NORDA STELO INC.
AND THE MEMBER OF ITS GROUP

Temporary employees
Group no. 91318

GFMD Employee Benefits Expert Consultants, advisors

LIST OF BENEFITS

Modified as of December 14, 2015

BENEFIT SUMMARY

The benefit summary must be read together with the benefit provisions that are described in the different sections of the booklet.

Plan waiting period	None

Extended Health Benefit - Drug

GENERAL INFORMATION

Deductible	$5 per prescribed drug
Percentage of reimbursement	80% of the first $3,500 of eligible expenses and 100% of the excess, per family, per calendar year
Payment type	Direct payment card
Supplemental coverage offered to Participants covered by RAMQ public plan	Integration of RAMQ parameters to this plan's parameters
Benefit extension after termination	90 days
Termination	Covered employee's retirement

	Maximum amount payable *
Regular list of drugs (including RAMQ's list of drugs for Quebec residents)	Unlimited
Preventive vaccines	$400 / calendar year

* Blue Cross will reimburse to the lowest ingredient cost Interchangeable Drug (generic drug).

The Participant may request a higher cost drug. However, they will be responsible for paying the difference in cost.

Regardless of whether the Participant's Physician indicates the prescribed drug cannot be substituted, Blue Cross will only reimburse to the lowest ingredient cost Interchangeable Drug (generic drug).

For Participants with an adverse reaction to the lowest cost interchangeable Drug (generic drug), Blue Cross will consider reimbursement of another Interchangeable Drug, on a case by case basis only through the Special Authorization process.

Extended Health Benefit - Accident /Sickness

GENERAL INFORMATION

Deductible	None
Benefit extension after termination	90 days
Termination	Retirement

HOSPITALIZATION

	Percentage of reimbursement	Maximum amount payable	Maximum duration
Active care	100%	Semi-private	Unlimited
Convalescence or physical rehabilitation	100%	Semi-private	180 days / period of hospitalization

REFERRALS OUTSIDE CANADA

Percentage of reimbursement	Maximum amount payable
80%	$500,000 / lifetime

VISION CARE

	Percentage of reimbursement	Total maximum amount payable
Eye examination	100%	$50 / 24 consecutive months
Eyeglasses, contact lenses and laser surgery	100%	$200 / 24 consecutive months

	PARAMEDICALS		
	Percentage of reimbursement	**Eligible maximum per visit**	**Eligible maximum per calendar year**
Acupuncturist	80%	$45	$500
Audiologist	80%	$45	$500
Chiropractor	80%	$45	$500
X-Rays (chiropractor)	80%	n/a	$25
Dietician	80%	$45	$500
Occupational therapist	80%	$45	$500
Homeopath	80%	$45	$500
Massage therapist	80%	$45	$500
Naturopath	80%	$45	$500
Speech therapist	80%	$45	$500
Osteopath	80%	$45	$500
Physiotherapist / Rehabilitation technician / Athletic therapist	80%	$45	$500*
Podiatrist (or chiropodist)	80%	$45	$500
Psychologist / Social worker / Guidance counselor	80%	$45	$500*

* *combined maximum for all paramedicals*

MEDICAL SUPPLIES AND SERVICES*	Percentage of reimbursement	Eligible maximum
Nursing Care	80%	$10,000 / calendar year
Ambulance transportation	80%	Unlimited
Orthopedic shoes	80%	$300 / calendar year
Moulded arch supports	80%	$300 / calendar year
Surgical stockings	80%	3 pairs / calendar year
Hearing aids	80%	$300 / 36 consecutive months
Intrauterine contraceptive device (I.U.D.)	80%	$500 / calendar year
TENS	80%	$700 / lifetime
Glucometer	80%	$200 1- appliance / 36 consecutive months
Dental care due to an accident	80%	Unlimited
Varicose vein injections	80%	$15 / visit and 10 visits / calendar year
Prostheses		
• **artificial limbs and artificial eyes**	80%	Unlimited
• **capillary prostheses after chemotherapy**	80%	$300 / calendar year
• **external breast prostheses following a mastectomy**	80%	$500 / calendar year
Mobility aids and orthopedic appliances		
• **wheelchair**	80%	$1,500 / lifetime
• **crutches, canes, walking aids, casts, trusses, orthopedic devices, cervical collars and ortheses**	80%	Unlimited
Major medical equipment		
• **hospital-type bed**	80%	1 / 5 calendar years
• **insulin pumps**	80%	$1,750 / 60 consecutive months
• **compression pump and percussor**	80%	1 / 5 calendar years
• **apnea monitor**	80%	1 / 5 calendar years
• **therapeutic appliances**	80%	$10,000 / lifetime
Diagnostic tests		
• **Laboratory analyses, X-rays, electrocardiograms, scanners, ultrasounds and magnetic resonance imagery (MRI)**	80%	$400 / calendar year
Other medical supplies and services *		
• **oxygen**	80%	Unlimited
• **appliances for the administration of oxygen**	80%	1 / 5 calendar years

