indication for use;
   e) is not dispensed by the pharmacist in accordance with the payment method shown under the Prescription Drugs benefit;
   f) is not being used and/or administered in accordance with Health Canada's approved indication for use (i.e. off-label use), even though such drug or procedure may customarily be used in the treatment of other illnesses or injuries;

6. Services or supplies that:
   a) are not recommended, provided by or approved by the attending legally qualified (in the opinion of GSC) medical practitioner or dental practitioner as permitted by law;
   b) are legally prohibited by the government from coverage;
   c) you are not obligated to pay for or for which no charge would be made in the absence of benefit coverage or for which payment is made on your behalf by a not-for-profit prepayment association, insurance carrier, third party administrator, like agency or a party other than GSC, your plan sponsor or you;
   d) are provided by a health practitioner whose license by the relevant provincial regulatory and/or professional association has been suspended or revoked;
   e) are not provided by a designated provider of service in response to a prescription issued by a legally qualified health practitioner;
   f) are used solely for recreational or sporting activities and which are not medically necessary for regular activities;
   g) are primarily for cosmetic or aesthetic purposes, or are to correct congenital malformations;
   h) are provided by an immediate family member related to you by birth, adoption, or by marriage and/or a practitioner who normally resides in your home. An immediate family member includes a parent, spouse, child or sibling;
   i) are provided by your plan sponsor and/or a practitioner employed by your plan sponsor, other than as part of an employee assistance plan;

j) are a replacement of lost, missing or stolen items, or items that are damaged due to negligence. Replacements are eligible when required due to natural wear, growth or relevant change in your medical condition but only when the equipment/prostheses cannot be adjusted or repaired at a lesser cost and the item is still medically required;
k) are video instructional kits, informational manuals or pamphlets;
l) are for medical or surgical audio and visual treatment;
m) are special or unusual procedures such as, but not limited to, orthoptics, vision training, subnormal vision aids and aniseikonic lenses;
n) are delivery and transportation charges;
o) are for Insulin pumps and supplies (unless otherwise covered under the plan);
p) are for medical examinations or hearing aid evaluation tests;
q) are batteries, unless specifically included as an eligible benefit;
r) are a duplicate prosthetic device or appliance;
s) are from any governmental agency which are obtained without cost by compliance with laws or regulations enacted by a federal, provincial, municipal or other governmental body;
t) would normally be paid through any provincial health insurance plan, Workplace Safety and Insurance Board or tribunal, the Assistive Devices Program or any other government agency, or which would have been payable under such a plan had proper application for coverage been made, or had proper and timely claims submission been made;
u) were previously provided or paid for by any governmental body or agency, but which have been modified, suspended or discontinued as a result of changes in provincial health plan legislation or de-listing of any provincial health plan services or supplies;
v) may include but are not limited to, drugs, laboratory services, diagnostic testing or any other service which is provided by and/or administered in any public or private health care clinic or like facility, medical practitioner's office or residence, where the treatment or drug does not meet the accepted standards or is not considered to be effective (either medically or from a cost perspective, based on Health Canada's approved indication for use);
w) are provided by a medical practitioner who has opted out of any provincial health insurance plan and the provincial health insurance plan would have otherwise paid for such eligible service;
x) relates to treatment of injuries arising from a motor vehicle accident;
   Note: Payment of benefits for claims relating to automobile accidents for which coverage is available under a motor vehicle liability policy providing no-fault benefits will be considered only if–
   i) the service or supplies being claimed is not eligible; or
   ii) the financial commitment is complete;
   A letter from your automobile insurance carrier will be required;
y) are cognitive or administrative services or other fees charged by a provider of service for services other than those directly relating to the delivery of the service or supply.

TRAVEL

Expenses arising as a result of a medical emergency while you or an eligible dependent are temporarily outside of your regular province of residence for vacation, business, or education will be considered eligible under the Travel benefit.

To qualify for benefits, the claimants must be covered by their respective provincial government health plan or equivalent at the time the expenses are incurred.

Eligible travel benefits will be considered based on the reasonable and customary charges in the area where they were received, less the amount payable by your provincial health insurance plan, if your province provides such coverage. This limitation is not applicable if you reside in a province that does not offer out-of-Canada coverage.

All dollar maximums and limitations are stated in Canadian currency. Reimbursement will be made in Canadian funds or U.S. funds for both providers and plan members, based on the country of the payee. For payments that require currency conversion, the rate of exchange used will be the rate in effect on the date of service of the claim.

Upon notification of the necessity for treatment of an accidental injury or medical emergency, **the patient must contact GSC Travel Assistance within 48 hours of commencement of treatment.**

> **Emergency means** a sudden, unexpected injury, illness or acute episode of disease that requires immediate medical attention **and could not have been reasonably anticipated based upon the patient's prior medical condition**. This includes treatment (non-elective) for immediate relief of severe pain, suffering or disease that cannot be delayed until you or your dependent is medically able to return to your province of residence.
>
> Any invasive or investigative procedures must be pre-approved by GSC Assistance Medical Team.

Eligible benefits are limited to the maximum days per trip shown in the Summary of Benefits commencing with the date of departure from your province of residence. If you are hospitalized on the last day shown in the Summary of Benefits, your benefits will be extended until the date of discharge.

Hospital services and accommodation up to a standard ward rate in a public general hospital;

Medical/surgical services rendered by a legally qualified physician or surgeon to relieve the symptoms of, or to cure an unforeseen illness or injury;

Emergency Transportation

- **Land ambulance** to the nearest qualified medical facility
- **Air ambulance -** the cost of air evacuation (including a medical attendant when necessary) between hospitals and for hospital admission into Canada when approved in advance by your provincial health insurance plan or to the nearest qualified medical facility

Referral services – (a) hospital services and accommodation, up to a standard ward rate in a public general hospital, and/or (b) medical surgical services rendered by a legally qualified physician or surgeon;

- **Prior to the commencement of any referral treatment, written pre-authorization** from your provincial health insurance plan and GSC **must be obtained**. Your provincial health insurance plan may cover this referral benefit entirely. You must provide GSC with a letter from your attending physician stating the reason for the referral, and a letter from your provincial health insurance plan outlining their liability. **Failure to comply in obtaining pre-authorization will result in non-payment**

Services of a registered private nurse up to a maximum of $5,000 per calendar year, at the reasonable and customary rate charged by a qualified nurse (R.N.) registered in the jurisdiction in which treatment is provided. You must contact GSC Travel Assistance for pre-approval;

Diagnostic laboratory tests and X-rays when prescribed by the attending physician. Except in emergency situations, GSC Travel Assistance must pre-approve these services (i.e. cardiac catheterization or angiogram, angioplasty and bypass surgery);

Reimbursement of prescriptions for drugs, serums and injectables which require a prescription by law and are prescribed by a legally qualified medical practitioner (vitamins, patent and proprietary drugs are excluded). Submit to GSC Travel Assistance the original paid receipt from the pharmacist, physician or hospital outside your province of residence showing the name of the prescribing physician, prescription number, name of preparation, date, quantity and total cost;

Medical appliances including casts, crutches, canes, slings, splints and/or the temporary rental of a wheelchair when deemed medically necessary and required due to an accident which occurs, and when the devices are obtained outside your province of residence;

Treatment by a dentist only when required due to a direct accidental blow to the mouth up to a maximum of $2,000. Treatments (prior to and after return) must be provided within 90 days of the accident. Details of the accident must be provided to GSC Travel Assistance along with dental X-rays;

Coming Home - when your emergency illness or injury is such that:

- GSC Assistance Medical Team specifies in writing that you should immediately return to your province of residence for immediate medical attention, reimbursement will be made for the extra cost incurred for the purchase of a one way economy airfare, plus the additional economy airfare if required to accommodate a stretcher, to return you by the most direct route to the major air terminal nearest the departure point in your province of residence

  This benefit assumes that you are not holding a valid open-return air ticket. Charges for upgrading, departure taxes, cancellation penalties or airfares for accompanying family members or friends are not included;

- GSC Assistance Medical Team or commercial airline stipulates in writing that you must be accompanied by a qualified medical attendant, reimbursement will be made for the cost incurred for one round trip economy airfare and the reasonable and customary fee charged by a medical attendant who is not your relative by birth, adoption or marriage and is registered in the jurisdiction in which treatment is provided, plus overnight hotel and meal expenses if required by the attendant

Cost of returning your personal use motor vehicle to your residence or nearest appropriate vehicle rental agency when you are unable to due to sickness, physical injury or death, up to a maximum of $1,000 per trip. We require original receipts for costs incurred, i.e. gasoline, accommodation and airfares;

Meals and accommodation up to $1,500 (maximum of $150 per day for up to 10 days) will be reimbursed for the extra costs of commercial hotel accommodation and meals incurred by you when you remain with a travelling companion or a person included in the "family" coverage, when the trip is delayed or interrupted due to an illness, accidental injury to or death of a travelling companion. This must be verified in writing by the attending legally qualified physician or surgeon and supported with original receipts from commercial organization;

Transportation to the bedside including round trip economy airfare by the most direct route from your province of residence, for any one spouse, parent, child, brother or sister, and up to $150 per day for a maximum of 5 days for meals and accommodation at a commercial establishment will be paid for that family member to:

- be with you or your covered dependent when confined in hospital. This benefit requires that the covered person must eventually be an inpatient for at least 7 days outside your province of residence, plus the written verification of the attending physician that the situation was serious enough to have required the visit

- identify a deceased prior to release of the body

Return airfare if the personal use motor vehicle of you or your covered dependent is stolen or rendered inoperable due to an accident, reimbursement will be made for the cost of a one-way economy airfare to return you by the most direct route to the major airport nearest your departure point in your province of residence. An official report of the loss or accident is required;

Return of deceased up to a maximum of $5,000 toward the cost of embalming or cremation in preparation for homeward transportation in an appropriate container of yourself or your covered dependent when death is caused by illness or accident. The body will be returned to the major airport nearest the point of departure in your province of residence. The benefit excludes the cost of a burial coffin or any funeral-related expenses, makeup, clothing, flowers, eulogy cards, church rental, etc;

GSC TRAVEL ASSISTANCE SERVICE

The following services are available 24 hours per day, 7 days per week through GSC's international medical service organization.

These services include:

- Access to Pre-trip Assistance (prior to departure): Canada Direct Calling Codes; information about vaccinations; government issued travel advisories; and VISA/document requirements for entry into country of destination
- Multilingual assistance
- Assistance in locating the nearest, most appropriate medical care
- International preferred provider networks
- GSC Assistance Medical Team consultative and advisory services, including second opinion and review of appropriateness and analysis of the quality of medical care
- Assistance in establishing contact with family, personal physician and employer as appropriate
- Monitoring of progress during treatment and recovery
- Emergency message transmittal services
- Translation services and referrals to local interpreters as necessary
- Verification of coverage facilitating entry and admissions into hospitals and other medical care providers
- Special assistance regarding the co-ordination of direct claims payment

- Co-ordination of embassy and consular services
- Management, arrangement and co-ordination of emergency medical transportation and evacuation as necessary
- Management, arrangement and co-ordination of repatriation of remains
- Special assistance in making arrangements for interrupted and disrupted travel plans resulting from emergency situations to include:
  - the return of unaccompanied travel companions
  - travel to the bedside of a stranded person
  - rearrangement of ticketing due to accident or illness and other travel related emergencies
  - the return of a stranded personal use motor vehicle and related personal items
- Knowledgeable legal referral assistance
- Co-ordination of securing bail bonds and other legal instruments
- Special assistance in replacing lost or stolen travel documents including passports
- Courtesy assistance in securing incidental aid and other travel related services

How Travel Assistance Service Works

For assistance dial **1.800.936.6226** within Canada and the United States or call collect **0.519.742.3556** when traveling outside Canada and the United States. These numbers appear on your GSC Identification Card.

