Northern Communications Services Inc.

All Eligible Sales Representatives

Your Group Benefits Booklet
with updates January 01, 2018

Arranged & Administered by:

DIBRINA SURE
Benefits Consulting (2011) Inc.

DIBRINA SURE
Financial Group Inc.

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Wealth Management Inc.

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Human Resources Inc.

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INTRODUCTION

To avoid any misunderstandings, this Plan is designed to assist with expenses currently not covered by your government Plan. However, if the government does cut back on health care benefits, the Northern Communications Services Inc. ("Company") benefits Plan ("this Plan") will not automatically pick up where the government program leaves off.

The information provided in this booklet is based on official plan documents. The descriptions do not create or confer any contractual or other rights upon any Member or Dependent. While every effort has been made to ensure the accuracy of this booklet, all rights with respect to the benefits of a Member or Dependent to coverage under this Plan will be governed solely by the official Company Plan and/or the master policies issued by the coverage provider(s) from time to time. The rights with respect to Provincial Hospital/Medical Plan Benefits will be governed by the appropriate legislation of the various provinces.

Although the Company intends to maintain this benefits Plan in the future, without restriction, the Company reserves the unilateral right to amend, limit, reduce and/or eliminate any of the current or post retirement benefits with or without notice, except as required by law, at any time in its absolute discretion.

IT IS YOUR RESPONSIBILITY TO UNDERSTAND THE TERMS, CONDITIONS, LIMITATIONS AND EXCLUSIONS OUTLINED IN THIS BOOKLET.

About This Booklet

This booklet provides details on benefits that may or may not be payable and outlines the terms, conditions, limitations and exclusions that may apply to your coverage.

About Definitions

Certain capitalized words found throughout this booklet are defined under the ***Definitions*** section of this booklet to provide further clarity.

Amendment

Although the Company intends to maintain this Plan in the future, without restriction, the Company reserves the unilateral right to amend, limit, reduce and/or eliminate any of the current benefits with or without notice, except as required by law, at any time in its absolute discretion.

About This Plan

Conformity with Law

If any provision of this Plan conflicts with any law which applies to individuals outlined in the Covered Class above, this Plan will be amended to conform to that law.

Making Changes

To ensure that coverage is kept up-to-date for the Employee and his/her eligible dependent(s), the Employee is obligated to report any changes to the Company by completing a change form. These changes could include:

- Addition or deletion of child(ren)
- Addition or deletion of spouse/common-law spouse
- Change in Address
- Change in the employee's name or change in the employee's dependents' name(s)
- Change of coverage

Participation in the Group Benefits Plan

The Employee's participation in this Plan is mandatory.

Evidence of Insurability

The Carrier/Adjudicator may request certain evidence of insurability from you. This evidence of insurability allows the Carrier/Adjudicator to determine whether or not it can approve your application for benefits and, if so, under which terms and conditions.

Effective Date of the Employee's Benefits

If the Employee is eligible for benefits, he/she must complete and return to the Plan Administrator an application for benefits. If the Plan Administrator receives this application for benefits within 31 days following the date he/she becomes eligible for benefits, the Employee's coverage will become effective on the date he/she becomes eligible for benefits. Otherwise, the Employee will be required to provide evidence of insurability and his/her benefits will become effective on the date the applicable Carrier(s)/Adjudicator(s) accepts this evidence.

(The next two paragraphs will apply to the Life and Long Term Disability benefits)

However, if the employee was not actively at work on the date his insurance would otherwise become effective, the insurance will not take effect until the earliest date thereafter on which he is again actively at work.

Any amount of insurance which is in excess of the non-evidence maximum(s) specified in the Summary of Benefits will not take effect until the date the insurer receives and approves the employee's evidence of insurability. If the employee's evidence of insurability should not be approved by the insurer, any future increases in the non-evidence maximum(s) will not automatically result in an increase in the employee's insurance. The increase in the non-evidence maximum(s) will only result in an increase in the employee's insurance if he submits evidence of his insurability and it is approved by the insurer.

Effective Date of Benefits for the Employee's Spouse and Children

If the Employee's spouse and children are eligible for benefits, an application for benefits must be completed, and returned to the Plan Administrator. If the Plan Administrator receives the application for benefits within 31 days following the date they become eligible for benefits, their coverage will become effective on the date they become eligible for benefits. Otherwise, they will be required to provide evidence of insurability and their benefits will become effective on the date the applicable Carrier(s)/Adjudicator(s) accepts this evidence.

If the Employee already has family coverage, benefits for an additional child will become effective automatically on the date the child meets the definition of a dependent child. At no time may benefits for the Employee's spouse and dependent children become effective before the Employee's own benefits comes into force.

(The next paragraph will apply to the Life benefits)

However, if the dependent is hospitalized on the date his insurance would otherwise become effective, the insurance will not take effect until the earliest date thereafter on which he is no longer hospitalized. (This clause shall not apply to the Life Insurance benefit or in the case of a newborn child.)

Time Benefits Becomes Effective

Any date specified in the context of this Plan is deemed to commence at 00:01 in the time zone of the Employee's place of residence.

Eligibility

Member Eligibility

In order to be eligible for benefits coverage under this Plan an Employee must satisfy the following conditions:

1) The Employee must complete ninety (90) working days of employment.

In addition, the Employee must fulfill the following requirements:

1) The Employee must be actively working for the Company on a regular and permanent full-time basis for a minimum of twenty-five (25) hours per week;
2) The Employee must be a full-time resident of Canada;
3) The Employee must be under age 65 for all benefits; and
4) The Employee must be covered under the Provincial Hospital and/or Medicare Plan of the Employee's province of residence (this is only applicable to the Extended Health Care benefit).

However, an employee will not be eligible to become insured under the Long-Term Disability Income Insurance benefit if he will attain age 65 before the end of the elimination period specified for the benefit under the Summary of Benefits.

If the Employee is absent from work on that first day due to a sickness or injury, coverage will begin when he/she returns to work. The Employee must complete an enrolment application form supplied by the Company for the Employee and any eligible Dependents.

Dependent Eligibility

An Employee's dependent(s), as defined in the ***Definitions*** section of this booklet, may be covered for the benefits for which dependent coverage is included. If an Employee and their spouse are both employed at Northern Communications Services Inc. and eligible for benefits with family coverage, they can submit under both individuals and the plan will be coordinated to achieve a co-pay to a maximum of 100% for health and dental benefits.

For verification of Dependent eligibility Canada Revenue Agency (CRA) documentation may be required.

The Employee's Dependents become eligible for coverage at the later of the following dates:

1) The day on which the Employee becomes eligible.
2) The day following 12 continuous months after a person is first reported to the Company as the Employee's common-law Spouse[1].
3) The day on which the Employee has a Dependent for the first time.

(The following will apply to the Life benefits)

A person will become eligible to be insured under the group policy as a dependent on the date (his "eligibility date") on which he satisfies the following conditions:

1) He satisfies the definition of dependent as defined in the ***Definitions*** section of this booklet.
2) He is a full-time resident of Canada.
3) The employee of whom he is a dependent has become eligible to be insured under the group policy.

Late Applicants

If the Employee's application for coverage is received by the Company more than thirty-one (31) days after the Employee's eligibility date, the Employee and his/her eligible Dependent(s) must provide satisfactory medical evidence of insurability, at no expense to the Carrier(s)/Adjudicator(s). Coverage will be offered only after written approval is provided by the applicable Carrier(s)/Adjudicator(s).

Eligibility Audits

From time to time DiBrina Sure Benefits Consulting, the administrator of Northern Communications Services Inc.'s group benefits program, may request from Employees documentation to substantiate the eligibility of an Employee's Dependents. Employees are obligated to provide this information and will be provided with a reasonable notice and time period in which to respond. Those Employees that do not respond after a given time period will be sent a final 30-day notice in which to send the requested information. Failure to provide the requested information will result in the Employee's ineligible Dependents being removed from the program. If at a later date the Employee provides the requested information, any eligible Dependents will be reinstated into the program, however, any expenses incurred in the period in which the Dependent was removed from the program will not be eligible under this Plan.

[1] Common-law Spouse as used in this definition will mean an individual who is publicly represented as the Employee's Spouse, who has resided with the Employee for at least twelve (12) months, and the Employee has filed that Spouse as such with CRA.

Other Eligibility Notes

In addition to the above, this Plan provides benefits to Employees and their eligible Dependents only. Coverage will not be extended in order to provide court assigned benefits for separated or divorced spouses. Separation and/or divorces are private and personal matters between an Employee and his/her separated or divorced Spouse.

