



Your Group Benefits Booklet

Dalhousie University (Post Doctoral Fellows)

All Employees

Group Number: 10157

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PRIVACY PROTECTION PRACTICES

In the course of providing customers with quality health, life and travel coverage, Medavie Blue Cross collects, uses and stores certain personal information about its members and their dependents. Protecting personal information is not new to us. Ensuring the privacy of client information has always been fundamental to the way we do business.

The purpose of our **privacy statement** is to keep you informed about privacy protection practices at Medavie Blue Cross. In addition to this privacy statement, we have an **online privacy statement** that describes our practices for protecting your personal information when you use our websites and mobile applications and a **Medavie Blue Cross mobile app privacy policy** that applies to your use of our mobile app.

For more information on our privacy protection practices, please visit our website. **medaviebc.ca**.

PLAN MEMBER WEBSITE

INSTRUCTION FOR MEMBERS

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

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

ON THE PLAN MEMBER WEBSITE

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

Coverage Inquiry: Detailed information about the Medavie Blue Cross benefit plan

Forms: Printable versions of generic Medavie Blue Cross claim forms

Member Information

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

Member Statements

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

Submit Claims electronically

FIRST-TIME ACCESS TO THE PLAN MEMBER WEBSITE

To register for the Plan Member Website, visit www.medaviebc.ca and log in.

Please ensure you make note of your password for future reference.

PLEASE NOTE

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

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

AN OVERVIEW OF YOUR GROUP COVERAGE

A group coverage 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 Company.

The information contained in this booklet is an overview of the provisions of the policy between your employer and the Company. Included is a summary of your benefits and pertinent information that you will require to optimize the coverage available to you and your family.

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

Where legislated, you have the right to request a copy of the group policy details pertaining to your insured coverage, a copy of your application for benefits, and any written statements or other records provided to 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 the 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.

Group Insurance Eligibility

To be eligible for group coverage, you must be a permanent employee who is a resident of Canada, covered under your provincial government plan, actively at work and working a minimum of 20 hours per week on a regular basis. Coverage commences upon employment.

To participate in your group plan, you must complete the coverage forms that are provided to you upon your eligibility to the various plans.

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

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

Definition of Dependents

Your dependents are:

- a) Your spouse, who is the person to whom you are married, or the person that you introduce as your spouse and with whom you have been living in a conjugal relationship for at least one year.
- b) Your unmarried children who are your financial dependents and
 - are under 21 years of age, or
 - are under 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 21 (or age 26 if a student).

AN OVERVIEW OF YOUR GROUP COVERAGE

Proof of Health Requirement

You must submit proof of health if your application for coverage for yourself or your dependents is presented to the Company more than 60 days after the eligibility date.

If, at the effective date or any renewal date, participation in the group to which you belong falls below three covered employees, evidence of health will be required for all employees and their dependents, regardless of the amount of coverage.

Conversion Privilege

If you should terminate employment, you may convert to an Individual Health and 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 after the termination of the Survivor Benefit.

Filing a Claim

Hospital Benefit

If you or one of your dependents are hospitalized, simply show your identification card at the time you are being admitted. The claim will be forwarded to our office by the hospital.

Drug Benefit

Reimbursement plan - complete the claim form, attach the original receipts and forward to the Company (See contact information).

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

Pay direct plan - simply show your identification card and the provider will arrange to bill the Company.

Extended Health Benefit

Reimbursement can be made electronically through Registered Health Care Providers. Company approved providers includes chiropractors, physiotherapists, and vision care providers; you must present your identification card to your provider at every visit. Two reimbursement options are possible depending on your provider's preference:

- a) You only have to pay for your deductible (if applicable) and your coinsurance, and excess expenses are paid directly to the provider by the Company; or
- b) You pay the total amount requested by your provider and you will receive in the next few days the portion of the expenses refundable by your plan.

If, however, your provider cannot use the electronic transaction network, complete and submit a claim form, attach the original receipts and forward to the Company (See contact information).

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

AN OVERVIEW OF YOUR GROUP COVERAGE

Travel Benefit

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

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

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

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

Dental Benefit

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

- a) You only have to pay for your deductible (if applicable) and your coinsurance, and excess expenses are paid directly to the dentist by the Company; or
- b) You pay the total amount requested by your dentist and you will receive in the next few days the portion of the expenses refundable by your plan.

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

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

Health Spending Account Benefit

You must first submit expenses through any other benefits plan (government sponsored or private). You can submit any remaining expenses through your HSA account.

Manual - Available credits will be used to pay an HSA claim, as directed by you on the claim form.

Complete the claim form, attach the original receipts or explanation of benefits from previously remaining claim amounts, and forward them to the Company (See contact information).

AN OVERVIEW OF YOUR GROUP COVERAGE

Limitation Periods for Legal Action

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

Coordination of Benefits

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

With the exception of Worldwide Travel Benefit, the benefit payable to you or one of your dependents follows the order described below:

- a) The benefits payable under a plan that does not include a co-ordination of benefits clause are payable before those which would otherwise be payable under this plan.
- b) The benefits of any plan that includes a co-ordination of benefits clause are payable in the following order:
 - the plan where you qualify as an employee
 - the plan where you qualify as a dependent

If you or one of your dependents qualifies as an employee, benefits are payable in the following order:

- an active full-time employee,
- an active part-time employee,
- a retiree.

For the co-ordination of benefits for dependent children priority will go to the plan of:

- the parent with the earlier birth date in the calendar year,
- the parent whose first name begins with the letter that comes first in the alphabet, if both parents have the same birth date.

Dependent children whose parents are separated or divorced; priority will go to the plan of:

- the parent with custody of the child,
- the spouse of the parent with custody of the child,
- the parent who does not have custody of the child,
- the spouse of the parent who does not have custody of the child.

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

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

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

Payment for Worldwide Travel Benefit provided under this policy is limited to amounts that are in excess of coverage provided by any other plan, as specified under Exclusions and Limitations for Worldwide Travel Coverage.

BLUE CROSS CONTACT INFORMATION

For more information about your group benefits coverage or the plan member website, please contact our Customer Information Contact Centre toll free at:

Ontario: 1-800-355-9133

Quebec: 1-888-588-1212

All other Provinces: 1-800-667-4511

Have your group policy number and identification number ready when you call for questions regarding your coverage.

Alternatively, you can email your questions to inquiry@medavie.bluecross.ca or visit our website at www.medaviebc.ca.