Quote your GSC Identification Number, found on your GSC Identification Card, and explain your medical emergency. **You must always be able to provide your GSC Identification Number and your provincial health insurance plan number.**

A multilingual Assistance Specialist will provide direction to the best available medical facility or legally qualified physician able to provide the appropriate care.

Upon admission to a hospital or when consulting a legally qualified physician or surgeon for major emergency treatment, we will guarantee the provider (hospital, clinic or physician), that you have the required provincial health insurance plan coverage and GSC travel benefits as detailed above.

GSC Assistance Medical Team will follow your progress to ensure that you are receiving the best available medical treatment. These physicians also keep in constant communication with your family physician and your family, depending on the severity of your condition.

When calling collect while travelling outside Canada and the United States, you may require a Canada Direct Calling Code. In the event that a collect call is not possible, keep your receipts for phone calls made to GSC Travel Assistance and submit them for reimbursement upon your return to Canada.

Travel Limitations

1. Coverage becomes effective at the time you or your dependent crosses the provincial border departing from their province of residence and terminates upon crossing the border returning to their province of residence on the return home. If traveling by air, coverage becomes effective at the time the aircraft takes off in the province of residence and terminates when the aircraft lands in the province of residence on the return home.

2. Upon notification of the necessity for treatment of an accidental injury or medical emergency, GSC's Assistance Medical Team reserves the right to determine whether repatriation is appropriate if the patient's medical condition will require immediate or scheduled care. Such repatriation is mandatory, where the Assistance Medical Team determines that the patient is medically fit to travel and appropriate arrangements have been made to admit the patient into the provincial government health care system of their province of residence. Repatriation will ensure continued coverage under the plan. Should the patient opt not to be repatriated or elects to have such treatment or surgery outside their province of residence, the expense of such continuing treatment will not be an eligible benefit.

   The patient must contact GSC Travel Assistance within 48 hours of commencement of treatment. Failure to notify us within 48 hours may result in benefits being limited to only those expenses incurred within the first 48 hours of any and each treatment/incident or the plan maximum, whichever is the lesser of the two.

3. Air ambulance services will only be eligible if:
   - they are pre-approved by GSC Travel Assistance
   - there is a medical need for you or your dependent to be confined to a stretcher or for a medical attendant to accompany you during the journey
   - you or your dependent are admitted directly to a hospital in your province of residence, and
   - medical reports or certificates from the dispatching and receiving legally qualified physicians are submitted to GSC Travel Assistance
   - proof of payment (including air ticket vouchers or air carrier invoices) is submitted to GSC Travel Assistance

4. If planning to travel in areas of political or civil unrest, or in areas where Global Affairs Canada (GAC) has issued a formal travel warning regarding non-essential travel, contact GSC Travel Assistance for pre-travel advice, as we may be unable to guarantee assistance services.

5. GSC reserves the right, without notice, to suspend, curtail or limit its services in any area in the event of political or civil unrest, including rebellion, riot, military uprising, labour disturbance or strike, act of God, or refusal of authorities in a foreign country to permit GSC to provide service. This includes travel in any area if at the time of booking the trip (including delay of travel), or before your departure date, Global Affairs Canada (GAC) issued a formal travel warning advising Canadians to avoid all or non-essential travel to that specific country, region or city due to a likely or actual epidemic or pandemic, (non-essential travel will be deemed as anything other than a significant medical or family emergency, such as the death of a family member).

Travel Exclusions

In addition to the Health Exclusions, eligible benefits do not include and reimbursement will not be made for:

1. Any expenses incurred for the treatment related directly or indirectly to a pre-existing or pre-diagnosed medical condition that, at the time of your departure from your province of residence, was not completely stable in the professional opinion of GSC Assistance Medical Team and where medical evidence suggested a reasonable expectation that treatment or hospitalization could be required while traveling. GSC reserves the right to review your medical information at the time of claim.

   Stable means that during the 90 days immediately preceding your departure:
   a) your pre-existing/pre-diagnosed medical condition:
      i) has been controlled by the consistent use of the same medications and dosages (excluding changes in medication that regularly occur as part of your ongoing treatment, or decreases in dosage resulting from an improvement in your pre-existing or pre-diagnosed medical condition) prescribed by a legally qualified medical professional;
      ii) has not, in the reasonable opinion of a legally qualified medical professional, required additional treatment for a recurrence, complications or any other reason related either directly or indirectly to your pre-existing or pre-diagnosed medical condition;
   b) you have not consulted a legally qualified medical professional for, or had investigated or diagnosed, a new medical condition for which you have not received medical treatment;
   c) you have not scheduled/are not awaiting any future appointments for non-routine examinations, consultations, tests or investigations (including results) for an undiagnosed medical condition;
   d) you have not scheduled/are not awaiting any exploratory surgical procedures for an undiagnosed medical condition or surgical procedures for a diagnosed medical condition

2. Any expenses incurred for any services received that were not required due to an Emergency. Eligible benefits will not be reimbursed for treatment or surgery that could reasonably be delayed until you return to your province of residence;

3. Any expenses incurred for treatment or surgery not covered under your provincial health insurance plan had the services been received in your province of residence;

4. Any expenses incurred for services normally covered under your provincial health insurance plan's out-of-Canada coverage (where applicable), when the provincial plan has declined payment;

5. Any expenses incurred for services, treatment or surgery received once the patient has opted to not be repatriated or elects to have such treatment or surgery outside their province of residence;

6. Any claims arising directly or indirectly from any medical condition you suffer or contract in a specific country, region or city due to an epidemic or pandemic, if at the time of booking the trip (including delay of travel), or before your departure date, Global Affairs Canada (GAC) issued a formal travel warning advising Canadians to avoid all or non-essential travel to that specific country, region or city. In this exclusion a medical condition is limited to the reason for which the formal travel warning was issued and includes complications arising from such medical condition;

7. Treatment or services required for ongoing care, rest cures, health spas, elective surgery, check-ups or travel for health purposes, even if the trip is on the referral of a physician;

8. Treatment or service that you elect to have performed outside Canada when the medical condition would not prevent your return to Canada for such treatment;

9. Any expenses for injuries caused by, arising from, or directly or indirectly contributed to by the abuse or excessive consumption or use of medications, drugs, alcohol or other toxic substances or for injuries caused by, arising from, or directly or indirectly contributed to as a result of the consequences of such abuse or excessive consumption. Use of alcohol which gives rise to a blood alcohol level of more than 80 milligrams in 100 millilitres of blood will be deemed to be excessive consumption or use and this exclusion will apply;

10. Any expenses relating directly or indirectly to an injury sustained as a result of the covered person's operation of a motorized vehicle while legally impaired or intoxicated as a result of the excessive use of a medication, drugs, alcohol or other toxic substances. Use of alcohol which gives rise to a blood alcohol level of more than 80 milligrams in 100 millilitres of blood will be deemed to be intoxication as a result of excessive use and this exclusion will apply. A motorized vehicle means any form of transportation which is propelled or driven by a motor and includes, but is not restricted to an automobile, truck, motorcycle, moped, snowmobile, or boat);

11. Amounts paid or payable under any Workplace Safety and Insurance Board or similar plan;

12. Hospital and medical care for childbirth occurring within 8 weeks of the expected delivery date from the date of departure, or deliberate termination of pregnancy;

13. Treatment or service provided in a chronic care or psychiatric hospital, chronic unit of a general hospital, Long-Term Care (LTC) Facility, health spa, or nursing home;

14. Services received from a chiropractor, chiropodist, podiatrist, or for osteopathic manipulation;

15. Cataract surgery or the purchase of eyeglasses or hearing aids;

16. Any expenses incurred during any trip taken for the purpose of seeking medical treatment or advice that have not been previously authorized as outlined in referral services.

GSC does not assume responsibility for nor will it be liable for any medical advice given, but not limited to a physician, pharmacist or other healthcare provider or facility recommended by GSC Travel Assistance.

DENTAL BENEFIT PLAN

The benefits shown below will be eligible, if based on the licensed dental practitioner's reasonable and customary charge in accordance with the Fee Guide and the maximum shown in the Summary of Benefits.

Basic Services

Basic Diagnostic and Preventive Services:

- complete oral examinations once every 2 benefit years
- emergency and specific oral examinations
- full series X-rays and panoramic X-rays once every 2 benefit years
- bitewing X-rays:
  Option 1 - once every 9 months (every 6 months for covered persons 18 years of age and under)
  Option 2 – once every 6 months
  Option 3 – once every 6 months
- recall examinations:
  Option 1 - once every 9 months (every 6 months for covered persons 18 years of age and under)
  Option 2 – once every 6 months
  Option 3 – once every 6 months
- cleaning of teeth (up to 1 unit of polishing) once per recall period
- cleaning of teeth (up to 1 unit of scaling) once per recall period (twice per calendar year for Quebec)
- topical application of fluoride twice per calendar year (once per recall period for Quebec)
- oral hygiene instruction once per lifetime
- denture cleaning once per recall period
- pit and fissure sealants on molars only
- space maintainers, for covered persons 17 years of age and under (maintenance of space maintainer, limited to twice every 12 months)

Basic Restorative Services:

- amalgam, tooth coloured filling restorations, and temporary sedative fillings
- inlay restorations – these are considered basic restorations and will be paid to the equivalent non-bonded amalgam

Basic Oral Surgery:

- extractions of teeth and/or residual roots

General anaesthesia, deep sedation, and intravenous sedation in conjunction with eligible oral surgery only

Comprehensive Basic Services

Standard Denture Services:

- denture repairs and/or tooth/teeth additions
- standard relining and rebasing of dentures once every 2 years, only after 6 months have elapsed from the installation of a denture
- denture adjustments and remount and equilibration procedures, only after 3 months have elapsed from the installation of a denture
- soft tissue conditioning linings for the gums to promote healing
- remake of a partial denture using existing framework, once every 5 years

Comprehensive Oral Surgery:

- surgical exposure, repositioning, transplantation or enucleation of teeth
- remodeling and recontouring - shaping or restructuring of bone or gum
- excision - removal of cysts and tumors
- incision - drainage and/or exploration of soft or hard tissue
- incision for removal of reaction producing foreign bodies, limited to $150 every benefit year
- fractures including the treatment of the dislocation and/or fracture of the lower or upper jaw and repair of soft tissue lacerations
- fracture reduction, limited to $750 every benefit year
- maxilofacial deformities - frenectomy - surgery on the fold of the tissue connecting the lip to the gum or the tongue to the floor of the mouth

Endodontic Treatment

- root canal therapy
- pulpotomy (removal of the pulp from the crown portion of the tooth)
- pulpectomy (removal of the pulp from the crown and root portion of the tooth)
- apexification (assistance of root tip closure)
- apical curettage, root resections and retrograde fillings (cleaning and removing diseased tissue of the root tip)
- root amputation and hemisection
- bleaching of non-vital tooth/teeth
- emergency procedures including opening or draining of the gum/tooth

Periodontal Treatment

- treatment of diseased bone and gums
- periodontal scaling and/or root planing 8 time units every 12 months (10 time units every 12 months for Quebec)
- occlusal equilibration - selective grinding of tooth surfaces to adjust a bite 2 time units every 12 months

The fees for periodontal treatment are based on units of time (15 minutes per unit) and/or number of teeth in a surgical site in accordance with the General Practitioners Fee Guide.

