Nutreco Canada

Salaried Employees

Group Numbers: 91726-001 and 91726-002

Updated Effective Date: August 27, 2014

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This booklet summarizes the benefit plan for the eligible employees of Nutreco Canada and Poirier-Bérard as of November 1, 2012. If there are any discrepancies between the information in this booklet and the group policy, the group policy will take priority. Nutreco Canada reserves the right to modify the contents of this booklet and related contracts at any time.

AN OVERVIEW OF YOUR GROUP COVERAGE

Nutreco Canada, hereafter called Nutreco, has provided a program covering your medical and financial security. This program is offered to you through Medavie Inc. and Blue Cross Life Insurance Company of Canada.

The information contained in this booklet is an overview of the provisions of the policy between Nutreco, and Medavie Inc. and Blue Cross Life Insurance Company of Canada. Included is a summary of your benefits and pertinent information that you will require to optimize the coverage available to you and your family.

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

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

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

Group Insurance Eligibility

Applicable to Part-time Employees:

To be eligible for group coverage, you must be a permanent employee who is a resident of Canada, covered under your provincial government plan, actively at work, and working a minimum of 60% of the standard working week at the designated location. Coverage commences immediately upon employment.

To participate in your group plan, you must complete your selections within the online flexible benefits site within 31 days of becoming eligible, and forward the appropriate forms to your group administrator.

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

If not actively at work when you would normally have become eligible, your coverage will commence when you return to work.

Applicable to Full-time Employees:

To be eligible for group coverage, you must be a permanent employee who is a resident of Canada, covered under your provincial government plan, actively at work and working minimum of 30 hours per work week. Coverage commences immediately upon employment.

To participate in your group plan, you must complete your selections within the online flexible benefits site within 31 days of becoming eligible, and forward the appropriate forms to your group administrator.

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

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

Definition of Dependents
Your dependents are:

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

b) Your unmarried children who are your financial dependents and
   - are under 21 years of age, or
   - are under 25* years of age if full-time students attending an institution providing instruction at a secondary, college or university level, as a duly registered student, or
   - regardless of their age, if they live with you and have become totally and permanently disabled before age 21 (or age 25* if a student).

*subject to applicable legislation

Policy Year
The policy year for your group runs from November 1st to October 31st.

Proof of Health Requirement
You must submit proof of health if your application for coverage for yourself or your dependents is presented to Medavie Inc. and Blue Cross Life Insurance Company of Canada more than 31 days after the eligibility date.

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

Filing a Claim
Hospital Benefit
If you or one of your dependents are hospitalized, simply show your identification card at the time you are being admitted. The claim will be forwarded to Medavie Inc. by the hospital.

Drug Benefit
Reimbursement drugs (those not provided by a pharmacy) - complete the claim form, attach the original receipts and forward to Medavie Inc. (See contact information).

The duly completed claim form must be sent to Medavie Inc. no later than 24 months after the date on which expenses were incurred or within a time agreed upon by Medavie Inc. when contract terminates.

Pay direct drugs (those provided by a pharmacy) - simply show your identification card and the provider will arrange to bill Medavie Inc.

Extended Health Benefit
Complete the claim form, if applicable, attach the original receipts and forward to Medavie Inc. (See contact information).

The duly completed claim form must be sent to Medavie Inc. no later than 24 months after the date expenses are incurred or within a time agreed upon by Medavie Inc. when contract terminates.

Travel Benefit

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

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

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

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

Dental Benefit

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

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

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

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

Hospital, Travel, Drug, Extended Health Benefit and Dental Benefits

Claims will be administered by the Blue Cross plan in the Covered Employee's province of residence.

Group Life Benefits

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

Long Term Disability Benefits

Written notice of proof of Total Disability, duly signed by the parties, must be provided to Blue Cross Life Insurance Company of Canada within ninety (90) days immediately following the end of the Elimination Period.

If the contract terminates, proof of claim must be provided to Blue Cross Life Insurance Company of Canada within six months of the onset of the disability.

Limitation Periods for Legal Action

Every action or proceeding against an insurer (i.e. Medavie Inc. or Blue Cross Life Insurance Company of Canada) for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the Insurance Act.

Coordination of Benefits

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

The benefit payable to you or one of your dependents follows the order described below:

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

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

If you (or one of your dependents) are covered under more than one plan as an employee, benefits are payable in the following order:
- the plan under which you are an active full-time employee,
- the plan under which you are an active part-time employee,
- the plan under which you are a retiree.

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

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

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

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

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

FLEXIBLE BENEFITS OVERVIEW

The flexible benefits enrolment site provides you with the opportunity to make benefit choices that best suit your needs.

Enrolment Details

You are automatically enroled in the following benefits:

- Basic Life Benefits
- Basic and Optional AD&D Benefits (underwritten and administered by AIG Insurance Company of Canada)
- Short Term Disability Benefits (administered by Nutreco)
- Standard Long Term Disability Benefits

Your Health and Dental Benefits options are as follows:

- Basic Plan
- Standard Plan
- Comprehensive Plan

Enrolment into the Health & Dental plan is mandatory; you may only opt out of Health and Dental Benefits if you already have alternative coverage through your spouse, evidence of coverage must be provided.

You can also choose to enrol in:

- Optional Comprehensive Long Term Disability Benefits
- Optional Life Benefits
- Optional AD&D Benefits (underwritten and administered by AIG Insurance Company of Canada)

For detailed benefit options, please refer to the Summary of Benefits.

Enrolment System

The flexible benefits enrolment site is simple to use, available 24 hours a day, 7 days a week, and is delivered in a secure environment.

Your group administrator will provide you with your log-in information.

First-Time Enrolment

You can enrol once your employment begins. You must make your selections within 31 days of becoming eligible.

If you have not made your plan selection within the 31 day enrolment period, you will be automatically registered as follows:

- Single status
- Standard Health and Dental Benefits Plan
- Basic Plans for Life and Long Term Disability Benefits

Annual Reenrolment

You will have the opportunity to move up or down one plan option level per benefit when you annually renew your enrolment.

If you have chosen the Comprehensive Plan for Dental Benefits, you must maintain this selection for a minimum of 2 policy years

If you have not made your plan selection within the annual 31 day enrolment period, you will be automatically registered under your previous year's status and plan selections.

Once you have made your plan selection, no changes can be made within the policy year, except in the case of a life event change (as described in the following section).

Changing Your Coverage

You may change your benefit selections between annual enrolments if you experience a life event change.

Life event changes are as follows:

1) You are adding your first eligible dependent, or will no longer have any eligible dependents as a result of one of the following:
    a) Marriage or common law union
    b) Birth or adoption of a child
    c) Divorce or legal separation
    d) Dependent no longer meets eligibility criteria
    e) Death of an eligible dependent
2) You have lost coverage under your spouse's plan
3) You have qualified for Long Term Disability Benefits under this policy (can choose a more cost effective plan by moving to the Standard Health and Dental plans.)

A change as a result of a life event must be made within 31 days. Evidence of health will be required if you have not applied for your change within this timeframe.

Using your Flex Credits (for Health and Dental Benefits)

Nutreco has provided flex credits that can be used towards your Health and Dental Benefit premiums.