Northern Communications Services Inc.'s benefit contract requires coordination of benefits between the Employee's and his/her Spouse's group benefits program under all circumstances. The Spouse of the employee is required to utilize his/her employer's group benefits plan first for any claims. Coordination of benefits will also take place if an Employee's Spouse has a group benefits program in place through that spouse's employer and where there is either a) premium contribution requirement by the spouse or b) the spouse has a flexible benefits program (i.e., a "flex plan") as a result of which the Spouse has opted out of his/her employee benefits program. Northern Communications Services Inc. expects that the Spouse will maintain coverage under his/her employer's group benefits program at all times.

Termination or Continuation of Benefits

While Disabled

For Employees not actively at work and receiving WSIB benefits, Extended Health Care and Dental Care benefits will terminate twenty-four (24) months following the employee's last workday prior to going on disability, or age 65, whichever comes first. For Employees not actively at work due to a long-term disability claim, Extended Health Care and Dental Care benefits will terminate twelve (12) months following the employee's last workday prior to the start of their absence, or age 65, whichever comes first. For all other benefits please see the applicable sections of this booklet. The Company may, at its sole discretion, decide upon the following: modification of this Plan, including the reduction of benefits; introduction of new plans; selection of carriers; funding arrangements; cost sharing arrangements; and benefits to be provided.

While on Notice of Employment Severance/Termination or Temporary Lay-off

For Employees whose employment are terminated, Extended Health Care and Dental Care benefits will be continued to the end of the month for which salary continuance is paid. If there is no continuance, statutory requirements will apply. All other benefits will be discontinued according to statutory requirements.

While on Employment Severance/Termination

During a severance period, the severed employee's coverage under the Company's group benefits program will only be extended up to the period required by the Employment Standards Act, or other such government Acts. Please note that Northern Communications Services Inc.'s liability is limited to the payment of applicable premiums. Any issues that may arise with respect to eligibility, entitlement, and level of benefits or other related questions are a matter between the employee and the Adjudicator/Carrier, subject to any of the benefit's exception, exclusions, limitations, and provisions. The Company may, at its sole discretion, decide upon the following: modification of this Plan, including the reduction of benefits; introduction of new plans; selection of carriers; funding arrangements; cost sharing arrangements; and benefits to be provided.

SUMMARY OF BENEFITS

Effective Date of This Plan:	February 1, 2007
Benefit Year:	January 1 to December 31
Covered Class:	All Eligible Sales Representatives

Benefit	Carriers/Adjudicators	Group/Contract #
Basic Life Benefit	Industrial Alliance	28555
Dependent Life Benefit	Industrial Alliance	28555
Optional Life Benefit	Industrial Alliance	28555
Short Term Disability Benefit	Acclaim SBA	N/A
Long Term Disability Benefit	Industrial Alliance	28555
Extended Health Care and Dental Care Benefits	ClaimSecure	2121

EMPLOYEE LIFE BENEFIT

AMOUNT OF BENEFIT: 100% of Annual Salary, rounded to next higher $1,000

NON-EVIDENCE MAXIMUM: $320,000

OVERALL MAXIMUM: $500,000

TERMINATION OF BENEFIT: Earlier of Employee's retirement or attainment of age 65

DEPENDENT LIFE BENEFIT

AMOUNT OF BENEFIT

- ***Spouse:*** $10,000
- ***Each Dependent Child:*** $2,500 (live birth to age 18, 25 if a student))

TERMINATION OF BENEFIT: Earlier of Employee's retirement or attainment of age 65

OPTIONAL LIFE BENEFIT

AMOUNT OF BENEFIT

- ***Employee:*** Units of $10,000; Overall Maximum $250,000
- ***Spouse:*** Units of $10,000; Overall Maximum $250,000

NON-EVIDENCE MAXIMUM: Evidence of insurability is required for all amounts

REDUCTION FORMULA: N/A

TERMINATION OF BENEFIT: Earlier of Employee's retirement or attainment of age 65

SHORT TERM DISABILITY BENEFIT

AMOUNT OF BENEFIT:	67% of Weekly Earnings
WEEKLY MAXIMUM:	$1,000
ELIMINATION PERIOD	*In order to be eligible for Short Term Disability benefit, an employee must be inactive, receiving appropriate treatment as well as be totally disabled from their role.*
▸ ***Accidents/Injury:***	0 days
▸ ***Hospitalization:***	0 days, granted that you are hospitalized for more than 48 hours
▸ ***Illness:***	7 calendar days
TAXABILITY:	Taxable
FREQUENCY OF BENEFIT PAYMENT:	Bi-Weekly
RECURRENCE CLAUSE:	A two (2) consecutive weeks recurrence will apply to the same disability
MAXIMUM PERIOD OF PAYMENT:	17 weeks
TERMINATION OF BENEFIT:	Earlier of Employee's retirement, attainment of age 65, payment of at least 15 weeks of benefits, or the end of the period of incapacity due to illness or injury

LONG TERM DISABILITY BENEFIT

AMOUNT OF BENEFIT:	67% of the first $2,000, 50% of the next $1,000, and 44% of the remainder of Monthly Salary
NON-EVIDENCE LIMIT:	$6,000
MONTHLY MAXIMUM:	$6,000
ELIMINATION PERIOD:	119 days
TAXABILITY:	Non-taxable
CPP/QPP OFFSETS:	Primary
PRE-EXISTING CONDITION EXCLUSION:	3/12
ALL-SOURCE MAXIMUM:	85% (the overall maximum must not exceed 85% of the pre-disability net monthly salary)
FREQUENCY OF BENEFIT PAYMENT:	Monthly
OWN-OCCUPATION CLAUSE:	24 months
SUCCESSIVE PERIODS OF DISABILITY	
▸ ***During the Elimination Period:***	30 days
▸ ***After the Elimination Period:***	6 months
MAXIMUM PERIOD OF PAYMENT:	To age 65
TERMINATION OF BENEFIT:	Earlier of Employee's retirement or attainment of age 65

Extended Health Care Benefit

Co-insurance

- ***Extended Health Benefits:*** 80% (100% co-insurance for Eye Exams)
- ***Prescription Drugs*:*** 80%
- ***Vision Care:*** 100%

Deductibles: No deductible

Reimbursement Method

- ***Extended Health Benefits:*** Via claim forms
- ***Prescription Drugs*:*** Via Pay-direct Drug Card and claim forms

Limitations and Maximum

- ***Overall Extended Health Care Maximum:*** Limited to Reasonable and Customary charges
- ***Prescription Drugs Plan Type:*** Formulary 5G (new drugs introduced in Canada on or after April 1, 2006 are not automatically covered under this Plan). Specialty drugs are excluded.
- ***Prescription Drugs Maximum:*** Limited to $10,000 per covered person every calendar year

**ClaimSecure adheres to applicable regulations (e.g., Regie de l'assurance-maladie du Quebec (RAMQ) in Quebec) with respect to this Plan's co-payments, deductibles, and maximum.*

- ***Private Practice Para-Medical Services' Maximum:*** Limited to $50 per visit per practitioner to a combined maximum of $600 for all practitioners, per covered certficate every calendar year
  - ***Practitioners Covered*:*** Chiropractor; Physiotherapist; Psychologist and Registered Massage Therapist

    Note: *There is no per visit maximum for Psychologist.*

**A Physician's referral is required.*

- ***Other Medical Equipment and Supplies' Maximum***
  - ***Accidental Dental:*** Limited to $2,500 per covered person per incident
  - ***Ambulance Services:*** Charges for professional ground ambulance service to the nearest hospital or other medical facility capable of providing the required care
  - ***Vision Care (Eye Glasses/Contact Lenses):*** Limited to $300 per covered person every twenty-four (24) consecutive months
  - ***Eye Examinations:*** Limited to one (1) exam of $80 per covered person every twenty-four (24) consecutive months

Extension of Benefit to Survivor: The date which is twelve (12) months from the Employee's death

Termination of Benefit: Earlier of Employee's retirement or attainment of age 65

Dental Care Benefit

Fee Guide: Current fee guide for general practitioners approved by the Provincial Dental Association in the Employee's province of residence; Specialist fees are covered up to the general practitioners' fees

Pre-determination Limit: $750

Co-insurance

- ***Level 1 - Basic Services:*** 85%
- ***Level 2 - Periodontics/Endodontics Services:*** 85%

DENTAL CARE BENEFIT

DEDUCTIBLE: No deductible

REIMBURSEMENT METHOD: Via claim forms

LIMITATIONS AND MAXIMUM

- ***Maximum :*** Limited to a combined maximum of $2,000 per covered person every calendar year for Level 1 and Level 2