- bruxism appliance once every 24 months

Major Services

- Standard onlays or crown restorations to restore diseased or accidentally injured natural teeth, once every 5 years

- Standard bridges, including pontics, abutment retainers/crowns on natural teeth, once every 5 years

- Standard dentures including complete, immediate, transitional, and partial dentures, once every 5 years

- Standard repair or recementing of crowns, onlays and bridge work on natural teeth

- Implants limited to the cost of a 3 unit bridge once per tooth per lifetime

Orthodontic Services (Option 1 & 2 only)

Reimbursement for orthodontic treatment to straighten teeth and/or correct the bite.

When a lump sum fee has been paid toward orthodontic treatment, the total amount of the claim will be split into separate portions to allow for payment of an initial fee (approximately one-third of the total lump sum), and the balance of the claim will be divided into monthly fees of equal amounts to be reimbursed over the duration of the treatment. Receipts for payment must be received by GSC no later than 12 months from the date the service is incurred while treatment is in progress, not at the end of the treatment.

If orthodontic treatment is terminated for any reason before completion, the obligation to pay benefits will cease with payment to the date of termination. If such services are resumed, benefit for the remaining services, will be resumed. The benefit payment for orthodontic services will be only for the months that coverage is in force.

Alternate Benefit Clause

This benefit plan will reimburse the amount shown in the Fee Guide for the least expensive service or supply where two or more professionally accepted courses of treatment are a benefit under the plan. The covered person can choose to have a more expensive treatment performed, however reimbursement will be limited to the cost of the least expensive alternative.

Predetermination

Before your treatment begins:

- for all proposed treatment for crowns, onlays, bridges, and implants, an estimate completed by your dental practitioner, **must** be submitted for assessment. Our assessment of the proposed treatment, may result in a lesser benefit being payable or may result in benefits being denied. Failure to submit an estimate prior to beginning your treatment will result in the delay of the assessment.
- if the total cost of any other proposed treatment is expected to exceed $300, it is recommended that you submit an estimate completed by your dental practitioner.

Limitations

1. Laboratory services must be completed in conjunction with other services and will be limited to the co-pay of such services. Laboratory services that are in excess of 40% of the dentist's fee in the applicable Fee Guide shown in the Summary of Benefits will be reduced accordingly; co-pay is then applied;

2. Reimbursement will be made according to standard and/or basic services, supplies or treatment. Related expenses beyond the standard and/or basic services, supplies or treatment will remain your responsibility;

3. Reimbursement will be pro-rated and reduced accordingly, when time spent by the dentist is less than the average time assigned to a dental service procedure code in the applicable Fee Guide shown in the Summary of Benefits;

4. Reimbursement for root canal therapy will be limited to payment once only per tooth. Extra charges for difficult access, exceptional anatomy, calcified canals, and retreatments are not included. The total fee for root canal includes all pulpotomies and pulpectomies performed on the same tooth;

5. Reimbursement for the initial installation of implants or bridgework is not eligible on teeth missing prior to the date of your employment.

6. Common surfaces on the same tooth/same day will be assessed as one surface. If individual surfaces are restored on the same tooth/same day, payment will be assessed according to the procedure code representing the combined surface. Payment will be limited to a maximum of 5 surfaces in any 36 month period;

7. When more than one surgical procedure, including multiple periodontal surgical procedures, is performed during the same appointment in the same area of the mouth, only the most comprehensive procedure will be eligible for reimbursement, as the fee for each procedure is based on complete, comprehensive treatment, and is deemed part of the multiple services factor;

8. The multiple services factor occurs when a minimum of 6 or more restorations (fillings) or multiple periodontal services are performed at the same appointment and the full fee guide price is charged for each restoration or periodontal service, the first service will be paid in full and all remaining services will be reduced by 20%;

9. Core build-ups are eligible only for the purpose of retention and preservation of a tooth when performed with crown treatment. Necessity must be evident on mounted pre-treatment X-rays. Core build-ups to facilitate impression taking and/or block out undercuts are considered included in the cost of a crown;

10. Root planing is not eligible if done at the same time as gingival curettage;

11. In the event of a dental accident, claims should be submitted under the health benefit plan before submitting them under the dental plan.

Dental Exclusions

Eligible benefits do not include and reimbursement will not be made for:

1. Services or supplies received as a result of disease, illness or injury due to:
   a) an act of war, declared or undeclared;
   b) participation in a riot or civil commotion; or
   c) committing a criminal offence;

2. Services or supplies provided while serving in the armed forces of any country;

3. Failure to keep a scheduled appointment with a legally qualified dental practitioner;

4. The completion of any claim forms and/or insurance reports;

5. Any dental service that is not contained in the procedure codes developed and maintained by the Canadian Dental Association, adopted by the provincial or territorial dental association of the province or territory in which the service is provided (or your province of residence if any dental service is provided outside Canada) and in effect at the time the service is provided;

6. Restorations necessary for wear, acid erosion, vertical dimension and/or restoring occlusion;

7. Appliances related to treatment of myofascial pain syndrome including all diagnostic models, gnathological determinants, maintenance, adjustments, repairs and relines;

8. Posterior cantilever pontics/teeth and extra pontics/teeth to fill in diastemas/spaces;

9. Service and charges for sleep dentistry;

10. Diagnostic and/or intraoral repositioning appliances including maintenance, adjustments, repairs and relines related to treatment of temporomandibular joint dysfunction;

11. Any specific treatment or drug which:
    a) does not meet accepted standards of medical, dental or ophthalmic practice, including charges for services or supplies which are experimental in nature;
    b) is not considered to be effective (either medically or from a cost perspective) as determined by GSC's drug review process regardless if Health Canada's approved the drug;
    c) is an adjunctive drug prescribed in connection with any treatment or drug that is not an eligible service;
    d) is administered in a hospital or is required to be administered in a hospital in accordance with Health Canada's approved indication for use;
    e) is not dispensed by the pharmacist in accordance with the payment method shown under the Health Benefit Plan Prescription Drugs benefit;
    f) is not being used and/or administered in accordance with Health Canada's approved indication for use (i.e. off-label use), even though such drug or procedure may customarily be used in the treatment of other illnesses or injuries;

12. Services or supplies that:
    a) are not recommended, provided by or approved by the attending legally qualified (in the opinion of GSC) medical practitioner or dental practitioner as permitted by law;
    b) are legally prohibited by the government from coverage;
    c) you are not obligated to pay for or for which no charge would be made in the absence of benefit coverage; or for which payment is made on your behalf by a not-for-profit prepayment association, insurance carrier, third party administrator, like agency or a party other than GSC, your plan sponsor or you;
    d) are provided by a health practitioner whose license by the relevant provincial regulatory and/or professional association has been suspended or revoked;
    e) are not provided by a designated provider of service in response to a prescription issued by a legally qualified health practitioner;
    f) are used solely for recreational or sporting activities and which are not medically necessary for regular activities;
    g) are primarily for cosmetic or aesthetic purposes, or are to correct congenital malformations;
    h) are provided by an immediate family member related to you by birth, adoption, or by marriage and/or a practitioner who normally resides in your home. An immediate family member includes a parent, spouse, child or sibling;
    i) are provided by your plan sponsor and/or a practitioner employed by your plan sponsor, other than as part of an employee assistance plan;
    j) are a replacement of lost, missing or stolen items, or items that are damaged due to negligence. Replacements are eligible when required due to natural wear, growth or relevant change in your medical condition but only when the equipment/prostheses cannot be adjusted or repaired at a lesser cost and the item is still medically required;
    k) are video instructional kits, informational manuals or pamphlets;
    l) are delivery and transportation charges;
    m) are a duplicate prosthetic device or appliance;
    n) are from any governmental agency which are obtained without cost by compliance with laws or regulations enacted by a federal, provincial, municipal or other governmental body;
    o) would normally be paid through any provincial health insurance plan, Workplace Safety and Insurance Board or tribunal, or any other government agency, or which would have been payable under such a plan had proper application for coverage been made, or had proper and timely claims submission been made;
    p) relates to treatment of injuries arising from a motor vehicle accident;
       Note: Payment of benefits for claims relating to automobile accidents for which coverage is available under a motor vehicle liability policy providing no-fault benefits will be considered only if–
       i) the service or supplies being claimed is not eligible; or

ii) the financial commitment is complete;
A letter from your automobile insurance carrier will be required;

q) are cognitive or administrative services or other fees charged by a provider of service for services other than those directly relating to the delivery of the service or supply.

HEALTH CARE SPENDING ACCOUNT (HCSA)

Your HCSA is governed at all times by the rules and regulations of the Income Tax Act. In the event of a dispute, the Income Tax Act shall prevail. The liability for the HCSA lies solely with your plan sponsor.

Your HCSA is provided by your plan sponsor and administered by GSC.

Your HCSA is a spending account funded by your plan sponsor that you can use to pay for health and dental expenses that are not covered by your group benefit plan or your provincial health plan.

At the beginning of each benefit year, a predetermined lump sum amount as shown in the Summary of Benefits will be allocated to your account annually to cover the reimbursement of your eligible expenses incurred during that benefit year. When you submit a claim, you will be reimbursed for eligible expenses up to the balance in your account.

Any balance remaining in your account on the last day of the benefit year will be carried forward to, but not beyond the end of, the next benefit year. This balance will be added to your new credits, and claims for the new benefit year will be applied to the combined amount, using the previous benefit year credits first. At the end of the new benefit year, any remaining previous benefit year credits will be forfeited.

ELIGIBLE EXPENSES

Eligible expenses include but are not limited to those that qualify for medical expense tax credits under the Canada Revenue Agency (CRA) Income Tax guidelines. It also includes the amount of the deductible and the percentage not covered by the group benefit plan or the amount in excess of group benefit plan maximums.

For a list of eligible medical expenses, visit our website at greenshield.ca, or for more information about eligible expenses you can consult a CRA office or visit the CRA website at cra-arc.gc.ca/medical

Exclusions

Expenses not eligible for reimbursement are at all times governed by the non-eligible expenses, restrictions and limitations outlined in the Canadian Income Tax Act. An example of expenses would be:

a) premiums paid to provincial medical or hospitalization plans; and
b) medical costs for which you or your dependent are reimbursed or entitled to be reimbursed under a provincial health insurance plan, your group benefit plan or your spouse's group benefit plan.

Maternity, Adoption or Parental Leave

If you elect to continue benefits under your group plan, you may continue to submit claims for expenses incurred prior to, or during, the period of your leave.

PERSONAL SPENDING ACCOUNT (PSA)

Your PSA is provided by your plan sponsor and administered by GSC. Your plan sponsor reserves the right to cancel, alter or amend the terms and provisions of the PSA to ensure the program is reaching the desired goal of increased health and wellness.

Your PSA is a spending account funded by your plan sponsor that you can use to pay for a range of personal wellness related expenses not covered by your group benefit plan or provincial health plan. Expenses claimed are subject to income tax as outlined by the Canada Revenue Agency.