Connect with Blue Cross

Like us on Facebook at facebook.com/MedavieBlueCross

Follow us on Twitter at [@MedavieBC](https://twitter.com/MedavieBC)

My Good Health®

My Good Health is a secure, interactive web portal that provides valuable health information and tools for managing your health. You can create your own health profile and use it to map personal goals using My Good Health resources.

Blue Cross is proud to help point your way to healthier living. Go to medaviebc.mygoodhealth.ca and simply follow the instructions to register for your free account!



Savings are available to Blue Cross members across Canada. To take advantage of these savings, simply present your Blue Cross identification card to any participating provider and mention the **Blue Advantage®** program. A complete list of providers and discounts is available at www.blueadvantage.ca.

How to Obtain a Claim Form

Health benefit claim forms can be obtained from any one of the following sources:

- the plan member website;
- your group benefits administrator; or
- our Customer Information Contact Centre at the toll-free number listed above.

How to Submit a Claim

Blue Cross offers several convenient options to quickly and efficiently submit your health benefit claims:

- eClaims through our secure plan member website;
- Mobile App (visit www.medaviebc.ca/app for more information or to download the app);
- Mail your completed claim form to the nearest Medavie Blue Cross office. To find the Medavie Blue Cross office nearest you, visit our website at www.medaviebc.ca.

SUMMARY OF BENEFITS

HOSPITAL BENEFIT In Canada Only

| | <u>% Co-insurance</u> | <u>Accommodation</u> | <u>Maximum duration</u> |
|-----------------------|-----------------------|----------------------|---|
| Active Care | 100% | Semi-private | Unlimited |
| Convalescence | 100% | Semi-private | \$50 per day to a maximum of 120 days per calendar year |
| Rehabilitation | 100% | Semi-private | \$50 per day to a maximum of 120 days per calendar year |

GENERAL INFORMATION

| | |
|-------------------------|---|
| Deductible | Nil |
| Survivor Benefit | 24 months, without dues |
| Termination | The benefit ceases upon termination of employment |

DRUG BENEFIT In Canada Only

| | <u>Co-payment</u> | <u>Maximum</u> |
|--------------------------------------|-------------------|---|
| Drug Benefit | 20% | Unlimited |
| Fertility Benefits | 20% | \$1,500 per calendar year up to a lifetime maximum of \$3,000 |
| Erectile Dysfunction Benefits | 20% | \$250 per calendar year |

GENERAL INFORMATION

| | |
|--------------------------------|---|
| Deductible | Nil |
| Method of Reimbursement | Drug card - direct payment |
| Survivor Benefit | 24 months, without dues |
| Termination | The benefit ceases upon termination of employment |

SUMMARY OF BENEFITS

**EXTENDED HEALTH BENEFIT
In Canada Only**

PARAMEDICAL PRACTITIONERS

| | <u>% Co-insurance</u> | <u>Eligible maximum per visit</u> | <u>Maximum per calendar year</u> |
|---|-----------------------|---------------------------------------|--------------------------------------|
| Mental Health Practitioners (Psychologist/Social Worker/Counselling Therapist/ Psychoeducator/ Psychotherapist (combined)) | 80% | U & C | \$1,500 |
| Chiropractor | 80% | U & C | \$300* |
| X-rays (Chiropractor, Osteopath, Chiropodist/ Podiatrist) | 80% | | \$50 |
| Dietician | 80% | U & C | \$300* |
| Osteopath | 80% | U & C | \$300* |
| Chiropodist/Podiatrist | 80% | U & C | \$300* |
| Audiologist | 80% | U & C | \$300* |
| Speech Therapist | 80% | U & C | \$300* |
| Occupational Therapist | 80% | U & C | \$300* |
| Physiotherapist | 80% | U & C | \$300* |

GENERAL INFORMATION

| | |
|-------------------------|---|
| Deductible | Nil |
| Survivor Benefit | 24 months, without dues |
| Termination | The benefit ceases upon termination of employment |

* To a total combined maximum of \$1,500 per calendar year for all practitioners, with the exception of Mental Health Practitioners.

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

SUMMARY OF BENEFITS

EXTENDED HEALTH BENEFIT In Canada Only

MEDICAL EXPENSES

| | <u>% Co-insurance</u> | <u>Maximum</u> |
|---------------------------------------|-----------------------|---------------------------|
| Nursing Care* | 80% | \$10,000/calendar year |
| Ambulance Transportation | 80% | \$1,000/calendar year |
| Orthopedic Shoes | 80% | \$200/calendar year |
| Molded Arch Orthotics | 80% | \$300/calendar year |
| Elastic Compression Stockings | 80% | \$200/calendar year |
| Prosthetics (limbs, eyes) | 80% | Up to U & C (see Annex A) |
| Mobility Aids (cast, canes, crutches) | 80% | Up to U & C (see Annex A) |
| Durable Medical Equipment | 80% | Up to U & C (see Annex A) |
| Diabetic Equipment | 80% | \$200/calendar year |
| Diabetic Supplies/Ostomy Supplies | 80% | Up to U & C |
| Hearing Aids | 80% | \$700/3 calendar years |
| Intrauterine Contraceptive Device | 80% | \$75/2 calendar years |
| Other Medical Services and Supplies** | 80% | Up to U & C (see Annex A) |
| TENS | 80% | \$300/5 calendar years |
| Diagnostic Tests*** | 80% | \$1,000/calendar year |
| Accidental Dental Care* | 80% | Subject to authorization |

GENERAL INFORMATION

| | |
|------------------|---|
| Deductible | Nil |
| Survivor Benefit | 24 months, without dues |
| Termination | The benefit ceases upon termination of employment |

* Benefits subject to pre-authorization

**Other medical expenses are listed in Annex A

*** Diagnostic imaging services coverage in Quebec only

SUMMARY OF BENEFITS

EXTENDED HEALTH BENEFIT In Canada Only

VISION CARE

| | <u>% Co-insurance</u> | <u>Maximum</u> |
|--|-----------------------|---|
| Eye Examination | 80% | \$50/24 consecutive months; 12 consecutive months for children under 21 years of age |
| Contact Lenses Due to Disease | 80% | \$200/24 consecutive months |
| Visual Training | 80% | \$150 per lifetime |
| Lenses/Frames/Contact Lenses/Laser Eye Surgery | 80% | \$150/24 consecutive months; 12 consecutive months for children under 21 years of age |

GENERAL INFORMATION

| | |
|------------------|---|
| Deductible | Nil |
| Survivor Benefit | 24 months, without dues |
| Termination | The benefit ceases upon termination of employment |