- ***Level 1 - Basic Services***
  - ***Recall or Periodical Examination:*** Limited to one (1) per covered person over age 18 every twelve (12) consecutive months and one (1) per covered person under age 18 every six (6) consecutive months
  - ***Complete Oral Examination:*** Limited to one (1) per covered person every thirty-six (36) consecutive months
  - ***Specific Examination:*** Limited to one (1) per covered person every twelve (12) consecutive months
  - ***Emergency Examination:*** Limited to one (1) per covered person every calendar year
  - ***Bitewing Radiographs:*** Limited to one (1) per covered person every twelve (12) consecutive months
  - ***Complete Series Radiographs/Panoramic Radiographs:*** Limited to one (1) per covered person every thirty-six (36) consecutive months
  - ***Light Polishing and Light Scaling:*** Limited to one (1) per covered person every Recall period
  - ***Pit & Fissure Sealants:*** Limited to Reasonable and Customary charges for children under age 18
  - ***Topical Fluoride Application:*** Limited to one (1) per covered person every Recall period for children under age 18
  - ***Restorations/Fillings:*** Acrylic/White/Tooth-coloured restorations/fillings on molars and pre-molars are covered up to the cost of non-bonded amalgam restorations/fillings
  - ***Pre-Fabricated Restorations (Pre-Fabricated Crowns):*** Limited to Primary Teeth only
  - ***Crown/Bridge/Denture Rebase (jump)/Reline:*** Limited to one (1) per arch per covered person every thirty-six (36) consecutive months
  - ***Crown/Bridge/Denture Repair:*** Repair with or without impression
- ***Level 2 - Periodontics/Endodontics Services***
  - ***Occlusal Equilibration:*** Limited to eight (8) 15-minute time units per covered person every calendar year
  - ***Scaling/Root Planing:*** Limited to eight (8) 15-minute time units per covered person every calendar year
  - ***Root Canal Therapy:*** Limited to Reasonable and Customary charges
  - ***Periodontal Appliances and Maintenance:*** Limited to one (1) appliance per arch per covered person every thirty-six (36) consecutive months for Dependent Children

EXTENSION OF BENEFIT TO SURVIVOR: The date which is twelve (12) months from the Employee's death

TERMINATION OF BENEFIT: Earlier of Employee's retirement or attainment of age 65

CLAIMS SUBMISSION & ENQUIRIES

COPY OF CONTRACT AND ENROLMENT MATERIAL

A participant may request from the insurer a copy of the policy, his enrolment form and any written documents (provided as evidence of insurability) that may have been provided to the insurer in relation to his insurance under the policy. The insurer will provide the first copy of the policy, enrolment form and relevant written documents without charge to the participant. Any additional copies will be subject to a charge set by the insurer.

PROTECTING PERSONAL INFORMATION

Administrator's Notice

The Plan Administrator sets up a file or series of files with personal information relative to the Employee's benefits when he/she applies for coverage under this Plan. This includes all of the information concerning the Employee's enrolment, benefits, and claims. The purpose of this file is to permit the Plan Administrator to administer the Employee's benefits under this Plan. This includes the following:

1) Arranging benefits coverage where applicable;
2) Claims adjudication, management and payment;
3) Internal and external audits;
4) Income tax reporting purposes where applicable; and
5) Preparation of reports used by the Company in the financial management of this Plan.

The Employee's file will be kept in the offices of our Plan Administrator. The Employee's personal information is used within the Company and shared only to the extent required by law with coverage provider(s) and financial institutions involved in caring for the Employee's plan(s). Only authorized persons have access to the Employee's file when required for coverage purposes. The information in the Employee's file is securely stored and is not shared with any other parties, unless the Employee authorizes us to release it to them, or the disclosure is required by law.

The Employee has the right to access the personal information in his/her file and, if necessary, have it corrected by submitting a written request to the Plan Administrator.

Industrial Alliance's Notice

Industrial Alliance is committed to protecting the privacy of a participant's (including his or her dependent's) personal information that it collects while providing services under the Group Plan issued to the Policyholder. Industrial Alliance recognizes and respects a person's right to privacy concerning his or her personal information.

When a participant enrolls under the Group Plan, Industrial Alliance will establish a confidential file containing the personal information collected. The file will be kept at Industrial Alliance's offices.

Access to the file will be limited to Industrial Alliance employees, agents and service providers who require access in the performance of their jobs, individuals to whom the participant has granted access, and persons authorized by law.

At Industrial Alliance the personal information that is collected is used to perform administrative services with respect to the Group Plan. Administrative services include, but are not limited to,

- Determining eligibility under the Group Plan or a particular benefit;
- Enrolling participants under the Group Plan;
- Adjudicating claims;
- Underwriting (includes determining the rates applicable to the Group Plan).

Participant's Right to Access His or Her Personal Information

A participant has the right to access his or her personal information and to request, in writing, that any inaccurate information be corrected. In addition, the participant can request that any outdated or unnecessary information be deleted.

If Industrial Alliance has medical information about the participant which was not obtained directly from the participant, Industrial Alliance will release the information to the participant only through the participant's physician.

To request access to his or her personal information or to have his or her name removed from the list to be shared within the Industrial Alliance Group, the participant must send a written request to:

Industrial Alliance Insurance and Financial Services Inc.
Access Officer
1080 Grande Allée West,
P.O. Box 1907, Station Terminus
Quebec City, Quebec G1K 7M3

LIFE AND LONG TERM DISABILITY BENEFITS

The claimant must contact the Plan Administrator to obtain the required forms and to also obtain instruction on how to submit a claim.

SHORT TERM DISABILITY BENEFIT

The Employee must first contact his/her immediate supervisor to obtain the required forms and to also obtain instruction on how to submit a claim.

EXTENDED HEALTH CARE AND DENTAL CARE BENEFITS

All claims must be received by ClaimSecure within one (1) year of the date the expense was incurred or within thirty (30) days of benefit coverage termination. The claimant should send all pertinent documents to:

ClaimSecure Inc.
P.O. Box 6500, Stn A
(40 Elm Street, Suite 225)
Sudbury, Ontario, Canada, P3A 5N5

Health and dental claim forms can be obtained from ClaimSecure's web site at www.claimsecure.com under the Forms section.

Member Claims Enquiries:	1-888-513-4464
Call Centre Hours (Prescription Drugs):	Monday to Friday 7:00AM to 11:00PM (EST) Saturdays 11:00AM to 4:00PM (EST)
Call Centre Hours (Health and Dental):	Monday to Friday 7:00AM to 11:00PM (EST)

eProfile from ClaimSecure

Through ClaimSecure's eProfile online service plan members can:

- Access electronic copy of this booklet
- Obtain personalized claim forms
- View a benefits guide that assists them with claims requirements and questions
- View their personal claims history
- Access dependant claims information
- Obtain details of claims adjustments or rejections
- Run consolidated statements for tax purposes

To register log onto www.claimsecure.com, click on the Register Now button located on the bottom-right of the page and follow the on-screen registration guide.

If you encounter difficulties and require additional support direct your call to the technical inquiries Help Desk at 1-888-513-4464 extension 2621. If the attendant is unavailable, leave a detailed message including your name, certificate number, date, time, nature of your call, and a contact number where you can be reached. The Help Desk will return calls in priority sequence normally on the same business day.

Prescription Drugs

With Your Drug Card - Direct Payment System

Your group benefits plan includes access to a direct payment system for eligible prescription drug expenses, which means that your claim is sent electronically by your pharmacist directly to the Carrier/Adjudicator, and the portion of your eligible prescription drug expenses covered under this Plan is automatically reimbursed.

Present your Drug Card to your pharmacist when purchasing prescribed medications and you pay only the portion of the expenses not covered under this Plan. The Carrier/Adjudicator pays the portion covered under this Plan directly to your pharmacist.

You do not need to show your card each time you visit your local pharmacy, as the pharmacist's computer system records your card information the first time you present your card. However, if you change group benefits plan (if you change jobs, for example) or go to a different pharmacy, you will have to show your card.

Without Your Drug Card

If you do not show your Drug Card to your pharmacist or if your pharmacist suggests you send in your claim yourself, you must complete a health benefit claim form and send it to Carrier/Adjudicator along with the original receipts or paid invoices.

If expenses were paid for a child who is a full-time student, you must include the following information with your claim:

- The name of the educational establishment where your child is enrolled;
- The school year in which your child is enrolled.

DETAILS OF BENEFITS

LIFE BENEFIT

Upon the death of the participant while insured under this benefit, the insurer undertakes to pay to the beneficiary the sum insured as indicated in the Summary of Benefits, subject to the terms and conditions of this benefit and the group policy.

Definition

As used in this benefit:

Disability and Disabled: A state of total and continuous incapacity, resulting from illness or injury, which prevents the participant from performing any work for which he is reasonably qualified by education, training or experience.

However, if the participant should be covered by a Long Term Disability Income Insurance benefit under the group policy, the definitions of “disability” and “disabled” shall be as defined under such benefit.

