YOUR BENEFITS

BOMBARDIER TRANSPORT CANADA
Toronto maintenance and Toronto operations
Unionized hourly paid employees

Group no. 93538-C

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Revised: September 2014

BENEFIT SUMMARY

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

Plan waiting periods	6 months of continuous employment
Minimum hours worked per week	40 hours

Covered employee's Basic Life Insurance	
Insurable amount	$ 40,000
Terminal illness benefit	Included
Termination	Retirement

Short-term Disability Insurance	
Insurable amount	66 2/3% of weekly salary, rounded to the next dollar
• **Maximum without evidence of health**	Maximum insurable amount under the Employment Insurance Act
• **Maximum with evidence of health**	Maximum insurable amount under the Employment Insurance Act
Elimination period:	
Hospitalization or day surgery	None
Accident	None
Illness	3 calendar days
Maximum duration of benefits	52 weeks
Taxable benefits	Yes
Termination	Retirement

Long-term Disability Insurance	
Insurable amount	$1,300
Elimination period	End of Short-term benefits
Maximum duration of benefits	To age 65
Taxable benefits	Yes
Duration of own occupation	24 months
Co-ordination: Total benefits cannot exceed	80% of gross salary
Termination of Eligibility	At your attainment of age 64 or your retirement, if earlier.
Termination	Age 65 (or retirement, if earlier)

Extended Health Benefit - Drug	
GENERAL INFORMATION	
Deductible	None
Payment type	Direct payment card
Survivor benefit	24 months, without payment of premiums
At age 65	The Provincial health plan, when applicable, is the first payer and the insurer is second payer
Termination	Retirement

	Percentage of reimbursement	**Maximum amount payable**
Dispensing fees	80%	$8 per drug
Extended list	80%*	Unlimited
Varicose vein injections	80%	Unlimited

*Drugs are limited to the cost of generic drugs (when a generic version exists)

Generic drug refers to any reproduction of the brand name drug and is usually less expensive. Brand name drug refers to the drug that was first developed and launched on the market.

Extended Health Benefit - Accident /Sickness

GENERAL INFORMATION	
Deductible	None
Survivor benefit	24 months, without payment of premiums
Termination	Retirement

HOSPITALIZATION CHARGES			
	Percentage of reimbursement	**Maximum amount payable**	**Maximum number of days per calendar year**
Active care	80%	Semi-private	Unlimited
Convalescent care	80%	$5,000 / 12 consecutive months	Unlimited
Chronic care	80%	$25 / day, $2,000 / calendar year	Unlimited

VISION CARE		
	Percentage of reimbursement	**Maximum amount payable**
Eye examination	100%	1 exam / 24 consecutive months
Eyeglasses, contact lenses and laser surgery	100%	Combined maximum of $150 / 2 consecutive calendar years
Eyeglasses or contact lenses following cataract surgery (expenses must be incurred before age 65)	80%	One pair / lifetime

PARAMEDICALS

	Percentage of reim-bursement	Maximum amount payable per visit	Maximum amount payable per calendar year	Combined or specific*
Chiropractor (including X-rays)	80%	Unlimited	$500	S
Dietician	80%	Unlimited	$500	S
Massage therapist	80%	Unlimited	$500	S
Physiotherapist	80%	Unlimited	$500	C1
Podiatrist (including X-rays)	80%	Unlimited	$500	S
Psychologist (excluding psychological evaluations)	80%	Unlimited	$500	C2
Rehabilitation therapist	80%	Unlimited	$500	C1
Social worker	80%	Unlimited	$500	C2
Speech therapist	80%	Unlimited	$500	S

*C = combined maximum for all paramedicals; S = specific maximum per professional

Paramedical services are limited to one treatment per day.

MEDICAL SUPPLIES AND SERVICES		
	Percentage of reimbursement	Maximum amount payable
Nursing Care	80%	$5,000 / 12 consecutive months
Ambulance transportation	80%	Unlimited
Dental care due to an accident	100%	$2,000 / accident
Diagnostic tests*	80%	Unlimited
Orthopedic shoes and podiatric ortheses	80%	$300 combined / calendar year
Medical elastic stockings	80%	4 pairs / calendar year
TENS	80%	$700 / lifetime
Blood glucose monitor	80%	One / 4 calendar years
Hearing aids	80%	$500 / 2 calendar years
Speech aids	80%	$500 / lifetime
Prostheses		
• **Artificial limbs and eyes and palate obturators**	80%	Unlimited
• **Myoelectric arm**	80%	$10,000 per prosthesis
• **Capillary prostheses after chemotherapy**	80%	$200 / lifetime
• **Breast prostheses**	80%	1 prosthesis / calendar year
• **Surgical brassieres**	80%	2 brassieres / calendar year
Mobility aids and orthopaedic appliances		
• **Hydraulic patient lifter**	80%	1 / $2,000 / 60 consecutive months
• **Standard manual wheelchair**	80%	Unlimited
• **Crutches, canes, walking aids, hernial belts, casts, orthopaedic devices (including lumbar supports, splints, shoulder harnesses, head halters and cervical collars)**	80%	Unlimited
• **Outdoors access ramp**	80%	$2,000 / lifetime
Major medical equipment*	80%	Unlimited
Other medical supplies and services*	80%	Unlimited

* The eligible charges are described under the Accident/Sickness Insurance.

Extended Health Benefit - Travel

GENERAL INFORMATION	
Deductible	None
Travel assistance	Included
Survivor benefit	24 months, without payment of premiums
Termination	Age 70, or retirement, if earlier (age of the Covered Employee)

	Percentage of reimbursement	**Maximum amount payable**
Hospital and Medical Travel Insurance	100%	$5,000,000 lifetime maximum, per Participant
Coverage duration per trip	The first 90 days of the trip	
Participant must remain insured at all times under the government health program in his province of residence.		

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

Dental Care Coverage

	GENERAL INFORMATION
Deductible	$25 per Participant, $50 per family, per calendar year
Payment type	Electronic transmission
Fee Guide	Current year
Recall examinations	2 per calendar year
Survivor benefit	24 months, without payment of premiums
Termination	Retirement

DENTAL CATEGORIES

	Percentage of reimbursement	**Maximum amount payable**	**Combined or specific***
Preventive Care	100%	Unlimited	S
Basic Care	100%	Unlimited	S
Endodontic treatments	100%	Unlimited	S
Periodontics	100%	Unlimited	S
Major restoration	50%	$2,000	S

*C = combined maximum per calendar year, per Participant; S = specific maximum per category, per calendar year, per Participant

An overview of your group insurance plan

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

In the event of any discrepancy between the contract and the booklet, the text of the contract shall prevail.