Health and Dental Benefit premiums are based upon the levels of coverage you have chosen. Your flex credit usage is automatically calculated when you make plan selections in the flexible benefits enrolment site.

If your plan selections cost more than your available flex credits, you are able to pay the cost difference through automatic payroll deductions over the course of the policy year.

If your plan selections cost less than your available flex credits, or if you have opted out of Health or Dental coverage, you can allocate your remaining flex credits to your Health Spending Account or your group RRSP.

For more information on your flexible benefits enrolment site, please contact your group administrator.

BLUE CROSS CONTACT INFORMATION

Blue Cross has offices at the following locations to answer any inquiries you may have relating to your group coverage or to allow you to submit claims.

ATLANTIC CANADA	P.O. Box 220, 644 Main St. Moncton, NB E1C 8L3
QUEBEC	550 Sherbrooke Street West Suite B9 Montreal, PQ H3A 6T6
ONTARIO	P.O. Box 2000 185 The West Mall, Suite 1200 Etobicoke, ON M9C 5P1
Customer Inquiry	**Toll Free 1-800-355-9133**
MANITOBA	599 Empress Street P.O. Box 1046 Station Main Winnipeg, MB R3C 2X7
SASKATCHEWAN	P.O. Box 4030 516 Second Avenue N Saskatoon, SK S7K 3T2
ALBERTA	10009 - 108th Street NW Edmonton, AB T5J 3C5
BRITISH COLUMBIA	Pacific Blue Cross 4250 Canada Way P.O. Box 7000 Burnaby, BC V6B 4E1
Customer Inquiry	**Toll Free 1-888-873-9200**
While Traveling:	**1-800-563-4444 (From Canada or the United States)** **1-506-854-2222 (collect from anywhere else)**

SUMMARY OF BENEFITS

COVERED EMPLOYEE'S BASIC LIFE BENEFIT

Benefit Formula	2 times the annual salary
Rounding Method	To the next higher $1,000
Maximum	$750,000
	Evidence of health is required for any amounts above 750,000
Waiver of premiums	Yes
Termination	The earlier of retirement, termination of employment or age 70

OPTIONAL LIFE BENEFIT

Benefit Formula	Coverage is provided to the covered employee in units of $10,000 to a maximum of $1,000,000
	Coverage is provided to the spouse in units of $10,000 to a maximum of $200,000
	Coverage is provided to dependent children in units of $5,000 to a maximum of $100,000
Maximum	Combination of Basic Life and Optional Life provided to the covered employee must not exceed $1,750,000
	Combination of Basic Life and Optional Life for the covered employee and spouse must not exceed $1,950,000
	Evidence of health is required for all amounts of coverage
Waiver of premiums	Yes
Termination	The earlier of retirement, termination of employment or age 70

COVERED EMPLOYEE'S SHORT TERM DISABILITY BENEFIT*

Benefit Formula	100% of weekly salary
Maximum Duration	26 weeks

*** The Short Term Disability Benefit is administered by Nutreco. Please contact your group administrator for details on this benefit.**

COVERED EMPLOYEE'S LONG TERM DISABILITY BENEFIT

STANDARD PLAN

Benefit Formula	60% of monthly salary
Rounding Method	To the next higher dollar
Elimination Period	26 weeks (182 days)
Maximum Benefit	$12,500 per month Evidence of health is required for amounts above $8,300
Benefit Period	To age 65
Taxable	No
Integration of Benefits (CPP or QPP and other social programs)	Direct
Duration Own Occupation	24 months
Pre-existing Conditions	3/6/12 months (please refer to page 28 for details)
Waiver of premiums	Yes
Termination	Benefit payments cease the earlier of retirement, termination of employment or age 65. Premiums and coverage terminates 26 weeks prior to your 65th birthday.

COVERED EMPLOYEE'S LONG TERM DISABILITY BENEFIT

OPTIONAL COMPREHENSIVE PLAN

Benefit Formula	60% of monthly salary
Rounding Method	To the next higher dollar
Elimination Period	26 weeks (182 days)
Maximum Benefit	$12,500 per month Evidence of health is required for amounts above $8,300
Benefit Period	To age 65
Taxable	No
Integration of Benefits (CPP or QPP and other social programs)	Direct
Duration Own Occupation	24 months
Cost of Living Adjustment	CPI adjustment up to a maximum of 3% Cost of Living Adjustment (COLA), beginning after 3 years of benefit payments
Pre-existing Conditions	3/6/12 months (please refer to page 28 for details)
Waiver of premiums	Yes
Termination	Benefit payments cease the earlier of retirement, termination of employment or age 65. Premiums and coverage terminates 26 weeks prior to your 65th birthday.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT*

Benefit Formula	2 times the annual salary
Maximum	$1,000,000

OPTIONAL ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT*

Benefit Formula	**Single Coverage is as follows:** Units of $10,000 up to a maximum of $350,000 **Family coverage is as follows:** - Spouse is insured for 60% of the amount purchased by you, and each dependent child is insured for 15% of the amount purchased by you. - Spouse is insured for 60% of the amount purchased by you if there are no dependent children. - Each dependent child is insured for 20% of the amount purchased by you if there is no spouse.

***These benefits are underwritten and administered by another carrier. Please contact your group administrator for benefit details.**

GENERAL INFORMATION
Applicable to all Health and Dental* Plan Options

Policy Year	Runs from November 1st to October 31st
Deductible (per policy year)	**Hospital Benefit:** Nil
	Drug Benefit: **Basic Plan:** $10 per participant per prescription **Standard Plan:** $5 per participant per prescription **Comprehensive Plan:** Nil
	Extended Health Benefit: Nil
	Worldwide Travel Benefit: Nil
	Dental Benefit: Nil
Payment Type	**Hospital Benefit:** Direct payment to provider
	Drug Benefit: Direct payment to pharmacy (drug card), or reimbursement for drugs not dispensed by a pharmacy
	Extended Health Benefit: Reimbursement
	Worldwide Travel Benefit: Direct payment to the provider, or reimbursement
	Dental Benefit: Reimbursement or direct payment (through CDA net)
Survivor Benefit	12 months
Termination	The earlier of retirement or termination of employment

*** Health and Dental Benefits include the Hospital Benefit, Drug Benefit, Extended Health Benefit, Worldwide Travel Benefit, and the Dental Benefit.**

HOSPITAL BENEFIT
In Canada Only

BENEFIT DESCRIPTION	BASIC PLAN	STANDARD PLAN	COMPREHENSIVE PLAN
Co-insurance	No coverage	100%	100%
Active Care	No coverage	**Room Accommodation:** Semi-Private **Maximum:** $125 per day	**Room Accommodation:** Semi-Private **Maximum:** $175 per day
Convalescent Care	No coverage	**Accommodation:** Room and Board **Maximum:** $20 per day to a maximum of 180 days per occurrence	**Accommodation:** Room and Board **Maximum:** $20 per day to a maximum of 180 days per occurrence
Chronic Care	No coverage	**Accommodation:** Room and Board **Maximum:** $20 per day to a maximum of 180 days per occurrence	**Accommodation:** Room and Board **Maximum:** $20 per day to a maximum of 180 days per occurrence
Physical Rehabilitation	No coverage	**Room Accommodation:** Semi-Private **Maximum:** $20 per day to a maximum of 180 days per occurrence, in combination with Rehabilitation Facility (Substance Abuse - Drugs and Alcohol)	**Room Accommodation:** Semi-Private **Maximum:** $20 per day to a maximum of 180 days per occurrence, in combination with Rehabilitation Facility (Substance Abuse - Drugs and Alcohol)
Rehabilitation Facility (Substance Abuse - Drugs and Alcohol)	No coverage	**Room Accommodation:** Room and Board **Maximum:** $20 per day to a maximum of 180 days per occurrence, in combination with Physical Rehabilitation	**Room Accommodation:** Room and Board **Maximum:** $20 per day to a maximum of 180 days per occurrence, in combination with Physical Rehabilitation
Overall Maximum	No coverage	Unlimited	Unlimited

