NORDA STELO INC.
AND THE MEMBERS OF ITS GROUP

Regular Employees
Group no. 91318

GFMD Employee Benefits Expert Consultants, advisors

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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	3 months of continuous employment

Covered employee's Basic Life Insurance	
Insurable amount	1 x the annual salary
Rounding method	To the next $1,000
Maximum without evidence of health	$750,000
Maximum with evidence of health	$1,000,000
Reduction at age 70	25% of the amount of insurance
Reduction at age 75	25 % of the amount of insurance in effect at age 70
Terminal illness benefit	Included
Beneficiary designation transferred from previous policy	Yes
Termination	Retirement

Dependents' Basic Life Insurance		
Amount of insurance		
	Spouse	$10,000
	Children	$5,000 per child *
Termination		Retirement

* a child is covered starting 24 hours after birth

Covered employee's Optional Life Insurance

Insurable amount	1, 2 or 3 x the annual salary
Rounding method	To the next $1,000
Maximum without evidence of health	$20,000
Maximum with evidence of health	$500,000 *
Reduction at age 65	50% of amount of insurance
Termination	Age 70 or retirement, if earlier

* *the Basic Life Insurance and Optional Life Insurance combined maximum cannot exceed $1,300,000*

Optional Life Rates (per $1,000 of volume)

	Male		Female	
Age Group	Smoker	Non-Smoker	Smoker	Non-Smoker
- 30 years	$0.074	$0.050	$0.033	$0.022
30 – 34	0.079	0.050	0.033	0.022
35 – 39	0.083	0.068	0.040	0.028
40 – 44	0.147	0.098	0.061	0.037
45 – 49	0.239	0.161	0.095	0.061
50 – 54	0.372	0.254	0.147	0.142
55 – 59	0.616	0.399	0.329	0.215
60 – 64	0.972	0.751	0.496	0.330
65 - 69	1.353	1.056	0.783	0.473

Short-term Disability Insurance

Insurable amount	75% of weekly salary, rounded to the next dollar
• **Maximum without evidence of health**	$2,000
• **Maximum with evidence of health**	$2,000
Elimination period:	
Hospitalization or day surgery	None
Accident	None
Illness	7 days
Maximum duration of benefits	17 weeks
Taxability of benefits	Taxable
Integration with C.E.I.C.	No
Termination	Retirement

Long-term Disability Insurance

Insurable amount	75% of monthly salary, rounded to the next dollar
• **Maximum without evidence of health**	$10,500
• **Maximum with evidence of health**	$15,000
Elimination period	End of Short-term benefits
Maximum duration of benefits	To age 65
Cost-of-Living Adjustment	None
Taxability of benefits	Taxable
Direct integration (CPP or QPP and other social programs)	Yes
Duration of own occupation	24 months following the end of the elimination period
Co-ordination: Total benefits cannot exceed	85% of gross salary
Termination	Age 65 (or retirement, if earlier)

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	80%	$1,500 / lifetime
• **wheelchair**		
• **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.

Dental Care Coverage

GENERAL INFORMATION

Deductible*	$50 per Participant, maximum of $100 per family, per calendar year
Fee Guide	Current year
Recall examination	1 per 9 consecutive months
Waiver of premiums	No
Termination	Retirement

* *Eligible expenses incurred during the last three months of a calendar year and which have not been used because the deductible for that year had not been met, may be used to reduce the deductible for the following calendar year.*

DENTAL CATEGORIES

	Percentage of reimbursement	Combined Maximum reimbursement
Preventive care **Basic care**	80%	$1,000 / calendar year

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.

  Note: For the **Dependents' Basic life Insurance Benefit**, a child is covered starting 24 hours after birth.

Is evidence of insurability required?

You must submit evidence of insurability if:

- the amount of insurance exceeds the Non-evidence maximum specified in the Benefit Summary.
- you apply for any amount of Optional Life Insurance or increase thereof.
- 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.

Dental Care Insurance
Reimbursement is made electronically through the ACDQ network; you must present your insurance certificate to your dentist at every visit. Two reimbursement options are possible depending on your dentist's preference:

- you only pay your deductible and your coinsurance (if applicable), and excess expenses are paid directly to the dentist by the Insurer; or
- 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 to your 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 at 1-888-873-9200**.**

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 "for cardholders" MAKING SURE YOU HAVE ON HAND YOUR BLUE CROSS IDENTIFICATION CARD (DRUG CARD). THE SPECIFIC INFORMATION SHOWN ON YOUR CARD WILL BE NEEDED WHEN YOU 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

Life Insurance

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

Basic Life Insurance

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

The Basic Life Insurance coverage reductions are specified in the Benefit Summary. Coverage terminates when your employment terminates or at retirement, whichever occurs first.