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

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

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

Is my enrolment in the group insurance plan mandatory?

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

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

When do I become eligible for group insurance?

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

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

Who are your eligible dependents?

Your dependents are:

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

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

- Your unmarried **children** who are your financial dependents and
  - are under 22 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 22 (or age 26 if a student) and who receive no allowance under the Act respecting income security.

Is evidence of insurability required?

You must submit evidence of insurability if:

- the amount of insurance exceeds the Non-evidence maximum specified in the Benefit Summary, if applicable.
- your application for insurance for yourself or your dependents is presented to the Insurer more than 31 days after the eligibility date.

How do I file a claim?

Life Insurance Benefit
Proof of death required by the Insurer must be submitted to the Insurer within 365 days of your death.

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

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

You will have no claim to submit to your insurer.

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

The duly completed Claim form must be sent to the Insurer no later than 24 months after the date expenses were incurred:

To find out the local Blue Cross address your claim must be sent to, please refer to your claim form or contact our Customer Service at 1-888-488-2288.

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

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

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

The duly completed Claim form must be filed with the Insurer no later than 6 months after the date expenses were incurred.

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

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

If, however, your dentist cannot use the electronic transaction network, complete and submit a dental Claim form to your Insurer.

The duly completed Claim form must be sent to the Insurer **no later than 24 months** after the date expenses were incurred.

To find out the local Blue Cross address your claim must be sent to, please refer to your claim form or contact our Customer Service at 1-888-488-2288.

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

1-888-488-2288

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

www.medavie.bluecross.ca

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

www.medavie.bluecross.ca

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

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

Who has access to my confidential information?

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

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

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

Life Insurance

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

Basic Life Insurance

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

The Basic Life Insurance coverage terminates when your employment terminates or at retirement, whichever occurs first.

Terminal Illness

If you are diagnosed with a terminal illness that is expected to result in your death within 12 months, a lump sum advance equivalent to **50%** of the amount of your Basic Life Insurance or $50,000, whichever is less, may be deducted from your death benefit and paid to you. This sum may be used at your discretion.

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

If the Insurer receives the request within the 12 months preceding the date on which your insured insurance amount is reduced, the amount payable will be reduced by the percentage specified in the Summary of Benefits.

If the Insurer received the request within the 12 months preceding the date on which your life insurance terminates, no amount will be payable.

Payment of benefits

Upon your death, the Insurer will pay to your named beneficiary the amount of your Basic Life Insurance.

Conversion privilege

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

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

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

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

Life insurance amount that can be converted

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

a) your total Life insurance amount that terminates under your group insurance plan or

b) $200,000.

Short-term Disability Insurance

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

Benefits are paid at weekly intervals. The benefits for each day of total disability are equal to 1/7 of the weekly benefit.

Total disability

For the purpose of the Short-term Disability Insurance, total disability means any state of incapacity resulting from an accident or illness, requiring continuous care and treatment from your physician from the beginning of the disability and wholly preventing you from performing the regular duties of your own occupation. At no time can you receive remuneration arising either directly or indirectly from any employment

Total disability beginning more than 30 days after an Accident shall be considered as resulting from an Illness.

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

Recurrence

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

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

Reduction of benefits

Integration

The weekly benefits payable under this benefit shall be reduced by an amount equal to the disability benefits paid by the following:

- Any compensation provided to you under any occupational health and safety board or any program of similar nature (excluding benefits received in relation to another employer).
- Any provincial automobile insurance plan in which benefits payable under Employment insurance are not taken into account.
- The Quebec Pension Plan or the Canada Pension Plan.
- A provincial crime victims compensation act, except for the period during which employment insurance benefits would or could have been payable.

Your weekly indemnities payable under the present benefit are taxable and they will be calculated as follows:

- the weekly indemnity payable by the Insurer,
- less the federal and provincial taxes applicable, according to your personal exemption,
- less the indemnity payable by the government plan.

The weekly indemnity will be reduced by any pension benefits that you receive from the Quebec or Canada Pension Plan.

The weekly indemnity will be reduced by any payment received according to the Employer’s policy regarding continuation of salary, vacation, statutory holidays or sick leave, if the Insurer receives notice to this effect at the time of claim and prior to any other subsequent period of paid leave.

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

If the total disability results from alcoholism or drug addiction, benefits are paid only if you:

- are under the care of a physician other than yourself, who is a specialist in the field related to your condition; and
- are undergoing an appropriate treatment, and
- are under a rehabilitation program deemed necessary by the Insurer.

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

- period during which you receive maternity benefits under any provincial or federal law;
- a maternity or parental leave taken in accordance with any provincial or federal law or any agreement between you and your employer.

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

- voluntary injury, whatever your state of mind at the time of the incident;
- injury sustained during active participation in a civil commotion, riot or an insurrection, unless while performing the duties of your occupation;
- injury sustained during a war, whether declared or not,
- cessation of work to receive care which is not medically required or which is given for cosmetic purposes, unless such care is for accidental injury and commenced within 90 days of the accident;
- injury sustained while perpetrating or attempting to perpetrate a criminal act.

Generally, no Short-term Disability benefit is payable if the disability begins during a strike, a lock-out, a temporary lay-off, an authorized leave of absence or imprisonment.

If disability occurs during a leave of absence taken in accordance with any provincial or federal law, a maternity leave, a parental leave or a preventive withdrawal during which this benefit has remained in force and the Short-term disability insurance premiums have been paid, the elimination period begins on the expected date of return to work, as notified to the Insurer in writing before the beginning of the absence and benefits will not be paid before the expiry date of the elimination period.

If disability occurs during any other leave of absence during which this benefit has remained in force and the Short-term disability insurance premiums have been paid, the elimination period begins on the expected date of return to work, as notified to the Insurer in writing before the beginning of the absence and benefits will not be paid before the expiry date of the elimination period.

Rehabilitation program

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

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

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

c) You are eligible to receive the indemnity payable under this benefit for a maximum period of 24 months in addition to receiving the remuneration payable under this Rehabilitation program.