Conversion Privilege

A participant whose life insurance is cancelled on or prior to his 65th birthday due to termination of:

1) His employment;
2) His group membership; or
3) The group policy and he has been continuously insured under a life insurance benefit provided by the policyholder for at least 5 years,

will be able to convert all or part of his life insurance to an individual life insurance policy without having to provide evidence of insurability.

The participant may choose to convert to one of the following types of insurance:

1) Permanent;
2) Term to age 65; or
3) One year term convertible into permanent or term to age 65 at the end of one year.

The amount that can be converted to an individual policy will include all amounts of life insurance that the participant was covered for under this benefit, an Optional Life Insurance benefit and any other group insurance policy issued by the insurer, and will not exceed the lesser of:

1) The amount selected by the participant;
2) The amount for which the participant was insured immediately prior to the termination of his insurance;
3) The difference between the amount for which the participant was insured immediately prior to the termination of his insurance, and the amount for which he is eligible under a new group insurance policy;
4) $200,000.

The individual insurance policy shall not include a disability benefit, nor an accidental death and dismemberment benefit, and the premium shall be based on the insurer's rates in effect which apply to the type and amount of such policy, according to the participant's sex and attained age.

The individual policy will only be issued if the insurer receives a written request to that effect, together with a deposit covering the monthly premium for a one year term policy within 31 days of the date of the termination of the participant's insurance, and will take effect only at the expiration of that period.

Should the participant die during the period of 31 days following the termination of his insurance, the insurer shall pay an amount equal to that which he could have converted whether or not he made application for the individual policy.

Waiver of Premium

1) A participant who becomes disabled will be eligible to have his premiums waived for this benefit, if he is under age 65 and is eligible to receive a benefit under the Long Term Disability Income Insurance benefit, if included in the group policy.
2) If the participant is not eligible to receive a benefit under the Long Term Disability Income Insurance benefit or there is no Long Term Disability Income Insurance benefit included in the group policy, he will be eligible to have his premiums waived for this benefit provided:
    a) the participant was less than 65 years of age at the onset of disability;
    b) the participant became disabled as defined under this benefit, while insured under this benefit and before any termination of employment;
    c) the participant has been disabled for at least 6 continuous months;
    d) proof of disability, satisfactory to the insurer, was submitted to the insurer within 12 months of the onset of the disability. The evidence will be submitted at no expense to the insurer.
3) The amount of insurance for which the waiver of premiums applies will be that which was in force on the participant's life at the onset of the disability, and will be subject to any reductions and termination indicated in the Summary of Benefits which would have been applicable to the participant if he had been actively at work.
4) The participant's premiums will begin to be waived on the earliest of the following dates:
    a) the day following completion of the elimination period under the Long Term Disability Income Insurance benefit, if applicable;
    b) the day following a continuous period of disability of 6 months.
5) The participant whose premiums are waived under this section must provide the insurer with proof of disability, as often as the insurer may reasonably require. Such proof will be provided at no expense to the insurer.
6) The waiver of premiums will terminate on the earliest of the following dates:
    a) the date on which the participant ceases to be disabled;
    b) the date on which the participant fails to submit to an examination by the physician designated by the insurer;
    c) the date on which the participant retires or reaches the normal retirement age under the employer's pension plan, but never beyond the normal retirement age indicated in the Summary of Benefits of the group policy;
    d) the date on which the participant reaches the termination age for his life insurance benefit as indicated in the Summary of Benefits, if applicable;
    e) the date on which the participant fails to provide any proof of disability required by the insurer;
    f) the date on which the participant is incarcerated after committing a criminal offence for which he was found guilty.
7) If on the date the waiver of premiums terminates with respect to the participant, he is not eligible to be covered under the Participant's Life Insurance benefit, he will be eligible to exercise the conversion privilege as provided for under this benefit.

PARTICIPANT'S OPTIONAL LIFE INSURANCE

A participant may obtain an amount of optional life insurance if he so requests it in writing to the insurer and furnishes evidence of insurability satisfactory to the insurer.

The sum insured that will be applicable to the participant will be the amount of insurance requested as provided for in the Summary of Benefits.

Upon the death of the participant while insured under this benefit, the insurer undertakes to pay the beneficiary the sum insured at the time of the participant's death, subject to the terms and conditions of this benefit and the group policy.

Non-Smoker Status

If the insurer provides reduced premium rates for non-smokers, the participant must provide a non-smoker statement on his application card to receive such rates.

Misrepresentation of Non-Smoker Status

A participant who states that he is a non-smoker on his application card or on his last evidence of insurability declaration, if it is more recent, when he is a smoker, will be considered to have made a misrepresentation.

If it is proven, after the participant's death, that he had made a misrepresentation, the optional life insurance benefit of the participant will become null and void and no optional life insurance will be payable under this benefit.

Proof of Status

The insurer reserves the right to request new proof of the participant's non-smoker status each time evidence of insurability may be required.

Exclusion

If a participant commits suicide, while sane or insane, less than 24 months after the date his coverage under this benefit commenced, no benefit will be payable by the insurer. The insurer will refund to the beneficiary the premiums paid in respect of the participant's optional life insurance and such refund will constitute a full discharge of the insurer's liability under this benefit.

The 24 month period starts anew on the date:

1) The optional life insurance is reinstated; or
2) The optional life insurance amount is increased at the participant's re-quest, but only for the additional amount of insurance.

Additional Provisions

Any provisions of the Participant's Life Insurance benefit which are not inconsistent with the provisions of this benefit will form part of this benefit.

DEPENDENTS' LIFE INSURANCE

Upon the death of a dependent, while insured under this benefit, the insurer undertakes to pay to the participant the sum insured, as indicated in the Summary of Benefits, subject to the terms and conditions of this benefit and the group policy.

Waiver of Premiums

A participant whose life insurance premiums are waived in accordance with the Waiver of Premiums provision of the Participant's Life Insurance benefit will also be entitled to have the premiums for this benefit waived, under the same terms and conditions.

Conversion Privilege

A participant whose spouse's life insurance is cancelled on or prior to the earlier of (i) his 65th birthday and (ii) his spouse's 65th birthday, due to the termination of

1) His employment;
2) His group membership; or
3) The group policy and his spouse had been continuously insured under a Dependents' Life Insurance benefit provided by the policyholder for at least 5 years,

will be able to convert all or part of his spouse's life insurance to an individual life insurance policy without having to provide evidence of insurability.

A spouse whose life insurance is cancelled on or prior to the earlier of (i) his 65th birthday and (ii) the 65th birthday of the participant, due to the death of the participant, will be able to convert all or part of his life insurance to an individual life insurance policy without having to provide evidence of insurability.

The participant or spouse, if applicable, will be able to convert the life insurance to one of the following types of insurance:

1) Permanent;
2) Term to age 65; or
3) One year term convertible into permanent term or term to age 65 at the end of the one year.

The amount that can be converted to an individual policy will include all amounts of life insurance that the spouse is covered for under the group policy, an Optional Life Insurance benefit and any other group insurance policy issued by the insurer and will not exceed the lesser of:

1) The amount selected by the participant or the spouse, if applicable;
2) The amount for which the spouse was insured immediately prior to the termination of his insurance; and
3) The difference between the amount for which the spouse was insured immediately prior to the termination of his insurance and the amount for which he is eligible under a new group insurance policy; and
4) $200,000.

The individual policy shall not include a disability benefit nor an accidental death and dismemberment benefit and the premiums shall be based on the insurer's rates in effect which apply to the type and amount of such policy, based on the spouse's sex and attained age.

The individual policy will only be issued if the insurer receives a written request to that effect, together with a deposit covering the monthly premium for a one year term policy, within 31 days of the date of the termination of the spouse's insurance and will take effect only at the expiration of that period.

Should the spouse die during the period of 31 days following the termination of his insurance, the insurer shall pay an amount equal to that which could have been converted to the participant, or the participant's estate if he is no longer living, whether or not application had been made for the individual policy.

SPOUSE'S OPTIONAL LIFE INSURANCE

A participant may obtain an amount of optional life insurance on his spouse if he so requests it in writing to the insurer and furnishes evidence of insurability satisfactory to the insurer.

The sum insured that will be applicable to the spouse will be the amount of insurance requested as provided for in the Summary of Benefits.

Upon the death of the spouse while insured under this benefit the insurer undertakes to pay to the participant the sum insured at the time of death, subject to the terms and conditions of this benefit and the group policy.

Waiver of Premiums

A participant whose life insurance premiums are waived in accordance with the Waiver of Premiums provision of the Participant's Life Insurance benefit will also be entitled to have the premiums for this benefit waived, under the same terms and conditions.