Dependents' Basic Life Insurance

Your dependents are also insured if you have chosen family coverage. Their amount of insurance is specified in the Benefit Summary.

The Dependents' Insurance terminates concurrently with your insurance termination, or when they are no longer eligible as dependents, whichever occurs first.

Optional Life Insurance

You may subscribe to the Optional Life Insurance in multiples of your salary, as stipulated in the Benefit Summary.

Your Optional Life Insurance coverage terminates when your employment terminates, at your retirement or when you reach **age 70**, whichever occurs first.

Terminal Illness

If you are diagnosed with a terminal illness that is expected to result in your death within 24 months, a lump sum advance equivalent to **50%** of the amount of your Basic Life Insurance or $100,000, whichever is less, may be deducted from your death benefit and paid to you. This sum may be used at your discretion.

Satisfactory medical certification must be provided to the Insurer by the attending physician and you must meet the eligibility requirements regarding the waiver of premiums applicable to certain benefits of the contract. It is also understood that the special advance payment will be deducted from the Basic Life Insurance amount payable to your beneficiary upon your death.

Payment of benefits

Upon your death, the Insurer will pay to your named beneficiary the amount of your Basic Life Insurance and of your Optional Life Insurance, if any. You are the beneficiary of the Dependents' Life Insurance.

Note: your beneficiary designation for the life benefit under the previous group insurance policy is continued under this plan.

Exclusion: suicide (applicable to Optional Life only)

If you or one of your dependents die as a result of suicide or any attempt thereof in the **24 months** following the effective date of the **Optional Life Insurance or increase thereof**, the Optional Life Insurance or its increase is not payable. In this particular instance, the Insurer's obligation is limited to the refund of paid premiums.

Conversion privilege

If your coverage terminates for one of the reasons listed below, which occurs **on or before attaining 65 years of age**, you may request **within 31 days** of such termination, to convert your group life insurance coverage to an individual insurance policy, without having to submit evidence of insurability, and subject to the following provisions for Covered employees residing in Quebec and Covered employees residing outside Quebec.

Conversion reasons : retirement, termination of your employment or membership in the group, termination of the insurance contract or the employee category to which you belong.

This conversion option also applies to scheduled reductions or termination of coverage which become effective at specific ages, without however exceeding age 65.

The conversion privilege is subject to the provisions of the contract, and the individual insurance premium will be determined according to the Insurer's rate schedule in force at the time of conversion, taking into consideration the amount of insurance, your age and the risk category to which you will belong at that time.

Life insurance amount that can be converted

1. If you reside in Quebec

   The amount of Life insurance being converted for yourself must be at least **$10,000** and may not exceed **the lesser of the following amounts**:

   a) your total Life insurance amount (including your Optional life insurance, if applicable) that terminates under your group insurance plan or

   b) $400,000.

   Your **Spouse** and D**ependent children** may also convert their group Life insurance to an individual insurance policy, within 31 days of your insurance termination for one of the above-listed reasons, or within 31 days of the date they cease to meet the definition of eligible Dependents under your group insurance plan.

   The converted Life insurance amount per Dependent must be **at least $5,000** and may not exceed the lesser of the Dependent's total Life insurance amount that terminates, or $400,000.

2. <u>If you reside outside Quebec</u>

The Life insurance amount to be converted for yourself may not exceed **the lesser of the following amounts:**

a) your total Life insurance amount (including your Optional life insurance, if applicable) that terminates under your group insurance plan or

b) $200,000.

Your **Spouse** may also convert his group Life insurance to an individual insurance policy, within 31 days of your insurance termination for one of the above-listed reasons, or within 31 days of the date he ceases to meet the definition of eligible Spouse under your group insurance plan.

The Spouse's converted Life insurance amount may not exceed the lesser of his total Life insurance amount that terminates, or $200,000.

The conversion option does not apply to your Dependent children's life insurance.

Short-term Disability Insurance

If you are absent from your work as the result of an accident or an illness, you are entitled to benefits for each day of total disability, up to the number of weeks specified in the Benefit Summary. Benefits are paid from the expiry date of the elimination period, which is the number of consecutive days at the start of disability and for which no benefits are payable under the contract. The elimination period is specified in the Benefit Summary.