***** *see text in Extended Health Benefit for the complete listing and details on coverage*

Extended Health Benefit - Travel

GENERAL INFORMATION

Deductible	None
Percentage of reimbursement	100%
Travel assistance	Included
Waiver or premiums	No
Termination	Age 75 (age of the Covered Employee) or retirement, if earlier

TRAVEL COVERAGE

	Maximum amount payable
Hospital and Medical Travel Insurance	$2,000,000 per event, per Participant
Coverage duration per trip:	
• **under age 65**	The first 180 days per trip*
• **age 65 to age 69**	The first 60 days per trip*
• **age 70 and older**	The first 30 days per trip*

***** *Participant must remain insured with the provincial plan at all times*

Note: If the duration of your trip is to exceed the maximum number of days covered under this benefit, we strongly recommend that you take out an individual Travel insurance policy prior to your departure for the number of days that will not be covered under this benefit.

An overview of your group insurance plan

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

The different sections of information summarize in a simplified form the provisions of the contract between your employer and the Insurer. In this section, you will find information dealing with eligibility and participation to the plan as well as pertinent information that you will require in order to use, in the best possible manner, the coverage that is offered for your well-being and that of your family.

This booklet together with your insurance certificate 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 coverage, a copy of your application for benefits and any written statements or other record provided to the Company as evidence of your health. You may also request, with reasonable notice, a copy of the contract for insured benefits. The first copy will be provided at no cost to you. A fee may be charged for subsequent copies. All requests for copies of documents should be directed to Medavie Blue Cross.

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

Is my enrolment in the group insurance plan mandatory?

Yes, you must select all the benefits for which you are eligible under the employee category to which you belong, while taking into consideration your family status as well.

However, you may also exercise your right of **exemption** under the Extended Health Benefit and the Dental Care Benefit if you provide the Insurer with proof that you and your dependents are covered under your spouse's plan. Should this other coverage terminate **involuntarily**, you and your dependents shall again become eligible under your group plan. Your request must then be submitted within **31 days** following the termination of the other insurance.

When do I become eligible for group insurance?

As a permanent employee, you become eligible for the group insurance coverage as soon as you have met the plan waiting period specified in the Benefit Summary. To participate in the plan, you must first complete the insurance forms that are provided to you upon your eligibility to the various plans.

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

Who are your eligible dependents?

Your dependents are:

- Your **spouse**, who is the person to whom you are married, or the person that you introduce as your spouse and have been living with for at least one year, or regardless of the duration when a child is born of such union.

Your spouse, the one you have designated on your application, remains covered until there is annulment of marriage or divorce, or until such time that you and your common-law spouse have been living separately for at least **90 consecutive days** because of a breakdown of your conjugal relationship.

- Your unmarried **children** who are your financial dependents and
    - are under 21 years of age, or
    - are under 26 years of age if full-time students attending an institution providing instruction at a secondary, college or university level, as a duly registered student, or
    - regardless of their age, if they live with you and have become totally and permanently disabled before age 18 (or age 26 if a student) and who receive no allowance under the Act respecting income security.

Is evidence of insurability required?

You must submit evidence of insurability if your application for insurance for yourself or your dependents is presented to the Insurer more than 31 days after the eligibility date.

How do I file a claim?

Extended Health Benefit - Hospitalization
If you or one of your dependents are hospitalized, simply show your insurance certificate at the time you are being admitted. The claim will be forwarded to our office by the hospital.

Extended Health Benefit - Drug
The claim procedure includes direct payments through the BLUE CROSS card. Show your BLUE CROSS card to your pharmacist and you will then have to pay only $5 per prescribed drug, as well as your coinsurance.

You will have no claim to submit to your insurer.

Extended Health Benefit – Accident/Sickness
Complete the Claim form, attach the original receipts and forward the whole to the Insurer.

The duly completed Claim form must be sent to the Insurer no later than 12 months after the date expenses were incurred.

To find out the local Blue Cross address your claim must be sent to, please refer to your claim form or contact our Customer Service 1-888-873-9200.

Extended Health Benefit - Travel
You must obtain detailed invoices for hospital, medical or other services and provide the Insurer with an attending physician's statement confirming that all services for which you submit a claim were rendered. The Insurer will see to it that the government plan's share is duly refunded.

You may obtain Claim forms from the Insurer at the following address:

Blue Cross
Claims/Travel Insurance
Postal Box 910, Station B
Montreal (Quebec) H3B 3K8

The duly completed Claim form must be filed with the Insurer no later than six months after the date expenses were incurred.