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

Loss of the right to benefits

The right to receive benefits may be revoked, if:

- you refuse to undergo a medical examination requested by the Insurer;
- you refuse to participate in a medical or rehabilitation employment program judged reasonable and appropriate by both the Insurer and your attending physician;
- you fail to produce proof satisfying the Insurer of the persistence of disability;
- you engage in remunerative work (except for a rehabilitation employment program);
- you are outside Canada for a 90-day period or longer, unless you obtain prior approval from the Insurer through a written request.

Termination of benefit

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

If you are disabled when you retire, benefits will continue to be paid for a maximum of 15 weeks. For example, if you have been receiving benefits for 10 weeks when you retire, benefits will continue for another 5 weeks before ending entirely.

Long-term Disability Insurance

If your total disability persists beyond the expiry of the elimination period specified in the Benefit Summary, you may become eligible for Long-term Disability Insurance benefits. The first payment is due at the end of the month during which the elimination period expires and on the last day of every month afterwards. The benefit is equal to 1/30 of the month for each day of total disability.

Total disability

For the purpose of the Long-term Disability Insurance, **total disability** means:

- during the elimination period and the **24** months immediately following the elimination period, you are totally and continuously unable, as the result of an illness or accident, to perform the regular duties of your own occupation; and
- subsequently, you are totally and continuously unable, as the result of an illness or accident, from performing the regular duties of any occupation for which you are reasonably qualified by training, education or experience.

You must be under the continuous care of a physician.

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

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

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

Recurrence

Before completion of the Elimination period
Successive periods of total disability separated by less than two consecutive weeks of continuous active employment are considered one period of disability, unless the new disability is due to an illness or accident totally unrelated to the cause of the previous disability and commences only after your return to work for at least one entire day.

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

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

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

Rehabilitation program

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

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

b) If, while participating in such a rehabilitation program, you again become totally disabled, the terms and conditions of this benefit will apply to you once again, as if you had remained totally disabled during the rehabilitation employment program.

c) You are eligible to receive the indemnity payable under this benefit for a maximum period of 24 months in addition to receiving the remuneration payable under this Rehabilitation program.

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

Exclusions and limitations

Reduction of benefits

Monthly benefits are subject to two kinds of reductions:

1. **Integration of benefits**

   Monthly benefits are reduced by an amount equal to the disability benefits you are entitled to receive for yourself from

   - the Quebec Pension Plan or the Canada Pension Plan, excluding benefits payable on behalf of dependent children,
   - any occupational health and safety board,
   - any provincial automobile insurance bureau, and
   - any provincial crime victims compensation act.

2. **Co-ordination of benefits**

- If the amount of monthly benefits payable under this benefit, or
- if the monthly benefits payable (after any integration in accordance with point 1 above, if applicable) plus any income, compensation, indemnity and benefits from the following:
  - any government body,
  - any group insurance plan or pension plan to which the Employer contributes,
  - any other insurance contract

  exceeds **80%** of your Pre-disability salary, the monthly benefits payable hereunder shall be reduced as necessary so that such sum does not exceed this percentage.

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

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

Inasmuch, that the benefits payable under the present benefit are taxable, they will be calculated as follows:

- indemnity payable by the insurer,
- less federal and provincial taxes applicable, according to the Participant Covered Employee's personal exemption,
- less the indemnity payable by the government plan.

Limitations to the payment of benefits

If the total disability results from alcoholism or drug addiction, benefits are paid only if you:

- are under the care of a physician other than yourself, who is a specialist in the field related to your condition; and
- are undergoing an appropriate treatment, and
- are under a rehabilitation program deemed necessary by the Insurer.

In addition, no benefit is payable during the following periods:

- when you receive maternity benefits under any provincial or federal law;
- when you are on a maternity or parental leave taken in accordance with any provincial or federal law or any agreement between you and your employer.

If disability occurs during a leave of absence taking in accordance with any provincial or federal law, a maternity leave, a parental leave or both or a preventive withdrawal during which this benefit has remained in force and the Long-term disability insurance premiums have been paid, the elimination period begins on the expected date of return to work, as notified to the Insurer in writing before the beginning of the absence, and benefits will not be paid before the expiry date of the elimination period.

If disability occurs during any other leave of absence during which this benefit has remained in force and the Long-term disability insurance premiums have been paid, the elimination period begins on the expected date of return to work, as notified to the Insurer in writing before the beginning of the absence, and benefits will not be paid before the expiry date of the elimination period.

Generally, no Long-Term Disability benefit is payable if the disability begins during a strike, a lock-out, a temporary lay-off, an authorized leave of absence or imprisonment.

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

- voluntary injury, whatever your state of mind at the time of the incident;
- injury sustained during active participation in a civil commotion, riot or an insurrection, unless while performing the duties of your occupation;
- injury sustained during a war, whether declared or not,
- cessation of work to receive care which is not medically required or which is given for cosmetic purposes, unless such care is for accidental injury and commenced within 90 days of the accident;
- injury sustained while perpetrating or attempting to perpetrate a criminal act.

Loss of the right to benefits

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

- you refuse to undergo a medical examination requested by the Insurer;
- you refuse to participate in a medical or rehabilitation employment program judged reasonable and appropriate by both the Insurer and your attending physician;
- your disability no longer meets the contract definition;
- you fail to produce proof satisfying the Insurer of the persistence of disability;
- you engage in remunerative work, unless it is part of a rehabilitation employment program;
- you are outside Canada for a 90-day period or longer, unless you obtain prior approval from the Insurer through a written request.

Your benefits terminate the date you start receiving pension benefits from the Quebec or Canada Pension plan.

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

Termination of benefit

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

Extended Health Benefit - Drug Coverage

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

Deductible

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

Eligible expenses

Eligible expenses are any drugs that are included on the Insurer's **extended list** of drugs as defined below.

The Insurer's **extended list** of drugs consists of usual, customary and reasonable expenses for drugs or products available in Canada and dispensed by a pharmacist (or a duly authorized physician or dentist in areas where there is no pharmacist) and obtained on the written prescription of a physician, a dentist or a podiatrist, for use in respect of a pregnancy, an illness or injury and that do not exceed a 90-day supply.

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

Also included:

- Dispensing fees, subject to the maximum eligible amount per drug, mentioned in the Benefit Summary.
- Injections and serums prescribed by a physician to treat an illness. For varicose vein injections for medical purposes, only the cost of the injected drug is covered.
- Injectable B12 vitamins.
- Syringes, needles, lancet devices, pen needles, urine testing supplies, alcohol swabs, test strips for the control of diabetes, as well as an aerochamber and spinhaler.