WORLDWIDE TRAVEL BENEFIT

| | <u>% Co-insurance</u> | <u>Maximum</u> |
|---------------------------------------|-----------------------|---|
| Emergency Hospital and Medical Travel | 100% | \$2,000,000 / Participant per incident*; limited to the first 180 days of a Trip if under age 75, limited to the first 60 days of a Trip if over age 75** |
| Referral Outside Canada | 100% | \$500,000 per lifetime on pre approval |

GENERAL INFORMATION

| | |
|-------------------|--|
| Survivor Benefit | 24 months, without dues |
| Travel Assistance | Provided by CanAssistance Inc. |
| Termination | The earlier of retirement or termination of employment |

*Incident: An individual occurrence of Emergency illness or injury

**Coverage duration will be determined based on the age of the participant on their departure date.

SUMMARY OF BENEFITS

DENTAL BENEFIT In Canada Only

| | <u>% Co-insurance</u> | <u>Maximum per calendar year</u> |
|---|-----------------------------|----------------------------------|
| Preventive Care | 100% | \$1,000* |
| Basic Plan | 100% | \$1,000* |
| Major Plan | 70% | \$1,000* |
| Payment Type | Reimbursement | |
| Fee Guide Schedule | Current year | |
| Number of Recall Examinations, Polishing and Topical Application of Fluoride | 1 per 12 consecutive months | |

GENERAL INFORMATION

| | |
|-------------------------|---|
| Deductible | Nil |
| Survivor Benefit | 24 months, without dues |
| Termination | The benefit ceases upon termination of employment |

* Preventive Care, Basic and Major Plan subject to a combined maximum

SUMMARY OF BENEFITS

HEALTH SPENDING ACCOUNT BENEFIT

Benefit Details

| | |
|--|-----------------------|
| Policy Year | July 1st to June 30th |
| Account Type | Credit Carry Forward |
| Grace Period for Active Employees | 90 days |
| Grace Period for Terminated Employees | 90 days |

GENERAL INFORMATION

| | |
|------------------------------------|--|
| Deductible | Nil |
| Payment Type | Manual Reimbursement (credits will be used to pay an HSA claim as directed by you on the claim form) |
| Credit Allocation Frequency | Annually |
| Termination | The benefit ceases upon termination of employment |

SUMMARY OF BENEFITS

ANNEX A – EXTENDED HEALTH BENEFITS

Applicable in Canada

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

Repairs and/or adjustments are provided to a maximum of \$300 per calendar year.

Hair: \$300 per lifetime

Mobility aids are subject to a frequency of one per lifetime

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

Other medical services and supplies as prescribed:

- Charges for casts, trusses, braces, cervical collars, and orthopedic supports are subject to usual and customary,
- Oxygen and rental of equipment for the administration thereof are subject to pre-authorization and purchase at the discretion of Medavie Blue Cross,
- Wheelchair/scooter cushions and inserts (as approved up to usual and customary),
- Ostomy supplies and incontinence supplies up to usual and customary,
- Artificial larynx subject to a frequency of one per lifetime up to usual and customary,
- Charges for the repair of artificial larynx: \$300 per calendar year,
- Burn pressure garments: \$500 per calendar year,
- Surgical brassieres: limited to two per calendar year,
- Speech aids: \$500 per lifetime,
- Spacing devices up to usual and customary,
- Allergy testing materials: \$50 per calendar year,
- Sleeves for lymphedema: two per calendar year.

HOSPITAL BENEFIT – IN CANADA ONLY

This benefit covers eligible expenses incurred by you or your dependents subject to the deductible (if applicable) and the percentage of reimbursement specified in the Summary of Benefits, providing eligible expenses are incurred in Canada.

Deductible

The deductible, if applicable, is the portion of eligible expenses that you must pay for you and your dependents before the Company begins to reimburse expenses eligible under this policy. The deductible applies only once per calendar year.

The eligible expenses incurred during the last three months of a calendar year and which were insufficient to meet the deductible for that year may be used to reduce the deductible for the following calendar year.

Eligible Expenses

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

HOSPITALIZATION

Hospital Room Benefit

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

Convalescent Care

Charges for convalescent care, if 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 daily maximum and maximum number of days specified in the Summary of Benefits.

Physical Rehabilitation

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

Survivor Benefit

After your death, your dependents continue to be covered without cost and up to the earliest of the following dates:

- a) 24 months after the date of your death,
- b) The date they cease to be eligible dependents,
- c) The effective date of any similar coverage with another insurer, or
- d) The termination date of the group policy.

DRUG BENEFIT – IN CANADA ONLY

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

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

Drugs must be dispensed by a provider approved by the Company.

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

Deductible

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

Eligible Expenses

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

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

Expenses not Reimbursed by the Plan

Incurred expenses for the following products or drugs are excluded:

- products not approved by the Company,
- products for the care of contact lenses,
- proteins or dietary supplements, amino acids,
- processed food for infants,
- hygiene products, including soaps and emollients,
- softeners and protective substances for the skin,
- minerals,
- homeopathic/naturopathic products,
- drugs or drug formats or preparations with no therapeutic indication.

DRUG BENEFIT – IN CANADA ONLY

Applicable to Quebec Residents

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

Decision to join the RAMQ plan at age 65

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

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

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

However, you and your dependents who have joined the RAMQ's plan remain covered under the group insurance plan for the expenses indicated below (by paying the increase in premium, if applicable, according to the premium rates schedule of the contract):

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

Decision to cancel registration with the RAMQ at age 65

When a Quebec resident reaches the age of sixty-five (65), he is automatically registered by the RAMQ as a beneficiary of its prescription drug coverage. When you or your spouse reaches the age of sixty-five (65) you must therefore cancel your automatic registration with the RAMQ plan in order to continue full drug coverage under the group insurance plan. Provisions relating to the increase in premium (if applicable) are mentioned in the premium schedule of the contract or, after the effective date of the contract, in the contract renewal provisions issued by the Insurer.

Termination of Coverage

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

Survivor Benefit

After your death, your dependents continue to be covered without cost and up to the earliest of the following dates:

- a) 24 months after the date of your death,
- b) The date they cease to be eligible dependents,
- c) The effective date of any similar coverage with another insurer, or
- d) The termination date of the group policy.

EXTENDED HEALTH BENEFIT – IN CANADA ONLY

This benefit covers eligible expenses incurred by you or your dependents subject to the deductible (if applicable) and the percentage of reimbursement specified in the Summary of Benefits, providing eligible expenses are incurred in Canada.

Deductible

The deductible, if applicable, is the portion of eligible expenses that you must pay for you and your dependents before the Company begins to reimburse expenses eligible under this policy. The deductible applies only once per calendar year.