Benefits are paid at weekly intervals. The elimination period is calculated in calendar days. However, because the total disability benefit is paid on a working day basis, benefits for each working day of total disability are equal to 1/5 of the weekly benefit.

Total disability

For the purpose of the Short-term Disability Insurance, total disability means any state of incapacity resulting from an accident or illness, requiring continuous care and treatment from your physician from the beginning of the disability and wholly preventing you from performing the regular duties of your own occupation.

Maternity Leave

For the purpose of the Short-term Disability Insurance, Maternity Leave shall mean any leave of absence from work due to pregnancy in accordance with any labour standards legislation that is applicable in your province of residence. Maternity Leave consists of a voluntary portion and a “health related portion”. The “health related portion” of the Maternity Leave commences on the date of the delivery and it lasts for at least 6 weeks (8 weeks for a caesarean birth). The rest of the Maternity Leave is the voluntary portion.

Recurrence

Two successive periods of disability resulting from the same cause or from related causes separated by a period of **less than two consecutive weeks** of full-time work are considered as a same period of disability. Successive periods of disability due to totally different and unrelated causes are also considered as a same period of disability if at the beginning of the second disability you had not resumed the work you performed before the start of the first disability, for at least one entire day.

When successive periods of disability are considered to be the same period of disability, a second elimination period does not apply. Benefits continue for the remainder of the maximum period indicated in the Benefit Summary.

Reduction of benefits

Weekly benefits are reduced by an amount equal to the benefits payable by the following:

- any Worker's Compensation Act or similar legislation;
- any provincial automobile insurance plan in which benefits payable under Employment insurance are not taken into account;
- any law or plan paying maternity benefits during the "health related portion" of the Maternity Leave, as defined in this Benefit;
- the Quebec Pension Plan or the Canada Pension Plan, excluding benefits paid for children and any increase in benefits due solely to the cost of living;
- any income replacement indemnity paid under any other federal or provincial legislation;
- any income or fringe benefits plan offered by the employer as defined by the Income Tax Act;
- any severance or wrongful dismissal payments.

The weekly benefits are reduced even if you fail or refuse to exercise your right to such benefits under the aforementioned acts and plans.

Furthermore, no weekly benefit is payable during any of the following periods:

- period during which you are on paid vacation;
- period during which you receive or are entitled to receive remuneration from your employer;
- period during which you receive maternity or parental benefits under any provincial or federal law, or when you take a Maternity, Parental or Family-related Leave under any provincial or federal law, or any agreement between you and your employer, subject to the following exception:
  - Short-term Disability benefits are paid during the "health related portion" of the Maternity Leave when required by the applicable legislation, whether the Participant's insurance was continued during the leave or not. The maternity benefits payable under any public or private plan are deducted from the benefits payable for this period, in accordance with the provisions of this contract.

Finally, no benefit is payable for any total disability resulting directly or indirectly from any one of the following causes:

- voluntary injury, whatever your state of mind at the time of the incident;
- injury sustained during active participation in a civil commotion, riot or an insurrection, unless while performing the duties of your occupation;
- injury sustained during a war, whether declared or not;
- cosmetic surgery or treatment, unless such surgery or treatment is required as a result of an accident that occurred while you were insured under this benefit;
- injury sustained when driving a motorized vehicle while impaired by drugs, or with an alcohol level that exceeds the limit set under the Criminal Code of Canada.

Generally, no Short-term Disability benefit is payable if the disability begins during a temporary lay-off, an authorized leave of absence without pay, a disciplinary suspension without pay, or imprisonment.

If disability occurs during the voluntary portion of a maternity leave, a parental leave or a family-related leave during which this benefit has remained in force and the Short-term disability insurance premiums have been paid, the elimination period begins on the first day of disability, but benefits will not be paid before the expiry date of the elimination period, nor before the expected date of return to work, as notified to the Insurer in writing before the beginning of the absence.

Rehabilitation program

While receiving weekly benefits payable hereunder, you may be required by the Insurer to participate in a rehabilitation employment program:

a) Total disability will not be considered as having ended for the sole reason that you participate in the program.

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

c) During the rehabilitation program, the weekly 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.

