WESTON/LOBLAW
National Benefits Plan
Full time Active Employees
93400 & Sections / 93403 & Sections

Schedule of Benefits

WESTON/LOBLAW
National Benefits Plan
For Full time Active Employees
Policy Numbers - 93400 & Sections / 93403 & Sections

WAITING PERIOD:	Eligible on the first day of the month following the date of hire
Date of Issue:	01 January 2012

PRIVACY PROTECTION PRACTICES

In the course of providing customers with quality health, life and dental coverage, Medavie Blue Cross acquires and stores certain personal information about its clients and their dependents. The purpose of this document is to keep you informed about privacy protection practices at Medavie Blue Cross.

Protecting personal information is not new to Medavie Blue Cross. Ensuring the confidentiality of client information has always been fundamental to the way we do business and our staff takes the privacy policies and procedures we have in place to ensure that confidentiality very seriously.

What is personal information?

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

How is your personal information used?

Your personal information is necessary to allow Medavie Blue Cross to process your application for coverage under its health, life and dental plans. Your personal information is used:

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

*not applicable in Ontario and Quebec

To whom could this personal information be disclosed?

Depending on the type of coverage you carry with us, release of selected personal information to the following may be necessary in order to provide the services outlined in your contract:

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

PRIVACY PROTECTION PRACTICES

To whom could this personal information be disclosed? (Cont'd)

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

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

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

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

For more information on Medavie Blue Cross's privacy policy, contact us using one of the following:

www.medavie.bluecross.ca

1-800-667-4511 or 1-800-355-9133 (in Ontario)

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

or

privacyofficer@medavie.bluecross.ca

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

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

ABOUT THIS BOOKLET

Medavie Blue Cross administers the following benefits on behalf of Weston/Loblaw:
- Hospital Benefit
- Worldwide Travel Benefit
- Extended Health Benefit
- Vision Benefit
- Drug Benefit
- Dental Benefit

Blue Cross Life Insurance Company of Canada administers the following benefits on behalf of Weston/Loblaw:
- Weekly Indemnity Benefit
- Long Term Disability Benefit

Blue Cross Life Insurance Company of Canada underwrites the following:
- Basic and Optional Group Life Insurance Benefits

Accidental Death and Dismemberment Benefits are underwritten by Chartis Insurance Company of Canada.

The information contained in this booklet summarizes the important features of your group program. It is prepared as information only and does not, in itself, constitute an agreement. The exact terms and conditions of your group benefit program are described in the group policy held by your employer. In the event of discrepancy, the express terms of the group policy will prevail.

The information contained in this booklet is important, and we suggest it be kept in a safe place.

This booklet replaces any previously issued booklet.

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Note: Information regarding the Accidental Death & Dismemberment benefit can be found at the back of this booklet.

HOSPITAL BENEFIT (IN CANADA)

If you (or your dependents, if applicable) incur charges for any of the following while insured, Medavie Blue Cross will pay the usual, customary and reasonable charges for these eligible expenses, based on any deductible, co-insurance or maximum amount shown below. Benefit maximums are applied on a per person basis.

Co-insurance: **100% reimbursement**

Deductible: **Nil**

Maximum: **Combined lifetime maximum of $500,000 per person for Hospital, Extended Health and Vision Benefits (combined maximum excludes prescription drugs and Worldwide Travel benefits).**

HOSPITAL ROOM
The difference between standard ward accommodation and semi-private room accommodation.

CONVALESCENT CARE FACILITY
Program pays $20 per day to a maximum of 120 days, must visit facility within 14 days of leaving the hospital.

TERMINATION
Benefits cease the earlier of retirement or termination of employment.

WHEN AND HOW TO MAKE A CLAIM
Hospital Benefits are paid directly to the hospital.

To make a claim, complete the claim form that is available from your employer.

Claims must be received within 90 days of the end of the calendar year in which services or supplies were received.

WORLDWIDE TRAVEL BENEFIT

The Group Travel Plan covers a wide range of benefits which may be a result of an accident or unexpected illness incurred outside the participant's province of residence while on business or vacation. Subject to the maximum amounts indicated below, the Plan pays 100% of the eligible expense with no overall maximum, less the amount allowed under any Government Health Program.

Co-insurance: 100% reimbursement

HOSPITAL ACCOMMODATION
The cost of hospital room accommodation (not a suite) and medically necessary inpatient/outpatient services.

PHYSICIANS AND SURGEONS
Customary charges by physicians and surgeons for services rendered.

MEDICAL APPLIANCES
The cost of casts, canes, slings, splints, trusses, braces and/or temporary rental of a wheelchair, when required due to an accident or sudden illness which occurs outside the province of residence and when ordered by a physician.

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

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

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

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

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

PARAMEDICAL SERVICES
Charges made by a licensed chiropractor, osteopath, chiropodist, podiatrist or physiotherapist, up to the usual and customary fee excluding charges for x-rays.

DRUG BENEFITS
Charges for drugs, serums and injectables, approved by Medavie Blue Cross, and purchased on the prescription of a physician (vitamins, patent and proprietary drugs excluded).

WORLDWIDE TRAVEL BENEFIT

DENTAL SERVICES
Up to $1,000 Canadian for dental treatment necessitated by a direct accidental blow to the mouth. Such services must be rendered or reported and approved within 180 days of the accident and be supported by details of the accident.

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

RETURN OF DECEASED
Up to $3,000 Canadian towards the cost of preparation and homeward transportation of a deceased covered person (excluding the cost of a coffin) to the point of departure in Canada by the most direct route.

MEALS AND ACCOMMODATION
Up to $700 Canadian ($100 per day for seven days) per trip for extra costs of commercial accommodation and meals incurred by the subscriber, or by a covered dependent remaining with a travelling companion when the trip is delayed due to illness or accident to a travelling companion or a covered person. This must be verified by the attending physician and supported with receipts from commercial organizations.

TRANSPORTATION TO VISIT THE COVERED PERSON
Return economy fare by the most direct route for transportation costs (air, bus, train) when the covered person has been confined to hospital or has died, and the attending physician advised the necessary attendance of a family member or close friend of the covered person.

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

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

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

Non Medical Assistance - the patient may call to obtain:

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

WORLDWIDE TRAVEL BENEFIT

COORDINATION OF BENEFITS

In the event that benefits may be covered simultaneously under more than one plan, the claim will be assessed in a manner, which provides the greatest benefit to the subscriber.

Benefit payments will be coordinated with any other plan or arrangement, in accordance with the Canadian Life and Health Insurance Association (CLHIA) guidelines, so that the total amount received from all sources will not be greater than the actual expense incurred.