DRUG BENEFIT
In Canada Only

BENEFIT DESCRIPTION	BASIC PLAN	STANDARD PLAN	COMPREHENSIVE PLAN
Co-insurance	80%	90%	100%
Eligible Benefits	• Drug Benefit • Diabetic Supplies (needles, syringes, test strips and lancets only) • Smoking Cessation Products (prescription drugs only) - limited to $500 per lifetime • Injectable Vitamins • Allergy Sera • Fertility Benefits- limited to $500 per lifetime • Anti-Obesity Drugs- limited to $500 per policy year • Erectile Dysfunction Benefits (oral products only) - limited to $500 per policy year • Vaccines		
Maximum	• Unlimited maximum • For QC residents, meets Régie de l'assurance-maladie du Québec (RAMQ) requirements		

EXTENDED HEALTH BENEFIT
In Canada Only

PARAMEDICAL PRACTITIONERS*

Psychologist/Social Worker, Chiropractor (includes one x-ray per policy year), Naturopath, Osteopath (includes one x-ray per policy year), Chiropodist/Podiatrist (includes one x-ray per policy year), Speech Therapist, Physiotherapist, Acupuncturist and Massage Therapist.

BASIC PLAN	STANDARD PLAN	COMPREHENSIVE PLAN
Co-insurance: 80%	**Co-insurance:** 90%	**Co-insurance:** 100%
• $300 max per practitioner per policy year, with the exception of physiotherapist which is $400 max per policy year	• $400 max per practitioner per policy year, with the exception of physiotherapist which is $600 max per policy year	• $500 max per practitioner per policy year, with the exception of physiotherapist which is $800 max per policy year
• Unlimited overall combined max per policy year	• Unlimited overall combined max per policy year	• Unlimited overall combined max per policy year

*** All practitioners subject to a U&C maximum per visit.**

EXTENDED HEALTH BENEFIT
In Canada Only

MEDICAL EXPENSES

BENEFIT DESCRIPTION	BASIC PLAN	STANDARD PLAN	COMPREHENSIVE PLAN
Co-insurance	80%	90%	100%
Nursing Care*	No coverage	$20,000/policy year max	$30,000/policy year max
Orthopedic Shoes and Molded Arch Orthotics	$300/policy year combined max	$400/policy year combined max	$500/policy year combined max
Hearing Aids	$500/5 policy years max	$600/5 policy years max	$700/5 policy years max

*** Benefits subject to pre-authorization**

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

SUMMARY OF BENEFITS

EXTENDED HEALTH BENEFIT
In Canada Only

MEDICAL EXPENSES

BENEFIT DESCRIPTION	BASIC PLAN	STANDARD PLAN	COMPREHENSIVE PLAN
Co-insurance	80%	90%	100%
	MAXIMUM		
Ambulance Transportation	$1,000 per policy year		
Compression Garments	4 pairs per policy year (up to U&C)		
Prosthetics (limbs, eyes)	One prosthetic appliance for each limb per lifetime (up to U&C)		
Breast Prosthesis	$200 per breast per policy year (includes repairs and adjustments)		
Mobility Aids - Crutches and Canes	Purchase is one per lifetime, rental is one per month (up to U&C)		
Mobility Aids - Casts and Splints	Purchase is up to U&C, rental is one per month		
Durable Medical Equipment	Up to U & C (see Annex A)		
Pneumatic Compression Pump	Purchase is one every 5 policy years, rental is one per month (up to U&C)		
Diabetic Equipment	$700 per lifetime, insulin pump is limited to one per 5 policy years		
TENS (purchase or rental)	$300 combined per 5 policy years		
Diagnostic Tests**	$1,000/policy year		
Radiotherapy/ Coagulotherapy	Up to U & C		
Blood Plasma/Blood Transfusion	Up to U & C		
Compound Serums	Up to U & C		
Varicose Vein Injections	Up to U & C		
Accidental Dental Care*	Subject to authorization		
Intrauterine Contraceptive Device (IUD)	$75 per 2 policy years		
Wigs	$300 per policy year (see page 37 for eligibility details)		
Manual or Electric Hospital-Type Bed (including mattress and safety side rails)	Purchase is one per 5 policy years (up to U&C)		
Wheelchair (Manual or Electric)/Scooter	Purchase is one per 5 policy years maximum, rental is two per month maximum		

*** Benefits subject to pre-authorization**
**** Diagnostic imaging services coverage in Quebec only**

EXTENDED HEALTH BENEFIT
In Canada Only

VISION CARE

BENEFIT DESCRIPTION	BASIC PLAN	STANDARD PLAN	COMPREHENSIVE PLAN
Co-insurance	No coverage, except eye examination	100%	100%
Maximum	**Eye Examination:** One eye examination (up to U & C)/24 consecutive months	**Eye Examination:** One eye examination (up to U & C)/24 consecutive months **Contact Lenses Due to Disease:** $150 per lifetime **Visual Training:** $150 per lifetime **Lenses/Frames/ Contact Lenses/ Laser Eye Surgery:** $200/24 consecutive months **Additional Lenses/ Frames (when due to surgical procedure or treatment of keracotonus):** $100 per lifetime	**Eye Examination:** One eye examination (up to U & C)/24 consecutive months **Contact Lenses Due to Disease:** $150 per lifetime **Visual Training:** $150 per lifetime **Lenses/Frames/ Contact Lenses/ Laser Eye Surgery:** $300/24 consecutive months **Additional Lenses/ Frames (when due to surgical procedure or treatment of keracotonus):** $100 per lifetime

EXTENDED HEALTH BENEFIT
Outside Canada

PHYSICIAN REFERRALS

BENEFIT DESCRIPTION	BASIC PLAN	STANDARD PLAN	COMPREHENSIVE PLAN
Co-insurance	100%		
Referrals Outside Canada	$500,000 max per lifetime on pre-approval		

WORLDWIDE TRAVEL BENEFIT

BENEFIT DESCRIPTION	BASIC PLAN	STANDARD PLAN	COMPREHENSIVE PLAN
Co-insurance	100%		
Hospital and Medical Benefit	$2,000,000 max/participant per incident; limited to the first 60 days of a trip		
Travel Assistance	Provided by CanAssistance Inc.		