Expenses not reimbursable by the plan

Incurred expenses for the following products or drugs are excluded:

- products for the care of contact lenses ∗;
- contraceptives (other than oral);
- drugs for the treatment related to fertility or infertility;
- proteins or dietary supplements, amino acids ∗;
- processed food for infants ∗;
- hygiene products, including soaps and emollients ∗;
- softeners and protective substances for the skin ∗;
- smoking cessation aids
- minerals ∗;
- homeopathic products ∗;
- hair growth stimulants;
- sexual stimulants, as well as drugs used to treat erectile dysfunction;
- anabolic steroids;
- growth hormones;
- drugs and injections for the treatment of obesity;
- food or nutritional supplements for the treatment of obesity, whether or not these are prescribed for a medical reason;
- drugs administered for experimental purposes;
- drugs used in surgery;
- vaccines;
- drugs and all forms of drugs without therapeutic indication and intended exclusively to improve the quality of life;
- mouthwashes, dressings, syrups and cough drops ∗;
- shampoos, oils, creams ∗;
- vitamins (with the exception of injectable B12 vitamin) and multivitamins ∗;
- prenatal supplements or vitamins ∗.

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

<u>Furthermore, the following services are not covered.</u>

- All expenses incurred due to an illness or accident covered under any occupational health and safety board or any automobile insurance plan, if applicable.
- Services, treatments or products received free of charge by the Participant.
- Expenses for drugs that are eligible under the TRAVEL INSURANCE benefit.

- Eligible charges incurred directly or indirectly because of
  - intentionally self-inflicted injuries (including suicide attempt), whether the Participant was sane or not;
  - active participation in a civil commotion, riot or insurrection, or injury sustained during war, whether war be declared or not.

Termination of coverage

The Drug coverage ends at your retirement or termination of employment whichever occurs first. The coverage for eligible dependents ends when your Drug Insurance benefit terminates (but not upon your death) or on the date they no longer meet the definition of dependent, whichever occurs first.

Survivors' benefits

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

- 24 months after the date of your death
- the date they cease to be eligible dependents
- the effective date of any similar coverage with another Insurer, or
- the termination date of the group contract.

Extended Health Benefit - Accident/Sickness Coverage

This insurance covers eligible expenses incurred by you or your dependents as the result of an illness, pregnancy or accident, subject to the deductible and the percentage of reimbursement specified in the Benefit Summary, providing eligible expenses are incurred in Canada.

Deductible

The deductible is, if any, the portion of eligible expenses that you must pay for you and your dependents before the Insurer begins to reimburse expenses eligible under this contract.

Eligible expenses

The expenses must be:

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

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

HOSPITALIZATION

- Short stay

  These benefits are paid to Participants admitted as inpatients in a Hospital for **active care** after their effective date of coverage and for as long as they are entitled to insured services under the Medicare program in his province of residence. Benefits are paid up to the preferred accommodation that is mentioned in the Benefit Summary.

- Convalescent care

  Charges for convalescent care shall be reimbursed for as long as the Participant is entitled to Insured services, and up to a daily maximum and a maximum of days for all periods of hospitalization during a 12 months period, as specified in the Benefit Summary.

  These benefits shall be payable only if the Participant is admitted in the convalescent care facility less than 14 days after his discharge from a Hospital where he received Active care of at least 3 days, provided he was admitted there after the effective date of his coverage.

- Hospitalization benefits for chronic care

  Charges for chronic care shall be reimbursed for as long as the Participant is entitled to Insured services, and up to a daily maximum and a maximum of days for all periods of hospitalization during a calendar year, as specified in the Benefit Summary.

PARAMEDICAL SERVICES
(The following do not require prior medical recommendation)

Charges are paid up to the maximum amount payable per visit and the maximum amount payable per calendar year mentioned in the Benefit Summary. Maximums apply either to each type of professional or to all of them together, according to the specifications in the Benefit Summary. The health professional may not be a member of your family, nor reside with you:

Chiropractor (including X-rays), dietician, massage therapist, physiotherapist, podiatrist (including X-rays), psychologist (excluding psychological evaluations), rehabilitation therapist, social worker and speech therapist.

MEDICAL SUPPLIES AND SERVICES

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

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

  Dental care following an accident
  Services of a dentist when required to repair or replace sound natural teeth following an accidental blow to the mouth received while the person is insured hereunder, but not due to an object or food being wittingly or unwittingly placed in the mouth, subject to the maximum amount payable per accident mentioned in the Benefit Summary. There will be no reimbursement for treatments performed more than 12 months after the date of the accident.

  The eligible amounts are determined according to the suggested ***Fee Guide for Dental Services*** **approved by the** ***Dental Surgeons' Association*** of the Participant's province of residence.

- **Diagnostic tests**
  Charges for the following diagnostic tests, when they are medically necessary:
  - laboratory analyses, X-rays, Electrocardiograms, Computer-assisted tomography (CT Scan), Ultrasounds and Magnetic Resonance Imaging (MRI).
- **Orthopedic shoes and podiatric ortheses**
  Subject to the combined maximum amount payable mentioned in the Benefit Summary:
  - Charges for the purchase of orthopaedic shoes.
  - Charges for the purchase of podiatric ortheses to accommodate, relieve, or remedy some mechanical foot defect or abnormality.
  - The cost of modifying a regular shoe or the cost of purchasing, repairing, modifying or adjusting an insert or device added to regular shoes.
- **Medical elastic stockings**
  The purchase of medical elastic stockings, prescribed for the treatment of varicose veins, following severe burns or surgery, subject to the maximum amount payable specified in the Benefit Summary.
- **TENS**
  Charges for the purchase of a transcutaneous electrical nerve stimulator (TENS), subject to the lifetime maximum amount payable specified in the Benefit Summary.
- **Blood glucose monitor**
  Charges for the purchase of a blood glucose monitor for an insulin-dependent diabetic Participant, subject to the maximum amount payable mentioned in the Benefit Summary.
- **Hearing aids**
  Charges for the initial purchase, replacement or repair of hearing aids or any related devices (with the exception of batteries) and for the professional services given by a hearing aid acoustician following the purchase are eligible, provided they have been prescribed by a physician, audiologist or speech therapist, subject to the combined maximum amount payable mentioned in the Benefit Summary.
- **Speech aids**
  Charges for speech aids such as Bliss boards and laryngeal speaking aids, when no alternative method of communication is possible, subject to the lifetime maximum amount payable mentioned in the Benefit Summary.