At the beginning of each benefit year, a predetermined lump sum amount as shown in the Summary of Benefits will be allocated to your account annually to cover the reimbursement of your eligible expenses incurred during that benefit year. When you submit a claim, you will be reimbursed for eligible benefits up to the balance in your account.

Any balance remaining in your account on the last day of the benefit year will be carried forward for up to 24 months. This balance will be added to your new credits, and claims for the new benefit year will be applied to the combined amount, using the previous benefit year(s) credits first. At the end of each new benefit year, any remaining previous benefit year(s) credits will be forfeited at the expiration of the earliest carry forward period in which it was allocated.

ELIGIBLE EXPENSES

The following items are covered under the Personal Spending Account. These items are a taxable benefit so all expenses submitted for payment will be shown on your T4A slip received from your plan sponsor. Any item not included in this list should be discussed with your Human Resources before purchasing to determine if it will be eligible for payment.

Fitness/Sports Fees
Recreational Program, Classes, Team Registration Fees
Personal Training, Consultation
Club, Resort, Park, Annual Memberships
Recreational, Individual Event Pass, Registration or Fee
Gym, Fitness Centre, Pool, Annual Memberships

Fitness Equipment
Fitness Equipment
Sports Equipment
Bicycle (Manual)
Heart Rate Monitor
Athletic Sportswear and Accessories
Wii Fit or Xbox Kinect, PlayStation Fitness (entertainment system not included)
Fishing Equipment
Fitness Tracker

Family Care
Child Care
Elder care
Homecare Assistance Services and Products (lifts, supportive aids)
Caregiver Support Programs and Services

Educational and Personal Development
Hobby and General Interest Classes
Education Fees, Tuition, Books
Training, Classes, Tutoring, Language, First Aid, CPR
Professional Designation and Membership Fees and/or dues

Personal Computer and Accessories
Music Equipment

Wellness Services
Smoking Cessation Programs
Safety Equipment
Health Assessments
Weight Loss Programs, Counseling (excluding food)
Nutritional Counseling
Vitamins, Supplements, Natural Products
Maternity Services (Pre-Natal Classes and Mid-Wife Services)
Stress Management Programs
Medical Tests
Alternative Health Practitioners (Examples: Reflexologist, Iridologist, Herbalist, Homeopath, Chinese medicine, Shiatsu therapist, Acupuncturist)
Holistic Health Services

Non-Health Professional Services
Legal Services
Financial Services

CLAIM INFORMATION

Inquiries

For detailed inquiries, contact your Benefits Administrator or contact us:

- Call our Customer Service Centre at 1.888.711.1119 to determine eligibility for a specific item or service and GSC's pre-authorization requirements, or
- Visit our website at greenshield.ca to e-mail your question

Submitting Claims

Claim forms, including Pre-Authorization forms, and valuable claims submission information, is available at greenshield.ca.

Please note that in addition to a completed claim form, claims reimbursement requires the original itemized paid receipt **(cash receipts or credit card receipts alone are not acceptable)**.

GSC reserves the right to request supplementary claims information, failure to respond to such requests may result in the denial of the claim.

The intentional omission, misrepresentation or falsification of information relating to any claim constitutes fraud. Submission of a fraudulent claim is a criminal offence and will be reported to the applicable law enforcement and/or regulatory agencies and your plan sponsor. This could result in termination of your coverage under this benefit plan.

For HCSA, forward a HCSA claim form and indicate on the claim form if you want your eligible expenses paid from your GSC health and/or dental plan first, and any unpaid portion of your eligible expenses paid from your HCSA. These claims must first be submitted to any provincial health insurance, or any private health care plan you may have (including another GSC plan, spousal plan, etc.).

Your HCSA does not have automatic coordination with your health and dental benefits. If you would like to enable this functionality, you may do so through Plan Member Online Services (the GSC Customer Service Centre is unable to arrange set up of this function).

Auto-Coordination with HCSA

Once you have accessed Plan Member Online Services and have set up your HCSA auto-coordination, your health and dental claims will automatically be coordinated with your HCSA. You must pay the provider of service the HCSA portion of the claim and you will be automatically reimbursed from your HCSA without having to submit a paper claim. The claim **will not** be re-directed to a secondary plan (COB) before paying out of the HCSA.

Manual Coordination with HCSA

If you choose **not** to have all your traditional health and dental claims automatically coordinated with your HCSA, you must pay the provider of service the HCSA portion of the claim, then complete a HCSA Claim Submission Form and attach proof of payment. You can indicate on this claim form if you want your eligible expenses paid from your GSC health and/or dental plan first, and any unpaid portion of your eligible expenses paid from your HCSA.

For PSA, forward a PSA claim form to GSC to have your eligible expenses paid from your PSA account.

All Health, Travel and Dental claims must be received by GSC no later than 12 months from the date the eligible benefit was incurred.

All HCSA claims must be received by GSC no later than 60 days after the end of the benefit year, or, no later than 60 days after your termination date, your retirement date, your date of death or your leave of absence date (other than a Maternity, Adoption or Parental Leave).

All PSA claims must be received by GSC no later than 60 days after the end of the benefit year, or, no later than 12 months from the date the eligible benefit was incurred after your termination date.

Reimbursement

Reimbursement will be made by one of the following methods:

a) Direct deposit to your personal bank account, when requested;
b) A reimbursement cheque; or
c) Direct payment to the provider of services, where applicable.

All dollar maximums and limitations stated are expressed in Canadian dollars. Reimbursement will be made in Canadian or U.S. funds for both providers and plan members, based on the country of the payee.

Overpayments

GSC reserves the right to recover all amounts resulting from overpaid or unsupported claims for benefits by deducting such amounts from future claims and/or by any other legal means.

Limitation on Legal Action

In Ontario, every action or proceeding against GSC for recovery of benefit payment under the plan is absolutely barred unless commenced within the time set out in the *Limitations Act, 2002.*

In British Columbia, Alberta and Manitoba, every action or proceeding against GSC for recovery of benefit payment under the plan is absolutely barred unless commenced within the time set out in the *Insurance Act.*

Emergency Travel

GSC Travel Assistance must be contacted by phone within 48 hours of commencement of treatment.

Call our Customer Service Centre at 1.888.711.1119 for detailed claims submission instructions.

If you have incurred out of pocket expenses, make sure you tell GSC Travel Assistance about all the travel coverage you have when submitting claims. Claims must be submitted together with supporting original receipts to GSC Travel Assistance who will then co-ordinate reimbursement of those approved, eligible expenses from all sources (e.g., provincial plans that provide out-of-Canada coverage, a spousal plan, travel coverage provided through your credit card, etc.).

To make a claim, submit the patient name, provincial health insurance plan number, address and GSC Identification Number with a detailed statement showing the services rendered and the fees charged for each service.

Subrogation

GSC retains the right of subrogation of benefits. This means if GSC paid benefits on behalf of you or your dependent, but the benefits either should have been paid or are subsequently paid or provided, in whole or in part, by a third party liability or other coverage(s), GSC has the right to recover such payment or reimbursement. In cases of third party liability, you must advise your lawyer of our subrogation rights.

Co-ordination of Benefits (COB)

If you are covered for extended health and dental benefits under more than one plan, your benefits under this plan will be coordinated with the other plan so that you may be reimbursed up to 100% of the eligible expense incurred.

Claims must be submitted to the primary payer first. Any unpaid balances should then be submitted to the secondary plan(s). Use the following guidelines to identify the primary and secondary plans:

GSC Plan Member

GSC coverage for you is always primary. If you are the plan member under two group plans, priority goes in the following order:

- The plan where you are a full-time plan member
- The plan where you are a part-time plan member
- The plan where you are a retiree

Spouse

If your spouse is a plan member under another benefit plan, this GSC coverage is always secondary. Your spouse must first submit claims to his/her benefit plan.

Children

When dependent children are covered under both your GSC plan and your spouse's benefit plan, use the following order to determine where to submit the claims:

- The plan of the parent whose birth date (month and day) occurs earliest in the calendar year
- The plan of the parent whose first name begins with the earlier letter of the alphabet, if the parents have the same birth date
- In cases of separation or divorce with multiple benefit plans for the children, the following order applies:
    - The benefit plan of the parent who has custody of the dependent child
    - The plan of the spouse of the parent who has custody of the dependent child
    - The plan of the parent who does not have custody of the dependent child
    - The plan of the spouse of the parent who does not have custody of the dependent child

    If the parents have joint custody and both have the children listed as dependents under their plans, claims should first be submitted to the plan of the parent whose birth date (month and day) occurs earliest in the calendar year. Balances can then be submitted to the other parent's plan.

Travel Benefits

In the event of a travel claim, all plans equally share the cost of the claim.

When GSC is identified as a secondary carrier, submit the original Explanation of Benefits statement from the primary carrier and a copy of the claim form in order to receive any balances owing.

Access to Information

If you live in a province where the law permits you to request copies of your records, GSC will provide one copy of the following at no charge:

a) any enrollment form you completed for coverage under this plan that was submitted to GSC;
b) any written statements or other record about your health that you submitted to GSC during the course of applying for coverage under this plan;
c) one copy of the group contract.

GSC may charge you to provide any additional copies.

DISCLAIMER

The Life Insurance and Long Term Disability Insurance benefits are provided by Industrial Alliance Financial Group (iA).

DESIGN GROUP STAFFING INC.

Class 1

GROUP INSURANCE PLAN

Policyholder: **DESIGN GROUP STAFFING INC.**

Policy No.: ***G24275***

Policy Effective Date: ***September 1, 2005***

This booklet is provided for the purpose of explaining the benefits provided under the group policy.

Possession of this booklet does not confer or create any contractual rights. All rights and obligations with respect to the benefits provided under the group policy will be governed solely by the terms and conditions of such policy.

The Policyholder reserves the right to amend or suspend any coverages, including coverages for retirees, that are provided under the group policy as well as terminate the group policy in its entirety at any time with respect to active Participants (including those that may be absent due to a disability) as well as retired Participants after their retirement.

In addition, the Policyholder reserves the right to change the contribution requirements for the coverages, including coverages for retirees, provided under the group policy at any time with respect to active Participants (including those that may be absent due to a disability) as well as retired Employees after their retirement.

For questions regarding the information in this booklet or if additional information about the benefits is required, the Participant should contact his Employer.

This booklet can also be viewed on our secure website My Client Space accessible via ia.ca, if offered as part of your plan. For any question about coverage options, contact iA Financial Group at 1 877 422-6487.

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SUMMARY OF BENEFITS

The Summary of Benefits briefly describes the coverage of the group insurance plan, based on the class the participant belongs to.

The following pages give a full description of the General Provisions and of each Benefit.

SPECIAL PROVISIONS

For the purposes of this booklet, the masculine form includes the feminine unless a different meaning is required from the context. In addition, the singular shall include the plural where required.

Participants are insured under the following class:

Class

1 – All Employees

GENERAL PROVISIONS

ELIGIBILITY DATE

Subject to all other provisions of the group policy, each employee shall become eligible on one of the following dates:

a) on the effective date of the policy, if he has completed 3 months of continuous service with the employer,

or

b) on the date on which he has completed 3 months of continuous service with the employer.

NORMAL RETIREMENT AGE

For the purpose of the group policy, the normal retirement age shall be the first day of the month coincident with or next following the participant's 65th birthday.