Loss of the right to benefits

The right to receive benefits may be revoked upon the earliest of the following events:

- the end of a 15-week period of benefits;
- you refuse to undergo a medical examination requested by the Insurer;
- you fail to produce proof satisfying the Insurer of the persistence of disability;
- you engage in remunerative work (except for a rehabilitation employment program);
- the date you retire;
- attainment of the maximum duration of benefits, as specified in the Benefit Summary; or
- you refuse to take part in a rehabilitation program that is reasonably appropriate for you.

Termination of benefit

The Short-term Disability Insurance Benefit ends upon termination of your employment or at retirement, whichever occurs first.

If you are disabled when you reach age 70, benefits will continue to be paid for a maximum of 15 weeks. For example, if you have been receiving benefits for 10 weeks on your 70th birthday, benefits will continue for another 5 weeks before ending entirely.

Long-term Disability Insurance

If your total disability persists beyond the expiry of the elimination period specified in the Benefit Summary, you may become eligible for Long-term Disability Insurance benefits. The first payment is due at the end of the month during which the elimination period expires and on the last day of every month afterwards. 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 Insurance, **total disability** means:

- during the elimination period and the **60 months** immediately following the elimination period, a state of total and continuous incapacity, resulting from an illness or an accident, that wholly prevents you from performing, without exception, each and every regular duty of your main occupation; and
- subsequently, a state of total and continuous incapacity, resulting from an illness or an accident, that wholly prevents you from engaging in any work
  - that would enable you to earn at least 60% of your pre-disability gross earnings, and
  - for which you are reasonably qualified by training, education or experience.

Regular duties are defined as those work-related activities which are considered essential to the employee's 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 occupation license or certification does not, in itself, constitute disability.

Maternity Leave

For the purpose of the Long-term Disability Insurance, Maternity Leave shall mean any leave of absence from work due to pregnancy in accordance with any labour standards legislation that is applicable in your province of residence. Maternity Leave consists of a voluntary portion and a “health related portion”. The “health related portion” of the Maternity Leave commences on the date of the delivery and it lasts for at least 6 weeks (8 weeks for a caesarean birth). The rest of the Maternity Leave is the voluntary portion.

Recurrence

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

When successive periods of disability are considered to be the same period of disability, a second elimination period does not apply. Benefits continue for the remainder of the maximum period indicated in the Benefit Summary.

Rehabilitation program

While receiving Long-term Disability monthly benefits, you may be required by the Insurer to participate in a rehabilitation program:

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 were receiving before the start of the rehabilitation 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.

Exclusions and limitations

Reduction of benefits

Monthly benefits are subject to two kinds of reductions: direct and indirect, as explained hereunder.

1. **Direct integration**

   Monthly benefits are reduced by an amount equal to the benefits you are entitled to receive for yourself (but not for your children) from

   - any disability benefit payable under the Quebec Pension Plan or the Canada Pension Plan,
   - any benefits paid under any Workers' Compensation Act or similar legislation;
   - any income payable under any legislation or plan paying maternity benefits during the "health related portion" of the Maternity Leave, as defined in this booklet;
   - any income replacement indemnity paid under any provincial automobile insurance plan, if applicable,
   - any disability benefits payable under any private pension plan;
   - any benefit paid under the Canada Employment Insurance Act,
   - any payable earnings under any other federal or provincial law.

2. **Indirect integration (co-ordination of benefits)**

- If the amount of payable monthly benefits under this benefit, or
- if the amount of monthly benefits payable by the Insurer after direct integration, if applicable, in accordance with point 1) above plus the following amounts:
  - income from a fringe-benefits plan offered by the employer
  - any disability benefits payable under any other group insurance plan by an employer or association;
  - any disability benefits payable under the Quebec Pension Plan or the Canada Pension Plan, excluding benefits paid for children;
  - income from a fringe-benefits plan set up according to any provincial or federal law, including the income sources mentioned in point 1) (excluding increase in benefits due solely to cost of living)
  - any disability benefits payable under any Workers' Compensation Act or any other similar legislation or any other government plan, excluding benefits paid under the Employment Insurance Act;
  - any income replacement indemnity payable under any provincial automobile insurance plan , if applicable;
  - any disability benefits payable under any private pension plan, excluding any increase in benefits after benefits commence due solely to cost of living

  exceed **85%** of your salary before the start of your disability, the monthly benefits payable under this coverage shall be reduced as necessary so that such sum does not exceed this percentage.

However, reductions will be made without taking into account subsequent increases, by way of adjustments to the cost of living, in the benefits granted under the above mentioned acts and plans.