The eligible expenses incurred during the last three months of a calendar year and which were insufficient to meet the deductible for that year may be used to reduce the deductible for the following calendar year.

Eligible Expenses

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

MEDICAL SERVICES AND SUPPLIES

Nursing Care

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

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

In addition, the participant may be eligible for services rendered by a personal care worker in the participant's home if under the active care of a nurse or if requiring home care during the recuperation period after a discharge from the hospital. Personal care workers offer essential services related to activities of daily living such as bathing, dressing, toileting, feeding and mobilization.

Charges for the following services are not covered:

- a) Custodial care, homemaking duties, shopping, transportation, respite care, and services not related to providing support for the five activities of daily living listed above,
- b) Services to those residing in a government funded facility or any other facility which provides similar care to its residents,
- c) Service available through a government funded nursing or personal care program or community health program available to the general population at no cost.

Ambulance Transportation

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

EXTENDED HEALTH BENEFIT – IN CANADA ONLY

Orthopedic Shoes

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

Custom Made Orthotic Shoe Inserts

Charges for custom made orthotic shoe inserts when required to accommodate, relieve, or remedy some mechanical foot defect or abnormality, excluding their replacement (except for pathological change), on written authorization of an orthopedic surgeon, physiatrist, rheumatologist, podiatrist or the attending physician. The maximum amount payable for this benefit is noted in the Summary of Benefits.

Surgical Stockings

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

Prostheses

Charges for the following remedial prosthetic appliances:

- artificial limbs (limited to one prosthetic appliance for each limb per lifetime),
- breasts (limited to a left and a right prosthesis every two (2) consecutive calendar years),
- artificial nose (limited to one (1) per lifetime),
- eyes (limited to one left and one right prosthesis per lifetime),
- casts and splints up to the usual, reasonable and customary amount,
- trusses (limited to one truss per five (5) consecutive calendar years),
- braces (limited to one (1) cervical collar per consecutive calendar year. All other braces are limited to one (1) per lifetime),
- canes and crutches (limited to a combined maximum of two (2) per lifetime).

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

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

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

Hearing Aids

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

EXTENDED HEALTH BENEFIT – IN CANADA ONLY

Intrauterine Contraceptive Device (IUD)

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

TENS

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

Diabetic Supplies

Charges for needles, syringes, swabs, test strips and lancets.

Diabetic Equipment

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

Medical Equipment

Charges for rental of a wheelchair, hospital-type bed (including mattress and safety side rails), and equipment for the administration of oxygen, when prescribed by a licensed physician. If, due to extended illness or disability, it is felt that the need for these items will be long-term, the Company, at its sole discretion, may approve the purchase of these items.

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

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

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

Paramedical Services

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

Diagnostic Test

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

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

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

EXTENDED HEALTH BENEFIT – IN CANADA ONLY

Other Medical Services and Supplies

- a) Charges for the purchase of wheelchair/scooter cushions and inserts, limited to the usual, reasonable and customary amount,
- b) Charges for artificial larynx, limited to one purchase per lifetime.
- c) Charges for the repair of artificial larynx, subject to the maximum amount payable noted in the Summary of Benefits.
- d) Charges for the purchase of burn pressure garments, subject to the maximum amount payable noted in the Summary of Benefits.
- e) Charges for the purchase of surgical brassieres, limited to two (2) per calendar year.
- f) Charges for the purchase of spacing devices up to the usual, reasonable and customary amount.
- g) Charges for allergy testing materials, subject to the maximum amount payable noted in the Summary of Benefits.
- h) Charges for sleeves for lymphedema, limited to two (2) per calendar year.

Ostomy Supplies

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

Speech Aids

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

Accidental Dental

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

This dental treatment must be rendered or reported and approved for payment by the Company within 180 days of the accident and dental work must be completed within 24 months from the date of the accident. Eligible expense will be the dentists' usual, reasonable and customary fee up to the "dental fee guide" for general practitioners in effect where services are rendered.

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

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

EXTENDED HEALTH BENEFIT – IN CANADA ONLY

VISION CARE

Eye Examination

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

Contact Lenses Due to Disease

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

Visual Training

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

Lenses/Frames/Contact Lenses/Laser Eye Surgery

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

Expenses not Reimbursed by the Plan

The following expenses are not reimbursed under the plan:

- a) Medical examinations or routine general check-ups required for use by a third party,
- b) Charges for rest cures, convalescent care, custodial care, rehabilitation services in a hospital for the chronically ill or a chronic care unit of a general hospital, or charges incurred by the participant when, in the opinion of the Company, proper treatment should be in a chronic care unit of an institution for the chronically ill,
- c) Charges relating to elective services obtained by a participant outside his province of residence when his provincial government health care programs have not accepted liability for those items normally covered in the participant's province of residence,
- d) Any services and supplies to which the participant is entitled under any workers compensation statute or any other legislation,
- e) Charges which normally would not be made if the participant were not covered by this policy,
- f) Services for cosmetic purposes or condition not detrimental to one's health,
- g) Any services and supplies normally available without cost, or at nominal cost, under any government statute on the effective date of this policy, whether or not such services or supplies continue to be eligible under a government program,
- h) Mileage and/or delivery charges to or from a hospital or health care professional,
- i) Services in connection with an injury or disease resulting from riot, insurrection or war, whether war be declared or not. This includes any condition caused directly or indirectly by any armed forces,
- j) Medications restricted under federal or provincial legislation that are prescribed and/or dispensed despite such regulations,
- k) Registration charges or non-residents surcharges in any hospital,

EXTENDED HEALTH BENEFIT – IN CANADA ONLY

Expenses not Reimbursed by the Plan (Cont'd)

- l) Services required as a result of attempting to commit a criminal act,
- m) Service performed by an unqualified practitioner,
- n) Charges for missed appointments or the completion of forms,
- o) Services which are normally paid for directly or indirectly by the employer,
- p) Any health care services and supplies which are not provided by a company approved provider,
- q) Charges for experimental or investigative health care services or supplies,
- r) Any health care service or supply that are not medically necessary nor proven effective,
- s) Charges for health care planning assessments including, but not limited to physiotherapy assessments. Health care planning assessments will be excluded as eligible benefits, unless otherwise specified in this policy,
- t) Any health care services and supplies administered in a hospital or by any agency or provider controlled by a hospital or by any agency or provider funded, in whole or in part, by government of any level, are not eligible for reimbursement under this policy, unless otherwise specified in this policy.