DENTAL BENEFIT
In Canada Only

BENEFIT DESCRIPTION	BASIC PLAN	STANDARD PLAN	COMPREHENSIVE PLAN
Preventive Care	**Co-insurance**: 80% **Maximum:** $1,000* per policy year	**Co-insurance:** 90% **Maximum:** $2,000* per policy year	**Co-insurance:** 100% **Maximum:** $3,000* per policy year
Basic	**Co-insurance**: 80% **Maximum:** $1,000* per policy year	**Co-insurance:** 90% **Maximum:** $2,000* per policy year	**Co-insurance:** 100% **Maximum:** $3,000* per policy year
Major	No coverage	**Co-insurance:** 50% **Maximum:** $2,000* per policy year	**Co-insurance:** 60% **Maximum:** $3,000* per policy year
Orthodontic	No coverage	**Co-insurance:** 50% **Maximum:** $1,500 per lifetime	**Co-insurance:** 60% **Maximum:** $2,500 per lifetime
Fee Guide Schedule	Current year	Current year	Current year
Number of Recall Examinations, Polishing and Topical Application of Fluoride	1 per 6 consecutive months for dependent children age 15 and under, 1 per 9 consecutive months for all other participants	1 per 6 consecutive months for dependent children age 15 and under, 1 per 9 consecutive months for all other participants	1 per 6 consecutive months for dependent children age 15 and under, 1 per 9 consecutive months for all other participants
Oral hygiene instruction	two instructions per lifetime	two instructions per lifetime	two instructions per lifetime
Occlusal adjustments	4 units** every 12 consecutive months	4 units** every 12 consecutive months	4 units** every 12 consecutive months

*** Preventive Care, Basic and Major (if applicable) are subject to a combined maximum**
**** A unit of time is equal to 15 minutes of service**

BLUE ADVANTAGE™

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

Applicable in Canada

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

Repairs and/or adjustments are provided to a maximum of $300 per policy year, with the exception of breast prosthesis which is $200 per policy year combined with the initial purchase.

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

Other medical services and supplies as prescribed:

- Oxygen and rental of equipment for the administration thereof are subject to pre-authorization and purchase at the discretion of Medavie Inc.,
- Wheelchair/scooter cushions and inserts: one every five (5) policy years,
- Cranial remolding helmet (limited to two per lifetime),
- Patient lifter (up to usual, customary, and reasonable charges),
- Ostomy supplies and incontinence supplies up to usual, customary and reasonable charges,
- Artificial larynx subject to a frequency of one per lifetime up to usual, customary and reasonable charges,
- Charges for the repair of artificial larynx: $300 per policy year,
- Burn pressure garments: $500 per policy year,
- Surgical brassieres: limited to two per policy year,
- Speech aids: $500 per lifetime,
- Spacing devices up to usual, customary and reasonable charges,
- Allergy testing materials: $50 per policy year,
- Sleeves for lymphedema: two per policy year.

LIFE BENEFIT

The Life Benefit plan offers the amounts of Life Benefit protection required to meet your needs.

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

Coverage terminates when your employment terminates, at retirement or at age 70, whichever occurs first.

Optional Employee and Spousal Life Benefit
You or your spouse may subscribe to the Optional Employee and Spousal Life Benefit in $10,000 increments, as stipulated in the Summary of Benefits.

The Optional Life Benefit coverage terminates when your employment terminates, at retirement or upon reaching age 70, whichever occurs first.

Optional Dependent Life Benefit
You may subscribe to the Optional Dependent Life Benefit in $5,000 increments, as stipulated in the Summary of Benefits.

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

Naming of Beneficiary
You are required to name your beneficiary for your Life Benefits.

If you designate "estate", be sure you have a will, otherwise estate taxes will apply. If you name a child who is under age 18, benefits cannot be paid directly to that child. You must indicate on the beneficiary designation form that the beneficiary is "in trust"; if a benefit becomes payable, the payment will be made to a designated trustee. Be sure to provide the full name and relationship of the trustee.

If you are a resident of Quebec: The appointment of your spouse as a beneficiary is irrevocable, which means it cannot be changed without your spouse's consent, unless you specify that the designation is revocable.

If two or more beneficiaries are designated (other than alternatively), and no division of the benefit is declared, then the benefit is payable to the beneficiaries in equal shares.

If your beneficiary predeceases you, and you have not indicated this beneficiary's share of the Life Benefit, the deceased beneficiary's share is payable.

- To the surviving beneficiary,
- To the surviving beneficiaries in equal shares, if there is more than one surviving beneficiary, or
- To your personal representative, if there is no surviving beneficiary.

You can change your beneficiary at any time (unless you have designated an irrevocable beneficiary) by completing a beneficiary change form available from the online enrolment tool or from your group administrator.

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

Payment of Benefits
Upon your death, Blue Cross Life Insurance Company of Canada will pay, to your named beneficiary, the amount of your Basic Life Benefit and of your Optional Life Benefit, if any. You are the beneficiary of the Dependent's Optional Life Benefit.

Waiver of Premiums
If you become totally disabled before your 65th birthday, your life benefit premiums are waived, beginning on a) the first of the month falling on or following the date you become eligible for Long-term Disability Benefits, if any or b) the expiry date of six consecutive months of total disability, whichever occurs first, provided satisfactory evidence of total disability is submitted to Blue Cross Life Insurance Company of Canada.

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

The waiver terminates on the earliest of the following dates:

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

Exclusions
If you or your spouse die as a result of suicide or any attempt thereof in the 24 months following the effective date of the Optional Life Benefit or increase thereof, the Optional Life Benefit or its increase is not payable. In this particular instance, Blue Cross Life Insurance Company of Canada's obligation is limited to the refund of paid premiums.

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

Your spouse is also entitled to this conversion right to an individual coverage policy within the 31 days of your coverage termination or the 31 days of the date he ceases to be eligible as a dependent spouse.

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

SHORT TERM DISABILITY BENEFIT (Administered by Nutreco)

The Short Term Disability Benefit is administered by Nutreco. Please contact your group administrator for benefit details.

The STD plan continues 100% of your *insurable earnings* for up to 26 weeks if you are unable to perform the essential duties of your own occupation. STD benefits are company-paid and are taxable.

You must contact your manager as soon as possible on the first day of your absence from work. If you do not do so without a satisfactory explanation, you will not be paid STD benefits.

If your disability is prolonged, to continue to qualify for STD benefits, you must be receiving appropriate treatment from a doctor and must provide appropriate medical evidence for approval by Nutreco's disability claims adjudicator. You are also expected to maintain regular contact with Nutreco while your absence from work continues. All costs associated with providing medical evidence are the responsibility of the employee.

Other Income Sources
STD benefits are reduced by any income you receive from the same or subsequent disability, such as the Canada/Quebec Pension Plan and/or Workers' Compensation or similar act, but are not reduced by income from private disability insurance.

Rehabilitative Employment
You may be required to participate in a rehabilitation program to help in your recovery and timely return to work. During your participation in an approved rehabilitation program you will continue to be eligible for STD benefit payments. However, during any week, your total income from all sources cannot exceed 100% of your basic earnings when your disability began. A rehabilitation program may include modified work.