Conversion Privilege

A participant whose spouse's optional life insurance is cancelled on or prior to the earlier of (i) his 65th birthday and (ii) his spouse's 65th birthday, due to the termination of

1) His employment;
2) His group membership; or
3) The group policy and his spouse had been continuously insured under a Dependents' Life Insurance benefit provided by the policyholder for at least 5 years,

will be able to convert all or part of his spouse's optional life insurance to an individual life insurance policy without having to provide evidence of insurability.

A spouse whose optional life insurance is cancelled on or prior to the earlier of (i) his 65th birthday and (ii) the 65th birthday of the participant, due to the death of the participant, will be able to convert all or part of his optional life insurance to an individual life insurance policy without having to provide evidence of insurability.

The participant or spouse, if applicable, will be able to convert the optional life insurance to one of the following types of insurance:

1) Permanent;
2) Term to age 65; or
3) One year term convertible into permanent term or term to age 65 at the end of the one year.

The amount that can be converted to an individual policy will include all amounts of optional life insurance that the spouse is covered for under the group policy, a Life Insurance benefit and any other group insurance policy issued by the insurer and will not exceed the lesser of:

1) The amount selected by the participant or the spouse, if applicable;
2) The amount for which the spouse was insured immediately prior to the termination of his insurance; and
3) The difference between the amount for which the spouse was insured immediately prior to the termination of his insurance and the amount for which he is eligible under a new group insurance policy; and
4) $200,000.

The individual policy shall not include a disability benefit nor an accidental death and dismemberment benefit and the premiums shall be based on the insurer's rates in effect which apply to the type and amount of such policy, based on the spouse's sex and attained age.

The individual policy will only be issued if the insurer receives a written request to that effect, together with a deposit covering the monthly premium for a one year term policy, within 31 days of the date of the termination of the spouse's optional insurance and will take effect only at the expiration of that period.

Should the spouse die during the period of 31 days following the termination of his insurance, the insurer shall pay an amount equal to that which could have been converted to the participant, or the participant's estate if he is no longer living, whether or not application had been made for the individual policy.

Non-Smoker Status

If the insurer provides reduced premium rates for non-smokers, the spouse must provide a non-smoker statement on the application card to receive such rates.

Misrepresentation of Non-Smoker Status

A spouse who states that he is a non-smoker on the application card or on his last evidence of insurability declaration, if it is more recent, when he is a smoker, will be considered to have made a misrepresentation.

If it is proven, after the spouse's death, that he had made a misrepresentation, the optional life insurance of the spouse will become null and void and no optional life insurance will be payable under this benefit.

Proof of Status

The insurer reserves the right to request new proof of the spouse's non-smoker status each time evidence of insurability may be required.

Exclusion

If a person insured for optional life insurance commits suicide, while sane or insane, less than 24 months after the date his optional life insurance commenced under this benefit no benefit will be payable by the insurer. The insurer will refund to the participant the premiums paid in respect of such person and the refund will constitute a full discharge of the insurer's liability under this benefit.

The 24 month period starts anew on the date:

1) The optional life insurance is reinstated; or
2) The optional life insurance amount is increased at the participant's request, but only for the additional amount of insurance.

LONG TERM DISABILITY BENEFIT

If a participant becomes disabled while insured under this benefit and while he is actively at work, the insurer will undertake to pay the participant the amount of the monthly indemnity benefit specified herein for each month or part of a month during which such disability lasts, subject to the terms and conditions of this benefit and the group policy.

Definitions

As used in this benefit:

Disability and Disabled: During the participant's elimination period and the first 24 months following the elimination period, the participant is not able to perform substantially all of the essential duties of his own occupation and earn at least 80% of his indexed pre-disability gross monthly salary due to an illness or injury, as determined by the insurer.

Thereafter, the participant is not able to perform substantially all of the essential duties of his own or any other occupation for which he is reasonably qualified by training, education or experience and earn at least 70% of his indexed pre-disability gross monthly salary due to the illness or injury, as determined by the insurer.
However, a participant who engages in any occupation or employment, except as specifically provided in this benefit, will be deemed to no longer be disabled.

Indexed pre-disability gross monthly salary: The monthly salary applicable to the participant immediately prior to the date his disability commenced, increased each March 1st coincident with or next following the anniversary of the date on which the participant became entitled to a monthly indemnity benefit by the Consumer Price Index (as published by the Government of Canada) during the immediately preceding calendar year.

Pre-disability gross monthly salary: The monthly salary applicable to the participant immediately prior to the date his disability commenced.

Pre-disability net monthly salary: The monthly salary applicable to the participant immediately prior to the date his disability commenced, less the deductions for Income Tax, Canada or Quebec Pension Plan, Employment Insurance and the Quebec Parental Insurance Plan.

Elimination period: The period specified in the Summary of Benefits during which the employee must be disabled before he can begin to receive monthly indemnity benefit payments.

Particulars

Beginning of Benefit Payments

Payment of the monthly indemnity benefit begins following completion of the elimination period specified in the Summary of Benefits.

Amount of Benefit Payments

The amount of the monthly indemnity benefit payable is determined according to the formula set forth in the Summary of Benefits and will not exceed the monthly maximum amount specified.

Reduction of Benefit Payments

The monthly indemnity benefit will be reduced, after the application of the monthly maximum amount, by any disability benefits which are payable or which would have been payable to the participant had a satisfactory application been made under:

1) The Quebec or Canada Pension Plan, excluding benefits payable on behalf of dependent children;
2) A workers' compensation act;
3) A provincial automobile insurance law;
4) A provincial crime victims compensation act.

Moreover, the amount of the monthly indemnity income benefit payable by the insurer will be adjusted so that the sum of all income, compensation, indemnity and benefits which the participant would or could receive, due to his disability, from: (a) the policyholder, (b) his employer, (c) any government body, (d) a franchise or association insurance plan, (e) any group insurance or pension plan to which the policyholder or employer contributes, and (f) a third party in the form of damages for loss of income, will not exceed the overall maximum, as specified in the Summary of Benefits.

After the first reductions made for each of the sources listed in this provision, future cost of living adjustments made to amounts received from such sources will not bring about further reductions.

Termination of Benefit Payments

The monthly indemnity benefit payments cease on the earliest of the following dates:

1) The date the maximum benefit period specified in the Summary of Benefits has been reached;
2) The date on which the participant ceases to be disabled;
3) The date on which the participant reaches the age of 65;
4) The date on which the participant retires or reaches the normal retirement age under the employer's pension plan, but never beyond the normal retirement age indicated in the Summary of Benefits of the group policy;
5) The date of the participant's death;
6) The date on which the participant fails to submit to an examination by the physician designated by the insurer;
7) The date on which the participant fails to provide any evidence of disability required by the insurer;
8) The date on which the participant refuses to participate in good faith in a trial work, part-time work or modified work program or a rehabilitation program which the insurer has recommended;
9) The date on which the participant is incarcerated after committing a criminal offence for which he was found guilty.

Successive Periods of Disability

If the participant who had been disabled returns to full-time active work and again becomes disabled while this benefit is in force, such disability will be considered a continuation of the previous disability, provided

1) It is due to the same cause or causes as the previous disability;
2) During the elimination period, he has been back at full-time active work for less than 30 consecutive days; and
3) After the elimination period has been completed, he has been back at full-time active work for less than 6 months.

However, if the successive period of disability is due to a cause or causes unrelated to the cause or causes of the previous period of disability, it will be considered to be a new disability and a new elimination period will apply.

Exclusions and Limitations

1) The monthly indemnity benefit will not be payable for a disability resulting from one of the following causes:
   a) Civil unrest, insurrection or war, whether war be declared or not, or participation in a riot;
   b) Attempted suicide or voluntarily self-inflicted injury, while sane or insane;
   c) Care which is not medically required or which is given for cosmetic purposes, unless such care is for an accidental injury and commenced within 90 days of the accident;
   d) Committing, attempting to commit a criminal offence, or provoking an assault or criminal offence.
2) The monthly indemnity benefit will not be payable:
   a) During any leave taken in accordance with provincial or federal legislation or during any leave taken in agreement with the employer;
   b) During any extension of such a leave, if the participant was entitled to and requested such extension.

   However, if the participant's benefit was kept in force during the leave, the elimination period will begin on the date the participant would have returned to work if not for his disability.

3) The monthly indemnity benefit will not be payable for any period the participant is not under the regular care and attendance of a physician, other than himself, who is a registered specialist in the field of medicine which is applicable to his disability, or is not undergoing a course of medical treatment or participating in a program of rehabilitation which, in the opinion of the insurer, is medically required.

4) The monthly indemnity benefit will not be payable to a participant who is out of Canada and the United States for a period of 90 consecutive days or more. The participant's entitlement to the monthly indemnity benefit will be restored only upon the participant's return to Canada or the United States, subject to all other provisions of this benefit.