EXCLUSIONS

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

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

3. Benefits under the Plan shall not be paid if the covered person receives the same from a third party.

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

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

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

7. Medavie Blue Cross will not cover expenses in excess of $2 million Canadian per covered Participant, per incidence outside the province of residence.

WORLDWIDE TRAVEL BENEFIT

TERMINATION

Travel benefit ceases at the earlier of retirement, termination of employment or age 65.

CLAIMING BENEFITS

When Emergency and Payment Assistance services are not required, obtain detailed receipts in duplicate for any expenses incurred outside your province of residence. Upon your return, send one of the receipts to your Provincial Government Health Plan for their consideration and payment. When a reply has been received from them, send proof of their payment together with appropriate receipts to Medavie Blue Cross - Claims Department for payment of the remaining eligible benefits. Always provide your Medavie Blue Cross Identification Number when submitting a claim to Medavie Blue Cross.

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

EXTENDED HEALTH BENEFIT (IN CANADA)

If you (or your dependents, if applicable) incur charges for any of the following while insured, Medavie Blue Cross will pay the usual, customary and reasonable charges for these eligible expenses, based on any deductible, co-insurance or maximum amount shown below. Benefit maximums are applied on a per person basis.

Coinsurance: **80% reimbursement**

Deductibles: **Nil**

Maximum: **Combined lifetime maximum of $500,000 per person for Hospital, Extended Health and Vision Benefits (combined maximum excludes prescription drugs and Worldwide Travel benefits).**

PROFESSIONAL AMBULANCE
Charges for professional ambulance or air transportation, if necessary for a stretcher patient, up to six economy seats on a regularly scheduled flight. The maximum is $1,000 in a calendar year.

PRIVATE DUTY NURSING
Charges for home nursing care by a private duty nurse as defined within the contract provisions, limited to a maximum of $20,000 in a calendar year, based on the payment schedule for Private Duty Nurses established by Medavie Blue Cross for the participant's province of residence. All nursing services are pre-approved by Medavie Blue Cross to be considered for reimbursement. All claims for this benefit must be accompanied by a claim form.

DIAGNOSTIC AND X-RAY SERVICES
Charges for laboratory services and X-ray examinations.

ACCIDENTAL DENTAL
Charges for dental treatment when natural teeth have been damaged by a direct accidental blow to the mouth or jaw. Services must be rendered within 12 months of the accident. Complete details of the required services from the dentist must be submitted to Medavie Blue Cross within 90 days of the accident.

DIABETIC EQUIPMENT
Charges for the following equipment used for treatment and control of diabetes: preci-jet, glucometer (maximum payable is $300 in three consecutive calendar years), insulin pump (maximum payable for is $5,000 in three consecutive calendar years) or equipment approved by Medavie Blue Cross that performs similar functions.

OSTOMY SUPPLIES
Charges for essential ostomy supplies.

OTHER PRACTITIONERS
Charges for treatment, except when performed in a hospital, by a licensed: speech therapist, massage therapist, chiropractor, osteopath, podiatrist/chiropodist, acupuncturist, cardiac rehabilitator or naturopath. The combined overall maximum (including x-rays) is $500 in a calendar year.

EXTENDED HEALTH BENEFIT (IN CANADA)

PHYSIOTHERAPY/ATHLETIC THERAPY

Charges for physiotherapy and/or athletic therapy treatment, except when performed in a hospital, when rendered by a physiotherapist or athletic therapist licensed or registered under the appropriate governing body. The combined maximum payable for physiotherapy and athletic therapy treatment is $400 in a calendar year.

PSYCHOLOGY

Charges for treatment, except when performed in a hospital, by a licensed clinical psychologist, limited to a maximum of $500 in a calendar year.

PROSTHETIC APPLIANCES

Charges for remedial appliances or supplies including artificial limbs, breasts, or eyes, crutches, splints, casts, trusses and braces. Replacement must be due to pathological or physiological change. Repairs and adjustments limited to a maximum of $300 in a calendar year. Charges for hair prosthetics (wigs) to a lifetime maximum payable of $500.

MEDICAL SUPPLIES

Charges for the purchase of burn pressure garments and oxygen to a maximum of $500 in a calendar year.

MEDICAL EQUIPMENT

Charges for rental (or purchase, if approved by Medavie Blue Cross) of a wheelchair, hospital-type bed, walker, equipment for the administration of oxygen and kidney dialysis equipment, on the written authorization of a physician.

ORTHOPEDIC SHOE(S) & SUPPLIES

Charges for orthopedic shoe(s) when the shoe(s) is (are) customized with special features, when prescribed by an orthopedic surgeon, physiatrist, rheumatologist or the attending physician. Also, charges for shoe modification, adjustment supplies, and/or molded arch supports when prescribed by one of the Health Care Professionals noted above. The combined maximum payable for orthopedic shoes and supplies is $400 in a calendar year. For dependent children less than 19 years of age, the maximum payable in a calendar year is $200.

HEARING AIDS

Charges for hearing aids (including repairs but excluding batteries and exams) when prescribed by an otolaryngologist, otologist and/or registered audiologist subject to a maximum payable of $500 every three calendar years.

MEDICAL ELASTIC STOCKINGS

Charges for the purchase of medical elastic stockings when prescribed by a physician up to a maximum payable of $100 in a calendar year.

EXTENDED HEALTH BENEFIT (IN CANADA)

TERMINATION
Benefits cease the earlier of retirement or termination of employment.

WHEN AND HOW TO MAKE A CLAIM
Extended Health Benefits are reimbursed to the employee (Claim payments that are authorized to be made to a hospital will be sent directly to the hospital).

To make a claim, complete the claim form that is available from your employer.

Claims must be received within 90 days of the end of the calendar year in which services or supplies were received.

VISION BENEFIT

If you (or your dependents, if applicable) incur charges for any of the following while insured, Medavie Blue Cross will pay the usual, customary and reasonable charges for these eligible expenses, based on any deductible, co-insurance or maximum amount shown below. Benefit maximums are applied on a per person basis.

Co-insurance: **80% reimbursement**

Maximums: **$150 every 24 consecutive months. Includes eye exams every 24 consecutive months, every 12 consecutive months for dependents under age 19**

Deductible: **Nil**

Maximum: **Combined lifetime maximum of $500,000 per person for Hospital, Extended Health and Vision Benefits (combined maximum excludes prescription drugs and Worldwide Travel benefits).**

EYE EXAMINATIONS, LENSES AND FRAMES
Charges of a licensed optometrist or ophthalmologist for eye examinations (including laser eye surgery examinations and surgery). Charges for contact lenses and/or corrective eyeglasses, including lenses and frames but excluding safety glasses or glasses for cosmetic purposes.