Recurring Disability
Successive periods of disability, resulting from the same cause or related causes, are considered one period of disability unless they are separated by at least two consecutive weeks of full-time work. Successive periods of disability due to totally different and unrelated causes are considered a same period of disability unless you completely recovered from the first disability when the second began, and have returned to work actively, full-time and with full pay for at least one entire day.

Exclusions and Limitations
STD benefits are not payable for a disability due to:

- Intentionally self-inflicted injuries
- Drug or alcohol abuse, unless you are participating in an approved treatment program or have a disease that would cause total disability even if drug or alcohol abuse ended
- The hostile action of any armed forces, insurrection or participation in a riot or civil commotion
- Illness or Injuries sustained while committing or attempting to commit a criminal offence.

In addition, STD benefits are not payable for any period during which you are:

- Not under the care of a licensed physician
- Receiving compensation under a workers' compensation board/commission or any program of similar nature
- On a leave of absence, including maternity leave, subject to applicable legislation
- Serving a prison term or confined in a similar institution
- Not participating in an approved rehabilitation program as required
- Working for wage or profit, except for an approved rehabilitation program
- On a temporary lay-off and in receipt of regular Employment Insurance Benefits
- In receipt of a company pension from the same employer, or for a period in which you are entitled to receive remuneration from same employer.

LONG TERM DISABILITY BENEFIT

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

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

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

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

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

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

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

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

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

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

Rehabilitation Program
If, while receiving monthly benefits, you participate in a rehabilitation program approved by Blue Cross Life Insurance Company of Canada:

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

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

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

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

Pre-existing Condition

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

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

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

Integration of Benefits

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

1. The amount of monthly benefits otherwise payable is reduced directly by any disability benefits available from the Canada or Quebec Pension Plan (primary benefits only), the Workers' Compensation Act and "income from all other sources". "Income from all other sources" includes:

    - disability benefits available under any other government program excluding secondary benefits under the Canada or Quebec Pension Plan,
    - retirement benefits provided by any employer or government program,
    - income or benefits payable under any group program provided by or through the employer,
    - income or benefits payable under a plan sponsored by an association, union or fraternal organization of which the covered employee is a member,
    - income replacement benefits payable under any plan of automobile insurance, where such reduction is not prohibited by law, and
    - wages or remuneration payable from any employer or from self-employment, but excluding 50% of pre-disability salary received under an approved rehabilitation program. (For non-taxable plans, pre-disability salary shall mean gross salary minus income tax. For taxable plans, pre-disability salary shall mean gross salary).

2. The amount determined in 1. above is further reduced if necessary, so that the amount of monthly income, including all amounts of benefits mentioned in 1. above, does not exceed 85% of the covered employee's pre-disability earnings.

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

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

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

Limitations and Exclusions

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

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

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

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

c) Any period during which you are imprisoned,

d) Any disability due to or resulting from self-inflicted injury or sickness, while sane or insane,

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

f) Any disability during the period:

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

Termination of the Right to Benefits

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

a) You refuse to undergo a medical examination requested by Blue Cross Life Insurance Company of Canada.

b) You refuse to participate in a medical or rehabilitative employment program judged reasonable and appropriate by both Blue Cross Life Insurance Company of Canada and your attending physician.

c) You fail to produce proof satisfying Blue Cross Life Insurance Company of Canada of the persistence of disability.

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

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

f) Your disability no longer meets the policy definition.

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

Cost-of-Living Adjustment (applicable only to the Comprehensive Plan)
If, on the first day of January, you have received disability income for more than three years since the expiry of the elimination period, your income will be indexed according to the Consumer Price Index (CPI) published by Statistics Canada, subject, however, to the maximum indexation specified in the Summary of Benefits.

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

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

BASIC AND OPTIONAL ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS (underwritten and administered by AIG Insurance Company of Canada)

Basic and Optional Accidental Death and Dismemberment Benefits are not underwritten by Medavie Inc. or Blue Cross Life Insurance Company of Canada. Please contact your group administrator for further details on these benefits.

The amount for which each eligible person is covered is known as the principal sum. The full principal sum is payable in the event of accidental death. A percentage of the principal sum is payable in the event of other eligible losses, in accordance with the following schedule of benefits.

Loss	Percentage of Principal Sum
Loss of life	100%
Loss of both hands or both feet	100%
Loss of entire sight of both eyes	100%
Loss of one hand and one foot	100%
Loss of one hand or one foot and entire sight of one eye	100%
Loss of speech and loss of hearing in both ears	100%
Loss of use of both arms	100%
Loss of use of both hands	100%
Loss of one hand or one foot	75%
Loss of use of one hand or one foot	75%
Loss of speech or hearing	75%
Loss of entire sight of one eye	75%
Loss of thumb and index finger of the same hand	33 1⁄3%
Loss of four fingers of same hand	33 1⁄3%
Loss of hearing in one ear	66 2/3%
Loss of all toes of one foot	25%
Loss of one arm or one leg	80%
Loss of use of one arm or one leg	80%
Quadriplegia (total paralysis of upper and lower limbs)	200%
Paraplegia (total paralysis of both lower limbs)	200%
Hemiplegia (total paralysis of upper and lower limbs of one side of the body)	200%

Note: If you or an insured dependent suffer multiple losses in the same accident, the maximum amount payable is 100% of the principal sum (except for paraplegia, quadriplegia or hemiplegia where the amount payable will not exceed 200% of the principal sum).

Other AD&D Benefits

As part of your basic AD&D insurance, you may also be eligible for:

- In-hospital indemnity benefit - a cash benefit if you are hospitalized as a result of an accident
- Repatriation of your body if you die in an accident
- Rehabilitation (job training) for you up to three years from the date of the accident
- Occupational training for your spouse if you die in an accident
- Transportation of a family member to you if you are hospitalized after an accident
- Education for your dependent children who are enrolled in post-secondary education if you die in an accident
- Day-care for your dependent children under age 13 if you die in an accident
- Increased benefit if you are wearing your seat belt when injured in a car accident
- Alterations of your home or vehicle to accommodate disabilities sustained in an accident
- Privilege to convert to an individual insurance contract within 30 days of termination.

Specific maximums may apply to these benefits.

You automatically receive company-paid Business Travel Accident Insurance which pays a benefit in the amount of 3 times your basic annual earnings in the event of accidental death or other eligible losses while you are travelling on company business.

Things to Consider

Keep in mind that Optional AD&D insurance is only payable in the event of an accidental death or injury. As you evaluate whether or not to purchase this coverage, you may wish to consider the following questions:

- What impact would a serious accident have on your financial security and that of your family?
- Do you have large debts or long-term expenses that would be difficult to pay if you or a family member were injured?
- Do you or any of your eligible dependents participate in potentially dangerous recreational activities that could result in accidental injury or death?
- How much coverage, in combination with other insurance, do you need to secure your dependents' financial security?
- Do you have other sources of accident insurance? If so, are the rates competitive?

Limitations and Exclusions

AD&D insurance is not payable for losses resulting from:

- Suicide or attempted suicide, while sane, self-destructive or insane
- Injury caused as a consequence of riding as a passenger or otherwise in any vehicle or device used for aerial navigation, except for chartered commercial or military aircraft
- Declared or undeclared war or any related act
- Active full-time service in the armed forces of any country,
- Undergoing the medical or surgical treatment of sickness, disease, or bodily or mental infirmity.