PARTICIPANT'S LIFE INSURANCE

Sum Insured

One times the annual salary, the result being rounded to the next higher $1,000, if not already a multiple thereof.

Maximum: $325,000 without evidence of insurability

or

$1,000,000 * with evidence of insurability.

*(Combined with the amount of the participant's optional life insurance.)

Minimum benefit: $5,000

This benefit terminates on the participant's 70th birthday or the date of retirement, if earlier.

PARTICIPANT'S OPTIONAL LIFE INSURANCE

Sum Insured

Units of $10,000

Maximum: $500,000*

*(Combined with the amount of the participant's life insurance.)

All amounts of optional life insurance require evidence of insurability.

This benefit terminates on the participant's 70th birthday or the date of retirement, if earlier.

SPOUSE's AND DEPENDENT'S OPTIONAL LIFE INSURANCE

Sum Insured

Spouse:	Units of $10,000 Maximum: $200,000

Evidence of insurability: All amounts in excess of $20,000 of spouse's optional life requires evidence of insurability.

Each Child upon a live birth	Units of $5,000 Maximum: $25,000

Evidence of insurability: A participant may obtain the dependent optional life insurance on children without evident of insurability if he elects it within 31 days of the date he is first eligible to elect the insurance or if he elects it within 31 days of the date on which he has a new child.

This benefit terminates on the insured person's 70th birthday or the participant's date of retirement, if earlier.

LONG-TERM DISABILITY INCOME INSURANCE

Monthly Indemnity

66.67% of the first $2,250 of monthly salary plus 50% of the next $3,500 of monthly salary, plus 44% of the remaining amount of monthly salary, the result being rounded to the next higher dollar, if not already a multiple thereof.

Monthly maximum:

$5,000

However, the overall maximum must not exceed 85% of the pre-disability net monthly salary.

Reductions: The amount payable will be subject to the reductions stated in the benefit.

Elimination Period: 112 days

Payment of benefits will begin after satisfaction of the maximum benefit period provided under the Short-Term Disability Income Insurance benefit, if such benefit is included under the group policy.

Maximum Benefit Period: To the participant's 65th birthday

Benefits are non-taxable.

This benefit terminates on the participant's 65th birthday or date of retirement, if earlier.

DEFINITIONS

Accident: A sudden, violent and unforeseeable occurrence which is external to the person.

Actively at Work: If it is a scheduled work day, the participant will be considered actively at work if he reports for work at his usual place of employment or at some other location where his employer's business requires him to be and when he so reports he is able to perform all of the usual and customary duties of his occupation on a regular and full-time basis.

If the participant is not at work due to it being a non-scheduled work day, holiday or vacation day, the participant will be considered to be actively at work if on such date he is neither (i) hospital confined nor (ii) disabled to a degree that he could not then have reported to his usual place of employment or some other location where his employer's business requires him to be and performed all of the usual and customary duties of his occupation on a regular, full-time basis.

Annual Salary: The participant's annual gross base remuneration received from the employer and which the employer or policyholder has reported to the insurer including any additional income earned on a regular basis (overtime, bonuses, commissions, shift differentials, gratuities) which is included in accordance with the standards of the Employment Insurance Act.

When a participant's remuneration is composed wholly or partly of commissions, his annual salary will be the total of his annual gross base remuneration plus commissions earned during the immediately preceding calendar year. However, for a participant who has been employed for less than one year of service, his annual salary shall be his annual gross base remuneration as estimated by his employer.

Approval of Evidence of Insurability: The date of approval of any evidence of insurability shall mean the date the insurer receives the last document which allows it to accept the risk on the person.

Calendar Year: The period from any January 1st to the next December 31st, both inclusive.

Day: A calendar day, except if otherwise defined in this booklet.

Dependent: The participant's spouse or a child of the participant or of the spouse. If dependents are insured under the group policy, "spouse" and "child" shall have the following meanings:

a) Spouse

The person who is married to or is in a civil union with the participant, or the person designated by the participant, whom he declares publicly to be his spouse and with whom he has been living on a permanent basis for at least one year.

A de facto separation of more than 3 months will result in the person no longer qualifying as the participant's spouse for the purposes of the group policy.

If according to this definition, the participant has had more than one spouse, spouse shall mean the person most recently qualified.

b) Child

An unmarried child of the participant or of his spouse who wholly depends on the participant for support and maintenance and who meets at least one of the following conditions:

i) He is under 21 years of age; or

ii) He is under 26 years of age and is attending a recognized educational institution on a full-time basis; or

iii) He is mentally or physically handicapped and is incapable of earning his own living due to such handicap provided such handicap commenced while he was a child as defined in (i) or (ii).

Eligibility Period: The period, as specified in the Summary of Benefits, during which an employee must be actively at work before being eligible for coverage under the group policy.

Employee: A person who is employed by his employer on a permanent, full-time basis and who is working a minimum of 20 hours per week for such employer.

Full-Time Resident of Canada: Has a permanent residence in Canada and resides in Canada for at least 182 days a year.

Illness: Any deterioration in health requiring regular, continuous and curative care actively provided by a physician.

Insured Person: A participant or a dependent of a participant who is insured under the group policy.

Monthly Salary: The participant's annual salary divided by 12.

Normal Retirement Age: The age indicated in the Summary of Benefits.

Participant: An employee who is insured under the group policy.

Physician: A person who is legally licensed and authorized to practice medicine and who is operating within the scope of his license.

Specialist: A physician licensed by the appropriate provincial licensing authority to practice medicine with a specialization.

Weekly Salary: The participant's annual salary divided by 52.

CHANGES IN GOVERNMENT PLANS

The benefits provided under the group policy are complementary to the benefits provided by government plans. Any modifications to these plans after the effective date of the group policy will not modify the benefits provided under the group policy, unless an agreement to modify the benefits is signed by the authorized signing officers of the insurer and the policyholder.

Notwithstanding the preceding paragraph, this plan will be modified to reflect any changes to the maximum insurable earnings as determined under the Employment Insurance Act. In addition, if either federal or provincial legislation mandates that an insurer provides a certain type or level of coverage or the means of providing a certain type of coverage, the group policy will be deemed to have been amended to reflect the requirements of the legislation.

MEDICAL SERVICES AND/OR SUPPLIES COVERED BY A GOVERNMENT SPONSORED PLAN OR PROGRAM

There will be no coverage under the group policy for any expenses related, directly or indirectly, to any medical services and/or supplies which would have been covered by a government sponsored plan or program if the insured person had not elected to receive the services and/or supplies on a private basis from a medical practitioner, medical facility, clinic or hospital, whether private or public, unless the services and/or supplies are explicitly stated as being covered under the group policy.

INCONTESTABILITY

Where evidence of insurability is required by the insurer in order to approve

a) insurance under the group policy or insurance under a benefit for a Participant or a Dependent; or

b) an increase, addition or change in such insurance for a Participant or Dependent,

the statements provided by the Participant or Dependent as evidence of insurability will be accepted as true and will not be contested by the insurer after the latest of the following dates, provided the Participant or Dependent is alive at the time:

a) 2 years from the effective date of the insurance for which the evidence was provided; or

b) 2 years from the effective date of the increase, addition or change to the insurance; or

c) 2 years from the effective date of the last reinstatement of the insurance.

However, this restriction on the insurer's right to contest the evidence of insurability will not apply in cases of fraud or misstatements of age.

Where evidence is required to approve an increase, addition or change in the insurance, the insurer's right to void the insurance will be limited to that increase, addition or change.

LAWFUL CURRENCY

All payments hereunder will be made in the lawful currency of Canada and according to the exchange rates effective at the time the event giving entitlement to a benefit took place.

COVERAGE ELSEWHERE

A participant who is eligible for Supplemental Health Insurance and/or Dental Care Insurance and whose spouse is covered for comparable insurance may decline coverage under the group policy for such insurance.

The refusal of insurance under the group policy may be in respect of the participant and his dependents or his dependents only.

If the insurance under the spouse's policy ceases because of termination of such policy or because eligibility for the insurance ceases, then application may be made to insure under the group policy those persons whose insurance has terminated.

The application must be made within 31 days after cessation of the insurance under the spouse's policy and the insurance under the group policy shall be effective on the day following the date of termination of the insurance under the spouse's policy.

ELIGIBILITY

Employee

An employee will become eligible to be insured under the group policy as a participant on the date (his "eligibility date") on which he satisfies the following conditions:

a) He satisfies the definition of employee in this booklet.

b) He is a full-time resident of Canada.

c) He is covered under the provincial health plan of his province of residence.

d) He has satisfied the eligibility period specified in the Summary of Benefits.

However, an employee will not be eligible to become insured under the Long-Term Disability Income Insurance benefit if he will attain age 65

before the end of the elimination period specified for the benefit under the Summary of Benefits.

Dependents

A person will become eligible to be insured under the group policy as a dependent on the date (his "eligibility date") on which he satisfies the following conditions:

a) He satisfies the definition of dependent in this booklet.

b) He is a full-time resident of Canada.

c) He is covered under the provincial health plan of his province of residence.

d) The employee of whom he is a dependent has become eligible to be insured under the group policy.

APPLICATION FOR GROUP INSURANCE

An employee who is eligible to become insured under the group policy must complete and submit an application for himself and for each of his dependents, on their respective eligibility dates, on forms supplied by, or satisfactory to, the insurer.

EFFECTIVE DATE OF INSURANCE

Whether membership under the group policy is compulsory or voluntary, the employee's insurance and dependents' insurance, if any, will take effect on the person's eligibility date, if the application for group insurance has been received by the insurer on or prior to such date, or within 31 days after such date.

If the application for group insurance is not received within 31 days of the eligibility date, the insurance will not take effect until the date on which the insurer receives and approves the person's evidence of insurability. The evidence of insurability will be provided at no expense to the insurer.

However, if

a) the employee was not actively at work on the date his insurance would otherwise become effective, the insurance will not take effect until the earliest date thereafter on which he is again actively at work; or

b) the dependent is hospitalized on the date his insurance would otherwise become effective, the insurance will not take effect until the earliest date thereafter on which he is no longer hospitalized. (This clause shall not apply to the Life Insurance benefit or in the case of a newborn child.)

Any amount of insurance in excess of any non-evidence maximum specified in the Summary of Benefits will not take effect until the date the insurer receives and approves the employee's evidence of insurability.

TERMINATION OF INSURANCE

Participant

A participant's insurance automatically terminates on the earliest of the following dates:

a) The date the group policy is terminated;

b) The date on which the participant retires, unless otherwise specified in the Summary of Benefits;

c) The date the participant reaches the age limit specified in the Summary of Benefits if an age limit is indicated;

d) The date the participant is no longer a full-time resident of Canada;

e) The date the participant is no longer covered by his provincial health plan;

f) The date of the participant's death;

g) The later of the following dates:

   i) the date indicated on a written notice received from the policyholder;

   ii) the date this notice was received by the insurer;

h) The date the participant is incarcerated after committing a criminal offence for which he was found guilty;

i) The date the participant ceases to qualify as an employee as defined in the group policy.

Insurance may be extended to a participant during periods the participant has ceased to be actively at work due to, but not limited to, illness, injury, temporary lay-off or a leave of absence. The participant should contact the policyholder for further information.