5) The monthly indemnity benefit will not be payable for a disability which occurs during a strike, lock-out or temporary lay-off, if the participant's benefit was not kept in force during the strike, lock-out or temporary lay-off.

   However, if the participant's benefit was kept in force during the strike, lock-out or temporary lay-off, the elimination period of the monthly indemnity benefit will begin on the date the participant would have returned to work if not for his disability, provided that on the date the disability occurred he would have satisfied the definition of being actively at work during a non-scheduled work day.

6) The monthly indemnity benefit will not be payable to a participant who refuses to enter a trial work, part-time work or modified work program or a rehabilitation program which has been recommended by the insurer.

7) The monthly indemnity benefit will not be payable to a participant during any period that the participant receives payment(s) in lieu of notice under a severance package from his employer. Where the payment is made to the participant in the form of a lump sum, this exclusion will apply to the period of notice for which the lump sum is attributed.

Pre-Existing Condition Exclusion

As used in this provision, "pre-existing condition" means an illness or injury:

1) Which was sustained or contracted, or
2) For the symptoms of which the participant was under treatment by a physician, or
3) For the symptoms of which a physician had undertaken an investigation or review of, or
4) For which the participant was taking medication as prescribed by a physician,

during the 3 months prior to the date on which the participant became covered under this benefit.

No monthly indemnity benefit will be payable for a disability:

1) That resulted either directly or indirectly from, or was in any manner or degree associated with or occasioned by a pre-existing condition; and
2) Which begins in the first 12 months after the participant became covered under this benefit.

However, if the group policy is a replacement policy, a monthly indemnity benefit will be payable for a disability due to a pre-existing condition, provided the participant:

1) Was covered under the previous policy on the date it was terminated; and
2) Became covered under this benefit on the effective date of the group policy; and
3) Was actively at work on the effective date of the group policy; and
4) Satisfies the pre-existing condition exclusion period under the group policy, giving consideration towards continuous time covered under both policies, or the prior policy giving consideration towards continuous time covered under both policies.

The monthly indemnity benefit payable to the participant will be determined in accordance with this benefit, but in no case will it exceed the previous policy's maximum monthly indemnity benefit.

Waiver of Premiums

A participant whose life insurance premiums are waived in accordance with the Waiver of Premiums provision of the Participant's Life Insurance benefit will also be entitled to waiver of premiums for this benefit, under the same conditions.

Work Re-Entry

If a disabled participant participates in

1) A trial work, part-time work or modified work program, which has been approved by the insurer, or
2) A rehabilitation program, which has been approved by the insurer,

with the intent of returning to his own or any other occupation, and at such time he is incapable of earning at least 80% of his indexed pre-disability gross monthly salary due to the illness or injury which caused his disability, he will still be considered by the insurer to be disabled.

The insurer reserves the right to require that a disabled participant engage in a rehabilitation program or a trial work, part-time work or modified work program which has been recommended by the insurer to assist him in returning to gainful employment, if the insurer determines that the program is appropriate to the participant based on his disability, and his level of education, training or experience. If the participant does not co-operate or participate in the program, the participant will no longer be eligible to receive a monthly indemnity benefit.

If the disabled participant receives an income as a result of his participation in the rehabilitation program, trial work, part-time work or modified work program, the amount of the monthly indemnity benefit payable to him under the terms of this benefit will not be reduced unless the total of the monthly indemnity benefit he is receiving under this benefit, the income received from his participation in the program and the sources listed in the Reduction of Benefit Payments provision exceeds

1) 100% of his pre-disability gross monthly salary, if the monthly indemnity benefit is taxable to him, or
2) 100% of his pre-disability net monthly salary, if the monthly indemnity benefit is non-taxable to him. (For the purposes of this calculation, the income for the program shall be net.)

If the total of the monthly income he is receiving exceeds 100% of the salary, the amount of monthly indemnity benefit payable to him under the terms of this benefit will be reduced so that his total monthly income does not exceed 100% of such salary.

The insurer will pay the expenses incurred by the participant, other than usual employment expenses, which are associated with the approved trial work, part-time work or modified work program or rehabilitation program, provided the expenses were approved, in writing, by the insurer prior to being incurred.

Survivor Benefit

If a participant should die while he is receiving a monthly indemnity benefit or he was entitled to receive a monthly indemnity benefit under this benefit, the insurer will pay a benefit to his eligible survivor or, if applicable, survivors. If there is no eligible survivor on the date of his death, no benefit will be payable.

The amount of the benefit to be paid to the eligible survivor or, if applicable, survivors, will be equal to 3 times the net monthly indemnity benefit payment which was made or would have been made to the participant by the insurer immediately prior to his death.

If the benefit becomes payable to the children of a participant, the insurer will make the payment to the children or to the individual legally entitled to receive payment on behalf of the children. If two or more children are entitled to a benefit, they shall share the benefit equally.
As used above:

- **Eligible survivor:** The participant's spouse or children, if the participant has no spouse at the time of death.
- **Spouse:** Will be as defined under the definition of Dependent of the Definitions provision.
- **Children:** Will be as defined under the definition of Dependent of the Definitions provision.

SHORT TERM DISABILITY BENEFIT

Purpose

If an Employee becomes disabled while eligible for disability benefits under this Plan the Employee will receive disability income for each day that the disability continues. In accordance with this benefit program the benefit payable will begin on the ***First Day of Absence*** specified under the ***Summary of Benefits*** section of this document, subject to a Proof of Claim.

The benefit payment will continue while the Employee remains disabled but not beyond the ***Maximum Period of Payment*** specified under the ***Summary of Benefits*** section of this document during any one continuous period of disability from one or more causes. The benefit will be subject to any reductions or limitations stated in this document.

Not more than one benefit will be payable for any one day of disability regardless of the fact that the Employee may be disabled by one or more causes on that day.

What Constitutes Total Disability

Employees are eligible to apply for STD coverage if they are Totally Disabled due to non-work related accident, illness or disability (see ***Work Related Injuries and Issues*** below for work-related injuries) and are unable to perform the essential duties of their own occupation.

STD benefits are not available for individuals whom are partially disabled or restricted from certain limited aspects of their work. The Company will attempt to accommodate these individuals in a modified work or modified hours program.

In the event an Employee is no longer deemed to be totally disabled but cannot return to regular full-time duties, and if the Company is unable to provide accommodation, future employment duties will then be determined at the discretion of the Company and at the commensurate wage rate for those employment duties.

The Company reserves the right to terminate employment with the Employee with a maximum payout per the Employment Standards Act.

When STD Payments Begin

To be considered for a STD benefit an Employee must provide confirmation from a treating Physician (Canadian licensed Medical Doctor) that he/she has been Totally Disabled from performing substantially all of the essential duties of his/her own occupation or a similar occupation due to a medically determinable physical or mental impairment.

In the event an Employee becomes Totally Disabled because of a current accident and the Total Disability begins after the period specified under the ***Elimination Period*** outlined under the ***Summary of Benefits*** section of this document, the Employee will be eligible for Short Term Disability payments on the date he/she becomes Totally Disabled or the first day he/she consults a doctor, whichever is later.

How to Make an STD Claim/Medical Documentation

To apply for STD benefits, the Employee and the Employee's treating Physician(s) must complete the Employee and Attending Physician's Statement (EAPS) provided by Human Resources and submit directly to the Carrier/Adjudicator. The EAPS defines the medical situation, the treatment plan and restrictions/limitations and estimates the length of actual disability.

The Carrier/Adjudicator will review the claim and issue a letter outlining their decision to both the Company and the Employee.

The Employee is responsible for providing updated medical documentation, as directed by the Carrier/Adjudicator's Nurse Case Manager that has been completed by their treating Physician to the Carrier/Adjudicator. An Employee may be required to attend an Independent Medical Evaluation (IME), as deemed necessary by the Carrier/Adjudicator's Nurse Case Manager, for more in-depth assessment of his/her medical condition.

> *Note: It is the Employee's responsibility to ensure that forms are completed promptly. The Employee is also responsible for any costs associated with having forms/medical documents completed.*

Prolonged Absences

In absences that require prolonged periods of recovery (i.e., more than 4 weeks), the Carrier/Adjudicator may require confirmation from a Medical Specialist in the field of disability (e.g., Psychiatrist for mental health issues, Orthopaedic specialist for musculoskeletal issues, etc.). The Medical Specialist's opinion is required not only to confirm that the Employee is Totally Disabled but also to ensure that an active treatment program is in place. If the Employee does not have access to a Medical Specialist within the required period of time or if a second opinion is recommended, the Carrier/Adjudicator may attempt to provide an IME.

Maximum Benefit Period

Approved STD medical leave is provided for the Maximum Period of Payment commencing the ***First Day of Absence***, as specified in the ***Summary of Benefits*** section of this document.