CONTACT LENSES
When medically necessary for ulcerated keratitis, severe corneal scarring, keratoconus or aphakia provided sight can be improved to at least the 20/40 level. The maximum eligible expense in two consecutive calendar years is $150.

TERMINATION
Vision benefit ceases the earlier of retirement or termination of employment.

WHEN AND HOW TO MAKE A CLAIM
Vision Care Benefits are reimbursed to the employee.

To make a claim, complete the claim form that is available from your employer.

Claims must be received within 90 days of the end of the calendar year in which services or supplies were received.

DRUG BENEFIT

DRUG COVERAGE

Co-insurance: **The program pays 100% of the eligible expense at company sponsored pharmacies.**
At other pharmacies, the subscriber pays 30% of the eligible expense plus 30% of $6.54 dispensing fee maximum, plus the cost of any dispensing fee over $6.54.

Method of payment: Paid directly to the pharmacy

Benefit formulary is Medavie Blue Cross standard, plus diabetic supplies. It includes prescription drug items approved by Medavie Blue Cross and certain over-the-counter items which are considered life-saving in nature and are approved by Medavie Blue Cross. The following diabetic supplies are also included: charges for needles, syringes, swabs, test tapes, and lancets as prescribed by a physician.

Certain prescription-requiring drugs on the eligible drug benefit list may be subject to quantity maximums.

Eligible drug expenses include medically necessary items which, by law, can only be obtained with a prescription of a physician or dentist, limited to a three month supply, which are authorized as benefits by Medavie Blue Cross, and which are dispensed by a licensed pharmacist.

Medavie Blue Cross will reimburse only for the lowest priced interchangeable drug when prescribed by a physician and dispensed by a pharmacist, unless the physician indicates no substitution.

Quebec Employees
Medications that are eligible are those products legislated by the province of Quebec, as determined by the Régies de l'assurance-maladie de Québec (RAMQ)

Certain prescription-requiring drugs on the eligible drug benefit list may be subject to quantity maximums.

- paid directly to the pharmacy
- the program pays 100% of the eligible expense

TERMINATION
Drug benefit ceases the earlier of retirement or termination of employment.

WHEN AND HOW TO MAKE A CLAIM
Drug benefits are paid directly to the pharmacy.

To make a claim, complete the claim form that is available from your employer.

Claims must be received within 90 days of the end of the calendar year in which services or supplies were received.

HEALTH BENEFIT - EXCLUSIONS AND LIMITATIONS

No amount of benefit will be paid for the following:

Health Care Benefits will not be payable for charges in connection with the following:

1. Custodial or rehabilitation services.

2. Conditions not detrimental to health.

3. Services or supplies normally provided without cost or at nominal cost by the participant's government health plan.

4. Benefits the participant receives or is entitled to receive from Workers' Compensation.

5. Mileage or delivery charges.

6. Insurrection or war.

7. Participation in the commission of a criminal offence.

8. A service or supply which is experimental or investigative in nature.

9. A service or supply which is not medically necessary.

DENTAL BENEFIT

Your dental program covers you and your dependents (if applicable) for a wide range of dental services including the following benefits. Dental benefits are based on the usual and customary charges up to the 2010 Dental Society Fee Guide for general or specialist practitioners in effect in the employee's province of residence.

If the dental expenses in connection with the covered person's treatment will exceed $500, the proposed treatment plan completed by the attending dentist must be filed with and approved by Medavie Blue Cross prior to the date on which the treatment is to start.

BASIC BENEFITS

Co-insurance: **90% reimbursement**

Maximums: **Combined annual maximum of $2,000 in combination with Major Restorative Benefits**

Fee Guide: **2010 Dental Society Fee Guide for general or specialist practitioners**

Diagnostics
- complete oral examinations once in 24 consecutive months
- recall examinations one every nine consecutive months
- X-ray examinations include: full mouth or panoramic (one of each type every 24 consecutive months), single films, bitewing films (every nine consecutive month), occlusal, extraoral films
- tests, laboratory examinations and treatment planning

Preventive Services
- cleaning and polishing (once in nine consecutive months)
- fluoride treatments (once in nine consecutive months for children 16 years of age and under)
- nutritional counselling
- pit and fissure sealants (for children 16 years of age and under)
- space maintainers, maintenance and repairs (for children 13 years of age and under).

Restorative Services
- caries, trauma and pain control
- silver and plastic fillings
- plastic veneer applications
- removal and/or repairs to inlays, onlays and crowns
- prefabricated stainless steel crowns

Endodontic Services
- diagnosis and treatment of the pulp (nerve) and tissue that supports the end of the root
- root canal therapy and emergency procedures

BASIC BENEFITS (Cont'd)

Periodontic Services
- diagnosis and treatment of disease which affects the supporting tissue of the teeth, such as the gums and bones surrounding the teeth, including surgery, provisional splinting, occlusal equilibration (not exceeding two units of time* per calendar year) and periodontal scaling/root planing (not exceeding 10 units* of time* per calendar year)
- periodontal appliances (limited to any one upper and any one lower appliance in two calendar years)

*one unit of time is equal to 15 minutes

Prosthodontic Services
- denture adjustments, repairs and additions as well as one upper and one lower complete or partial denture rebase, reline, or remake (using existing framework) in two calendar years
- tissue conditioning
- removal, repair and recementing fixed bridge.

Surgical Services
- extraction of teeth
- surgical movement of teeth
- incision and excision of benign tumors and cysts
- control of hemorrhage.

General Services
- emergency treatment of pain
- local anaesthesia as well as conscious sedation
- consultation with another dentist

DENTAL BENEFIT

MAJOR RESTORATIVE BENEFITS

Co-insurance: 60% reimbursement

Maximums: Combined annual maximum of $2,000 in combination with Basic Benefits

Extensive Restoratives
- remodelling and recontouring oral tissues; major repairs and restorations, including inlays, onlays and crowns.

Prosthodontic Services
- *****complete dentures (limited to one complete upper and one complete lower denture every five consecutive calendar years)
- *****partial dentures (limited to one partial upper and one partial lower denture every five consecutive calendar years)
- transitional dentures, (limited to one complete upper transitional and one complete lower transitional denture every five consecutive calendar years, and/or one partial upper transitional and one partial lower transitional denture every five consecutive calendar years)
- pontics
- abutments
- crowns
- fixed bridges.