The monthly benefits are reduced even if you, who must submit the required claim, neglect or refuse to exercise your rights under the aforementioned acts and plans.

Limitations to the payment of benefits

If the total disability results directly from alcoholism or drug addiction, benefits are paid only if you enter an in-house detoxification program, under the supervision of a physician.

In addition, no benefit is payable during a period during which you receive maternity or parental benefits under any provincial or federal law or when you are on a maternity or parental or family-related leave taken in accordance with any provincial or federal law or any agreement between you and your employer, subject to the following exception:

- Long-term Disability benefits are paid during the "health related portion" of the Maternity Leave when required by the applicable legislation, whether the Participant's insurance was continued during the leave or not. The maternity benefits payable under any public or private plan are deducted from the benefits payable for this period, in accordance with the provisions of this contract.

If disability occurs during the voluntary portion of a maternity leave, a parental leave or a family-related leave during which this benefit has remained in force and the Long-term disability insurance premiums have been paid, the elimination period begins on the first day of disability, but benefits will not be paid before the expiry date of the elimination period, nor before the expected date of return to work, as notified to the Insurer in writing before the beginning of the absence.

Finally, no benefit is payable for any disability which results directly or indirectly from one of the following causes:

- voluntary injury, whatever your state of mind at the time of the incident;
- injury sustained during active participation in a civil commotion, riot or an insurrection, unless while performing the duties of your occupation;
- injury sustained during a war;
- cosmetic surgery or treatment, unless such surgery or treatment is required as a result of an accident that occurred while you were insured under this benefit;
- injury sustained when driving a motorized vehicle while impaired by drugs, or with an alcohol level that exceeds the limit set under the Criminal Code of Canada.

Loss of the right to benefits

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

- you refuse to undergo a medical examination requested by the Insurer;
- you refuse to participate in a medical or rehabilitation employment program judged reasonable and appropriate by both the Insurer and your attending physician;
- your disability no longer meets the contract definition;
- you fail to produce proof satisfying the Insurer of the persistence of disability;
- you engage in remunerative work, unless it is part of a rehabilitation employment program;
- you move or live temporarily outside Canada, unless you have notified the Insurer in writing and he has given his prior approval.

In any event, benefits terminate at your retirement, when you reach age 65 or when the maximum duration of payment specified in the Benefit Summary expires.

Termination of benefit

The Long-term Disability Insurance benefit ends upon termination of your employment, at retirement or when you reach age 65, whichever occurs first.

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 the 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 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, sphygmomanometer 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.

<u>Termination of benefit while travelling</u>

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.

<u>TRAVEL ASSISTANCE LINES</u>

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.

Dental Care Coverage

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

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

Expenses are subject to the deductible, percentages of reimbursement and maximums specified in the Benefit Summary.

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

Calculation of eligible expenses

The eligible amount for insured services is the amount indicated in the *Suggested Fee Guide for Dental Services* approved by the *Dental Surgeons' Association* or the *Denturists' Fee Guide* of your province of residence, as per the edition year mentioned in the Benefit Summary.

Deductible

The deductible is the portion of eligible expenses that you must pay for you and your dependents before the Insurer begins to reimburse expenses eligible under the contract. The deductible applies only once per calendar year.

The eligible expenses incurred during the last three months of a calendar year and which totally or partially met the deductible for that year may be used to reduce the deductible for the following calendar year.

Eligible expenses

Preventive care

- Oral examination and diagnostic
    - complete oral examination (one per 24-month period)
    - recall oral examination (one per 9-month period)
    - emergency oral examination
    - specific oral examination (once every 6 months)

- X-rays
    - intra-oral films - periapical
    - intra-oral films - occlusal
    - intra-oral films - bitewings
    - complete series and panoramic film (one per 24-month period combined)
    - extra-oral films
    - sialography
    - radiopaque dyes
    - photograph, diagnostic

- Laboratory tests and examinations
  - bacteriologic culture
  - vitality test
  - biopsy of soft oral tissue
  - biopsy of hard oral tissue
  - diagnostic cast unmounted
  - cytological examination

- Preventive treatment
  - polishing of coronal portion of teeth (once per 9-month period)
  - topical application of fluoride (once per 9-month period)
  - pit and fissure sealants (for Participants under age 16)
  - scaling (14 units per calendar year)

- Space maintainers (for Participants under age 16).