FOR ADDITIONAL INFORMATION REGARDING YOUR INSURANCE PLAN, SIMPLY CALL THE MEDAVIE BLUE CROSS CUSTOMER SERVICE AT THE FOLLOWING NUMBER:

1-888-873-9200

A MEMBER PORTAL IS ALSO AVAILABLE FOR YOUR GROUP INSURANCE PLAN AT THE FOLLOWING ADDRESS:

www.medavie.bluecross.ca

SELECT "LOG IN" AND MAKE SURE YOU HAVE YOUR BLUE CROSS IDENTIFICATION CARD (DRUG CARD) AT HAND TO REGISTER FOR ACCESS TO THE PORTAL.

Note: For insurance purposes, you and your dependents are deemed covered under the Hospital and Health Insurance acts in your province of residence, and under no circumstances will the amount paid by the Insurer to a Participant without such coverage ever exceed the amount that would have been paid had he been insured under such acts, unless specified otherwise.

Who has access to my confidential information?

The personal information transmitted to us will be kept in your Medavie Inc. and Blue Cross Life Insurance Company of Canada insurance file. This information will be used only in the processing of your claims. Only duly authorized employees and representatives of the Insurer will have access to this information in the course of the Insurer's current business practices.

Upon a 30-day written notice, you will be entitled to access the information contained in your file and, if necessary, request that it be corrected, according to the provisions of the *Act respecting the protection of personal information in the private sector*. Please forward your inquiries to:

Access to information
Medavie Inc. and
Blue Cross Life Insurance Company of Canada
550 Sherbrooke Street West
Montreal (Quebec) H3A 6T6

Extended Health Benefit - Drug Coverage

This insurance benefit covers drug expenses incurred by you or your dependents as the result of an illness, a pregnancy or an accident, subject to the deductible and percentage of reimbursement specified in the Benefit Summary. These drug expenses must be incurred in Canada.

Applicable to Quebec residents
When you have spent in any calendar year an amount equivalent to the maximum contribution established by the Régie de l'assurance maladie du Québec (RAMQ), (through deductible and coinsurance, if applicable), for yourself or your dependents, the percentage of reimbursement for eligible drugs increases to 100% until the end of the calendar year.

Deductible

The deductible is the portion of eligible expenses that you must pay for you or your dependents before the Insurer begins to reimburse expenses eligible under this contract. The deductible is applied per prescribed drug.

Eligible expenses

1. The Insurer's **regular list** of drugs consists of usual, customary and reasonable expenses for drugs or products available in Canada and dispensed by a pharmacist (or a duly authorized physician or dentist in areas where there is no pharmacist) that can only be obtained on the written prescription of a physician, a dentist or a podiatrist, for use in respect of a pregnancy, an illness or injury and that do not exceed a 100-day supply.

   The prescribed drugs and products must be sold in accordance with the Regulations to the Foods and Drugs Act of Canada, they must bear a Drug Identification Number (DIN), they must be used in accordance with the official indications for which the drug or product has been authorized.

   Also included are:

   - Injections and serums prescribed by a physician to treat an illness.
   - Preventive vaccines, subject to the maximum eligible amount mentioned in the Benefit Summary.
   - Growth hormones (for Participants under 18 years old).
   - Anaesthetic administered during surgery that is not performed in a hospital.
   - Syringes, needles, lancet devices, pen needles, urine testing supplies, alcohol swabs, test strips for the control of diabetes, as well as an aerochamber and spinhaler.

2. Drugs that are necessary for survival, or for the treatment of a clearly diagnosed chronic illness, notably in case of heart disease, pulmonary disease, diabetes, arthritis, Parkinson's disease, epilepsy, cystic fibrosis and glaucoma. The claim must then include, as corroboration, the physician's prescription and written statement giving his diagnosis and the period for which the drugs were prescribed.

Important notice

For Quebec residents**,** this benefit must always include the drugs and products that appear on the List provided by the Régie de l'assurance-maladie du Québec (RAMQ) and dispensed by a pharmacist on the written prescription of a physician, a resident physician, a dentist or a podiatrist.

Some of these drugs are covered only in the cases, on the conditions and for the therapeutic indications specified in the regulation, namely exception drugs.

Furthermore, the drugs covered under the Insurer's list, as described above, must appear on the list of drugs made and updated by the Quebec Association of Pharmacy Owners (AQPP).