Limitation

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

Termination of Benefit

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

Survivor Benefit

After your death, your dependents continue to be covered without cost and up to the earliest of the following dates:

- a) 24 months after the date of your death,
- b) The date they cease to be eligible dependents,
- c) The effective date of any similar coverage with another insurer, or
- d) The termination date of the group policy.

WORLDWIDE TRAVEL BENEFIT

Purpose of Coverage

The Company will pay the eligible expenses described in this benefit, subject to the conditions outlined below.

Additional Definitions

The following definitions apply to this benefit.

Emergency: A sudden and unexpected illness or injury that requires immediate medical Treatment due to:

- an injury resulting from an Accident;
- a new medical condition which begins during a Trip; or
- a medical condition that existed prior to a Trip (or prior to booking a Trip) provided that it is not part of an established treatment program.

Hospital: A facility that:

- is licensed as an accredited hospital outside of the participant's province of residence;
- offers care and treatment to either inpatients or outpatients;
- has a registered nurse on duty 24 hours a day;
- has a laboratory; and
- has an operating room where surgical operations are performed by a legally qualified surgeon.

Coverage excludes any facility used primarily as a clinic, continued or extended care facility, convalescent home, rest home, health spa or drug addiction or alcohol treatment centre unless specifically authorized by the Company.

Immediate Family Member: A participant's parents, spouse, child, brother or sister.

Incident: An individual occurrence of Emergency illness or injury.

Travel Companion: Persons who are sharing prepaid travel arrangements with the participant. No more than 3 persons can qualify as a Travel Companion for any given Trip.

Trip: Travel outside of the participant's province of residence.

WORLDWIDE TRAVEL BENEFIT

What the Company Will Pay

The Company will pay for the expenses explicitly listed in the categories below, subject to the following terms and conditions:

- payment is limited to the reimbursement level, benefit maximums and coverage duration specified below and in the Summary of Benefits;
- prior approval of the Company must be obtained before the eligible expense is incurred;
- the charges must be usual, customary and reasonable, meaning that:
 - the amount charged is consistent with the amount generally charged by health practitioners for similar products or services in the geographical area in which the service or supply is being purchased; and
 - the frequency and quantity in which services or supplies are purchased by the participant are, in the opinion of the Company in consultation with its health care consultants, consistent with the frequency and quantity that would usually be prescribed or needed for the participant's condition;
- payment is limited in accordance with the Exclusions and Limitations provision of this benefit;
- payment of this benefit is limited to amounts that are in excess of coverage provided by any other plan (where a court determines that this policy and any other plans provide primary coverage, this benefit will be co-ordinated with the other plan as specified under the Co-ordination of Benefits provision); and
- payment is subject to post-payment audit.

Emergency Hospital and Medical Travel Coverage

The Company will pay the eligible expenses listed in this section if:

- they are incurred as a result of an Emergency;
- the participant is covered by government health care coverage when the Emergency occurs; and
- the Company is satisfied the expense is necessary to stabilize the participant's medical condition.

Hospitalization

Charges for Hospital room accommodation (not a suite of rooms) and for medically necessary inpatient and outpatient services.

Physician Fees

Fees charged for physician or surgeon services.

Medical Appliances

The cost of casts, crutches, canes, slings, splints, trusses, braces or the temporary rental of a wheelchair or scooter, when prescribed by the attending physician.

Nursing Care

Fees for private duty nursing performed by a professional nurse or nursing assistant when prescribed by the attending physician. The nurse providing the service must not be a family member of the participant or an employee of the Hospital.

This coverage excludes nursing fees for custodial care.

Diagnostic Services

Charges for laboratory tests, X-rays and diagnostic imaging, when prescribed by the attending physician.

WORLDWIDE TRAVEL BENEFIT

Emergency Hospital and Medical Travel Coverage (Cont'd)

Drugs

The cost of drugs prescribed by a physician, but only in a quantity sufficient to treat the condition for the duration of the Trip. The participant must provide satisfactory proof of purchase of this medication that includes:

- the name of the participant;
- the date of purchase;
- the name of the medication;
- the drug identification number, if available;
- the quantity and strength of the drug; and
- the total cost.

Paramedical Services

The cost of services rendered by chiropractors, osteopaths, chiropodists/podiatrists and physiotherapists. This coverage excludes charges for X-rays.

Accidental Dental and Other Dental Emergencies

Fees of a dental practitioner for treatment:

- a) of damage to natural teeth that occurs as a result of a direct accidental blow to the mouth;
- b) that is necessary to repair a fracture or reposition a dislocation of the jaw resulting from an accident; or
- c) that is needed to relieve pain caused by an Emergency other than those listed in (a) or (b).

With respect to treatment under categories (a) or (b):

- treatment must begin while the participant is covered by this benefit and end within 6 months of the accident, unless deferred treatment is approved by the Company due to the age of the participant; and
- the maximum reimbursement per participant per Incident is \$2,000.

With respect to treatment under category (c), the maximum reimbursement per participant per Incident is \$200.

Ambulance Service

The cost of ground or air ambulance for transportation of a stretcher patient to the nearest qualified medical facility. This includes the cost of an inter-Hospital transfer if the attending physician and the Company determine that existing facilities are inadequate for treatment or stabilization.

Repatriation to the Province of Residence

The cost of repatriating the participant to their province of residence to receive immediate medical attention, along with the cost of simultaneously returning a Travel Companion or any Immediate Family Member covered by the policy. If medically necessary, this cost may include an accompanying medical attendant.

If returning on a commercial aircraft, coverage includes:

- economy fare to the participant's home city in Canada; and
- in the case of a medical attendant, round-trip economy fare.

Unless the repatriation or transfer of the participant is not possible for medical reasons acceptable by the Company, the Company may require repatriation of any participant or transfer to other medical facilities. If the participant refuses repatriation or transfer, all rights to benefits in relation to the Incident are terminated.

WORLDWIDE TRAVEL BENEFIT

Emergency Hospital and Medical Travel Coverage (Cont'd)

Transportation to Visit the Participant

The cost of round-trip economy fare (by airline, bus or train) for an immediate family member to the Hospital where the participant has been confined for 7 or more days if the attending physician provides written acknowledgement that this attendance is required. The Company may waive the 7 day waiting period if the Company is satisfied that this waiver is required.

The cost of round-trip economy fare (by airline, bus or train) for an immediate family member to identify the body of the participant, if deceased.

Vehicle Return

The fees charged by a commercial agency to return the participant's vehicle, whether private or rental, to the participant's residence or to the nearest appropriate vehicle-rental agency, when the participant is unable to drive as a result of an Emergency illness or injury. A medical certificate from the attending physician confirming the participant's medical incapacity to operate the vehicle is required. This benefit is subject to a maximum of \$1,000 per Trip.