- **Prostheses**
  - Charges relating to other **artificial limbs and eyes and palate obturators**, if the loss occurred while the insured is covered.
  - Charges for the purchase of a **myoelectric arm**, subject to the maximum amount payable mentioned in the Benefit Summary.
  - Charges for the purchase of **capillary prostheses** required after chemotherapy, subject to the lifetime maximum amount payable mentioned in the Benefit Summary.
  - Charges for the purchase of **breast prostheses**, subject to the maximum amount payable mentioned in the Benefit Summary.
  - Charges for the purchase of **surgical brassieres** when required following a mastectomy, subject to the maximum amount payable mentioned in the Benefit Summary.
- **Mobility aids and orthopaedic appliances**
  - Charges for the purchase or rental of a **hydraulic patient lifter**, subject to the maximum amount payable mentioned in the Benefit Summary. The Participant must obtain the prior approval from the Insurer before any purchase or rental, otherwise the claim may be rejected.
  - Charges for the purchase or rental, at the Insurer's option, of a wheelchair, up to the usual cost of a standard manual **wheelchair** (excluding electric wheelchairs except for quadriplegics). The Participant must obtain the prior approval from the Insurer before any purchase or rental, otherwise the claim may be rejected.
  - Charges for the purchase or rental of crutches, canes and walking aids, as well as charges for hernial belts, casts, orthopaedic devices (including lumbar supports, splints, shoulder harnesses, head halters, traction apparatus, cervical collars and prone standers) other than orthopaedic shoes and podiatric apparatus. Orthopaedic devices must be purchased through a known orthopaedic supplier authorized under the provincial health and welfare ministry.
  - Charges for the purchase or rental of an **outdoor access ramp**, subject to the lifetime maximum amount payable mentioned in the Benefit Summary. The Participant must obtain the prior approval from the Insurer before any purchase or rental, otherwise the claim may be rejected.

- **Major medical equipment**
  For all the following eligible items, the Participant must obtain prior approval from the Insurer before any purchase or rental, otherwise the claim may be rejected.

  - Charges for the purchase or rental, at the Insurer's option, of a **hospital-type bed** for bedridden patients, up to the usual cost of a standard manual bed.
  - Charges for insulin pumps and supplies, compression pumps, percussors, suction pumps.
  - Charges for BiPAP, CPAP, VPAP and ventilators (including supplies).
  - Charges for the purchase of a pressurized insulin injector.
  - Charges for the purchase of traction equipment.
  - Charges for therapeutic appliances (excluding batteries) including an external electrospinal stimulator for the correction of scoliosis, extremity pumps for lymphoedema or severe postphlebitic syndrome, aerosol equipment, mist tents and nebulisers for cystic fibrosis, acute emphysema, chronic obstructive bronchitis or chronic asthma, and drainage boards, sputum stands and tracheostoma tubes.

  Major medical equipment means an appliance currently used according to the manufacturer's standards and recognized as specifically for the immediate treatment of a pathological condition following an illness or an accident, such as appliances for the control of pain, extended physiotherapy and the administration of medication, respiratory assistance and diagnostic devices.

  Exclusions

  - Articles that are not primarily medical in nature or are for comfort or commodity (e.g. domestic accessories such as whirlpools, air purifiers, humidifiers, air conditioners and other similar appliances).
  - Appliances used by a physician to administer treatment or diagnostic aids (e.g. stethoscopes, sphygmomanometers and other similar appliances).
  - Support articles of any nature (e.g. "Obus form" cushions, belts and corsets).

- **Other medical services and supplies**
  - Charges for oxygen and the purchase or rental of appliances for the administration thereof. The Participant must obtain prior approval from the Insurer before any purchase or rental, otherwise the claim may be rejected.
  - Charges for the purchase of burn pressure garments.
  - Charges for ostomy supplies.
  - Charges for stump socks.
  - Charges treatments by x-rays, radium and radio-active isotopes.

VISION CARE

- **Eye examination**
  Charges for eye examinations by an ophthalmologist or optometrist, for Participants age 18 to 64 inclusively, subject to the maximum amount payable mentioned in the Benefit Summary.
- **Eyeglasses and contact lenses**
  The cost of eyeglasses (frames and lenses) and contact lenses, when prescribed by an ophthalmologist or optometrist. The cost of laser surgery is also included in the combined maximum amount payable for the continuous period mentioned in the Benefit Summary.

  The cost of eyeglasses or contact lenses, following cataract surgery, provided these expenses are incurred before age 65, subject to the combined maximum amount payable mentioned in the Benefit Summary.

  Specific exclusions
  Expenses incurred for safety glasses and sunglasses are excluded but the costs of tinting, photograying and hardening of lenses are covered.

General exclusions

The following expenses are not reimbursed under the plan:

- medical care to which the Participant is entitled under any federal or provincial government legislation or that is covered under such legislation, including charges payable under any occupational health and safety board, or any automobile insurance plan, or any other similar law or public plan, if applicable;
- medical care that was covered under the above mentioned legislation or plans at the time this benefit was issued and subsequently was modified, suspended or discontinued;
- services, treatments or supplies received free of charge;
- services, treatments or supplies that are experimental in nature;

- preventive care;
- cosmetic prostheses;
- surgery or treatment which is not medically required and which is given for cosmetic purposes or for any reason other than curative, or which exceeds ordinary surgery or treatment given in accordance with current therapeutic practice, and surgery or treatment which is given in relation to an operation or treatment of experimental nature;
- services of a nurse, at home, when acting as a midwife or psychotherapist, or when services other than nursing care are provided;
- dental services, with the exception of treatment rendered after an accident;
- all processes relating to family planning, including intrauterine contraceptive devices (IUD), artificial insemination and laboratory, or any other charges incurred in any infertility treatment, regardless as to whether infertility is considered to be an illness or not;
- all charges incurred for a vasectomy or for tubal ligation;
- all charges, services, articles or supplies that do not appear on the above Eligible Expenses list;
- charges for psychological evaluations;
- all charges that would not have been made if no insurance coverage had existed;
- charges for any care, treatment, services or supplies other than those declared necessary for the treatment of an injury or illness;
- charges incurred outside Canada;
- charges for rest cure or travel for reason of health;
- charges for services eligible under the Travel benefit;
- eligible charges incurred directly or indirectly because of
  - intentionally self-inflicted injuries, whether the Participant is sane or not;
  - active participation in a civil commotion, riot or insurrection or injury sustained during warm whether war be declared or not;
  - perpetration or attempt to perpetrate a criminal act.