***Dentures attached to implants are eligible for reimbursement up to the cost of a standard denture.**

ORTHODONTIC BENEFITS (dependent children under the age of 16)

Co-insurance: 50% reimbursement
Maximums: $1,500 per participant in a lifetime

Orthodontic Services
- proper fitting of natural teeth and the correction of irregularities.

DENTAL BENEFIT

ASSIGNMENT OF BENEFITS

The benefits under this provision may be assigned; however, we reserve the right to refuse any assignment of benefits under this provision.

PREDETERMINATION OF BENEFITS

If the dental expenses in connection with a participant's treatment will exceed $500, the proposed treatment plan completed by the attending dentist must be filed with and approved by Medavie Blue Cross prior to the date on which the treatment is to begin.

COORDINATION OF BENEFITS

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

Benefit payments will be coordinated with any other plan or arrangement, in accordance with the Canadian Life and Health Insurance Association (CLHIA) guidelines, so that the total amount received from all sources will not be greater than the actual expense incurred.

BENEFITS FOR LATE APPLICANTS

If application for dental benefits (subscriber or dependent) is made more than 31 days after the date on which the employee and/or dependent first becomes eligible, the maximum benefit will be limited to $200 per participant during the first 12 months of coverage. This provision does not apply to dental services required as a result of natural teeth being damaged by a direct accidental blow to the mouth after the effective date of the late applicant's coverage.

TERMINATION

Dental benefit ceases the earlier of retirement or termination of employment.

WHEN AND HOW TO MAKE A CLAIM

Dental benefits are reimbursed to the employee.

To make a claim, complete the claim form that is available from your employer.

Claims must be received within 90 days of the end of the calendar year in which services or supplies were received.

DENTAL BENEFIT – EXCLUSIONS AND LIMITATIONS

This benefit does not cover the following expenses:

1. Services for which the employee or dependent is entitled to indemnity from any government plan, or any plan or arrangement.

2. Dental treatment required as a result of self-inflicted injuries, insurrection, war or engaging in a riot.

3. Services for which the government prohibits the payment of benefit.

4. Services provided without charge or paid for by the employer.

5. Services performed by an unqualified practitioner.

6. Examination required for the use of a third party.

7. Cosmetic surgery.

8. Replacement of any lost or stolen appliances.

9. Charges for missed appointments or the completion of claim forms.

10. Services not listed as a covered benefit.

HEALTH AND DENTAL INFORMATION

TERMINATION

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

- the date you terminate employment
- the date you cease to be eligible due to retirement, age limitation, change in classification etc.
- the termination date of the Group Contract

CONVERSION PRIVILEGE

If you should terminate employment, you may convert to an Individual Health & Dental Plan currently issued by Blue Cross provided that application is made within 31 days following your date of termination. This conversion privilege is also available to the surviving spouse and/or dependents in the event of your death.

CO-ORDINATION OF BENEFITS

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

Benefit payments will be coordinated with any other plan or arrangement, in accordance with the Canadian Life and Health Insurance Association (CLHIA) guidelines, so that the total amount received from all sources will not be greater than the actual expense incurred.

SURVIVOR BENEFITS

In the event of the Subscriber's death, Dependents shall continue to be covered for Health and Dental Benefits without paying the premiums; however, coverage will end on the earliest of the following dates:

- the contract termination date,
- twelve (12) months after the Subscriber's death,
- the effective date of any similar coverage with another Insurer,
- whenever they cease to be eligible Dependents as defined in the contract.

BASIC AND OPTIONAL GROUP LIFE INSURANCE

Benefit Formula:	1.5 x base Annual Earnings (Basic Group Life)
Benefit Maximum:	$200,000 (Basic Group Life)
Benefit Maximum:	$500,000 (Optional Group Life)
Benefit Reduction:	benefit reduces to a flat amount of $10,000 at age 65

All amounts of insurance are rounded up to the next higher $1,000 amount.

Benefit ceases at the earlier of retirement or termination of employment.

OPTIONAL GROUP LIFE INSURANCE

Each employee covered by Basic Group Life Insurance may purchase additional life insurance in units of $10,000 to a maximum of $500,000 for the employee and to a maximum of $250,000 for the spouse. Child Optional Life is $10,000 per child.

Evidence of health is required for all amounts of Optional Group Life Insurance.

Benefit ceases at the earlier of retirement, termination of employment or age 65.

DEATH BENEFIT

The death benefit provides for payment to your designated beneficiary.

EXTENSION OF COVERAGE

In the event of your death within 31 days following termination of employment, the Group Life Insurance benefit will be paid to your designated beneficiary provided that any Individual Policy issued under the conversion privilege is surrendered.

WAIVER OF PREMIUM

If you become totally disabled prior to your 65th birthday, and remain disabled for a period of six months, optional insurance coverage is continued without payment of premium from the first of the month following the date of disability, provided that proof of total and continuous disability is submitted as required. Total Disability means a state of incapacity due to accidental bodily injury or illness which prevents you from engaging in any occupation for which you are reasonably qualified by education, training or experience, and you are not performing work for remuneration or profit.

CONVERSION PRIVILEGE

If you terminate employment prior to your 65th birthday, you may convert to an Individual Policy issued by the insurer, without evidence of insurability. Written application must be made and the required premium submitted during the 31-day period immediately following the date of termination.

BASIC AND OPTIONAL GROUP LIFE INSURANCE

TERMINATION OF COVERAGE

All Group Life Insurance will terminate on the earliest of:

- the date that the you cease to be eligible for Group Life insurance under this policy,
- the date of termination of this provision.

WHEN AND HOW TO MAKE A CLAIM

Claims for Group Life Insurance must be made as soon as reasonably possible and in no event later than one year from the date of the loss. Claim forms are available from your employer.

WEEKLY INDEMNITY BENEFIT

Benefit Formula:	80% of base weekly earnings
Benefit Maximum:	Unlimited
Elimination Period:	5 days for Accident
	5 days for Hospital
	5 days for Sickness
Benefit Period:	26 weeks

Claim payments received are taxable benefits.

Benefit ceases at the earlier of retirement or termination of employment.

This plan is designed to partially replace earnings lost as a result of a disability due to accident or sickness.

Hospitalization means that you must be admitted to a licensed general hospital as an in-patient for a minimum period of an overnight stay.

DISABILITY

To be eligible for this benefit, you must be under the continuing care of a physician for the period of the disability, which normally commences on your first day of absence. As an employee, you will be considered disabled and entitled to weekly indemnity payments if, as a result of sickness or accident you are unable to perform a substantial portion of the duties of your own occupation or regular employment and are not engaged in any occupation or employment for wage or profit.