Dependents

A dependent's insurance terminates on the earliest of the following dates:

a) The date the participant of whom he is a dependent ceases to be covered under the group policy;

b) The date the dependent ceases to be a dependent as defined in this booklet;

c) The date the dependent reaches the age limit specified in the Summary of Benefits, if an age limit is indicated;

d) The date the dependent is no longer a full-time resident of Canada;

e) The date the dependent is no longer covered by the provincial health plan;

f) The later of the following dates:

   i) the date indicated on a written notice received from the policyholder;

   ii) the date this notice was received by the insurer.

The above terms and conditions also apply in the case of the partial cancellation of insurance owing to the cancellation of one or more benefits.

CLAIMS

- **Life Insurance**

  The insurer must receive notice of any claim for a Life Insurance benefit as soon as possible after the date of the event which gives entitlement to the benefit, but in any event within one year of the event.

- **Long-Term Disability Income Insurance**

  The insurer must receive notice of any claim for a Long-Term Disability Income Insurance benefit within 90 days of the end of the participant's elimination period.

  If notice of a claim for a Long-Term Disability Income Insurance benefit is received more than 90 days after the end of the participant's elimination period, the insurer reserves the right to limit the participant's monthly indemnity benefit to the 90 days preceding the date the claim was received from the participant.

All notices of claims must be submitted to the insurer on the forms provided for that purpose by the insurer and must include all information that the insurer deems necessary for the assessment of the claim. If all information that is required by the insurer is not received, the insurer will have the right to deny the claim.

The insurer reserves the right to require additional proof or information regarding a claim whenever it deems necessary.

If notice of claim is not received by the insurer within the periods set out above or additional proof or information requested by the insurer is not provided, the insurer will have the right to deny the claim.

At the time of claim for a benefit which is based on the participant's salary, the amount of salary that will be used to determine the benefit will be the lesser of

a) the salary that the policyholder had last reported to the insurer and which has been used in the calculation of the premium payable; and

b) the participant's actual salary at the time of the event for which a claim is being made, as determined in accordance with the definition of salary included in the group policy.

The insurer will undertake all necessary actions to detect and investigate fraudulent claims under the group policy.

It is a crime if a participant should knowingly, and with the intent to defraud the insurer and the group plan, file a claim that contains any false, incomplete or misleading information.

The insurer retains the right to audit all claims at any stage, including after payment has been made, for fraud or misrepresentation. If the insurer determines that a participant has intentionally submitted a claim that contains false or misleading information, the insurer shall have the right, at its sole discretion, to notify the policyholder, decline the claim or

require reimbursement if the claim has been paid. In addition, the insurer will have the right to terminate the participant's entire coverage under the group policy including any coverage for the participant's dependents, and will have the right to undertake the prosecution of the participant in accordance with provincial and/or federal law.

BENEFICIARY

The participant's beneficiary shall be the person or persons designated by the participant, in writing, to receive the death benefit payable under the participant's life insurance benefit, and if applicable, the participant's Accidental Death and Dismemberment Insurance benefit, participant's Optional Life Insurance benefit and participant's Optional Accidental Death and Dismemberment Insurance benefit. If the Participant does not designate a beneficiary, any death benefit payable under such benefits will be payable to the Participant's estate.

All benefits, other than the participant's Life Insurance benefit, participant's Accidental Death and Dismemberment Insurance benefit, participant's Optional Life Insurance benefit and participant's Optional Accidental Death and Dismemberment benefit, will be payable only to the participant, or if the participant is deceased at the time of the payment of the benefit, to his estate.

The participant will be able to designate a beneficiary or change a named beneficiary by a signed written declaration, subject to the provisions of the law.

The insurer will not be responsible for the sufficiency or validity of the beneficiary designation or change of beneficiary.

If the participant had named a beneficiary under the policyholder's prior group policy, such designation will be applicable to the insurance provided under the group policy, unless the participant has changed the designation in writing with the insurer. The Participant should review the beneficiary designation made under the policyholder's prior group policy to ensure that it reflects the participant's current intentions in regard to his insurance.

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

INSURER'S RIGHT TO EXAMINATION(S) OF A CLAIMANT

The insurer, at its own expense and its sole discretion, shall have the right, whenever and how often it deems it necessary, to:

a) Require any medical, psychiatric, psychological, functional, vocational or any other examinations of a Participant who has submitted a claim or of any other Insured Person for whom a claim has been submitted. The insurer may designate, at its sole discretion, a Physician, a Specialist, a healthcare provider or any other examiner for such examination(s). The Participant or any other Insured Person being examined must comply with any terms and conditions of an examination that are required by such examiner; and

b) Require an autopsy, where it is not forbidden by law.

The insurer reserves the right to obtain the clinical notes and records or any other reports of a participant who has submitted a claim or of any other insured person for whom a claim has been submitted, from any physician or specialist, including but not limited to, a psychologist, a psychiatrist, a healthcare provider or any other examiner who has treated, examined or assessed such participant or insured person. The participant and any insured person must cooperate fully with the insurer in obtaining any such records or reports.

The insurer, at its own expense and its sole discretion, shall have the right to conduct any investigation, or an examination under oath, of a participant who has submitted a claim, or of any person for whom a claim has been submitted, whether or not a legal action has been commenced by such participant or person.

SUBROGATION

Where a benefit is payable under the group policy with respect to a participant or to a dependent of a participant and if such person has a right to recover damages from an individual or organization, the insurer will be subrogated to the rights to recovery of the participant or dependent against such individual or organization to the extent of all benefits paid in the past and all benefits payable in the future.

Without limiting the generality of this provision, the term damages will include any lump sum or periodic payments received on account of:

a) Past, present or future loss of income, wages, or earnings; and

b) Any other benefits paid or payable under the group policy.

The participant or dependent shall reimburse the insurer up to the amount of any benefits paid in the past or that are payable in the future under the group policy out of the gross damages recovered whether recovered at trial, or prior to trial by way of any form of settlement, and without regard to whether the participant or dependent has obtained full recovery of his losses.

Where the participant or dependent recovers damages in a lump sum, either by way of settlement or court order, and no allocation has been made in that settlement for the benefits paid or payable by the insurer, the insurer shall be reimbursed, out of the gross damages recovered, the full amount of benefits that have been paid to the participant or dependent. The insurer shall also be entitled to be reimbursed an amount, as determined by the insurer, which reasonably reflects the value of the future benefits payable to the participant or dependent under the group policy. The insurer's recovery in this regard shall not exceed the participant or dependent's gross damages recovered or gross settlement. These rights of reimbursement shall be without regard to the terms of settlement or allocation that may have been agreed to by the participant or dependent and the third party.

In the event that the participant or dependent fails to reimburse the insurer in accordance with the group policy, no future benefits will be paid by the insurer until such time as the insurer recovers:

a) The total amount of benefits paid to the participant or dependent; and

b) An amount that reasonably reflects, as determined by the insurer, the total amount or value of any future benefits payable to the participant or dependent.

The insurer's recovery in this regard shall not exceed the participant or dependent gross damages recovered or gross settlement.

The insurer shall also have the right to seek recovery directly from the participant or dependent, or exercise any other right or remedy it may have under the group policy or under the law, in the event that any overpayment has resulted from the lack of reimbursement.

The participant shall notify the insurer as soon as any action is commenced by him or his dependent against any third party which involves a claim for damages. The participant or dependent shall provide the insurer information, including copies of all relevant documentation, about any judgement or settlement of any claim against a third party which involves a claim for damages. The participant or dependent will ensure that the subrogated rights of the insurer are advanced in any third party action and shall instruct his solicitor accordingly. The insurer shall

not be responsible for any legal fees or expenses in regards to the advancement of its subrogated claim unless it has clearly agreed to such fees and expenses in writing in advance. The insurer reserves the right to retain its own counsel and/or pursue its subrogated rights against the third party and, in this respect, the participant and dependent and his solicitor shall fully cooperate with the insurer in the pursuit of its claim.

The insurer's subrogated claims shall not be settled or compromised in any way without its prior written consent. Unless the prior consent of the insurer has been obtained, no such settlement of any claim against the third party shall be binding on the insurer and the insurer shall have the right to seek recovery directly from the participant and dependent in accordance with its rights under the group policy or under the law.

LIMITATION ON LEGAL ACTIONS

No action or proceeding against the insurer shall be commenced within the first 60 days following the date on which written proof of claim is provided to the insurer in accordance with all of the terms and conditions of the group policy.

Every action or proceeding against an insurer for the recovery of insurance money payable under this contract is absolutely barred unless commenced within the time set out in the *Insurance Act*, or other similar applicable legislation (e.g. *Limitations Act, 2002* [Ontario]; Civil Code of Quebec) in the Participant's province.

PARTICIPANT'S LIFE INSURANCE

Upon the death of the participant while insured under this benefit, the insurer undertakes to pay to the beneficiary the sum insured as indicated in the Summary of Benefits, subject to the terms and conditions of this benefit and the group policy.

DEFINITION(S)

As used in this benefit:

Disability and Disabled: A state of total and continuous incapacity, resulting from illness or injury, which prevents the participant from performing any work for which he is reasonably qualified by education, training or experience.

However, if the participant should be covered by a Long-Term Disability Income Insurance benefit under the group policy, the definitions of "disability" and "disabled" shall be as defined under such benefit.

CONVERSION PRIVILEGE

A participant whose life insurance is cancelled on or prior to his 65th birthday due to termination of

a) his employment;

b) his group membership; or

c) the group policy and he has been continuously insured under a life insurance benefit provided by the policyholder for at least 5 years,

will be able to convert all or part of his life insurance to an individual life insurance policy without having to provide evidence of insurability.

The participant may choose to convert to one of the following types of insurance:

a) permanent;

b) term to age 65; or

c) one-year term convertible into permanent or term to age 65 at the end of one year.

The amount that can be converted to an individual policy will include all amounts of life insurance that the participant was covered for under this benefit, an Optional Life Insurance benefit and any other group insurance policy issued by the insurer, and will not exceed the lesser of:

a) The amount selected by the participant;

b) The amount for which the participant was insured immediately prior to the termination of his insurance;

c) The difference between the amount for which the participant was insured immediately prior to the termination of his insurance, and the amount for which he is eligible under a new group insurance policy;

d) $200,000 ($400,000 for participants living in the province of Quebec).

The individual insurance policy shall not include a disability benefit, nor an accidental death and dismemberment benefit, and the premium shall be based on the insurer's rates in effect which apply to the type and amount of such policy, according to the participant's sex and attained age.

The individual policy will only be issued if the insurer receives a written request to that effect, together with a deposit covering the monthly premium for a one-year term policy within 31 days of the date of the termination of the participant's insurance, and will take effect only at the expiration of that period.

Should the participant die during the period of 31 days following the termination of his insurance, the insurer shall pay an amount equal to that which he could have converted whether or not he made application for the individual policy.

WAIVER OF PREMIUM

a) A participant who becomes disabled will be eligible to have his premiums waived for this benefit, if he is under age 65 and is eligible to receive a benefit under the Long-Term Disability Income Insurance benefit, if included in the group policy.