Termination of Benefit

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

Conversion privilege

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

This conversion privilege also applies to your dependents.

Survivors' benefits

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

- 24 months after the date of your death
- the date they cease to be eligible dependents
- the effective date of any similar coverage with another Insurer, or
- the termination date of the group contract.

Extended Health Benefit - Travel Coverage

Purpose of coverage

All customary and reasonable expenses and services described in the Hospital and medical travel insurance are eligible if they are incurred following an emergency which occurs during the **Eligible period** of a trip outside the Participant's province of residence, as indicated in the Benefit Summary, provided the Participant is covered under the hospital and health government programs of his province of residence when emergency occurs.

Eligible treatments shall be deemed to be those necessary to stabilize the Participant's medical condition, and the benefits provided are over and above and may not be a duplication or substitution of benefits granted by government programs.

Expenses under this benefit are reimbursed up to a lifetime maximum per Participant of $5,000,000.

Benefits are paid to the covered employee.

Specific definition

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

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

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

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

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

General provisions

1) Refund condition

For reimbursement purposes, the eligible expenses described in the Travel Insurance section must be incurred with the prior approval of Canassistance Inc.

2) Repatriation

In the absence of medical contra-indication, the Insurer may require repatriation of any Participant or transfer to other medical facilities. Refusal by the Participant cancels all rights to benefits.

3) Method of payment

The Insurer shall make any refund by means of a cheque in the name of the provider of services and/or the covered employee or assignee, after receiving and assessing the relevant invoices and the necessary information pertaining thereto, in accordance with the terms and conditions provided herein. However, in all cases, the Insurer reserves the right to pay the provider of services directly.

Any amount paid by the Insurer or on its behalf relieves the Insurer of all obligations, to the extent of such amount.

4) Interest

No sum payable for Travel Insurance shall bear interest.

5) Responsibility limit

The Insurer and Canassistance Inc. are not responsible for the availability or quality of medical and Hospital care provided, nor for the unavailability of such care.

Eligible expenses

1) Hospital, medical and paramedical expenses

a) Hospitalization
The cost of Hospital services in a semi-private or private room that exceeds the amount refunded or refundable under the government health program in the Participant’s province of residence.

b) Incidental expenses
Expenses inherent (telephone, television, parking, etc.) to hospitalization, upon presentation of documentary proof, up to a maximum of $100 per hospitalization.

c) Physicians' fees
The difference between the fees charged by a Physician and the benefits provided under the government health program in the Participant’s province of residence.

d) Medical appliances
The purchase or rental cost of crutches, canes or splints and the rental cost of standard manual wheelchairs, orthopaedic devices and other medical appliances, when prescribed by the attending Physician.

e) Nursing care
Fees of a Registered Nurse (other than a relative) for private care while hospitalized and when medically necessary and prescribed by the attending Physician.

f) Diagnostic services
Charges for laboratory tests and X-rays when prescribed by the attending Physician.

g) Drugs
The cost of drugs prescribed by a Physician when they are required for an emergency treatment.

h) Accidental Dental
Fees of dental surgeons for treatment required when, as the result of an external injury (and not due to an object wittingly or unwittingly placed in the mouth), natural, sound and previously untreated teeth are damaged or when it is necessary to reduce a fracture or dislocation of the jaw. In all cases, treatment must begin during the period of coverage and end within 6 months of the Accident. The maximum refund is $2,000 per Accident per Participant.

Fees of a dental surgeon for any other emergency treatment required to relieve pain are reimbursed up to a maximum of $200 per Participant.

2) Transportation expenses

The following services must be approved and planned by Canassistance Inc.

a) Ambulance service
The cost of ground or air ambulance for transportation to the nearest qualified medical facility including inter-Hospital transfer, when the attending Physician and Canassistance Inc. determine that existing facilities are inadequate to treat or stabilize the patient's condition.

b) Repatriation to the province of residence
The cost of repatriating the Participant to the province of residence by means of appropriate transportation to receive immediate medical attention, following authorization of the attending Physician and Canassistance Inc.

The cost of simultaneously repatriating a travelling companion or any member of the Participant's immediate family who is also covered under the Hospital and medical travel insurance, if he is unable to return to the departure point by means of the transportation initially planned for such return.

c) **Transportation to visit the Participant**
The economy class round-trip fare for transportation of a family member going to

- the Hospital where the Participant has been confined for 7 days or more (requires the attending Physician's written acknowledgement that the attendance was necessary), or
- to identify the deceased, where required, prior to disposal of the body.

d) **Return of the vehicle**
The cost of returning the Participant 's vehicle, either private or rental, by a commercial agency, to the Participant 's residence or nearest appropriate vehicle-rental agency, when the Participant is unable to drive due to an Illness or an Accident, subject to a maximum refund of $1,000. A medical certificate is required from the attending Physician in the locality where the incapacity occurred, stating that the Participant is incapable of using the vehicle.

e) **Disposal of the deceased**
Up to $7,500 for the cost of preparing and transporting the mortal remains to the departure point in the province of residence (excluding the cost of a coffin), or for the cost of cremation or burial at the place of death.

3) **Subsistence allowance**
Up to $3,000 (maximum of $150 per day for up to 20 days) for accommodation and meals in a commercial establishment, when the Participant 's return must be delayed due to Illness or bodily injury to himself, or to an accompanying member of his immediate family, or to a travelling companion.