RECURRENT DISABILITY

Successive periods of disability separated by less than two consecutive weeks of permanent employment, will be considered one period of disability, unless the subsequent disability is due to an accident or sickness entirely unrelated to the cause of the previous disability and commences after return to permanent employment.

WEEKLY INDEMNITY BENEFIT

EXCLUSIONS AND LIMITATIONS

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

1. Any period during which the employee is not under the continuing care and treatment by a physician, or

2. Any period during which the employee is imprisoned, or

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

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

5. Any disability due to or resulting from committing or attempting to commit a criminal offence, or provoking an assault, or

6. Any disability due to or resulting from any cause for which indemnity or compensation is provided under any Workers' Compensation law or other legislation of similar purpose, or

7. Any disability during the period:
   - of formal maternity leave taken by the employee pursuant to provincial or federal law, or pursuant to mutual agreement between the insured person and the employer, or

   - in which employment insurance maternity benefits are being paid or would be paid if the employee were eligible, whichever is the longer.

WEEKLY INDEMNITY BENEFIT

WHEN AND HOW TO MAKE A CLAIM

To make a claim, complete the notice of claim for Weekly Indemnity benefits that is available from your employer.

We must receive written notice of claim on the earlier of the following dates:

- within 90 days immediately following the end of the elimination period,
- within 6 months of the termination of this Weekly Indemnity benefit.

LONG TERM DISABILITY BENEFIT

Benefit Formula: 66 2/3% of base monthly earnings
Benefit Maximum: $7,500 per month
Elimination Period: 26 weeks

Claim payments received are taxable benefits.

Benefit ceases at the earlier of retirement, termination of employment or age 65.

Long Term Disability (LTD) plans are designed to provide a monthly income to you if you are confronted with loss of income during a lengthy or permanent disability.

DEFINITION OF DISABILITY

To be eligible for this benefit, you must be under the continuous care of a physician. You are considered totally disabled during the first 24 months following the elimination period if you are deemed unable, by the insurer, to do the substantial portion of the regular duties of your own occupation for any employer.

Thereafter, you are considered totally disabled if you are deemed unable, by the insurer, to perform at least the substantial duties of any occupation for any employer for which you are reasonably fitted, or could so become, by education, training or experience.

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

PARTIAL DISABILITY

As long as you continue to satisfy the definition of total disability following the elimination period, yet are able to return to the workforce in a reduced capacity, the insurer will apply the regular provisions under the Long Term Disability coverage.

RECURRENT DISABILITY

Successive periods of disability separated by less than six months of continuous full-time employment will be considered one period of disability, unless the subsequent disability is due to an accident or sickness entirely unrelated to the cause of the previous disability and commences after return to full-time employment.

ELIMINATION PERIOD

The benefit elimination period is the period of time which you must wait from the onset of the disability before the insurer begins paying Long Term Disability benefits.

When the disability is not continuous, the days you are disabled may be accumulated to satisfy the elimination period, provided that no interruption is longer than two weeks and the disabilities are due to the same cause.

LONG TERM DISABILITY BENEFIT

DRUG AND ALCOHOL PROVISION

Long Term Disability benefits are not payable for any disability caused by the use of drugs or alcohol unless the employee is engaged in, and completes, a recognized rehabilitation program specifically for the treatment of substance abuse.

REHABILITATION

Rehabilitation program means any of the following that are approved as a rehabilitation program by the plan administrator and the attending physicians:

- any occupation for compensation or profit,
- any assessment, counselling, training or vocational programs and work related activity,
- any educational program, or
- any reasonable and customary treatment program recommended by the licensed treating physician.

LONG TERM DISABILITY BENEFIT

INTEGRATION OF BENEFITS

Direct Offset Plan

Monthly benefits are coordinated with income payments to which the employee becomes entitled as a result of the current disability. The benefit coordination is applied as follows:

A. The amount of monthly income from the LTD plan is reduced directly by any disability benefits available from the Canada or Quebec Pension plan (primary benefits only), the Workers' Compensation Act and "income from all other sources".

   "Income from all other sources" includes:

   - disability benefits available under any other government program, excluding secondary benefits under the Canada or Quebec Pension plan,
   - retirement benefits provided by any employer or government program,
   - income or benefits payable under any group program provided by or through the employer,
   - income or benefits payable under a plan sponsored by an association, union or fraternal organization of which the employee is a member,
   - income replacement benefits payable under any plan of automobile insurance, where such reduction is not prohibited by law, and
   - wages or remuneration payable from any employer but excluding 50% of earnings received under an approved rehabilitation program as defined below during the first 24 months and 100% thereafter.

B. The amount determined in A above is further reduced if necessary, so that the amount of monthly income, including all amounts of income mentioned in A. above plus secondary disability benefits from the CPP/QPP does not exceed 85% of gross earnings on taxable plans, except as provided under a rehabilitation program.

   During the period of an approved Rehabilitation Program, the amount of monthly income as defined above, will be further reduced if necessary, so that the amount of monthly income together with all amounts of income in A. above, including 100% of earnings received from a Rehabilitation Program and secondary disability benefits under the Canada or Quebec Pension Plan, that are payable to the disabled employee, does not exceed 100% of gross earnings on taxable plans.

Canada/Quebec Pension Plan Freeze

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

LONG TERM DISABILITY BENEFIT

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

(a) any period during which the employee is not under the continuous care and treatment of a medical physician who is a duly qualified specialist, or

(b) any period during which the employee is imprisoned, or

(c) any disability due to or resulting from self-inflicted injury or sickness, while sane or insane, or

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

(e) any disability due to or resulting from committing or attempting to commit a criminal offence or provoking an assault, or

(f) any disability during the period:

- of formal maternity leave taken by the employee pursuant to provincial or federal law, or pursuant to mutual agreement between the insured person and the employer,

- in which employment insurance maternity benefits are being paid or would be paid if the employee were eligible, or whichever is longer, or

(g) after an employee refuses to participate and co-operate in a rehabilitation program, or

(h) for disabilities arising from medical or surgical treatment which was not medically necessary, or

(i) if an employee does not comply with the right of subrogation provision, or

(j) for any period of total disability during which an employee is not participating or co-operating in a reasonable and customary treatment program for each disabling condition. Such a program must be recommended by the licensed physician treating the employee and be of the nature and frequency usually required for each disabling condition

ADDITIONAL BENEFIT INFORMATION

ELIGIBLE EMPLOYEES

To be eligible to enrol for group benefits, you must be a permanent full-time employee who is a resident of Canada, covered under your provincial government plan, actively at work and have completed the plan waiting period. Benefits commence on the first day of the month following the date of hire.