Other limitations and exclusions may apply. Contact your Group Administrator for information.

HOSPITAL BENEFIT – IN CANADA ONLY

This benefit covers eligible expenses incurred by you or your dependents and the percentage of reimbursement specified in the Summary of Benefits, providing eligible expenses are incurred in Canada, except for Referrals outside Canada.

Eligible Expenses

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

HOSPITALIZATION

Hospital Room Benefit

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

Convalescent Care

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

Chronic Care

Charges for chronic care when admitted on the recommendation and written approval of a physician, subject to the daily maximum and maximum number of days specified in the Summary of Benefits.

Physical Rehabilitation

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

Rehabilitation Facility (Substance Abuse - Drugs and Alcohol)

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

Survivor Benefit

After your death, your dependents continue to be covered up to the earliest of the following dates:

a) 12 months after the date of your death,
b) The date they cease to be eligible dependents,
c) The effective date of any similar coverage with another insurer, or
d) The termination date of the group policy.

DRUG BENEFIT – IN CANADA ONLY

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

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

Drugs must be dispensed by a provider approved by Medavie Inc.

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

Medavie Inc. will reimburse only for the lowest priced interchangeable drug when prescribed by a physician and dispensed by an approved provider, unless the physician indicates no substitution.

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

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

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

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

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

Expenses not Reimbursed by the Plan
Incurred expenses for the following products or drugs are excluded:

- products not approved by Medavie Inc.,
- products for the care of contact lenses,
- proteins or dietary supplements, amino acids, essential fatty acids,
- processed food for infants,
- hygiene products, including soaps and emollients,
- softeners and protective substances for the skin,
- minerals, vitamins,
- homeopathic/naturopathic products,
- drugs or drug formats or preparations with no therapeutic indication,
- herbal remedies,
- traditional medicines,
- probiotics,
- drugs administered in a hospital,
- allergy sera’s without an assigned drug identification number (DIN),
- anti-obesity vitamin B6 and B12 injectables.

Applicable to Quebec Residents
When you and your spouse reach the age of sixty-five (65), you have a decision to make regarding your drug coverage.

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

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

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

However, you and your dependents who have joined the RAMQ's plan remain covered under the group insurance plan for the expenses indicated below (continuing payroll deductions, if applicable):

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

Decision to cancel registration with the RAMQ at age 65
When a Quebec resident reaches the age of sixty-five (65), he is automatically registered by the RAMQ as a beneficiary of its prescription drug coverage. When you or your spouse reaches the age of sixty-five (65) you must therefore cancel your automatic registration with the RAMQ plan in order to continue full drug coverage under the group insurance plan.

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

Survivor Benefit
After your death, your dependents continue to be covered up to the earliest of the following dates:

a) 12 months after the date of your death,
b) The date they cease to be eligible dependents,
c) The effective date of any similar coverage with another insurer, or
d) The termination date of the group policy.

EXTENDED HEALTH BENEFIT – IN CANADA ONLY

This benefit covers eligible expenses incurred by you or your dependents subject to the percentage of reimbursement specified in the Summary of Benefits, providing eligible expenses are incurred in Canada, except for Referrals outside Canada.

Eligible Expenses

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

MEDICAL SERVICES AND SUPPLIES

Nursing Care

Services of a registered nurse, registered nursing assistant or licensed practical nurse, who is not a member of the participant's family, whether residing with him or not, provided such services are rendered at the participant's home and are not primarily for custodial care, subject to the overall maximum amount payable noted in the Summary of Benefits.

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

Charges for the following services are not covered:

a) Custodial care, homemaking duties, shopping, transportation, and respite care,

b) Services to those residing in a government funded facility or any other facility which provides similar care to its residents,

c) Service available through a government funded nursing or personal care program or community health program available to the general population at no cost.

Ambulance Transportation

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

Orthopedic Shoes and Custom Made Orthotic Shoe Inserts

Charges for orthopedic shoes when the shoes have been customized with special features to accommodate relieve or remedy some mechanical foot defect or abnormality. A prescription from an orthopedic surgeon, physiatrist, rheumatologist, chiropodist/podiatrist or the attending physician is required along with a copy of the biomechanical or gait analysis from the health care professional. Also, charges for shoe modifications, adjustments and supplies when prescribed by one of the health care professionals noted above to accommodate, relieve or remedy some mechanical foot defect or abnormality.

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

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

Compression Garments

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

Prostheses

Charges for the following remedial prosthetic appliances:

- artificial limbs (see Summary of Benefits),
- breasts (see Summary of Benefits),
- artificial nose (limited to one (1) per lifetime),
- eyes (limited to one left and one right prosthesis per lifetime),
- crutches, canes, casts, and splints (see Summary of Benefits),
- trusses (limited to one truss per five (5) consecutive policy years),
- braces (purchase is limited to one (1) per lifetime, rentals are limited to one per month),
- residual limb socks (limited to five (5) pairs per policy year).

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

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

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

Hearing Aids

Charges for hearing aids (excluding batteries and exams), when prescribed by an otolaryngologist, otologist and/or recommended by a registered audiologist. Eligible dependent children less than 21 years of age, requiring a hearing aid for each ear, are eligible for two (2) hearing aids (one for each ear). The maximum amount payable for this benefit is noted in the Summary of Benefits.

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

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

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

Medical Equipment
Charges for rental equipment for the administration of oxygen, when prescribed by a licensed physician. If, due to extended illness or disability, it is felt that the need for these items will be long-term, Medavie Inc., at its sole discretion, may approve the purchase of these items.

Charges for the rental of a wheelchair (manual or electric), scooter, or a hospital-type bed (manual or electric) when prescribed by a licensed physician. The maximum payable for this equipment is noted in the Summary of Benefits. If, due to extended illness or disability, it is felt that the need for these items will be long-term, Medavie Inc., at its sole discretion, may approve the purchase of these items. The maximum payable for this equipment is noted in the Summary of Benefits.

Charges for the purchase of a cranial remolding helmet, pneumatic compression pump or patient lifter. The maximum payable for this equipment is noted in the Summary of Benefits and Annex A.

Charges for rental of a pneumatic compression pump or patient lifter are limited to one per month.

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

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

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

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

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

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

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

Radiotherapy/Coagulotherapy
Charges for radiotherapy/radiation therapy or coagulotherapy when required for cancer treatment, less the amount allowed under the provincial government health plan, when ordered by the attending physician. The maximum amount payable is noted in the Summary of Benefits.

Blood Plasma/Blood Transfusions
Charges for blood or blood products when not provided by Canadian Blood Services or other agencies to the usual, customary & reasonable charges, less the amount allowed under the provincial government health plan, when ordered by the attending physician. The maximum amount payable is noted in the Summary of Benefits.