   If the participant is not eligible to receive a benefit under the Long-Term Disability Income Insurance benefit or there is no Long-Term Disability Income Insurance benefit included in the group policy, he will be eligible to have his premiums waived for this benefit provided:

i) The participant was less than 65 years of age at the onset of disability;

ii) The participant became disabled as defined under this benefit, while insured under this benefit and before any termination of employment;

iii) The participant has been disabled for at least 6 continuous months;

iv) Proof of disability, satisfactory to the insurer, was submitted to the insurer within 9 months of the onset of the disability. The evidence will be submitted at no expense to the insurer.

b) The amount of insurance for which the waiver of premiums applies will be that which was in force on the participant's life at the onset of the disability, and will be subject to any reductions and termination indicated in the Summary of Benefits which would have been applicable to the participant if he had been actively at work.

c) The participant's premiums will begin to be waived on the earliest of the following dates:

i) The day following completion of the elimination period under the Long-Term Disability Income Insurance benefit, if applicable;

ii) The day following a continuous period of disability of 6 months.

d) The participant whose premiums are waived under this section must provide the insurer with proof of disability, as often as the insurer may reasonably require. Such proof will be provided at no expense to the insurer.

e) The waiver of premiums will terminate on the earliest of the following dates:

i) The date on which the participant ceases to be disabled;

ii) The date on which the participant fails to submit to an examination by the physician designated by the insurer;

iii) The date on which the participant retires or reaches the normal retirement age under the employer's pension plan, but never beyond the normal retirement age indicated in the Summary of Benefits of the group policy;

iv) The date on which the participant reaches the termination age for his life insurance benefit as indicated in the Summary of Benefits, if applicable;

v) The date on which the participant fails to provide any proof of disability required by the insurer;

vi) The date on which the participant is incarcerated after committing a criminal offence for which he was found guilty.

f) If on the date the waiver of premiums terminates with respect to the participant, he is not eligible to be covered under the Participant's Life Insurance benefit, he will be eligible to exercise the conversion privilege as provided for under this benefit.

PARTICIPANT'S OPTIONAL LIFE INSURANCE

A participant may obtain an amount of optional life insurance if he so requests it in writing to the insurer and furnishes evidence of insurability satisfactory to the insurer

The sum insured that will be applicable to the participant will be the amount of insurance requested as provided for in the Summary of Benefits.

Upon the death of the participant while insured under this benefit, the insurer undertakes to pay the beneficiary the sum insured at the time of the participant's death, subject to the terms and conditions of this benefit and the group policy.

NON-SMOKER STATUS

If the insurer provides reduced premium rates for non-smokers, the participant must provide a non-smoker statement on his application card to receive such rates.

Misrepresentation of Non-Smoker Status

A participant who states that he is a non-smoker on his application card or on his last evidence of insurability declaration, if it is more recent, when he is a smoker, will be considered to have made a misrepresentation.

If it is proven, after the participant's death, that he had made a misrepresentation, the optional life insurance benefit of the participant will become null and void and no optional life insurance will be payable under this benefit.

Proof of Status

The insurer reserves the right to request new proof of the participant's non-smoker status each time evidence of insurability may be required.

EXCLUSION

If a participant commits suicide, regardless of any impairment, illness, or state of mind, less than 24 months after the date his coverage under this benefit commenced, no benefit will be payable by the insurer. The insurer will refund to the beneficiary the premiums paid in respect of the

participant's optional life insurance and such refund will constitute a full discharge of the insurer's liability under this benefit.

The 24 month period starts anew on the date:

a) the optional life insurance is reinstated; or

b) the optional life insurance amount is increased at the participant's request, but only for the additional amount of insurance.

ADDITIONAL PROVISIONS

Any provisions of the Participant's Life Insurance benefit which are not inconsistent with the provisions of this benefit will form part of this benefit.

SPOUSE AND DEPENDENT'S OPTIONAL LIFE INSURANCE

A participant may obtain an amount of optional life insurance on his spouse and dependents if he so requests in writing to the insurer and furnishes evidence of insurability satisfactory to the insurer.

The sum insured that will be applicable to the spouse will be the amount of insurance requested as provided for in the Summary of Benefits.

Upon the death of the spouse or dependent while insured under this benefit the insurer undertakes to pay to the participant the sum insured at the time of death, subject to the terms and conditions of this benefit and the group policy.

WAIVER OF PREMIUMS

A participant whose life insurance premiums are waived in accordance with the Waiver of Premiums provision of the Participant's Life Insurance benefit will also be entitled to have the premiums for this benefit waived, under the same terms and conditions.

CONVERSION PRIVILEGE

A participant whose spouse's optional life insurance is cancelled on or prior to the earlier of (i) his 65th birthday and (ii) his spouse's 65th birthday, due to the termination of

a) his employment;

b) his group membership; or

c) the group policy and his spouse had been continuously insured under a Dependents' Life Insurance benefit provided by the policyholder for at least 5 years,

will be able to convert all or part of his spouse's optional life insurance to an individual life insurance policy without having to provide evidence of insurability.

A spouse whose optional life insurance is cancelled on or prior to the earlier of (i) his 65th birthday and (ii) the 65th birthday of the participant, due to the death of the participant, will be able to convert all or part of his life insurance to an individual life insurance policy without having to provide evidence of insurability.

The participant or spouse, if applicable, will be able to convert the optional life insurance to one of the following types of insurance:

a) permanent;

b) term to age 65; or

c) one year term convertible into permanent term or term to age 65 at the end of the one year.

The amount that can be converted to an individual policy will include all amounts of optional life insurance that the spouse is covered for under the group policy, a Life Insurance benefit and any other group insurance policy issued by the insurer and will not exceed the lesser of:

a) the amount selected by the participant or the spouse, if applicable;

b) the amount for which the spouse was insured immediately prior to the termination of his insurance; and

c) the difference between the amount for which the spouse was insured immediately prior to the termination of his insurance and the amount for which he is eligible under a new group insurance policy; and

d) $200,000 ($400,000 for participants living in the province of Quebec.

The individual policy shall not include a disability benefit nor an accidental death and dismemberment benefit and the premiums shall be based on the insurer's rates in effect which apply to the type and amount of such policy, based on the spouse's sex and attained age.

The individual policy will only be issued if the insurer receives a written request to that effect, together with a deposit covering the monthly premium for a one year term policy, within 31 days of the date of the termination of the spouse's optional insurance and will take effect only at the expiration of that period.

Should the spouse die during the period of 31 days following the termination of his insurance, the insurer shall pay an amount equal to that which could have been converted to the participant, or the participant's estate if he is no longer living, whether or not application had been made for the individual policy.

NON-SMOKER STATUS

If the insurer provides reduced premium rates for non-smokers, the spouse or the dependent must provide a non-smoker statement on the application card to receive such rates.

Misrepresentation of Non-Smoker Status

A spouse who states that he is a non-smoker on the application card or on his last evidence of insurability declaration, if it is more recent, when he is a smoker, will be considered to have made a misrepresentation.

If it is proven, after the spouse's death, that he had made a misrepresentation, the optional life insurance of the spouse will become null and void and no optional life insurance will be payable under this benefit.

Proof of Status

The insurer reserves the right to request new proof of the spouse's non-smoker status each time evidence of insurability may be required.

EXCLUSION

If a person insured for optional life insurance commits suicide, regardless of any impairment, illness, or state of mind, less than 24 months after the date his optional life insurance commenced under this benefit no benefit will be payable by the insurer. The insurer will refund to the participant the premiums paid in respect of such person and the refund will constitute a full discharge of the insurer's liability under this benefit.

The 24 month period starts anew on the date:

a) the optional life insurance is reinstated; or

b) the optional life insurance amount is increased at the participant's request, but only for the additional amount of insurance.

ADDITIONAL PROVISIONS

Any provisions of the of the Spouse and Dependents' Life Insurance benefit which are not inconsistent with the provisions of this benefit will form part of this benefit.

Upon the participant becoming disabled while insured under this benefit, the insurer undertakes to pay the participant the amount of the monthly indemnity benefit specified herein for each month or part of a month during which the disability lasts, subject to the terms and conditions of this benefit and the group policy.

DEFINITIONS

As used in this benefit:

Disability and Disabled: During the participant's elimination period and the first 24 months following the elimination period, the participant is not able to perform substantially all of the essential duties of his own occupation and earn more than 80% of his indexed pre-disability gross monthly salary due to an illness or injury, as determined by the insurer.

Thereafter the participant is not able to perform substantially all of the essential duties of his own or any other occupation for which he is reasonably qualified by training, education or experience and earn more than 70% of his indexed pre-disability gross monthly salary, due to the illness or injury, as determined by the insurer.

However, a participant who engages in any occupation or employment, except as specifically provided in this benefit, will be deemed to no longer be disabled.

Indexed pre-disability gross monthly salary: The monthly salary applicable to the participant immediately prior to the date his disability commenced, increased each March 1st coincident with or next following the anniversary of the date on which the participant became entitled to a monthly indemnity benefit by the Consumer Price Index (as published by the Government of Canada) during the immediately preceding calendar year.

Pre-disability gross monthly salary: The monthly salary applicable to the participant immediately prior to the date his disability commenced.

Pre-disability net monthly salary: The monthly salary applicable to the participant immediately prior to the date his disability commenced, less

the deductions made by his employer for Income Tax, Canada or Quebec Pension Plan and Employment Insurance.

Elimination period: The period specified in the Summary of Benefits during which the employee must be disabled before he can begin to receive monthly indemnity benefit payments.

PARTICULARS

Beginning of Benefit Payments

Payment of the monthly indemnity benefit begins following completion of the elimination period specified in the Summary of Benefits.

Amount of Benefit Payments

The amount of the monthly indemnity benefit payable is determined according to the formula set forth in the Summary of Benefits and will not exceed the monthly maximum amount specified.

Reduction of Benefit Payments

The monthly indemnity benefit will be reduced, after the application of the monthly maximum amount, by any disability benefits which are payable or which would have been payable to the participant had a satisfactory application been made under:

a) the Quebec or Canada Pension Plan, excluding benefits payable on behalf of dependent children;

b) a workers' compensation act;

c) a provincial automobile insurance law;

d) a provincial crime victims compensation act.

Moreover, the amount of the monthly indemnity income benefit payable by the insurer will be adjusted so that the sum of all income, compensation, indemnity and benefits which the participant would or could receive, due to his disability, from: (a) the policyholder, (b) his employer (c) any government body, (d) a franchise or association insurance plan, (e) any group insurance or pension plan to which the policyholder or employer contributes, and (f) a third party in the form of damages for loss of income, will not exceed the overall maximum, as specified in the Summary of Benefits.

After the first reductions made for each of the sources listed in this provision, future cost of living adjustments made to amounts received from such sources will not bring about further reductions.

Termination of Benefit Payments

The monthly indemnity benefit payments cease on the earliest of the following dates:

a) The date the maximum benefit period specified in the Summary of Benefits has been reached;

b) The date on which the participant ceases to be disabled;

c) The date on which the participant reaches the age of 65;

d) The date on which the participant retires or reaches the normal retirement age under the employer's pension plan, but never beyond the normal retirement age indicated in the Summary of Benefits of the group policy;

e) The date of the participant's death;

f) The date on which the participant fails to submit to an examination by the physician designated by the insurer;

g) The date on which the participant fails to provide any evidence of disability required by the insurer;

h) The date on which the participant refuses to participate in good faith in a trial work, part-time work or modified work program or a rehabilitation program which the insurer has recommended;

i) The date on which the participant is incarcerated after committing a criminal offence for which he was found guilty.