Interrupted Periods of Total Disability (i.e., Recurrence Clause)

Interrupted Periods of Total Disability are considered to be a single period of Disability if the Employee returns to full-time regular duties for a period of less than the interrupted period specified in the ***Summary of Benefits*** section of this document and if the Total Disability is due to the same or related cause. If the Total Disability is due to an entirely unrelated or new cause, the Employee must return to full-time regular duties for at least one (1) day.

If Total Disability is due to the same or related cause a new first day of absence is not applied. The amount that will be paid to the Employee will be the same as for the initial period of Total Disability and the combined period that will be paid will not exceed the ***Maximum Period of Payment*** as specified in the ***Summary of Benefits*** section of this document.

Approval Process for STD

Medical information provided by the Physician(s) related to the illness or disability must be submitted to the Carrier/Adjudicator who will assess the claim based on this information. If additional medical information is required to assess a claim, the Carrier/Adjudicator may request an IME, a telephone consultation with the treating Physician, or further information.

If an Employee's STD claim is approved, pending medical evidence for such approval, any income paid to the Employee during the assessment period will also be deemed to be STD income and any further income will be paid as a STD benefit.

Income Reductions

If an Employee becomes eligible to receive a benefit in accordance with the terms of this Plan, the amount of benefit will be reduced by the amount of any payments that the Employee receives or is eligible to receive from the following sources:

1) Damages for loss of income recovered from a third party and arising out of the same circumstances that caused the disability; or
2) Any continuation of salary from the Company, other than that which is received as a severance allowance.

Return to Work

Once the period of Total Disability has concluded or if the Employee is no longer recommended for benefits, the Employee is expected to return to work. Every effort will be made to ensure an Employee's current position is available for him/her upon return. Once an Employee is able to return to active employment status and is deemed to be able to perform his/her own job or a modified job or is entering a Rehabilitation Program as described below, the Employee will return to a position within the Company that is suited to that Employee's qualifications and at the commensurate wage rate for those employment duties being undertaken.

Rehabilitation Program

It is recognized that some Employees either no longer meet the criteria for being Totally Disabled or will require work modifications for an early return to work. These individuals can often be accommodated through graduated return to work programs, work hardening programs, or with limitations and restrictions in job requirements. The rehabilitation program provides a work modification arrangement (by temporarily reducing work hours or activities) to a Disabled Employee who is not yet fully recovered but can work at some jobs. In order to qualify for a modified work or modified hours program:

1) An Employee must be capable of productive and useful work, participate in any reasonable treatment or rehabilitation program and accept any reasonable offer of modified duties from the Company; and
2) The expected period for modified work or modified hours must be less than four (4) weeks.

The Carrier/Adjudicator will work with the Employee, his/her Physician and the Company in setting up a rehabilitation program to assist the Disabled Employee to return to full time active employment. It is expected that an Employee will participate in all aspects of return to work and rehabilitation.

An Employee participating in a modified work or modified hours program will be paid at 100% of their hourly rate for any hours when completing his/her regular duties, at a commensurate wage rate for other employment duties being undertaken and at the disability benefit rate for the balance of normal working hours, with total compensation not to exceed 100% of the employee's normal salary.

Employee's Responsibility

The Employee will notify Human Resources on the ***First Day of Absence***.

The Employee will provide the Carrier/Adjudicator with the necessary medical documents on a timely basis. The Employee also has a responsibility to keep the Carrier/Adjudicator and the Company advised of the leave situation and to contact the Company's Human Resources department at least six (6) weeks prior to expiration of the leave to discuss return to work or the need to convert to the Long Term Disability Plan. The Employee is responsible for any cost associated with the filling out of information on the EAPS form. It is expected that the Employee will follow a recognized treatment program, promptly return all forms, co-operate in programs designed to facilitate the Employee's return to work including any modified work or modified hours and meetings, assist in all aspects of claims management, and attempt to accelerate a prompt return to productive work.

> ***Note: At all times the Employee must provide all necessary medical documents (i.e., a Short Term Disability Claim form (Employee and Attending Physician Statement (EAPS) form) completed in full and any other required information related to an STD claim to Acclaim SBA. Failure to do so will result in the STD claim being rejected.***

Pregnancy/Parental and Other Leaves of Absence

If an Employee while on Pregnancy Leave of Absence, a Parental Leave of Absence or a Leave of Absence for which Extended Health Care Plan benefits are continued becomes disabled and thereby is prevented from returning to work at the end of the Leave of Absence, a continuous period of disability will be regarded as having begun on the date the Employee became so disabled. The benefit payable in accordance with this document will commence the later of:

1) That day in the period of disability which is shown under the Summary of Benefits section of this document as the day of disability when benefits begin for the disability; and
2) The expiration of the Leave of Absence.

To be eligible for STD benefits for health-related absences which occur while on Leave of Absence the Employee must:

1) Advise the Company of both the beginning and, when appropriate, the end of the period that the Employee is to be reported as absent for health related reasons;
2) Request STD benefits and provide supporting medical documentation for all days that benefits are being claimed; and;
3) Not be on an unpaid leave of absence, including Pregnancy or Parental leave.

Termination from Leave of Absence

If an Employee resigns while on a Leave of Absence, the termination of STD coverage will be the date of receipt of the letter of resignation.

Work Related Injuries and Issues

The purpose of the STD benefit program is to ensure on-going benefit coverage for non-work related injuries or illness. If a work-related injury or illness occurs an application may be made to the Employee's provincial workers compensation board (e.g., WCB, CSST or WSIB). If the condition is accepted by the provincial worker compensation board, then any benefits related to the claim will be paid by the provincial compensation board and the injury/illness will not be considered for STD.
If the condition is not accepted by the provincial compensation board then the Employee may apply for STD benefits. However, if it is concluded that work factors (e.g., stress, conflict, performance issues, etc.) are causing disability, the Employee may not be eligible for benefits unless an underlying medical condition exists and an IME may be requested to support the underlying medical condition.

In addition, the Employee may be asked to attend a three-way meeting (Employee, manager and a Human Resources representative) to discuss and document any work related concerns.

Cost and Tax Implications

The Company pays the cost for this program. Therefore, any income received during Short Term Disability period will be considered as taxable income to the Employee.

STD Limitations

No benefit is payable during any period that the Employee:

1) Has not provided all necessary medical documents (i.e., a Short Term Disability Claim form (Employee and Attending Physician Statement (EAPS) form) completed in full and any other required information related to an STD claim to Acclaim SBA;
2) Has not provided proof of a claim;
3) Is not under the care of a Physician/Medical Specialist (Canadian licensed Medical Doctor);
4) Refuses to work on rehabilitation basis as approved by a Physician/Medical Specialist;
5) Refuses to follow an active treatment program as approved by a Physician/Medical Specialist;
6) Refuses to attend an IME unless current clinical notes and consultative reports from an appropriate Physician/Medical Specialist have been forwarded to and are deemed acceptable by the Carrier/Adjudicator;
7) Is Disabled as a result of accident, injury or illness while on a Leave of Absence for which Extended Health Care Plan benefits were not continued;
8) Is Disabled as a result of the commission or attempted commission of a criminal offence;
9) Would otherwise be taking an agreed-upon leave of absence, a Parental Leave of Absence, or a Pregnancy Leave of Absence;
10) Is eligible for or in receipt of Workers Compensation, the Canada Pension Plan or the Quebec Pension Plan for illness or injury;
11) Is ill or injured while on Leave of Absence or on paid vacation;
12) Who, in the case of a recurring Disability, is receiving benefits according to a reinstatement provision of a group Long Term Disability plan (provided the reinstatement period does not exceed 6 months);
13) Is in receipt of maternity, parental or compassionate care benefits under the Employment Insurance (EI) Act;
14) Receives accident benefits under a provincial automobile insurance plan that does not take income benefits payable by EI into account when paying their benefits;
15) Is engaged in employment for wage or profit while receiving Disability benefits;
16) Is serving a prison sentence;
17) Is not entitled to income benefits payable by EI by reason of being outside of Canada;
18) Is Disabled as a result of accident, injury or illness occurring before becoming eligible to participate in the STD program;
19) Is Disabled due to a self-inflicted injury or attempted suicide, while sane or insane;
20) Is Disabled as a result of hostile actions of any armed forces, insurrection or participation in any riot or civil commotion;
21) Incurs a loss of income due to cosmetic surgery unless the treatment is for accidental illness or injuries; or
22) Is Disabled due to drug or alcohol abuse unless the Employee is receiving continued treatment from a licensed Physician for this type of Disability (Note: a Last Chance agreement may be required).

Benefits may be suspended if:

1) The required forms or documentation are not returned by the due date; or
2) Medical documentation determines that the Employee is no longer Disabled and the Employee is able to return to work but there are repeated postponements in return to work dates.