Expenses not reimbursable by the plan

Incurred expenses for the following products or drugs are excluded:

- products for the care of contact lenses;
- contraceptives (other than oral);
- proteins or dietary supplements, amino acids;
- processed food for infants;
- hygiene products, including soaps and emollients;
- softeners and protective substances for the skin;
- smoking cessation aids (for Quebec residents: only the excess of eligible expenses payable under the Act respecting prescription drug insurance is excluded);
- minerals;
- homeopathic products;
- hair growth stimulants;
- fertility drugs (for Quebec residents: only the excess of eligible expenses payable under the Act respecting prescription drug insurance is excluded);
- sexual stimulants, as well as drugs used to treat erectile dysfunction;
- anabolic steroids;
- drugs and injections for weight loss;
- drugs administered for experimental purposes;

- drugs and material used in surgery (except for anaesthetic mentioned in the **Eligible Expenses** section of this benefit);
- drugs and all forms of drugs without therapeutic indication and intended exclusively to improve the quality of life;
- mouthwashes, dressings, syrups and cough drops ∗;
- shampoos, oils, creams ∗;
- vitamins and multivitamins ∗;
- prenatal supplements or vitamins ∗.

∗ These elements are covered when requiring a physician's prescription, as specified by Health Canada.

Furthermore, the following services are not covered.

- All expenses incurred due to an illness or accident covered under any occupational health and safety board or any automobile insurance plan, if applicable.
- Services, treatments or products received free of charge by the Participant.

Provisions applicable to Quebec residents

When you reach the **age of 65**, you and your Spouse have a decision to make regarding your drug coverage.

Decision to join the RAMQ plan at age 65

When you or your Spouse reach the age of 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 full drug coverage under the group insurance plan. **Such choice is then irrevocable**.

If, at age 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 for drugs covered under the RAMQ's plan.

If, at age 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 for drugs covered under the RAMQ's plan.

However, if you and your dependents are covered under the RAMQ's basic plan, you remain covered for the supplementary coverage under the complementary group insurance plan as described below, subject to the deductible and the percentage of reimbursement mentioned in the Benefit Summary for drug coverage:

1. deductible and coinsurance paid by the Participant under the RAMQ's plan; and
2. 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 you or your Spouse reach the age of 65, you are automatically registered by the RAMQ as a beneficiary of its prescription drug coverage. When you and your Spouse reach the age of 65, **you must therefore cancel your automatic registration** with the RAMQ plan in order to continue the full drug coverage under the group insurance plan.

Terms and conditions relating to premiums, if applicable, are mentioned in the Premium rate schedule given to the policyholder or, after the effective date of the contract, in the rate renewal conditions issued by the Insurer.

Benefit Extension after termination

If you are totally disabled or if one of your dependents is confined to a hospital on the date your insurance terminates for any reason other than policy termination, Eligible Expenses incurred as a result of such disability or confinement will continue to be reimbursed as if the insurance had not ended for such person, until the earliest of the following dates:

- the date you cease to be Totally disabled;
- the date the dependent is no longer confined in a hospital;
- the 91st day after the date your insurance terminated;
- the date this Benefit terminates.

Termination of coverage

The Drug coverage ends at your retirement or termination of employment whichever occurs first. The coverage for eligible dependents ends when your Drug Insurance benefit terminates or on the date they no longer meet the definition of dependent, whichever occurs first.

Extended Health Benefit - Accident/Sickness Coverage

This insurance covers eligible expenses incurred by you or your dependents as the result of an illness, pregnancy or accident, subject to the deductible and the percentage of reimbursement applicable to each category of services as specified in the Benefit Summary, provided eligible expenses are incurred in Canada, except for Referrals outside Canada.

Deductible

No deductible applies to the Extended Health Benefit – Accident/Sickness Coverage.

Eligible expenses

The expenses must be:

- usual, customary and reasonable,
- necessary from a medical point of view and
- recommended by a physician, unless otherwise indicated.

Paramedical fees are payable only when services are provided by practitioners who are duly registered members of their professional order and who practice within the limits of their authority, as established by law. If no professional order is applicable to the practitioner, he must be a duly registered member of an association recognized by the Insurer and provide care and treatments within the limits of his professional competence.

HOSPITALIZATION

- Short stay
  Hospitalization charges for a Participant admitted as an inpatient in a hospital for **active care** after the effective date of his insurance and for as long as he is entitled to insured services under the medical program in his province of residence, subject to the maximum amount payable specified in the Benefit Summary.

- Convalescent care and physical rehabilitation
  Charges for convalescent care and physical rehabilitation, if the Participant is admitted less than **14 days** after obtaining his discharge from a hospital where he has been receiving active treatment, subject to the maximums specified in the Benefit Summary.

REFERRALS OUTSIDE CANADA

When the attending physician refers the Participant 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 provincial government health care allowances. The maximum lifetime amount payable is specified in the Benefit Summary.

Eligible expenses

Hospital services
Hospital room accommodation, intensive care, nursing services, operating and recovery rooms, diagnostic services (including laboratory charges and X-rays), oxygen and blood, prescription drugs (including intravenous solution), physiotherapy.

Physicians and surgeons
Charges of physicians and surgeons for services rendered.

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 registered nurse or medical attendant, other than a relative, when medically necessary and approved by the Insurer.