Employees may elect coverage, within the 31 days of becoming eligible following the waiting period, by completing an application. Coverage is effective on the date of eligibility, except when: (a) the employee is not actively at work on the day that coverage would otherwise become effective, or (b) the application is made after the 31 day period.

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

All benefits described in this booklet are available to employees of the Group, subject to application by the employee and underwriting approval when applicable.

ELIGIBLE DEPENDENTS

Dependents are defined as your legal spouse (as described below), and unmarried, unemployed dependent children including natural, adopted, foster, legal guardianship, stepchildren, or children of a common-law spouse who may be covered if they reside with and are dependent for financial care and support upon the employee. Dependents must be a resident of Canada and covered under the provincial government plan

The term "spouse" is defined as a person of the opposite or same sex who is legally married to the employee, or has continuously resided with the employee for not less than one full year having been represented as members of a conjugal relationship (common law). Medavie Blue Cross will at no time provide coverage for more than one spouse under the same policy.

Dependent children are eligible for benefits if they are less than 19 years of age or; if 19 years of age but less than 26 years of age, they must be attending an accredited educational institution, college or university on a full-time basis.

Unmarried, unemployed, or employed on a part-time basis only, children 19 years of age or older qualify if they are dependent upon the covered employee by reason of a mental or physical disability and have been continuously so disabled since the age of 19. Unmarried, unemployed children who became totally disabled while attending an accredited educational institution, college or university on a full-time basis prior to the age of 26 and have been continuously so disabled since that time also qualify as a dependent.

Dependent coverage begins for your eligible dependents on the same date as your coverage, or as soon as they become eligible dependents if added later, provided that dependent benefits were applied for within 31 days of their becoming eligible. If coverage is not applied for within this 31 day period, evidence of health on the dependents may have to be submitted and approved before coverage begins.

ADDITIONAL BENEFIT INFORMATION

EVIDENCE OF HEALTH

Proof of good health is not required if application is made within 31 days of first becoming eligible. If coverage is not applied for within this 31 day period, evidence may be requested for the employee and his dependents, if any, before benefits commence.

Certain other situations may require the submission of evidence of health before coverage will be approved. These could include benefits where medical evidence is required. The cost of obtaining evidence of health shall be paid by Blue Cross if you or your dependent apply for coverage within 31 days of becoming eligible.

CLAIMING BENEFITS

The following procedures should be followed in the event of a claim:

1. In reference to Group Life, Optional Life, Accidental Death & Dismemberment, Optional Accidental Death and Dismemberment, Short Term Disability or Long Term Disability Income claims, please obtain the necessary forms from HR or your local administrator. Certain portions must be completed by the employer, the claimant and/or the attending physician. Once the claim forms are completed, they should be submitted to the insurer for processing. Short Term Disability claims should be submitted to the Company, if applicable. Written notice of claim must be given to the insurer within 31 days of loss. Claims for Long Term Disability benefits should be reported within 30 days before the end of the elimination period; or, if this is not reasonably possible, at least within six months of the commencement of disability.

   The insurer may at any time require a totally disabled employee to join a program of Rehabilitative Employment, which is appropriate, for his circumstances and has been approved by his attending physician. Participation in a program of Rehabilitative Employment will not disqualify him for Long Term Disability benefits while the Rehabilitative Employment continues and while he continues to be otherwise eligible for benefits.

   Refusal to enter and participate in a rehabilitative program considered appropriate by the insurer and the Company will result in termination of benefit payments.

2. All Health and Dental Benefits are on a reimbursement basis unless otherwise specified. Claims must be submitted within 90 days of the end of the calendar year in which services or supplies were received. To claim benefits on a reimbursement basis, please follow the procedures described in paragraph (b) below.

   For Health Care, Drugs, or Dental claims, the employee or dependent should ensure they are dealing with a Health Care Professional approved by Medavie Blue Cross. After this, one of the procedures below should be followed:

   (a) Direct payment plan: the participant's Medavie Blue Cross identification card should be shown and the provider will arrange to bill Medavie Blue Cross directly for drugs only, or

CLAIMING BENEFITS (Cont'd)

(b) Reimbursement plan: the employee must pay the provider, obtain an official receipt and submit this to Medavie Blue Cross for payment. The employee should also arrange for the completion of the appropriate claim forms, which are available from your employer. For drug claims on a reimbursement basis, receipts must indicate the following information for each prescription item:
- patient's name
- prescription number and date dispensed
- D.I.N. (Drug Identification Number) or drug name, strength and quantity.

3. For Group Travel Benefits, please refer to the appropriate page in this booklet for claims filing procedures.

CARDHOLDER SITE

INSTRUCTION FOR MEMBERS

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

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

ON THE CARDHOLDER SITE

There are a variety of options available to you on the Cardholder Site.

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

Member Information

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

Member Statements

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

FIRST-TIME ACCESS TO THE CARDHOLDER SITE

1. Log on to the Medavie Blue Cross Web site at www.medavie.bluecross.ca
2. Select "English"
3. Select "For Cardholders / Member Services" from the e-Service Centre menu on the right
4. Select "Go to Secure Site"
5. Select "First Time, Register Now"
6. Complete the online registration form
7. A temporary password will be e-mailed to the e-mail address entered during registration
8. Return to the Cardholder Site and enter the user ID and temporary password
9. The member will be prompted to change the password. Click "Submit" to save the new password
10. Click "Done" once the changes are saved, you will be directed to the "Welcome Page"

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

PLEASE NOTE

For security reasons, the Cardholder Site is for use of the cardholder only.

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

BLUE CROSS CONTACT INFORMATION

Blue Cross has offices at the following locations to answer any inquiries you may have relating to your benefit plan.