<u>Basic care</u>

- Restorations
  - amalgam, acrylic, silicate or composite on posterior and anterior teeth
  - retentive pins
  - pre-formed steel or plastic crowns (for Participants under age 16)

- Removable denture adjustments
  - minor adjustments (once per 6-month period)
  - rebasing and relining
  - prophylaxis and polishing
  - repairs

- Oral surgery
  - removal of erupted tooth (uncomplicated)
  - complicated surgical removal
  - surgical excision of cysts and neoplasms
  - remodelling and recontouring of oral tissue
  - surgical incision and drainage
  - oro-dental trauma
  - other oral surgery

- General adjunctive services
  - General anaesthesia and conscious sedation (related to surgery)

- Temporary dressing for the emergency relief of pain
- Finishing restorations

<u>Endodontics</u>

- pulp capping
- pulpotomy
- emergency pulpotomy
- endodontic traumatism
- root-canal therapy
- endodontic surgery
- bleaching (endodontically treated teeth)
- apexification

Periodontics

- periodontal surgery
- provisional splinting
- management of acute infections
- desensitization (maximum of 3 teeth per 12-month period)
- other adjunctive periodontal services (post-operative visits are limited to 4 visits per calendar year)
- curetage including root planning (one per 60-month period)
- periodontal appliances (bruxism) (adjustments are limited to one per calendar year)

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 the Insurer before the start of treatment. You will thus know, beforehand, the exact amount of the reimbursement. If you change dentist in the course of treatment, you will be required to submit a new treatment plan to the Insurer.

Expenses not covered by the plan

The following expenses are not covered:

- treatment or appliance, related directly or indirectly to full mouth reconstruction, or to correct vertical dimension and temporomandibular joint dysfunction;
- 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;
- dental services eligible under the Accident/Sickness coverage;
- services and supplies relating to any appliance worn in the practice of a sport;
- expenses that are paid under a public plan or that would normally be so if a claim had been submitted;
- charges eligible under an occupational health and safety board or by an automobile insurance bureau, or any other similar law or public plan, if applicable;
- expenses resulting from any suicide attempt or self-inflicted injury, whether the Participant was sane or not;
- expenses due to any injury resulting from any active participation in civil unrest, riot, insurrection, unless while performing work-related functions, or injury sustained in a war;
- services that are not medically required, that are given for cosmetic purposes (this exclusion does not apply to composite restoration);
- services that exceed the ordinary services given in accordance with current therapeutic practice;
- care or services rendered free of charge, or that would be if the Participant had no coverage;
- expenses incurred for implants;

- precision attachment, stress-breaker, telescoping crown and transfer coping;
- splinting for periodontal reasons, where cast crowns or inlays are used for this purpose, with or without onlays;
- all charges, services, articles or items that are not included on the list of Eligible Expenses described in this benefit.

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 usual, customary and reasonable charges for such services in the area where the services are provided. However, in no event will the total reimbursement of laboratory fees exceed 50% of the suggested fee in the appropriate fee guide for the particular dental treatment requiring laboratory services.

Termination of Benefit

The Dental Care benefit 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.

***Basic accidental death and dismemberment insurance plan (Underwritten by* ACE INA Life Insurance)**

Policy Number: **AB30085101**
Effective Date: **October 1st, 2013**

COVERAGE

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

ELIGIBILITY

All active, permanent full-time employees of the policyholder.

BENEFIT AMOUNT

One (1) times annual earnings* rounded to the next $1,000 (if not already a multiple thereof) to a maximum of $1 000 000 $.

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

Benefit reduces by 25% at age 70 and further reduces by 25% at age 75 and terminates at retirement.

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

Benefits payable under the following section will be limited to only one (1) policy in the event the benefits are contained in two (2) or more policies issued to the Policyholder by ACE INA Life Insurance *(not applicable to the Schedule of Losses, Exposure and Disappearance and Conversion).*

SCHEDULE OF LOSSES

Accidental Death & Dismemberment

If such injuries shall result in any one of the following specific losses within 1 year from the date of the accident, ACE INA Life Insurance will pay the percentage of the benefit amount, based on the amount stated under the benefit amount section, however, that not more than one (the largest) of such benefits shall be paid with respect to injuries resulting from one accident.