Specific exclusions and reductions

- The referral outside Canada must be medically necessary and must not be for services available in Canada, as determined by the Insurer.
- The claim must have prior approval for payment from the Insurer.
- Payment will be made for the usual, customary and reasonable charges applicable in the area in which the services are rendered.
- All services must be rendered while the patient is under the active care of a physician.
- Payment will not be made for treatment of any illness commencing within **12 months** after the Participant's effective date of his Accident/Sickness coverage, and for which he has received medical treatment or has been prescribed drugs in the **12 months** prior to the effective date of this Accident/Sickness coverage.
- The services to be provided outside Canada must not be experimental or investigative in nature.

- Services do not cover unavailable health care services due to waiting lists or refused treatments from a licensed physician in Canada.
- In order to be eligible, the provincial government health care plan of the Participant's province of residence must agree to cover a part of the expenses.

MEDICAL SUPPLIES AND SERVICES

- **Nursing care**
  Services of a registered nurse (or registered nursing assistant when a registered nurse is not available), who is not a member of the Participant's family, nor resides with him, provided such services are rendered at the Participant's home and are not primarily for custodial care, subject to the overall maximum amount payable specified in the Benefit Summary.

- **Ambulance transportation**
  Charges for transportation by ambulance, including air or rail transport in Canada, when it is necessary to transport the Participant to or from the nearest hospital equipped to provide the emergency care required. The claim must indicate the medical reason for ambulance transportation and may stand in lieu of the prior recommendation from a physician that could not be obtained due to the emergency situation.

- **Orthopedic shoes**
  Charges for the purchase and repair of made-to-measure orthopedic shoes and Denis Browne splints, subject to the eligible maximum amount specified in the Benefit Summary. Purchases must be made from a known orthopedic supplier authorized under the provincial health and welfare ministry. Pre-fabricated shoes with modifications or adjustments are also eligible.

  Specific exclusion
  Charges for the purchase of off-the-shelf shoes that are regular stock, as well as extra-depth shoes are not covered.

- **Moulded arch supports**
  Charges for the purchase of moulded arch supports to accommodate, relieve or remedy some mechanical foot defect or abnormality, subject to the eligible maximum amount specified in the Benefit Summary. Purchases must be made from a known orthopedic supplier authorized under the provincial health and welfare ministry.

- **Surgical stockings**
  The purchase of medical elastic stockings, subject to the maximum number of pairs specified in the Benefit Summary.

- **Prostheses**
  - The purchase and repair of artificial limbs (including the myoelectric arm) and artificial eyes.
  - The purchase of capillary prostheses required after chemotherapy, subject to the eligible maximum amount specified in the Benefit Summary.
  - The purchase of external breast prostheses when required because of a total or radical mastectomy, including the purchase of two surgical brassieres, subject to the overall eligible maximum amount specified in the Benefit Summary.

- **Hearing aids**
  Charges for the purchase and repair of hearing aids, subject to the eligible maximum amount specified in the Benefit Summary.

- **Intrauterine contraceptive device (IUD)**
  Charges for the purchase of an intrauterine contraceptive device (iud), subject to the eligible maximum amount specified in the Benefit Summary.

- **TENS**
  Charges for the purchase or rental, at the Insurer's option, of a transcutaneous electrical nerve stimulator (TENS), subject to the eligible maximum amount specified in the Benefit Summary.

- **Glucometer**
  Charges for the purchase of a glucometer, subject to the eligible maximum amount specified in the Benefit Summary.

- **Varicose vein injections for medical purposes**
  Only the cost of the injected drugs is covered. The eligible maximum amount per visit and the maximum number of visits per calendar year are specified in the Benefit Summary.

- **Mobility aids and orthopedic appliances**

  - Charges for the purchase or rental, at the Insurer's option, of a wheelchair (with cushions and inserts), as well as the purchase of an adjustable axle plate and repairs of the axle plate, subject to the eligible maximum amount specified in the Benefit Summary. **The Participant must obtain the Insurer's approval before any purchase or rental, otherwise the claim may be rejected.**
  - Charges for the purchase or rental of crutches, canes and walking aids, as well as charges for casts, trusses, orthopedic devices, cervical collars and ortheses. Ortheses and orthopedic devices must be purchased through a known orthopedic supplier authorized under the provincial health and welfare ministry.

- **Diagnostic tests**
  Charges for the following diagnostic tests, when deemed required for the treatment of an illness or following an accident, or for a check-up (if applicable), subject to the overall eligible maximum amount specified in the Benefit Summary:
  - laboratory analyses, X-rays, Electrocardiograms, Computer-assisted tomography (CT Scan), Ultrasounds and Magnetic Resonance Imaging (MRI);
  - radiotherapy or radium therapy.
  - **Major medical equipment**

    For all the following eligible items, the Participant must obtain the Insurer's approval before any purchase or rental, otherwise the claim may be rejected.