ATLANTIC CANADA	P.O. Box 220, 644 Main St. Moncton, NB E1C 8L3
QUEBEC	550 Sherbrooke Street West Suite B9 Montreal, PQ H3A 3S3
ONTARIO	P.O. Box 2000 185 The West Mall, Suite 1200 Etobicoke, ON M9C 5P1
MANITOBA	599 Empress Street P.O. Box 1046 Station Main Winnipeg, MB R3C 2X7
SASKATCHEWAN	P.O. Box 4030 516 Second Avenue N Saskatoon, SK S7K 3T2
ALBERTA	10009 - 108th Street NW Edmonton, AB T5J 3C5
BRITISH COLUMBIA	Pacific Blue Cross 4250 Canada Way P.O. Box 7000 Burnaby, BC V6B 4E1

Customer Inquiry **Toll Free 1-888-873-9200**

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AD&D as ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE PLAN (AD&D)

CHARTIS INSURANCE COMPANY OF CANADA
having issued POLICIES NOS. **BSC 9025257A AND PAI 9107064A**

GENERAL

The Accidental Death and Dismemberment Plan provides benefits in the event of the accidental loss of life, sight, limbs, speech, hearing, or the accidental loss of use of limbs, or paralysis. You are covered 24 hours a day, anywhere in the world.

ELIGIBLE PERSONS AND AMOUNTS COVERED UNDER THE BASIC AD&D

You are automatically covered as follows:

Class I: All George Weston Limited and Loblaw Companies Limited Active Employees who are insured under the Policyholder's current Basic Life Insurance, until age 65.

Principal Sum: Equal to Basic Life Group Insurance – Maximum $200,000.

ELIGIBLE PERSONS AND AMOUNTS COVERED UNDER THE VOLUNTARY AD&D

You and your dependents may elect to subscribe to a voluntary AD&D amount, if you are under age 65, as follows:

Employee Only: From a minimum of $10,000 to a maximum of $500,000 in units of $10,000.

Family Plan: From a minimum of $10,000 to a maximum of $500,000 in units of $10,000. The following % would apply: Yourself: 100%; Your Spouse: 50%; Children 25%.

PAYMENT RESULTING FROM ACCIDENTAL DEATH OR DISMEMBERMENT

The percentage of the principal sum payable to you in the event of an accident will depend on the nature of the loss as described below. Loss must occur within 365 days of an accident.

TABLE OF LOSSES

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

(total paralysis of both upper and lower limbs)
Paraplegia ..... Two Times The Principal Sum
(total paralysis of both lower limbs)
Hemiplegia ..... Two Times The Principal Sum
(total paralysis of both limbs of one side of the body)

"Loss" as above used with reference to quadriplegia, paraplegia, and hemiplegia means the complete and irreversible paralysis of such limbs; as above used with reference to hand or foot means complete severance through or above the wrist or ankle joint, but below the elbow or knee joint; as used with reference to arm or leg means complete severance through or above the elbow or knee joint; as used with reference to thumb and index finger means complete severance through or above the first phalange; as used with reference to fingers means complete severance through or above the first phalange of all four fingers of one hand; as used with reference to toes means, complete severance of both phalanges of all the toes of one foot and as used with reference to eye means the irrecoverable loss of the entire sight thereof.

"Loss" as above used with reference to speech means complete and irrecoverable loss of the ability to utter intelligible sounds; as used with reference to hearing means complete and irrecoverable loss of hearing in both ears. "Loss" as used with reference to "Loss of Use" means the total and irrecoverable loss of use provided the loss is continuous for 12 consecutive months and such loss of use is determined to be permanent.

Indemnity provided under this section for all losses sustained by any one Insured Person as the result of any one accident will not exceed the Principal Sum with the exception of quadriplegia, paraplegia and hemiplegia, two times the Principal Sum.

EXPOSURE AND DISAPPEARANCE

Should you be unavoidably exposed to the elements as a result of an accident and consequently suffer a covered loss within 365 days after the date of the accident, the Company will provide benefits for that loss.

If you are in a transportation vehicle that disappears, is forced to land, is stranded, sinks or is wrecked, and you are not found within 365 days of the incident, you will be considered to have died, and the Company will pay benefits accordingly.

REHABILITATION

If you sustain a covered injury payable under the Table of Losses, the Company will reimburse all reasonable and necessary expenses you incur for special training to become specifically qualified to perform an occupation for which you previously lacked the qualifications. Benefits are payable for up to three years following the accident, to a maximum of $15,000 per covered individual for any one accident. The Company will not pay for any room, board or other ordinary living, travelling or clothing expenses.

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HOME ALTERATION AND VEHICLE MODIFICATION

Should you sustain a coverd injury payable under the Table of Losses for the loss of both feet or become quadriplegic, paraplegic or hemiplegic as the direct result of an accident, and subsequently need a wheelchair to be ambulatory, the Company will refund:

a) the one-time cost of modification to your principal residence to make it weel-chair accessible and habitable, and
b) the one-time cost of alterations to your motor vehicle, to make it accessible and driveable.

These two benefits combined are payable up to $15,000, provided that:

a) proof of payment for these alterations is given,
b) the home alterations are made on your behalf by someone with experience in this area and recommended by an organization recognized for its support and assistance to wheelchair users, and
c) the vehicle modifications are made on your behalf by someone with experience in this area and approved by the provincial vehicle licensing authorities.

WORKPLACE MODIFICATION AND ACCOMMODATION

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

PSYCHOLOGICAL THERAPY

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

IN-HOSPITAL INDEMNITY BENEFIT

If you sustain an accident which requires that you be hospitalized for more than 5 consecutive days, the Company will pay:

a) a monthly benefit of 1% of your Principal Sum; or
b) for periods of less than 1 month, 1/30 of the above monthly benefit per day.

Benefits are retroactive to the first day of hospital confinement. This benefit is limited to:

a) a monthly amount not to exceed $1,000; and
b) a total of (12) months for any covered accident.

Successive periods of hospital confinement for loss from the same covered accident separated by a period of less than 3 months will be considered as 1 period of hospital confinement. The term "*hospital*" is defined as an establishment which meets all of the following requirements.

a) holds a license as a hospital (if licensing is required in the province);
b) operates primarily for the reception, care and treatment of sick, ailing or injured persons as in-patients;
c) provides 24-hour a day nursing service by registered or graduate nurses;
d) has a staff of one or more licensed physicians available at all times;
e) provides organized facilities for diagnosis, and major medical surgical facilities; and
f) is not primarily a clinic, nursing, rest or convalescent home or similar establishment or is not, other than incidentally, a place for alcoholics or those addicted to drugs.

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FAMILY TRANSPORTATION

Should you be hospitalized for a covered injury payable under the Table of Losses, the Company will pay an immediate family member's visiting expenses to a maximum amount of $15,000 provided the following criteria are met:

a) the hospital confinement occurs within 365 days of the accident,
b) the hospital is at least 100 kilometers away from home,
c) the attending physician recommends the personal attendance of a member of the immediate family,
d) the visiting family member takes the most direct route, by a licensed common carrier, to the hospital, and
e) the visiting family member is the spouse, parent, grandparent, child (aged 18 or over) or sibling of the covered person confined to the hospital.