Return of the Deceased

The cost of preparing and transporting the remains of the deceased participant to their province of residence to a maximum of \$5,000.

Meals and Accommodation

The cost of commercial accommodation and meals when the participant's travel is delayed due to Emergency illness or injury of the participant or Travel Companion. The medical reason for the delay must be verified by the attending physician. The maximum reimbursement is \$150 per participant per day for a maximum of 20 days (up to a total maximum of \$3,000 per Incident).

All costs must be supported by receipts from commercial organizations.

Worldwide Travel Assistance

The Company, through its travel assistance provider, will provide an emergency toll-free line available 24 hours a day, 7 days a week, for participants who need medical assistance or general assistance while travelling.

Medical Assistance

If the participant requires hospitalization or a consultation with a physician as a result of an Emergency, the travel assistance provider appointed by the Company will provide the following support services:

- direct the participant to an appropriate clinic or Hospital;
- confirm with the service provider that the participant is covered;
- ensure a follow-up of the medical file and communicate with the participant's family physician;
- co-ordinate the return home of a child if the participant is hospitalized;
- repatriation of the participant to the province of residence if the participant meets the eligibility requirements of this expense;
- arrange for the transportation of an immediate family member to the participant's bedside if the participant meets the eligibility requirements of this expense; and
- co-ordinate the return of the participant's vehicle if the participant meets the eligibility requirements of this expense.

WORLDWIDE TRAVEL BENEFIT

General Assistance

In Emergency situations, the travel assistance provider appointed by the Company will also provide the participant with the following services:

- 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 with the loss or theft of identity papers; and
- information regarding embassies and consulates.

In addition, pre-travel advice regarding visas and vaccines is available.

The Company and its travel assistance provider are not responsible for the quality of medical and Hospital care provided to the participant or for the availability of such care.

Referral Outside Canada

When an attending physician refers a participant outside of Canada for medical services not available in Canada, the Company will cover the portion of expenses listed below which exceed those covered by the participant's government health care coverage.

Hospital Services

Charges for:

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

Physicians and Surgeons

Charges for services rendered by a physician or surgeon.

Ambulance Transportation and Attendant

Charges for licensed ambulance services needed to transport a stretcher patient to and from the nearest hospital able to provide acute care, including any charges for travel expenses of an accompanying registered nurse or qualified medical attendant, other than a relative.

To be eligible for coverage under this category, all expenses must be pre-approved by the Company and the participant's government health care coverage must agree to cover a portion of the expenses.

PAYMENT OF CLAIMS

How Payments are Made

The Company may approve payment directly to the service provider. In certain circumstances, the participant will pay the full cost of any eligible expense at the time of purchase. The Company will then reimburse any eligible expenses on receipt of proof of payment from the Participant.

WORLDWIDE TRAVEL BENEFIT

EXCLUSIONS AND LIMITATIONS

Exclusions Applicable to all Travel Benefit Claims

No payment will be made (or payment may be reduced) if:

- a) the participant fails to communicate with the Company in the event of medical consultation or hospitalization following an injury or illness;
- b) expenses are incurred beyond the coverage duration period specified in the Summary of Benefits;
- c) the purpose of the Trip is primarily or incidentally to seek medical advice or treatment, even if this Trip is on the recommendation of a physician;
- d) expenses have already been paid or are eligible for refund from a third party;
- e) expenses are incurred while travelling in a country (or a specific region of a country) for which there is a Government of Canada travel warning to avoid all travel or avoid non-essential travel, when such travel warning was issued before the departure date and the loss or expense is related to the reason for which the travel warning was issued; or
- f) expenses are incurred as a result of:
 - participation in a criminal act or attempt to commit a criminal act, regardless of whether charges are laid or a conviction is obtained;
 - an illness or injury that occurred while operating a vehicle under the influence of any intoxicant or with a blood alcohol level that was proven to be in excess of the legal limit in the jurisdiction in which the accident occurred;
 - an injury or illness resulting from non-compliance with medical treatment or therapy that has been prescribed;
 - suicide, attempted suicide or voluntary injury or illness; or
 - services in connection with an injury or disease resulting from riot, insurrection or war, whether war be declared or not. This includes any condition caused directly or indirectly by any armed forces.

Emergency Hospital and Medical Travel Coverage

No payment will be made for:

- a) expenses for any care, treatment, surgery, products or services that:
 - are not incurred as a result of an Emergency;
 - are not medically necessary;
 - are performed for cosmetic purposes only;
 - are not required for the immediate relief of acute pain and suffering; or
 - could be delayed until the participant's return to Canada;
- b) expenses incurred due to pregnancy or pregnancy complications that occur within 8 weeks of the expected date of delivery; or
- c) expenses incurred due to an Emergency that occurs while participating in:
 - a sport for remuneration;
 - a motor vehicle or speed contest of any kind; or
 - any Extreme Sport, defined as an activity with a high level of inherent danger and which often involves speed, height, a high level of physical exertion, highly specialized gear or spectacular stunts.

WORLDWIDE TRAVEL BENEFIT

SPECIFIC EXCLUSIONS AND LIMITATIONS

Referral Outside Canada

Expenses associated with the following services, treatment or supplies are not eligible for reimbursement:

- a) referral outside Canada for services available in Canada;
- b) health care services or treatments unavailable in Canada due to waiting lists;
- c) health care services or treatments that physicians in Canada have refused to perform;
- d) services, treatment or supplies that are Experimental or Investigative;
- e) services provided while the participant is not under the treatment of a physician; and
- f) any expenses relating to any Pre-Existing Condition, as defined below.

Pre-Existing Condition: An Illness:

- that begins within 12 months of the date the participant obtained coverage under this benefit; and
- for which, in the 12 month period before the date the participant obtained coverage under this benefit, the participant has:
 - had a medical consultation;
 - been prescribed or taken medication; or
 - received treatment, including diagnostic services.

Termination of Travel Benefit

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

Survivor Benefit

After your death, your dependents continue to be covered without cost and up to the earliest of the following dates:

- a) 24 months after the date of your death,
- b) The date they cease to be eligible dependents,
- c) The effective date of any similar coverage with another insurer, or
- d) The termination date of the group policy.

DENTAL BENEFIT – IN CANADA ONLY

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

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

Expenses are subject to the deductible (if applicable), percentages of reimbursement and maximums specified in the Summary of Benefits.

However, if you or your dependents become covered more than 60 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 coverage.