    - Charges for the purchase or rental, at the Insurer's option, of a standard manual hospital-type bed for bedridden patients, up to the usual cost of a standard manual bed, subject to the limit and frequency specified in the Benefit Summary.
    - Charges for the purchase of insulin pumps, subject to the eligible maximum amount specified in the Benefit Summary.
    - Charges for the purchase of compression pumps and percussors, subject to the eligible maximum amount specified in the Benefit Summary.
    - Charges for the purchase or rental of an apnea monitor for respiratory dysrhythmia, subject to the limit and frequency specified in the Benefit Summary.
    - Charges for the purchase or rental, at the Insurer's option, of therapeutic equipment currently used according to the manufacturer's standards and specifically recognized for the immediate treatment of a pathological condition following an illness or accident, subject to the eligible overall maximum amount specified in the Benefit Summary. This category of equipment includes, for example: non-union bone stimulators, aerosol therapy equipment, feeding pump and intermittent positive pressure breathing machines.
  - **Other medical services and supplies**
    - Charges for the purchase of oxygen and the purchase or rental of appliances for the administration thereof, subject to the limit and frequency specified in the Benefit Summary. The Participant must obtain the Insurer's approval before any purchase or rental, otherwise the claim may be rejected.
    - Charges for ostomy supplies and artificial larynx.
    - Charges for the purchase of burn pressure garments.
    - Charges for medicated dressings.

- Charges for supplies for paraplegics, provided such supplies are required for the treatment and the care of a paraplegic Participant.
- Charges for medical supplies for gavage.
- Charges for an opaque glass required during radiotherapy or psoriasis treatments.

- **Dental care following an accident**
  Services of a dentist when required to repair or replace sound natural teeth following an accidental blow to the mouth received while the person is insured hereunder, but not due to an object or food being wittingly or unwittingly placed in the mouth, provided that treatments begin or a satisfactory treatment plan is submitted to the Insurer within 12 months following the date of the accident. There will be no reimbursement for treatments performed more than two years after the date of the accident.

  The eligible amounts are determined according to the suggested *Fee Guide for Dental Services* approved by the *Dental Surgeons' Association* of the Participant's province of residence. The maximum amount payable per accident is specified in the Benefit Summary.

VISION CARE

- **Eye examination**
  Charges for an eye examination by an ophthalmologist or optometrist, subject to the eligible maximum amount specified in the Benefit Summary.
- **Eyeglasses, contact lenses and laser surgery**
  The cost of eyeglasses (frames and lenses) and contact lenses, when prescribed by an ophthalmologist or optometrist. As well as the cost of laser surgery to correct myopia, hypermetropia or astigmatism, subject to the overall eligible maximum amount mentioned in the Benefit Summary.

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

PARAMEDICALS

Care or treatments rendered by the following practitioners do not require prior medical recommendation :

- subject to the eligible maximum amount per visit and per calendar year specified in the Benefit Summary, for each type of practitioner or all of them together, as indicated in the Benefit Summary. The health professional may not be a member of your family, nor reside with you:

  acupuncturist, audiologist , chiropractor, dietician, occupational therapist, homeopath, massage therapist, naturopath, speech therapist, osteopath, physiotherapist (or a rehabilitation technician or athletic therapist), podiatrist (or chiropodist) and psychologist (or social worker or guidance counselor).

- Charges for X-rays taken by a chiropractor, subject to the eligible maximum amount mentioned in the Benefit Summary.

General exclusions

The following expenses are not reimbursed under the plan:

- medical care to which the Participant is entitled under any federal or provincial government legislation or that is covered under such legislation, including charges payable under any occupational health and safety board, or any automobile insurance plan, or any other similar law or public plan, if applicable;
- medical care that was covered under the above mentioned legislation or plans at the time this benefit was issued and subsequently was modified, suspended or discontinued;
- services, treatments or supplies received free of charge;
- services, treatments or supplies that are experimental in nature;
- preventive care;
- cosmetic treatment or prostheses;
- services of a nurse, at home, when acting as a midwife or psychotherapist, or when services other than nursing care are provided;
- dental services, with the exception of treatment rendered after an accident;
- with the exception of intrauterine contraceptive devices (IUD), all processes relating to family planning, including artificial insemination and laboratory, or any other charges incurred in any infertility treatment, regardless as to whether infertility is considered to be an illness or not;
- with regards to therapeutic equipment:
  - items which are not mainly medical in nature or which are intended for comfort and commodity (e.g. domestic appliances such as whirlpools, air purifiers, humidifiers, air conditioners and other similar equipment);
  - monitoring and diagnostic devices (e.g. stethoscopes, sphygmomanometers and similar equipment);
- all charges, services, articles or supplies that do not appear on the above Eligible Expenses list;
- all charges that would not have been made if no insurance coverage had existed;
- charges for any care, treatment, services or supplies other than those declared necessary for the treatment of an injury or illness;
- charges incurred outside Canada (except those mentioned under Referrals outside Canada);
- charges for services eligible under the Travel benefit;
- eligible charges incurred directly or indirectly because of
  - intentionally self-inflicted injuries, whether the Participant is sane or not;
  - active participation in a civil commotion, riot or insurrection, except while the Participant was performing the duties of his occupation, or injury sustained during war;
  - perpetration or attempt to perpetrate a criminal act.