REPATRIATION

In the event of your accidental death due to an accident at least 50 kilometers away from your normal place of residence and within 365 days after the accident, the Company will reimburse the expenses incurred for preparing the deceased for burial and shipping the body to your city of residence. The maximum amount payable under this provision is $15,000 per covered individual.

IDENTIFICATION BENEFIT

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

SEAT BELT

Should you sustain a covered injury payable under the Table of Losses and you were wearing a properly fastened seat belt at the time of the accident, the Company will pay 125% of the amount that would otherwise be payable for such covered loss. Verification of actual use of the seat belt must be part of the official report of accident or certified by the investigating officer.

DAYCARE

In the event of your accidental death due to an accident, benefits will also be paid for each covered dependent child currently enrolled in an accredited day-care centre or enrolled in an accredited day-care centre within 90 days after the date of the accident.

The benefits payable for the day-care services of each eligible dependent are equal to the lowest of the following amounts:

a) the actual cost charged annually by such day-care center; or
b) 3% of the principal sum you chose for yourself under this Plan; or
c) $5,000 a year.

The benefit is payable annually for a maximum of four consecutive payments but only if the dependent child is under age 13 and continues his or her enrolment in an accredited day-care center.

EDUCATION

In the event of your accidental death due to an accident, for each of your eligible dependent children who were enrolled in an institution of higher learning on the date of the accident, the Company will reimburse the annual tuition, excluding room and board, charged by the institution for each school year; for the lowest of the following benefits:

(b) 5% of the principal sum; or
(c) $5,000 per school year.

This benefit is payable annually up to a maximum of four (4) consecutive payments per Dependent Child:

(a) only for such Dependent Child who is, at the time of such Insured Employee's Loss of Life, enrolled as a full-time student in an Institution of Higher Learning beyond the twelfth (12^{th}) grade level; and
(b) only while such Dependent Child continues his or her continuous enrollment in an Institution of Higher Learning.

"Dependent Child" as used herein means any unmarried child under 26 years of age who was dependent upon the Insured Employee for at least 50% of his maintenance and support.
"Institution of high learning" as used herein includes, but is not limited to, any University, Private College, or Trade School.

SPOUSAL EDUCATIONAL BENEFIT

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

FUNERAL EXPENSE

When injuries covered by this policy result in accidental loss of life of an Insured Employee, the Company will pay the actual expense incurred for preparing the deceased for burial and funeral expenses subject to a maximum of $5,000.

BEREAVEMENT BENEFIT

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

FELONIOUS ASSAULT BENEFIT

Pays an additional benefit of 10% of the Principal Sum if you suffer an injury for which you receive a benefit under the Plan as a result of a deliberate felonious act of another person directed at you as an employee of the Policyholder, unless such an act was committed by a fellow employee or a member of your family or household.

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SERIOUS ILLNESS BENEFIT (NON-CANCER)

Pays an additional benefit of 10% of the Principal Sum to a maximum of $5,000 if you are diagnosed with the following covered serious illness:

- ✓ Major Burns (3rd degree)
- ✓ Multiple Sclerosis
- ✓ Necrotizing Fasciitis
- ✓ Parkinson's Disease
- ✓ Major Organ Failure Requiring Transplant
- ✓ Motor Neuron Disease
- ✓ Major Organ Transplant

Please see the Policy for specific diagnosis requirements. You must be confined to a hospital for at least 48 hours as a result of the serious illness, survive at least 30 days after the diagnosis and be under the age of 65 at the time of the diagnosis. This is a one-time benefit even if you are diagnosed with more than one covered serious illness.

COMA BENEFIT

Pays a monthly benefit of 1% of your Principal Sum for a maximum of 100 months after 6 months in a continuous coma caused by an accident. Please see the Policy for details.

BURN BENEFIT

Pays a percentage of the Principal Sum up to a maximum of $25,000 if you suffer a 3rd degree burn by means of exposure to fire, heat, caustics, electricity or radiation. Please see the Policy for details.

WAIVER OF PREMIUM

Your premiums will be waived if you become totally disabled and eligible for Waiver of Premium under your Basic Group Life Insurance Plan. Such waiver will then apply until the earliest of:

(1) your 65th birthday anniversary;
(2) your death or recovery, and
(3) the date on which this policy is terminated.

BENEFICIARY DESIGNATION

If you die accidentally, benefits shall be payable as designated in writing under your current Basic Group Life Insurance Plan. In the absence of such designation, benefits shall be payable to your Estate.

You are automatically the beneficiary of any benefits payable in the event of an accidental injury.

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WHEN BENEFITS ARE NOT PAYABLE

Benefits are not payable from this Plan for losses resulting from:

(a) suicide or any attempt thereat by you while sane;
(b) self inflicted injury or any attempt thereat by you while sane or insane;
(c) declared or undeclared war or any act thereof;
(d) sickness, disease, mentally incapacity or bodily infirmity whether the loss or claim results directly or indirectly from any of these;
(e) mental incapacity whether the Loss or claim results directly or indirectly from any mental incapacity;
(f) Injury sustained while the Insured person are undergoing the medical or surgical treatment of sickness, disease, or bodily or mental infirmity;
(g) stroke or cerebrovascular accident or event; cardiovascular accident or event; myocardial infarction or heart attack; coronary thrombosis; aneurysm;
(h) travel or flight in or on (including getting in or out of, or on or off of) any vehicle used for aerial navigation, if you are:
   I. riding as a passenger in any aircraft not intended or licensed for the transportation of passengers;
   II. performing, learning to perform or instructing others to perform as a pilot or crew member of any aircraft; or
   III. riding as a passenger in an aircraft owned or leased by the Policyholder;
(i) infections of any kind regardless of how contracted, except bacterial infections that are directly caused by botulism, ptomaine poisoning or an accidental cut or wound independent and in the absence of any underlying sickness, disease or condition including but not limited to diabetes;
(j) injury sustained while the Insured Person is on full-time active duty in the armed forces or organized reserve corps of any country or international authority. (Unearned premium for any period for which you are on full-time active duty shall, upon application to the Company by the Policyholder, be refunded);
(k) the commission or attempted commission by you or injury incurred while you are in the course of committing or attempting to commit any act which if adjudicated by a court would be an indictable offence under the laws of the jurisdiction where the act was committed; and
(l) natural causes.

EFFECTIVE DATE

Your coverage begins on the date you satisfy the definition of “Insured Employee”.

TERMINATION DATE

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

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