Calculation of Eligible Expenses

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

Deductible

The deductible, if applicable, is the portion of eligible expenses that you must pay for you and your dependents before the Company begins to reimburse expenses eligible under this policy. The deductible applies only once per calendar year.

The eligible expenses incurred during the last three months of a calendar year and which were insufficient to meet the deductible for that year may be used to reduce the deductible for the following calendar year.

Eligible Expenses

After payment of the deductible (if applicable), the following expenses are reimbursed, according to the percentage of reimbursement and maximum specified in the Summary of Benefits.

Preventive Care

a) Oral examinations and diagnosis

- Complete oral examination (once per two calendar years)
- Recall oral examination (as mentioned in the Summary of Benefits)
- Emergency oral examination
- Specific oral examination

b) X-rays

- complete series films or panoramic film (one per two consecutive calendar years)
- Intra-oral films – periapical
- Intra-oral films – occlusal
- Intra-oral films – bitewings (once per calendar year)
- Extra-oral films
- Sialography
- Radiopaque dyes

DENTAL BENEFIT – IN CANADA ONLY

Preventive Care (Cont'd)

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

- d) Preventive treatment
 - Polishing of coronal portion of teeth (as mentioned in the Summary of Benefits)
 - Topical application of fluoride (as mentioned in the Summary of Benefits)
 - Oral hygiene instruction (lifetime maximum of one instruction)
 - Pit and fissure sealants (for participants under age 18)
 - Scaling (15 units* every 12 consecutive months in combination with root planing)

- e) Space maintainers

Basic Care

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

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

- c) Periodontics
 - Periodontal surgery
 - Provisional splinting
 - Management of acute infections
 - Desensitizations
 - Other adjunctive periodontal services
 - Root planing (15 units* every 12 consecutive months in combination with scaling)
 - Periodontal curettage
 - Occlusal adjustments (three units* per calendar year)
 - Periodontal appliances (one per two calendar years)
 - Adjustments to appliances (three units* per calendar year)

- d) Removable denture adjustments
 - Minor adjustments
 - Rebasing and relining (one per two calendar years)

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

DENTAL BENEFIT – IN CANADA ONLY

Basic Care (Cont'd)

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

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

Major Restoration

The following charges are eligible if major restorations are included in the Summary of Benefits:

- a) Extensive Restorations
 - Inlays/onlays/crowns (once per tooth every five calendar years)

- b) Prosthodontic Services
 - Complete and partial dentures (once every five calendar years)
 - Bridgework (once every five calendar years)
 - Implants (once per tooth every 10 calendar years)
 - Restorations over implants (i.e. crowns, bridgework and dentures) (once per tooth every 10 calendar years)

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

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 Company 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 Company.

DENTAL BENEFIT – IN CANADA ONLY

Expenses not Covered by the Plan

The following expenses are not covered:

- a) Treatment or appliance, related directly or indirectly to full mouth reconstruction, or to correct vertical dimension and temporomandibular joint dysfunction, unless specified otherwise in your Summary of Benefits.
- b) Services rendered by a dental hygienist but not administered under the supervision of a dentist, except in those provinces where it is no longer a legal requirement.
- c) Services and supplies relating to any appliance worn in the practice of a sport.
- d) Expenses that are payable or reimbursable under a public or private plan or that would normally be so if a claim had been submitted.
- e) Charges payable under an occupational health and safety board or by an automobile insurance bureau, or any other similar law or public plan, if applicable.
- f) Expenses resulting from any suicide attempt or self-inflicted injury, whether the participant is sane or not.
- g) Expenses due to any injury or illness resulting from the participant's active participation in civil unrest, riot or insurrection, unless while performing work related functions, or injury sustained in a war.
- h) Services that are not medically required, that are given for cosmetic purposes (this exclusion does not apply to composite restoration).
- i) Services that exceed the ordinary services given in accordance with current therapeutic practice.
- j) Care or services rendered free of charge, or that would be if there were no benefit coverage, or that are not chargeable to the participant.
- k) Expenses incurred for veneers.
- l) Splinting for periodontal reasons, where cast crowns or inlays are used for this purpose, with or without onlays.

DENTAL BENEFIT – IN CANADA ONLY

Restriction

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

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

Alternate Benefits

When one or more form of alternative treatment exists, the Company, in consultation with its health care consultants, reserves the right to make payment for eligible services and supplies based on an alternate procedure with a lower cost, when deemed appropriate and consistent with good health management.

Termination of Benefit

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

Survivor Benefit

After your death, your dependents continue to be insured without cost and up to the earliest of the following dates:

- a) 24 months after the date of your death,
- b) The date they cease to be eligible dependents,
- c) The effective date of any similar coverage with another Insurer, or
- d) The termination date of the group policy.

HEALTH SPENDING ACCOUNT BENEFIT

A Health Spending Account (HSA) provides additional flexibility within your group benefit plan, and allows you to cover medical expenses with pre-tax dollars (except in the province of Quebec).

Under an HSA, you have access to a pre-determined amount of HSA credits. Credits represent the value allocated to the HSA in any particular policy year (specified in the Summary of Benefits).

The HSA credits will be available to you according to the Credit Allocation Frequency specified in the Summary of Benefits.

Under no circumstances will unused HSA credits be paid out as cash.

These credits are intended to pay for medical and dental expenses, and can also be used to supplement existing benefits. For example, they can be used cover deductibles, co-payments, or amounts above plan maximums.

Dependent Coverage

Your dependents can also be covered if you have chosen family coverage.

CRA dependents are eligible for coverage, according to the Canada Revenue Agency definition. This could include members of your extended family, such as parents, grandparents or grandchildren.

Eligible Expenses

Eligible expenses will be assessed and reimbursed by the Company based upon the Canada Revenue Agency guidelines, and must be deemed reasonable and medically necessary by the Company. Eligible expenses include deductible amounts, co-payment amounts, amounts exceeding plan maximums, as well as expenses which are not covered by any applicable group policy, individual policy, government health care program, or any other private program.