Other Medical Services and Supplies
a) Charges for the purchase of wheelchair/scooter cushions and inserts, limited to the usual, customary and reasonable amount.
b) Charges for artificial larynx, limited to one purchase per lifetime.
c) Charges for the repair of artificial larynx, subject to the maximum amount payable noted in the Summary of Benefits.
d) Charges for the purchase of burn pressure garments, subject to the maximum amount payable noted in Annex A.
e) Charges for the purchase of surgical brassieres, limited to two (2) per policy year.
f) Charges for the purchase of spacing devices up to the usual, customary and reasonable amount.
g) Charges for allergy testing materials, subject to the maximum amount payable noted in the Summary of Benefits.
h) Charges for sleeves for lymphedema, limited to two (2) per policy year.
i) Compound serums, subject to the maximum amount payable noted in the Summary of Benefits.
j) Varicose vein injections, subject to the maximum amount payable noted in the Summary of Benefits.

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

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

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

This dental treatment must be rendered or reported and approved for payment by Medavie Inc. within 180 days of the accident and dental work must be completed within 12 months from the date of the accident. Eligible expense will be the dentists' usual and customary fee up to the "dental fee guide" for general practitioners in effect where services are rendered.

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

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

VISION CARE

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

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

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

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

Additional Lenses/Frames
Charges incurred for one additional lenses/frames when required due to surgical procedure or treatment of keracotonus, limited to the maximum payable amount stated in the Summary of Benefits.

Expenses not Reimbursed by the Plan

The following expenses are not reimbursed under the plan:

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

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

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

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

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

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

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

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

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

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

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

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

m) Service performed by an unqualified practitioner,

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

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

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

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

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

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

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

EXTENDED HEALTH BENEFIT – IN CANADA ONLY

Limitation

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

Termination of Benefit

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

Survivor Benefit

After your death, your dependents continue to be covered up to the earliest of the following dates:

a) 12 months after the date of your death,
b) The date they cease to be eligible dependents,
c) The effective date of any similar coverage with another insurer, or
d) The termination date of the group policy.

EXTENDED HEALTH BENEFIT – REFERRALS OUTSIDE CANADA

When the attending physician refers you to a physician outside Canada for medical care not available in Canada, this benefit will pay the usual, customary and reasonable charges for services listed below, in excess of the amount paid by the provincial government health insurance plan. The maximum lifetime reimbursement per participant is specified in the Summary of Benefits.

Eligible Expenses

Hospital Services

All hospital charges for medically necessary services, less the amount refunded by the provincial government health program, such as:

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

Physicians and Surgeons

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

Ambulance

Charges for licensed ambulance services required to transport a stretcher patient to and from the nearest hospital able to provide essential care.

Ambulance Attendant

Charges for travel expenses of an accompanying person (namely a registered nurse or qualified medical attendant, other than a relative, when medically necessary and approved by Medavie Inc..

Specific Exclusions and Limitations

1. The referral outside Canada must be medically necessary and must not be for services available in Canada, as determined by Medavie Inc.
2. Prior authorization from Medavie Inc. must be obtained.
3. Payment will be made for the reasonable and customary charges applicable in the area in which the services are rendered.
4. All services must be rendered while the patient is under the active care of a licensed physician.
5. No benefit is payable for treatment of an illness that began within 12 months of the patient's effective date of coverage or for which he has received medical treatment or has been prescribed drugs in the 12 months preceding the effective date of this coverage.
6. The services to be provided outside Canada must not be experimental or investigative in nature.
7. Referrals outside of Canada exclude, but are not limited to, services not available due to waiting lists and/or treatment that has been refused by a physician in Canada.
8. In order to be eligible, the provincial government health care plan of the province of residence must agree to cover a part of the expenses.

WORLDWIDE TRAVEL BENEFIT

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

WORLDWIDE TRAVEL COVERAGE

Travel Assistance Lines

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

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

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

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

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

Eligible Expenses for Worldwide Travel Coverage

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

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

Hospital Accommodation

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

Physicians and Surgeons

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

Medical Appliances

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

Nurse

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

Ambulance

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Non-medical Assistance
The patient may call to obtain:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8. Medavie Inc. will not cover expenses in excess of $2 million Canadian per covered participant, per incidence outside the province of residence. All claims and required government forms must be submitted within four (4) months of the date of service.

Restrictions on the Duration of Trips

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

Termination of Travel Benefit

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

Survivor Benefit

After your death, your dependents continue to be covered up to the earliest of the following dates:

a) 12 months after the date of your death,
b) The date they cease to be eligible dependents,
c) The effective date of any similar coverage with another insurer, or
d) The termination date of the group policy.

DENTAL BENEFIT – IN CANADA ONLY

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

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

Expenses are subject to the percentages of reimbursement and maximums specified in the Summary of Benefits.

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

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

Preventive Care

a) Oral examinations and diagnosis
   - Complete oral examination (once every 24 consecutive months)
   - Recall oral examination (as mentioned in the Summary of Benefits)
   - Emergency oral examination and specific oral examination (combined limit of once per provider per policy year)

b) X-rays
   - complete series films or panoramic film (combined limit of one every 36 consecutive months)
   - Intra-oral films – periapical
   - Intra-oral films – occlusal
   - Intra-oral films – bitewings (once every 9 consecutive months)
   - Extra-oral films
   - Sialography
   - Radiopaque dyes

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

Preventive Care (Cont'd)

d) Preventive treatment
- Polishing of coronal portion of teeth (as mentioned in the Summary of Benefits)
- Topical application of fluoride (as mentioned in the Summary of Benefits)
- Oral hygiene instruction (as mentioned in the Summary of Benefits)
- Pit and fissure sealants
- Scaling (12 units* every policy year, in combination with root planing)

e) Space maintainers

Basic Care

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

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

c) Periodontics
- Periodontal surgery
- Provisional splinting
- Management of acute infections
- Desensitizations
- Other adjunctive periodontal services
- Root planing (12 units* every policy year, in combination with scaling)
- Periodontal curettage
- Occlusal adjustments (as mentioned in the Summary of Benefits)
- Periodontal appliances (one upper and one lower every two policy years)
- Adjustments to appliances (three units* per policy year)

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

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

f) Obstructive Airway Dental Appliance (once every five policy years)
- Maintenance, repair and monitoring (4 units* of each service per policy year)

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

Major Restoration

a) Extensive Restorations
   - Inlays/onlays/crowns (once per tooth every five policy years)
   - Repairs to inlays/onlays/crowns (up to the usual, customary, and reasonable amount)

b) Prosthodontic Services
   - Complete and partial dentures (one upper and one lower every five policy years)
   - Bridgework* (once every five policy years)
   - Repairs to bridgework (up to the usual, customary, and reasonable amount)
   - Restorations over implants (i.e. crowns, bridgework and dentures) (once per tooth every 10 policy years)

c) Removable denture adjustments
   - Minor adjustments
   - Rebasing and relining (one upper and one lower every two policy years)

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

*The initial request for bridgework must be as a result of the extraction of two or more natural teeth while insured. The cost of such an initial request for bridgework is limited to the cost of a partial denture.

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

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

Reasonable expenses incurred for orthodontic services given by an orthodontist to correct the dental irregularities.

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

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

b) If a single charge is estimated for the entire course of treatment and you pay this charge to the orthodontist in one lump sum, Medavie Inc. will reimburse up to 1/3 of the total cost initially and equal instalments thereafter over the entire treatment period.