	Percentage of Benefit Amount
Loss of Life	100%
Loss of Entire Sight of Both Eyes	100%
Loss of One Hand and One Foot	100%
Loss of Use of One Hand and One Foot	100%
Loss of One Hand and Entire Sight of One Eye	100%
Loss of One Foot and Entire Sight of One Eye	100%
Loss of Speech and Hearing in Both Ears	100%
Brain Death	100%
Loss of Both Arms, Both Hands, Both Legs or Both Feet	200%
Loss of Use of Both Arms, Both Hands, Both Legs or Both Feet	200%
Quadriplegia	200%
Paraplegia	200%
Hemiplegia	200%
Loss of One Arm or One Leg	75%
Loss of Use of One Arm or One Leg	75%
Loss of One Hand or One Foot	75%
Loss of Use of One Hand or One Foot	75%
Loss of Entire Sight of One Eye	75%
Loss of Speech or Hearing in Both Ears	75%
Loss of Thumb and Index Finger of Same Hand	33 1/3%
Loss of Use of Thumb and Index Finger of Same Hand	33 1/3%
Loss of Four Fingers of Same Hand	33 1/3%
Loss of Hearing in One Ear	33 1/3%
Loss of All Toes of Same Foot	25%

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

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

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

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

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

Repatriation Benefit

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

Rehabilitation Benefit

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

a. such training is required because of such injuries and in order for an Insured Employee to become qualified to engage in an occupation in which he or she would not have been engaged except for such injuries;
b. expenses are to be incurred within 2 years from the date of the accident;
c. no payment will be made for ordinary living, travelling, or clothing expenses.

Family Transportation Benefit

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

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

Spousal Occupational Training Benefit

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

Home Alteration and Vehicle Modification Benefit

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

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

Benefit payments herein will not be paid unless:

(i) home alterations are made by a person or persons experienced in such alterations and recommended by a recognized organization, providing support and assistance to wheelchair users; and

(ii) vehicle modifications are carried out by a person or persons with experience in such matters and modifications are approved by the Provincial vehicle licensing authorities.

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

Day Care Benefit

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

The "Day Care Benefit" will be paid each year for 4 consecutive years, but only upon receipt of satisfactory proof that a child is enrolled in a legally licensed day care centre.

"Dependent Child" means the Employee's eligible unmarried natural, legitimate, illegitimate, adopted, step child or common law child who is principally dependent on the Employee or the Employee's spouse for financial support

Special Education Benefit

If an Insured Person suffers a loss of life in a covered accident while the policy is in force, ACE INA Life Insurance will pay, in addition to all other benefits payable under the policy, a Special Education Benefit up to 5% of an Insured Person's Principal Sum amount, (subject to a maximum of $5,000 per year), on behalf of any dependent child who, on the date of the accident, is enrolled as a full-time student in any post-secondary institution of higher learning or was at the 12th grade level and subsequently enrolls as a full-time student in any post-secondary institution of higher learning within 365 days following the date of the accident.

The "Special Education Benefit" is payable annually for a maximum of 4 consecutive annual payments but only if the dependent child continues his or her education as a full-time student in an institution of higher learning.

Bereavement Benefit

When injuries covered by the policy result in loss of life of an Insured Person within 365 days from the date of the accident, ACE INA Life Insurance will pay the reasonable and necessary expenses actually incurred by the spouse and dependent children of an Insured Person for up to 6 sessions of grief counseling, by a "Professional Counsellor", subject to a maximum of $1,000.

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

In-Hospital Confinement Monthly Income Benefit

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

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

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

Cosmetic Disfigurement Benefit

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

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

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

Seat Belt Benefit

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

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

Identification Benefit

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

a. transportation by the most direct route to the city or town where the body is located; and
b. hotel accommodation in such city or town, subject to a maximum duration of 3 days.

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

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

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

Conversion Privilege

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

Exposure and Disappearance

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

If the body of an Insured Person has not been found within 1 year of disappearance, stranding, sinking or wrecking of the conveyance in which an Insured Person was riding at the time of the accident, it shall be presumed, subject to all other conditions of the policy, that an Insured Person suffered a loss of life resulting from bodily injuries sustained in the accident covered under the policy.

WAIVER OF PREMIUM

If an Insured Employee, under age 65, becomes totally disabled for 6 consecutive months and an Insured Employee provides evidence of total disability satisfactory to ACE INA Life Insurance, ACE INA Life Insurance will then waive the payment of each premium which falls due with respect to an Insured Employee and any Insured Dependents. Subject to all the terms and conditions of the policy, waiver of any premium as herein provided will continue with respect to an Insured Employee until age 65 or earlier termination of the policy. If an Insured Employee ceases to be disabled and an Insured Employee returns to employment with the Policyholder and is a member of an eligible class, insurance with respect to an Insured Employee may be continued upon resumption of premium payments by an Insured Employee or the Policyholder.