Benefit Extension after termination

If you are totally disabled or if one of your dependents is confined to a hospital on the date your insurance terminates for any reason other than policy termination, Eligible Expenses incurred as a result of such disability or confinement will continue to be reimbursed as if the insurance had not ended for such person, until the earliest of the following dates:

- the date you cease to be Totally disabled;
- the date the dependent is no longer confined in a hospital;
- the 91st day after the date your insurance terminated;
- the date this Benefit terminates.

Termination of Benefit

The Accident/Sickness coverage ends at your retirement or the termination of your employment, 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.

Conversion privilege

If you cease to be eligible for Accident/Sickness coverage, you may convert your insurance to an individual insurance policy without submitting evidence of insurability by completing the form provided for this purpose within 31 days of the end of your coverage. However, the entire amount of the first premium, in accordance with the chosen method of payment accepted by the Insurer, must be included with the conversion request.

This conversion privilege also applies to your dependents

Extended Health Benefit - Travel Coverage

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

To be reimbursed, incurred eligible expenses must first be authorized by Canassistance.

Specific definition

In this benefit **Emergency or Emergency situation** means an illness or injury that requires immediate medical treatment due or related to:

- an injury resulting from an accident;
- a new medical condition which begins during the trip
- a medical condition that existed prior to the trip provided that it is **stable**.

Stable means the Participant, in the 90 days before the departure date has not:

- been treated or evaluated for new symptoms or related conditions;
- had symptoms that increased in frequency or severity, or examination findings indicating the condition has worsened;
- 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);
- been admitted to or treated in a hospital for the condition; or
- 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.

Eligible expenses

The plan reimburses all usual, customary and reasonable expenses incurred following an **emergency situation** resulting from an accident or a sudden and unexpected illness, up to a maximum amount payable of $2,000,000 per event, 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, medical and paramedical expenses

- The cost of hospital services that exceeds the amount refundable under the government health program in your province of residence;
- expenses inherent (telephone, television, parking, etc.) to hospitalization, up to a maximum of $100 per hospitalization;

- the difference between the fees charged by a physician and the benefits provided under the government health program in your province of residence;
- the purchase or rental cost of crutches, canes or splints and the rental cost of standard manual wheelchairs, orthopedic devices and other medical appliances, when prescribed by the attending physician;
- fees of a registered nurse (other than a relative) for private care while hospitalized and when prescribed by the attending physician;
- charges for laboratory tests and X-rays when prescribed by the attending physician;
- the cost of drugs prescribed by a physician when they are required for an emergency treatment (excluding over-the-counter products or drugs whether prescribed or not);
- dental treatment required to repair or replace sound natural teeth damaged as the result of an accidental blow to the mouth (and not due to an object or food wittingly or unwittingly placed in the mouth), up to a maximum refund of $2,000 per accident for each Participant. Treatment must begin during the period of coverage and be completed within six months of the accident;
- fees of a dental surgeon for any other emergency treatment required to relieve pain are reimbursed up to a maximum of $200 per Participant.

Transportation expenses

The following services must be approved and planned by Canassistance:

- the cost of ground or air ambulance for transportation to the nearest qualified medical facility, including inter-hospital transfer when the attending physician and Canassistance determine that existing facilities are inadequate to treat or stabilize the patient's condition;
- the cost of repatriating the Participant to his province of residence to receive immediate medical attention, following authorization of the attending physician and Canassistance;
- the cost of simultaneously repatriating a travelling companion or any member of the Participant's immediate family also covered under this benefit, if he is unable to return to the departure point by means of the transportation initially planned for such return;
- the economy class-round trip fare for transportation of a family member going to
  - the hospital where the Participant has been confined for more than 7 days, or
  - to identify the deceased, when required, prior to disposal of the body;
- the cost of returning a Participant's vehicle, either private or rental, by a commercial agency, subject to a maximum refund of $1,000. A medical certificate is required from the attending physician, stating that the Participant is incapable of using his vehicle;
- up to $7,500 for the cost of preparing and transporting the mortal remains (excluding the cost of a coffin), or for the cost of cremation or burial at the place of death.

Subsistence allowance

- Up to $3,000 (maximum of $150 per day for up to 20 days) for accommodation and meals in a commercial establishment, when your return must be delayed due to sickness or bodily injury to yourself, or to an accompanying member of your immediate family, or to a travelling companion.