SUCCESSIVE PERIODS OF DISABILITY

If the participant who had been disabled returns to full-time active work again becomes disabled while this benefit is in force, such disability will be considered a continuation of the previous disability, provided

a) it is due to the same cause or causes as the previous disability;

b) during the elimination period, he has been back at full-time work for less than 15 days; and

c) after the elimination period has been completed, he has been back at full-time active work for less than 6 months.

However, if the successive period of disability is due to a cause or causes unrelated to the cause or causes of the previous period of disability, it will be considered to be a new disability and a new elimination period will apply.

EXCLUSIONS AND LIMITATIONS

a) The monthly indemnity benefit will not be payable for a disability resulting from one of the following causes:

   i) Civil unrest, insurrection or war, whether war be declared or not, or participation in a riot;

   ii) Self-inflicted injury unless medical evidence establishes that the injury was directly related to a mental health illness;

   iii) Care which is not medically required or which is given for cosmetic purposes, unless such care is for an illness or an accidental injury;

   iv) Committing, attempting to commit a criminal offence, or provoking an assault or criminal offence.

b) The monthly indemnity benefit will not be payable:

   i) During any leave taken in accordance with provincial or federal legislation or during any leave taken in agreement with the employer;

   ii) During any extension of such a leave, if the participant was entitled to and requested such extension.

   However, if the participant's benefit was kept in force during the leave, the elimination period will begin on the date the participant would have returned to work if not for his disability.

c) The monthly indemnity benefit will not be payable for any period the participant is not under the regular care and attendance of a physician, other than himself, who is a registered specialist in the field of medicine which is applicable to his disability, or is not undergoing a course of medical treatment or participating in a program of rehabilitation which, in the opinion of the insurer, is medically required.

d) The monthly indemnity benefit will not be payable to a participant who is out of Canada and the United States for a period of 90 consecutive days or more. The participant’s entitlement to the monthly indemnity benefit will be restored only upon the

participant's return to Canada or the United States, subject to all other provisions of this benefit.

e) The monthly indemnity benefit will not be payable for a disability which occurs during a strike, lock-out or temporary lay-off, if the participant's benefit was not kept in force during the strike, lock-out or temporary lay-off.

However, if the participant's benefit was kept in force during the strike, lock-out or temporary lay-off, the elimination period of the monthly indemnity benefit will begin on the date the participant would have returned to work if not for his disability.

f) The monthly indemnity benefit will not be payable to a participant who refuses to enter a trial work, part-time work or modified work program or a rehabilitation program which has been recommended by the insurer.

PRE-EXISTING CONDITION EXCLUSION

As used in this provision, "pre-existing condition" means an illness or injury

a) which was sustained or contracted, or

b) for the symptoms of which the participant was under treatment by a physician, or

c) for the symptoms of which a physician had undertaken an investigation or review of, or

d) for which the participant was taking medication as prescribed by a physician,

during the 3 months prior to the date on which the participant became covered under this benefit.

No monthly indemnity benefit will be payable for a disability that

a) resulted either directly or indirectly from, or was in any manner or degree associated with or occasioned by a pre-existing condition; and

b) which begins in the first 12 months after the participant became covered under this benefit.

However, if the group policy is a replacement group policy, a monthly indemnity benefit will be payable for a disability due to a pre-existing condition, provided the participant

a) was covered under the previous policy on the date it was terminated; and

b) became covered under this benefit on the effective date of the group policy; and

c) was actively at work on the effective date of the group policy; and

d) satisfies the pre-existing condition exclusion period under the group policy, giving consideration towards continuous time covered under both policies, or the prior policy giving consideration towards continuous time covered under both policies.

The monthly indemnity benefit payable to the participant will be determined in accordance with this benefit, but in no case will it exceed the previous policy's maximum monthly indemnity benefit.

WAIVER OF PREMIUMS

A participant whose life insurance premiums are waived in accordance with the Waiver of Premiums provision of the Participant's Life Insurance benefit will also be entitled to waiver of premiums for this benefit, under the same conditions.

WORK RE-ENTRY

If a disabled participant participates in

a) a trial work, part-time work or modified work program, which has been approved by the insurer, or

b) a rehabilitation program, which has been approved by the insurer,

with the intent of returning to his own or any other occupation, and at such time he is incapable of earning more than 80% of his indexed pre-disability gross monthly salary due to the illness or injury which caused his disability, he will still be considered by the insurer to be disabled.

The insurer reserves the right to require that a disabled participant engage in a rehabilitation program or a trial work, part-time work or modified work program which has been recommended by the insurer to assist him in returning to gainful employment, if the insurer determines that the program is appropriate to the participant based on his disability,

and his level of education, training or experience. If the participant does not co-operate or participate in the program, the participant will no longer be eligible to receive a monthly indemnity benefit.

If the disabled participant receives an income as a result of his participation in the rehabilitation program, trial work, part-time work or modified work program, the amount of the monthly indemnity benefit payable to him under the terms of this benefit will not be reduced unless the total of the monthly indemnity benefit he is receiving under this benefit, the income received from his participation in the program and the sources listed in the Reduction of Benefit Payments provision exceeds

a) 100% of his pre-disability gross monthly salary, if the monthly indemnity benefit is taxable to him, or

b) 100% of his pre-disability net monthly salary, if the monthly indemnity benefit is non-taxable to him. (For the purposes of this calculation, the income for the program shall be net.)

If the total of the monthly income he is receiving exceeds 100% of the salary, the amount of monthly indemnity benefit payable to him under the terms of this benefit will be reduced so that his total monthly income does not exceed 100% of such salary.

The insurer will pay the expenses incurred by the participant, other than usual employment expenses, which are associated with the approved trial work, part-time work or modified work program or rehabilitation program, provided the expenses were approved, in writing, by the insurer prior to being incurred.

SURVIVOR BENEFIT

If a participant should die while he is receiving a monthly indemnity benefit or he was entitled to receive a monthly indemnity benefit under this benefit, the insurer will pay a benefit to his eligible survivor or, if applicable, survivors. If there is no eligible survivor on the date of his death, no benefit will be payable.

The amount of the benefit to be paid to the eligible survivor or, if applicable, survivors, will be equal to 3 times the net monthly indemnity benefit payment which was made or would have been made to the participant by the insurer immediately prior to his death.

If the benefit becomes payable to the children of a participant, the insurer will make the payment to the children or to the individual legally entitled to receive payment on behalf of the children. If two or more children are entitled to a benefit, they shall share the benefit equally.

As used above:

- **Eligible survivor:** The participant's spouse or children, if the participant has no spouse at the time of death.
- **Spouse:** Will be as defined under the definition of Dependent of the Definitions provision.
- **Children:** Will be as defined under the definition of Dependent of the Definitions provision.

SUBMITTING CLAIMS

Disability Claims

The participant must submit a completed claim form to the following address:

For participants residing in Quebec

Industrial Alliance Insurance and Financial Services Inc.
Group Insurance
Disability Claims Department
P.O. Box 800, Station Maison de la Poste
Montreal, Quebec, H3B 3K5

For participants residing outside Quebec

Industrial Alliance Insurance and Financial Services Inc.
Group Insurance - Disability Claims Department
522 University Ave.
Toronto, Ontario, M5G 1Y7

PROTECTING PERSONAL INFORMATION

Industrial Alliance Insurance and Financial Services Inc. (hereafter "the Company") is committed to protecting the privacy of a participant's (including his or her dependent's) personal information that it collects while providing services under the Group Plan issued to the Policyholder. The Company recognizes and respects a person's right to privacy concerning his or her personal information.

When a participant enrolls under the Group Plan, the Company will establish a confidential file containing the personal information collected. The file will be kept at the Company's offices.

Access to the file will be limited to the Company employees, agents and service providers who require access in the performance of their jobs, individuals to whom the participant has granted access, and persons authorized by law.

At the Company, the personal information that is collected is used to perform administrative services with respect to the Group Plan. Administrative services include, but are not limited to,

- Determining eligibility under the Group Plan or a particular benefit;
- Enrolling participants under the Group Plan;
- Adjudicating claims;
- Underwriting (includes determining the rates applicable to the Group Plan).

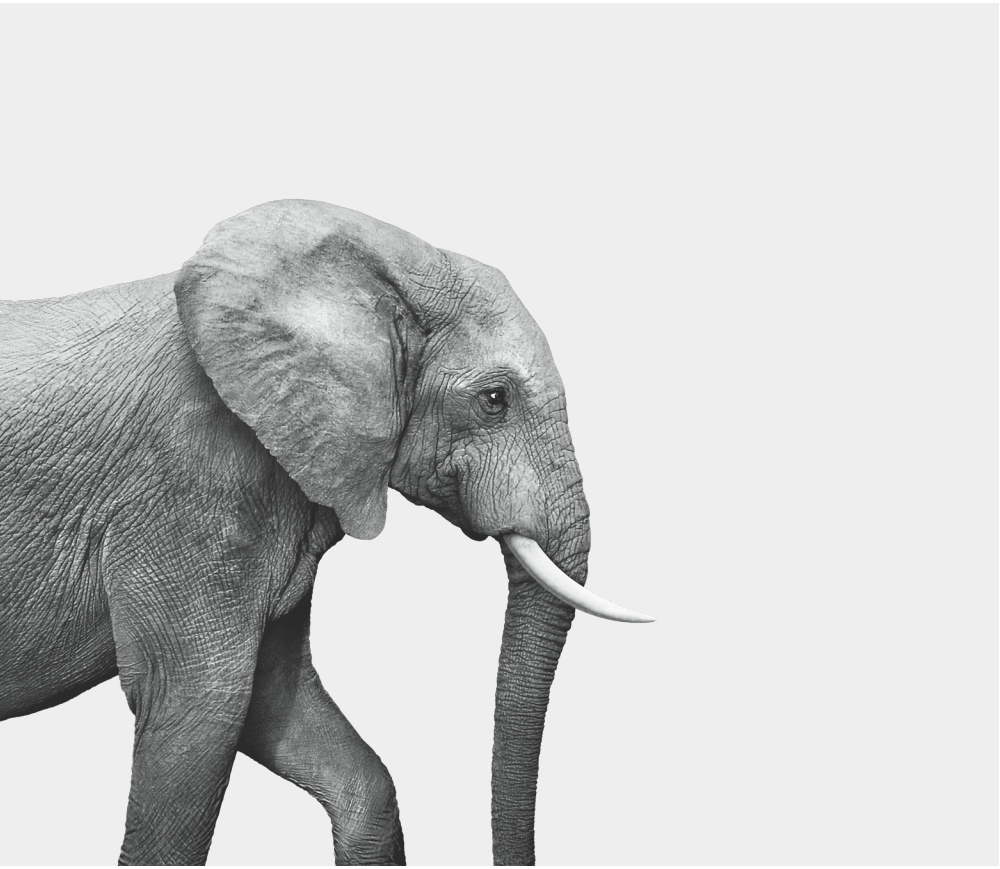
Participant's Right to Access His or Her Personal Information

A participant has the right to access his or her personal information and to request, in writing, that any inaccurate information be corrected. In addition, the participant can request that any outdated or unnecessary information be deleted.

If the Company has medical information about the participant which was not obtained directly from the participant, the Company will release the information to the participant only through the participant's physician.

To request access to his or her personal information or to have his or her name removed from the list to be shared within the Company, the participant must send a written request to:

Industrial Alliance Insurance and Financial Services Inc.
Access Officer
1080 Grande Allée West
P.O. Box 1907, Station Terminus
Quebec City, Quebec G1K 7M3



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