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

Proposed Dental Treatment in Excess of $500

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

Expenses not Covered by the Plan

The following expenses are not covered:

a) Treatment or appliance, related directly or indirectly to full mouth reconstruction, or to correct vertical dimension and temporomandibular joint dysfunction.

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

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

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

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

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

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

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

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

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

k) Expenses incurred for veneers.

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

m) Mouth guards.

n) Implant procedures.

o) Basic prosthetic services other than the eligible items listed, including tissue conditioning.

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

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

Alternate Benefits
If one or more forms of alternative treatment exist, the eligible expense is limited to the cost of the least expensive cost procedure, service or treatment that meets the participant's basic dental needs. This applies, but is not limited to, inlays and crowns, amalgam, acrylic, silicate or composite restorations and bridgework.

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

Survivor Benefit
After your death, your dependents continue to be insured up to the earliest of the following dates:

a) 12 months after the date of your death,
b) The date they cease to be eligible dependents,
c) The effective date of any similar coverage with another Insurer, or
d) The termination date of the group policy.

HEALTH SPENDING ACCOUNT

Under a Health Spending Account (HSA), you have access to a varying amount of flex credits. Please see the Flex Options section of this booklet, or contact your Group administrator for further information on flex credits. These credits are intended to pay for medical and dental expenses not covered under your medical and dental plan or your provincial plan. Health Spending Account credits can also be used to supplement existing benefits. These include costs exceeding the plan's maximum payable amounts, deductibles, co-insurance or any other portion of a claim that is not automatically paid. The amount in your Health Spending Account is not taxed as income except in Quebec where it is required to pay Quebec Provincial Income Tax.

About your Health Spending Account

The policy year of your Health Spending Account is from November 1st to October 31st. Your Health Spending Account credits may be used to reimburse expenses incurred during the year or may be carried over to the following year's account. If unused balances are rolled forward, any claims incurred in the new year must be applied first to the roll-over amount to reduce the chance of forfeiture by the end of the second year. If Health Spending Account credits have not been used by the end of the second year, a 90 day grace period is available during which all credits from the previous year must be exhausted. If these credits are not exhausted, they will be forfeited. Canada Revenue Agency does not allow the payout of unused balances in taxable cash as an alternate to the carry over requirement.

Co-ordination of Benefits

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

Claims for dependent children should be submitted first to the benefit plan of the spouse who has the earlier birth month in the calendar year, and then to the other spouse's benefit plan, and then to the Health Spending Account.

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

When and How to Make a Claim

Health Spending Account benefit is reimbursed to the employee. The employee must pay the provider of service, obtain an official paid in full receipt and complete a Health Spending Account claim form or, when a claim is for pay-direct drugs or dental services, submit the receipt or proof of billings to Medavie Inc., indicating "pay the balance from my HSA" and sign each receipt or proof of billing. You may obtain claim forms from Nutreco or from Medavie Inc.

The explanation of benefits, printed for employees after claim payment, indicates the amount of dollars paid under the health or dental program, the dollars paid under the HSA and the credit balance remaining.

Allowable Expenses

A Health Spending Account is a way to give employees more flexibility within the benefit plan, and a way to remunerate an employee with tax free dollars. Expenses eligible under a Health Spending Account is based on the Canada Revenue Agency Income Tax Act and differ from eligible expenses covered under group benefits plan. Any health related expense that meets requirements for a tax credit on your income tax return is eligible for reimbursement. The following is a general overview of several expenses considered eligible for the Medical Expense Tax Credit under the Canadian Income Tax Act. For additional information regarding reimbursable expenses please contact your group administrator.

Medavie Inc. does not assume responsibility to inform you of any changes made to the Canada Revenue Agency allowable expenses hereinafter.

Allowable expenses are those listed under the Canada Revenue Agency guide. They include, but are not limited to:

Medical Practitioners	• Chiropodist or podiatrist • Chiropractor • Christian Science practitioner • Dentist • Dietician • Medical Doctor • Naturopath	• Registered Nurse • Optometrist oculist or ophthalmologist • Osteopath • Physiotherapist • Psychologist • Registered massage therapist • Speech therapist or audiologist
Care and Facilities	• Rehabilitative therapy, including laser eye surgery • Full-time attendant or full-time care in a nursing home for a person who has a severe and prolonged mental illness	• Public or licensed private hospital (inside or outside Canada)
Supplies, Devices and Equipment	• Artificial eye • Crutches • Laser eye surgery • Wheelchair • Rocking bed for poliomyelitis victims • Oxygen tent or other equipment necessary to administer oxygen • Brace for a limb • Truss for hernia • Hearing aid • Needles and syringes for injections • Orthopaedic shoes or boots • Drugs, medicines and preparations or substances prescribed by a physician or dentist and dispensed by a pharmacist	• Artificial limbs • Eye glasses or contact lenses • Pacemaker • Spinal brace/support • Cloth diapers, disposable briefs, catheters catheter trays • External breast prosthesis required because of a mastectomy • Ileostomy or colostomy pad • Laryngeal speaking aid • Artificial kidney machine • Iron lung/portable chest respirator • Custom-made wig for a person who has suffered abnormal hair loss due to a disease medical treatment or accident
Dental	• Preventative, diagnostic, restorative, orthodontic and therapeutic care	• Making or repairing of dentures, including impressions, bite registrations and insertions for the denture

Non-Eligible Expenses

- Non-prescription birth control devices
- Wigs - unless made to order for individuals who have suffered abnormal hair loss owing to disease, medical treatment or accident.
- Maternity clothes
- Athletic club memberships
- Toothpaste
- Scales for weighing food
- Funeral, cremation or burials, cemetery plot, monument, mausoleum
- Illegal operations, treatments or drugs illegally procured
- Payments to a municipality where the municipality employed a doctor to provide medical services to the residents.

Termination

Coverage for you and your dependents will cease on the earliest of:

- the date you termination employment;
- the date you cease to be eligible for benefits;
- the date you cease to be eligible due to death, leave of absence, retirement, change in classification, etc.

If you should leave your current employment, or your group terminates coverage with Medavie Inc., you will have a period of 90 days to claim against your remaining balance before your credits are forfeited. Only Allowable Expenses incurred prior to the termination date will be eligible for reimbursement.

PLAN MEMBER WEBSITE

INSTRUCTION FOR MEMBERS

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

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

ON THE PLAN MEMBER WEBSITE

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

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

Member Information

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

Member Statements

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

FIRST-TIME ACCESS TO THE PLAN MEMBER WEBSITE

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

Please ensure you make note of your user ID and password for future reference

PLEASE NOTE

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

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

PRIVACY PROTECTION PRACTICES

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

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

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

How is your personal information used?
Your personal information is necessary to allow Medavie Inc. and Blue Cross Life Insurance Company of Canada to process your application for coverage under its health, life and travel plans. Your personal information is used:

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

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

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

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

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

PRIVACY PROTECTION PRACTICES

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

Please note that not allowing Medavie Inc. and Blue Cross Life Insurance Company of Canada to use information about you may mean we may not be able to provide you with certain products or services that may be of use to you.

For more information on Medavie Inc. and Blue Cross Life Insurance Company of Canada's privacy policy, contact us using one of the following:

www.medavie.bluecross.ca

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

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

or

privacyofficer@medavie.bluecross.ca

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

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