4) **Travel Assistance (Canassistance Inc.)**

a) **Medical assistance**
The Insurer provides the Participant, through Canassistance, with a toll free emergency hotline, 24 hours a day, 7 days a week, to assist him if he must consult a Physician or requires hospitalization following an Accident or sudden Illness. Canassistance will intervene where required and provide the following supportive services:

- for the State of Florida, direct the Participant to an appropriate clinic or Hospital in the Preferred Patient Care network;
- for the State of South Carolina, direct the Participant to an appropriate clinic or Hospital in the Preferred Personal Care network;
- for all other destinations, direct the Participant to an appropriate clinic or Hospital and advance funds to the Hospital, if necessary;

- confirm the medical insurance coverage to spare the Participant a substantial monetary deposit;
- ensure a follow-up of the medical file and communicate with the family Physician;
- repatriate the Participant to the province of residence, when necessary;
- co-ordinate the safe return home of dependent children, if the Participant is hospitalized;
- make the necessary arrangements for transporting a family member to the patient's bedside if the Participant is hospitalized for at least 7 days and if the attending Physician advises such attendance;
- co-ordinate the return of the Participant's vehicle if he is unable to bring it back due to an Illness or Accident.

b) General assistance

In emergency situations, the Insurer shall also provide the Participant with the following services, via Canassistance Inc.:

- toll-free assistance lines available 24 hours a day and 7 days a week
- transmittal of urgent messages
- co-ordination of claims
- services of an interpreter for emergency calls
- referral to legal counsel in the event of a serious Accident
- settlement of formalities in the event of death
- assistance in the event of loss or theft of identity papers
- information regarding embassies and consulates

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

Exclusions and reductions

No benefits are paid in the following cases:

1) All expenses incurred following an emergency situation that occurred after the first 90 days of the trip.

2) Expenses incurred after the Participant has been repatriated by the Insurer for medical reasons.

3) Expenses incurred due to pregnancy or complications arising from it within 8 weeks prior to the expected date of delivery.

4) Accident sustained while participating in a sport for remuneration, any kind of motor-vehicle or speed contest, gliding or hang-gliding, mountain climbing (trails graded 4 or 5 according to the Yosemite Decimal System – YDS), parachuting or skydiving, and bungee jumping.

5) Abuse of medication or use of drugs, and driving a motor vehicle, an aircraft or a boat while under the influence of drugs or with an alcohol level exceeding 80 milligrams per 100 millilitres of blood.

6) Suicide, attempted suicide or self-inflicted injury, whether the Participant is sane or not.

7) War (declared or not), invasion, acts or attacks of foreign enemies, hostilities or conflicts between nations, civil war, guerrilla warfare, military campaign or operation, revolt, rebellion, insurrection, riot, public commotion or upheaval, public disorder, mutiny, piracy, coup d'état, terrorism, threat of terrorism, attacks of all natures, violence with an aim of achieving a political goal.

   Notwithstanding the preceding paragraph, the above-mentioned events are not excluded for covered employees who are on business trips for the Policyholder, subject to an overall maximum of $600,000 per event for all Participants involved by such event.

8) Trip in any country for which the Canadian government has issued a recommendation to the effect that Canadians should not travel in such country, when the recommendation has been issued before the Participant's departure.

   Notwithstanding the preceding paragraph, the above-mentioned trip is not excluded for employees who are on business trips for the Policyholder, subject to an overall maximum of $600,000 per trip for all Participants involved in such a trip.

9) Committing or attempting to commit a criminal act, whether directly or indirectly, under any legislation.

10) Expenses for any care, treatments, products or services other than those declared by the appropriate authorities to be necessary to treat the injury or disease or to stabilize the medical condition.

11) Nurses' fees for custodial care or services rendered mainly for the patient's convenience.

12) Expenses incurred for cosmetic purposes.

13) Expenses incurred outside the Participant's province of residence, when such expenses could have been incurred in the province of residence without endangering the life or health of the Participant, with the exception of expenses for treatment that is immediately necessary following an emergency due to an Accident or sudden Illness. Under this exclusion, the fact that the treatment available in the province of residence could be of lesser quality than the treatment available outside the province of residence does not constitute a danger for the Participant's life or health.

    Without restricting the generality of this exclusion, no benefits are available under this plan for any Participant travelling outside the province of residence primarily or incidentally to seek medical advice or treatment, even if such a trip is on the recommendation of a Physician.

14) Medical or Hospital costs incurred outside the Participant's province of residence that are not eligible covered under the government health program in such province.

15) The following products are not covered under this plan, even when obtained with a prescription:

    Processed food for infants, dietary or food supplements or substitutes of any kind, including proteins, so-called natural food stuffs, multivitamins and over the counter drugs, antacids, digestives, laxatives, antidiarrheals, decongestants, cough syrups, expectorants and any other flu or cold medications, gargles, oils, shampoos, lotions, soaps and all other dermatological products.

16) All expenses refunded or liable for refund through the government health program in the Participant's province of residence.

17) The insurer reserves the right to deny a claim linked to a medical consultation or hospitalization for which the Participant has failed to contact Canassistance incurring expenses.

Termination of Travel Coverage

The Travel benefit ends at your retirement, the termination of your employment or when you reach age 70, whichever occurs first. Coverage for your dependents 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.

Coverage for any Participant ceases when he is no longer covered under the government health program in his province of residence.

Survivors' benefits

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

- 24 months after the date of your death
- the date they cease to be eligible dependents
- the effective date of any similar coverage with another Insurer, or
- the termination date of the group contract.

TRAVEL ASSISTANCE LINES

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

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

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

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

Dental Care Coverage

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 specialist, or
- a denturist, when such services are within the scope of his abilities.

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

Calculation of eligible expenses

The eligible amount for insured services shall be the amount indicated in the **Suggested Fee Guide for Dental Services** approved by the **Ontario Dental Surgeons' Association Fee Guide** or, for a denturist, the **Ontario Fee Guide for Denturists,** as per the edition year mentioned in the Benefit Summary. If no fee is indicated, the eligible amount must be determined by prior agreement with the Insurer. In the absence of prior agreement, any settlement by the Insurer shall be final and without appeal.

Expenses incurred for treatment provided by a specialist are limited to the normal suggested fee for general practitioners in Ontario.