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

Recurrent Disabilities

When an Insured Employee becomes totally disabled again from the same or related causes within 6 months of cessation of the Waiver of Premiums, then all such recurrences will be considered a continuation of the same disability and ACE INA Life Insurance will waive the 6 month qualification period.

If the same disability recurs more than 6 months after cessation of the Waiver of Premiums, such disability will be considered a separate disability. Two disabilities which are due to unrelated causes are considered separate disabilities if they were separated by a return to work of at least one 1 day.

Termination of Waiver of Premium

Waiver of Premiums will cease on the earliest of:

a. the date an Insured Employee ceases to meet the policy's definition of totally disabled;
b. the date an Insured Employee does not supply ACE INA Life Insurance with appropriate medical evidence as deemed necessary by ACE INA Life Insurance;
c. the date an Insured Employee is no longer receiving regular, ongoing care and treatment of a Physician appropriate for the disabling condition, as determined by ACE INA Life Insurance;

d. the date an Insured Employee does not attend a medical, psychiatric, psychological, functional, educational and/or vocational examination evaluation by an examiner selected by ACE INA Life Insurance;
e. the date the policy terminates;
f. the date an Insured Employee turns 65; or
g. the date an Insured Employee dies.

Coverage During Waiver of Premium

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

"Totally Disabled or Total Disability" with respect to Waiver of Premium means disability resulting from injury or sickness which prevents engagement in an Insured Person's regular occupation for 6 consecutive months.

CONTINUANCE OF COVERAGE

If an Insured Employee is: (1) laid off on a temporary basis; (2) temporarily absent from work due to short-term disability; (3) on leave of absence; or (4) on maternity leave, coverage shall be extended for 12 months, subject to the payment of premiums. If an Insured Employee assumes other occupational duties during the leave or lay-off period, no benefits shall be payable for a loss occurring during the performance of such other occupation.

EXCLUSIONS

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

1. intentionally self-inflicted injuries, suicide or any attempt thereat, while sane or insane;
2. declared or undeclared war or any act thereof;
3. travel or flying in an aircraft owned or leased by the Policyholder, an Insured Person or a member of an Insured Person's household, or aircraft being used for any test or experimental purpose, firefighting, power line inspection, pipeline inspection, aerial photography or exploration;
4. losses occurring while an Insured Person is serving on full-time active duty in the Armed Forces of any country or international authority (any premium paid to be returned by ACE INA Life Insurance pro-rata for any such period of full-time active duty);
5. travel or flight in any vehicle or device for aerial navigation; except to the extent such travel or flight is provided in the "Hazards Insured Against" section of the Accidental Death & Dismemberment portion of the policy.

HOW TO CLAIM

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

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

Failure to give notice of claim or furnish proof of claim within the time prescribed in the policy condition will not invalidate the claim if the notice or proof is given or furnished as soon as reasonably possible and if it is shown that it was not reasonably possible to give notice or furnish proof within the time so prescribed. In no event, will ACE INA Life Insurance accept notice of claim beyond one (1) year.

GENERAL PROVISIONS

Beneficiary
An employee or any spouse has the right to name a beneficiary when he applies for insurance.

It is understood that the beneficiary designation made under the Policyholder's Group Life Insurance Policy shall be recognized as the beneficiary under the policy, unless a further designation has been made that specifically identifies the policy. Failing such designation, all benefits will be paid to the estate of the insured person.

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

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

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

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

Legal Actions
No action at law or in equity shall be brought to recover on the policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with requirements of the policy. For residents of Alberta and British Columbia: Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the Insurance Act. For residents of Manitoba: Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in The Insurance Act. For residents of Ontario: Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the Limitations Act, 2002. Otherwise, every action must be brought within one year from the date of loss or such longer period as may be required under the law applicable in the insured person's province of residence.

Change of Insurer

An insured person under a former policy may not be excluded from the new policy or be denied benefits solely because of a pre-existing condition limitation that was not applicable or that did not exist in the former policy, or because the person is not at work on the date of coming into force of the new policy.

The insured person and any claimant under the policy has the right, as determined by law applicable in the insured person's province of residence, to obtain a copy of his/her application, any written evidence of insurability (as applicable) and the Policy, on request, subject to certain access limitations.

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