Travel Assistance

The Insurer provides you, through Canassistance, with a toll free emergency hotline, **24 hours a day, seven days a week**, to assist you if you must consult a physician or require hospitalization following an accident or sudden illness. Canassistance will intervene where required and provide the following supportive services:

- direct you to an appropriate clinic or hospital;
- advance funds to the hospital, if necessary;
- confirm the medical insurance coverage to spare the Participant a substantial monetary deposit;
- ensure follow-up of the medical file and communicate with the family physician;
- co-ordinate repatriation, when necessary;
- co-ordinate the safe return home of dependent children, if a parent is hospitalized;
- make the necessary arrangements for transporting a family member to the patient's bedside if you are hospitalized for at least seven days and if the attending physician advises such attendance;
- co-ordinate the return of your vehicle if you are unable to bring it back due to illness or accident.

You will also be provided with the following services:

- toll-free assistance lines available 24 hours a day and seven days a week;
- transmittal of urgent messages;
- co-ordination of claims;
- services of an interpreter for emergency calls;
- referral to legal counsel in the event of a serious accident;
- settlement of formalities in the event of death;
- assistance in the event of loss or theft of identity papers;
- information regarding embassies and consulates.

Canassistance may also provide pre-travelling information with regard to visas and vaccines.

Restrictions on the duration of trips

All expenses described in the Hospital and Medical Travel coverage are eligible if they are incurred following **an emergency,** resulting from an accident or a sudden and unexpected illness, which occurs during the first ***180 days*** of a trip outside the Participant's province of residence, provided he is covered under the hospital and health government programs of his province of residence when emergency occurs.

For Participants from **65 to 69 years old**, ***180 days*** is replaced by ***60 days***, and for Participants **70 years of age and older**, it is replaced by ***30 days***.

General exclusions

No benefits are paid in the following cases:

- failure to communicate with Canassistance in the event of medical consultation or hospitalization or an event giving rise to a claim, under the Trip Cancellation and Interruption coverage;
- All expenses incurred following an emergency situation that occurred after the first 180 days of the trip (after the first 60 days of the trip for Participants from 65 to 69 years old, and after the first 30 days of the trip for Participants 70 years of age and older).
- expenses incurred after repatriation for medical reasons;
- expenses incurred due to pregnancy or complications arising from it within eight weeks prior to the expected date of delivery;
- accident sustained while participating in a sport for remuneration, any kind of motor-vehicle or speed contest, gliding or hang-gliding, mountain climbing (trails graded 4 or 5 according to the Yosemite Decimal System - YDS), parachuting or skydiving, and bungee jumping;
- abuse of medication or drug use;
- driving a motor vehicle, an aircraft or a boat with an alcohol level exceeding 80 milligrams in 100 millilitres of blood;
- expenses for any care other than those declared medically necessary;
- nurses' fees for custodial care or services rendered mainly for the patient's convenience;
- expenses incurred for cosmetic purposes;
- expenses incurred outside the Participant's province of residence, when such expenses could have been incurred in his province of residence without endangering his life or health;
- expenses incurred when travelling outside the Participant's province of residence primarily or incidentally to seek medical advice or treatment, even if such a trip is on the recommendation of a physician;
- medical or hospital services incurred outside the Participant's province of residence that are not eligible under the government health program in his province of residence;

- expenses refunded or liable for refund through the government health program in the Participant's province of residence;
- eligible expenses arising from
  - suicide, attempted suicide or self-inflicted injury, whether the Participant is sane or not;
  - injury sustained while participating in a public confrontation, a riot or an insurrection;
  - injury sustained during a war or an act of war, declared or not;
  - injury or illness resulting directly or indirectly from any force or threat entailing the use of nuclear, chemical or biological agents or weapons by a person, a group of persons or an organization for a political, religious or ideological purpose;
  - perpetration or attempt to perpetrate a criminal act.

Termination of Travel Coverage

The Travel benefit ends at your retirement, the termination of your employment or when you reach age 75, 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.

Termination of benefit while travelling

Travel coverage during a trip ceases on the earliest of the following dates:

- The date the Participant ceases to be covered under his government health program in his province of residence, or

- On the 181st day of any trip for Participants under 65 years of Age, or on the 61st day of any trip for Participants from 65 to 69 years old, or on the 31st day of any trip for Participants 70 years of age and older.

TRAVEL ASSISTANCE LINES

In the event of a medical EMERGENCY, the Participant travelling outside his province of residence, or his representative, must call CANASSISTANCE as soon as possible at one of the following numbers:

From Canada or the United States: 1-866-491-7726
From anywhere else: 514-286-7726 (collect)

For better service, the caller must give his name, the phone number from which he is calling and the group and certificate numbers.

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