Deductible

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

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

Eligible expenses

1) PREVENTIVE CARE

   a) Polishing, scaling and fluoride
      - polishing twice a year
      - scaling: limited to a maximum combined with periodontal root planning of 6 time units a year (a time unit is considered to be a 15-minute interval or any portion of a 15-minute interval).
      - topical application of fluoride twice a year

   b) Sealants
      - pit and fissure sealants on bicuspids and permanent molars, once every 5 years

   c) Space maintainers
      - acid etched pontic type space maintainers are covered only when provided for missing central and lateral teeth
      - maintenance of space maintainers

   d) Other services
      - appliances for the control of harmful habits, including related observations, adjustments, repairs, alterations and removal
      - finishing restorations
      - interproximal disking
      - recontouring of teeth

      Limitations: No benefits will be paid for

      - custom fluoride appliances
      - oral hygiene instructions
      - nutritional counselling

2) BASIC CARE

   a) Examinations
      - one complete oral examination every 3 years
      - oral pathology, periodontal, surgical, prosthodontic and endodontic examinations
      - limited oral examinations twice a year, except that only one limited oral examination is covered in any year that a complete oral examination is also performed
      - limited periodontal examinations twice a year
      - specific and emergency examinations

b) Radiographs
- complete series of intra-oral radiographs, once every 3 years
- intra-oral radiographs to a maximum of 15 films every 3 years and a panoramic radiograph every 3 years; services provided in the same year as a complete series are not covered
- sialography
- extra-oral radiographs other than panoramic and sialography
- radiopaque dyes used to demonstrate lesions
- interpretation of radiographs or models from another source

c) Tests and laboratory reports**
- microbiological, histological, cytological and pulp vitality tests
- laboratory reports

**No benefits will be paid for duplicate radiographs under this provision.

d) Minor restorative services
- caries, trauma and pain control
- amalgam and tooth-coloured fillings; replacement fillings are covered only if the existing filling is at least 2 years old or the existing filling was not covered under this plan
- retentive pins and prefabricated posts for fillings
- prefabricated crowns for primary teeth

e) Oral surgery
- removal of teeth
- surgical exposure of teeth
- the following procedures for remodelling and recontouring oral tissues:
  i) minor alveolosplasty
  ii) gingivoplasty and stomatoplasty
- surgical incisions
- surgical excision of tumors, cysts and granulomas
- treatment of fractures, including related bone grafts to the jaw
- treatment of maxillofacial deformities, including related bone grafts to the jaw and cheiloplasty

Palatal obturators, although not listed with oral surgery in the Canadian Dental Association Uniform System of Coding and List of Services, are also covered under this provision. Cleft palate obturators are not covered.

Limitations: No benefits will be paid for
- implantology
- surgical movement of teeth
- services performed to remodel or recontour oral tissues, other than those listed above
- alveoloplasty or gingivoplasty performed in conjunction with extractions

f) Adjunctive services
  - minor remedies for relief of dental pain when provided on an emergency basis
  - therapeutic injections
  - anesthesia required in relation to covered services; the provision of general anesthetic facilities, equipment and supplies is covered only when a separate anesthetist is required

  Specific exclusion: No benefits will be paid for hypnosis or acupuncture.

3) ENDONTIC TREATMENTS (excluding endodontic appliances)

4) PERIODONTICS

  a) Periodontal treatments

  b) Periodontal appliances

5) MAJOR RESTORATION

  a) Provision of crowns (other than stainless steel), inlays, onlays and caps

  b) Provision of an initial prosthodontic appliance (e.g. fixed bridge restoration, removable partial or complete dentures)

  c) Replacement of an existing prosthodontic appliance, if:
    - The replacement appliance is required because at least 1 additional natural tooth was necessarily extracted after the date the existing appliance was installed, and the existing appliance cannot be made serviceable. If the existing appliance can be made serviceable, only the expenses for that portion of the replacement appliance which replaces the extracted teeth shall be covered.
    - The replacement appliance replaces an existing appliance which is at least 5 years old and cannot be made serviceable.
    - The replacement appliance replaces an existing appliance which was temporarily installed after the date the Covered employee first became covered under this benefit provision in respect of the Participant requiring the replacement appliance; in this event, such replacement appliance shall be considered a permanent (as opposed to temporary) installation.
    - The replacement appliance is required as the result of the installation of an initial opposing denture after the date the employee became covered under this benefit provision in respect of the Participant requiring the replacement appliance.
    - The replacement appliance is required as the result of an accidental dental injury which occurs after the date the Covered employee first became covered under this benefit provision in respect of the Participant requiring the replacement appliance.

d) Repairs to bridgework

e) Adjustments to bridgework after the 3-month post-insertion care period

f) Procedures involving the use of gold if such treatment could have been rendered at a lower cost by means of a reasonable substitute consistent with generally accepted dental practice.

   If such treatment could have been rendered at lower cost by means of a reasonable substitute, only the expense that would have been incurred for treatment by means of the reasonable substitute shall be covered.

Proposed dental treatment in excess of $500

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

Expenses not covered by the plan

1) The following expenses are not covered:

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

   b) services rendered by a dental hygienist but not administered under the supervision of a dentist;

   c) dental services eligible under the Accident/Sickness coverage or any other group insurance contract;

   d) services or supplies associated with myofacial pain;

   e) services and supplies relating to any appliance worn in the practice of a sport;

   f) expenses that are paid under a public plan or that would normally be so if a claim had been submitted;

   g) charges eligible under an occupational health and safety board or by an automobile insurance bureau, or any other similar law or public plan, if applicable;

   h) expenses resulting from any suicide attempt or self-inflicted injury, whether the Participant was sane or not;

   i) expenses due to any injury resulting from any active participation in civil unrest, riot, insurrection or injury sustained in a war, whether war be declared or not, or participation in a riot;

j) services that are not medically required, that are given for cosmetic purposes or that exceed the ordinary services given in accordance with current therapeutic practice;

k) care or services related to implants;

l) care or services rendered free of charge, or that would be if the Participant had no coverage;

m) splinting for periodontal reasons, where cast crowns or inlays are used for this purpose, with or without onlays;

n) all charges, services, articles or items that are not included on the list of Eligible Expenses described in this benefit;

o) dentures which have been lost, mislaid or stolen;

p) services, treatment or supplies that are experimental in nature;

q) the amount of benefits is reduced by any benefit that is payable or reimbursable under a government plan, a group plan or an individual plan, or that would have been payable had the Participant submitted a claim.

2) Restriction

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

Reimbursement of laboratory fees will be limited to the usual, customary and reasonable charges for such services in the area where the services are provided. However, in no event will the total reimbursement of laboratory fees exceed 60% of the suggested fee in the appropriate fee guide for the particular dental treatment requiring laboratory services.

Termination of Benefit

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

Survivors' benefits

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

- 24 months after the date of your death
- the date they cease to be eligible dependents
- the effective date of any similar coverage with another Insurer, or
- the termination date of the group contract.

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