HEALTH SPENDING ACCOUNT BENEFIT

| Common Eligible Expenses | | | |
|---|---|--|--|
| Attendant Care (requires certification of need from physician) | <ul style="list-style-type: none"> Services provided in Home, Retirement Home, Nursing Home or Group Home | <ul style="list-style-type: none"> Includes Fees from: <ul style="list-style-type: none"> - Personal Care Worker - Registered Nurse - Respite Care | <ul style="list-style-type: none"> Includes Fees for: <ul style="list-style-type: none"> - Food Preparation - Housekeeping - Laundry Services |
| Dental Services (excluding teeth whitening and cosmetic veneers) | <ul style="list-style-type: none"> Diagnostic Services (x-rays) Dentures Orthodontics | <ul style="list-style-type: none"> Preventive Services, such as: <ul style="list-style-type: none"> - Recall Examinations, - Polishing, and - Application of Fluoride | |
| Diagnostic Services* | <ul style="list-style-type: none"> Diagnostic laboratory, radiological tests and scans | | |
| Drugs | <ul style="list-style-type: none"> Drugs requiring a prescription and/or dispensed by a pharmacist, physician or practitioner* | <ul style="list-style-type: none"> Fertility Treatments Flu Shots Insulin* Liver Extract Injections* | <ul style="list-style-type: none"> Smoking Cessation Drugs* Vaccines Vitamin B12 Injections* |
| Facility Care (excluding television rentals and phone fees) | <ul style="list-style-type: none"> Convalescent care home Hospital | <ul style="list-style-type: none"> Nursing home Psychiatric facility Substance abuse facility | |
| Medical Devices and Services* | <ul style="list-style-type: none"> Air Conditioners (required for severe chronic ailment, disease or disorder) Artificial Eyes and Limbs Blood Transfusion Fees Breast Prosthesis Cochlear Implants Crutches Diabetic Supplies | <ul style="list-style-type: none"> Electronic Bone Healing Devices Electronic Speech Synthesizers Hearing Aids Heart Monitoring Devices Needles and Syringes Ostomy Supplies Oxygen Equipment Physician Fees | <ul style="list-style-type: none"> Prosthetics Repairs to Eligible HSA Devices Respirators Scooters Trusses Walkers Wheelchairs (excluding accessories) |
| Medical Practitioner Services | <ul style="list-style-type: none"> Acupuncturist Athletic Therapist Audiologist Chiroprapist/Podiatrist Chiropractor Dental Hygienist Dentist | <ul style="list-style-type: none"> Dietician Homeopath Massage Therapist** Naturopath Occupational Therapist Osteopath | <ul style="list-style-type: none"> Personal Care Worker* Physiotherapist Psychiatrist Psychologist Registered Nurse Social Worker Speech Therapist |
| Medical Transportation Services | <ul style="list-style-type: none"> Ambulance Services Bone Marrow Transplant Charges (patient and donor), such as transportation charges and meals and expenses | <ul style="list-style-type: none"> Meals and Transportation Expenses, when patient transportation is required (plus one attending person - if required) | <ul style="list-style-type: none"> Organ Donor Charges (patient and donor), such as transportation charges and meals and expenses |
| Miscellaneous | <ul style="list-style-type: none"> Health and Dental Plan Premiums (private insurance) | <ul style="list-style-type: none"> Home or Vehicle Modifications, when required for disabled persons | <ul style="list-style-type: none"> Seeing Eye Dog Miscellaneous Charges |
| Rehabilitative Training | <ul style="list-style-type: none"> Lip Reading | <ul style="list-style-type: none"> Sign Language | |
| Vision Care | <ul style="list-style-type: none"> Contact Lenses Eye Examinations | <ul style="list-style-type: none"> Laser Eye Surgery | <ul style="list-style-type: none"> Prescription Lenses and Frames |

*Prescription Required

**For therapeutic massage services only

HEALTH SPENDING ACCOUNT BENEFIT

Expenses not Reimbursed by the Plan

The following are examples of expenses which are not covered:

| Common Ineligible Expenses | | | |
|---|--|---|---|
| Adoption Fees | <ul style="list-style-type: none"> Adoption Fees | | |
| Cosmetic Procedures (aimed at purely enhancing appearance) | <ul style="list-style-type: none"> Augmentations Botox Injections Liposuction | <ul style="list-style-type: none"> Hair Replacement Procedures and Supplies (ex. hair plugs, hair extensions) | <ul style="list-style-type: none"> Laser Hair Removal Tattoo Removal Teeth Whitening |
| Cosmetics and Hygiene Products | <ul style="list-style-type: none"> Contact Lens Solution Lotions and Creams | <ul style="list-style-type: none"> Make-up Sunscreen | <ul style="list-style-type: none"> Toothpaste |
| Dietary Supplements | <ul style="list-style-type: none"> Food (except when required for enteral feeding) | <ul style="list-style-type: none"> Minerals and Supplements | <ul style="list-style-type: none"> Meal Replacements |
| Esthetic Massage Therapy | Such as: | <ul style="list-style-type: none"> Aromatherapy Massage | <ul style="list-style-type: none"> Body Wraps |
| Fees for missed appointments | <ul style="list-style-type: none"> Fees for missed appointments | | |
| Health Programs | <ul style="list-style-type: none"> Weight loss program fees | | |
| Home Appliances | <ul style="list-style-type: none"> Air Conditioners Air Purifiers | <ul style="list-style-type: none"> Dehumidifiers Fans | <ul style="list-style-type: none"> Humidifiers (except when required for CPAP machines) |
| Hot Tubs and Saunas | <ul style="list-style-type: none"> Hot Tubs | <ul style="list-style-type: none"> Saunas | |
| Life and Disability Plan Premiums | <ul style="list-style-type: none"> Life and Disability Plan Premiums | | |
| Over the counter medications | Such as: | <ul style="list-style-type: none"> Creams and Lotions Digestive Aids Herbal Remedies Pain Relievers | <ul style="list-style-type: none"> Smoking Cessation Products Vitamins |
| Personal Response Systems | <ul style="list-style-type: none"> Lifeline Services Health Line Services | | |
| Shoes | <ul style="list-style-type: none"> Off the shelf | <ul style="list-style-type: none"> Athletic | |
| Sports Equipment | <ul style="list-style-type: none"> Treadmills | | |

***Prescription Required**

Further to this list, please refer to the Summary of Benefits for Specific Benefit Exclusions or Specific Expense Exclusions (if any).

About your Health Spending Account

Credits may be used to reimburse eligible expenses incurred in the same Policy Year the credits were allocated.

Unused credits can also be carried forward into the following Policy Year. Credits cannot be carried forward more than one year. At the end of the second Policy Year, unused credits from the first are forfeited.

Claims must be applied to any carry forward credits before current Policy Year credits are used.

Claims must be submitted in the Policy Year they were incurred. However, there is a Grace Period specified in the Summary of Benefits, within which claims may be submitted after the Policy Year end.

HEALTH SPENDING ACCOUNT BENEFIT

Termination of Benefit

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

If your employment ends, or your group terminates coverage with the Company, you will have the Grace Period for terminated employees (specified in the Summary of Benefits) within which to use the remaining balance. Only eligible expenses incurred prior to the termination of coverage are eligible.