EXTENDED HEALTH CARE BENEFIT

Extended Health Care claims will be paid provided that the charges incurred are Reasonable and Customary, as defined in the ***Definitions*** section of this booklet, in the geographic area where the claim occurs, for the services, supplies and equipment set out below when the services, supplies and equipment are:

- Ordered by a Physician or other Health Care Providers, as defined in the ***Definitions*** section of this booklet;
- Medically Necessary, as defined in the ***Definitions*** section of this booklet (the order, recommendation or approval of a Physician does not make the service Medically Necessary);
- Not covered or eligible for coverage by any Government program or plan;
- Subject to all applicable limitations, exclusions and maximum benefit limits and any deductible or co-insurance; and
- Incurred while the covered person is eligible under this Plan.

If the covered person is not sure about the eligibility or reasonableness of the cost of an item or service it is strongly recommended that he/she contact the Carrier/Adjudicator first for a written approval prior to your purchase.

******ALL ELIGIBLE EXPENSES MAY BE SUBJECT TO ALL APPLICABLE LIMITATIONS, EXCLUSIONS AND MAXIMUM BENEFIT LIMITS AND ANY DEDUCTIBLE OR CO-INSURANCE. THIS PLAN WILL NOT AUTOMATICALLY COVER SERVICES AND SUPPLIES THAT MAY NO LONGER BE COVERED BY A PROVINCIAL MEDICARE PROGRAM.******

Covered Expenses

Coverage is integrated with coverage provided by your Provincial Health Plan and you must be covered by your Provincial Health Plan to be eligible for this benefit.

Accidental Dental

The coverage includes charges for the services of a licensed dental provider for the repair or replacement of sound natural teeth when a damage is caused by an external force or blow to the face (but not when caused by an object wittingly or unwittingly placed in the mouth) including the setting of a fractured or dislocated jaw, provided the charges are incurred within 12 months of the accident.

Note: *Services must be pre-approved by the Carrier/Adjudicator.*

Ambulance Service

The coverage includes charges for Ambulance Service to the nearest Hospital or other medical facility capable of providing the required care.

Note: *Emergency transportation to the nearest Hospital or other medical facility capable of providing the required care. Includes the cost of return transportation for a Registered Nurse when it is Medically Necessary for a Registered Nurse to accompany the covered person. Pre-approval by the Carrier/Adjudicator is required. Limitations may apply. Where a government program or plan for ambulance services, exists, coverage will be limited to ambulance user fees applicable under such government program or plan.*

Eye Exams

The coverage includes charges for services provided by a licensed ophthalmologist or optometrist.

Vision Care

The coverage includes charges for frames, prescription lenses, or prescription contact lenses.

The following Vision Care exclusions will apply:

1) Refractions required by the Company, Government body or other third party.
2) Safety glasses or safety goggles.
3) Replacement of lost, stolen or broken lenses or frames.
4) Duplicate or spare eye glasses.

5) Intra-ocular lens implants.

6) Prescription or non-prescription sunglasses.

General Limitations and Exclusions for the Extended Health Care Benefit

In addition to the limitations and exclusions of this Plan, and those limitations and exclusions contained in the ***Summary of Benefits*** and ***Details of Benefits*** sections of this booklet, the Extended Health Care benefit will not cover expenses or charges for:

1) Any services, supplies or equipment not listed as covered under the ***Summary of Benefits*** and ***Details of Benefits*** sections of this booklet.

2) Any services, supplies or equipment provided by an immediate family member.

3) Any services, supplies or equipment incurred during a period of hospital confinement which began before the covered person became covered under this Plan. This limitation will not apply to a child who became covered at birth.

4) Any portion of the charge for services in excess of the Reasonable and Customary charge normally incurred for an illness of the same nature and severity in the locality where the service is provided.

5) Broken appointments, transportation costs (including travelling time) of the practitioner, advice received by telephone or other means of telecommunication, or the completion of claim forms required by this provision.

6) Control devices such as reflectometers, dextrometers, stethoscopes, sphygmomano-meters or other similar devices.

7) Expenses for services, treatment or supplies, which are considered experimental in nature.

8) Expenses paid under any Welfare Act, any Act respecting Workmen's Compensation, care and services provided in municipal, provincial or federal clinics as well as charges incurred for cosmetic purposes or for treatment of mental illnesses which would normally be paid by public organizations.

9) Expenses resulting from any attempted suicide or self-inflicted injuries or illness while sane or insane.

10) Expenses resulting from the committing of, attempt to commit a criminal offence including, without restriction, an assault.

11) Expenses that private insurers are not permitted to cover by law.

12) Extra medical supplies that function as spares or alternates.

13) For dental services except covered expenses under the accidental dental benefit.

14) Expenses resulting from participation in a riot or civil disturbance.

15) Home accessories such as a whirlpool, air purifiers, humidifiers, air conditioners or other similar devices. "Home accessories" include: toilet seats, support rails, humidifiers, air conditioners, "air filters", Doctor Gibaud articles (articles supplying heat), electric cushions, heating pads for cars, solar lamps, thermometers, sitbaths, pressure devices, sphygmomanometers or similar devices, ("water pik") electric toothbrushes, hydrotherapeutic apparatus, sheep skins (for bed sores), alarms for children suffering enuresis (night time incontinence), etc.

16) Homeopathic services and homeopathic supplements and remedies.

17) Infant formulas, caloric supplements with or without vitamins or minerals.

18) Medical care for the replacement of an appliance which has been lost, mislaid or stolen or to provide any duplicate appliance.

19) Medical care for which benefits are payable under any other benefit provision of this plan.

20) Medical care for which the claimant is entitled to indemnity or compensation under any Workplace Safety and Insurance Board (WSIB) or similar legislation unless prohibited by any Government legislation.

21) Medical care payable in whole or in part by a government under any Government Health Insurance Plan or which would have been payable had the claimant been covered there under or had proper application been made.

22) Medical care provided by a medical or dental department maintained by an employer, an association, labour union, trustee or similar type of group.

23) Medical care rendered principally for cosmetic purposes (as determined by the administrator), except when such medical care is necessitated by accidental injury.

24) Medical care resulting from riot, insurrection, war or hostilities of any kind, or any act incident thereto whether war be declared or not and whether or not the claimant was participating therein.

25) Medical care to the extent that the applicable government jurisdiction prohibits the payment of any benefits.

26) Medical care which is experimental or not necessary according to generally accepted standards of medical practice in Canada.

27) Medical care, the charge for which the claimant is not legally required to pay, or for which there is no charge, or for which there would have been no charge but for the existence of a group health benefit plan.

28) Medical screening or examinations required for the use of a third party.

29) Patient lifters.

30) Services or supplies associated with covered items, unless specifically listed as a covered expense.

31) Services or supplies associated with recreation or sports rather than with other daily living activities.

32) Services or supplies associated with: services rendered for exercise, weight loss, physical fitness or sports, environmental or atmospheric control in the home or workplace.

33) Services or supplies not listed as covered expenses.

34) Services or supplies received outside Canada except as provided under the out-of-country emergency care.

35) Shipping and handling charges.

36) Supplies ordered or services rendered prior to the date the claimant became eligible for this benefit.

37) The diagnosis or treatment of infertility.

PRESCRIPTION DRUGS BENEFIT

Prescription Drug coverage provides protection against the cost of Medically Necessary prescription drugs in the treatment of sickness or injury. The benefit will pay the Reasonable and Customary charges in the geographic area where the claim occurs for Prescription Drugs when the charges for such Prescription Drugs are:

1) Incurred by the covered person while covered under this Plan;

2) Prescribed in writing by a Physician;

3) Not covered or eligible for coverage under any Government plan or program any other government-sponsored plan or program;

4) Legally insurable and approved for coverage by the Company; and

5) Incurred in Canada.

Important Note

- In the case of a generic plan, the pharmacist will only be reimbursed for the lowest priced substitutable drug, as provided for in the Provincial Drug Benefit Formulary.
- Charges will be payable for up to a 100-day supply per prescription.

****ALL ELIGIBLE EXPENSES MAY BE SUBJECT TO ALL APPLICABLE LIMITATIONS, EXCLUSIONS AND MAXIMUM BENEFIT LIMITS AND ANY DEDUCTIBLE OR CO-INSURANCE.****

Drug Expenses Included

- Prescribed drugs which bear a valid Drug Identification Number (DIN), are listed as prescription requiring in the federal or provincial drug schedule, and require a prescription by convention.
- Extemporaneous preparations or compounds provided one of the ingredients is eligible for coverage.
- A drug prescribed by a Physician by its brand name where it has been specified in writing that the product is not to be interchanged, otherwise this Plan will cover only the cost of the lowest priced equivalent generic drug.
- Oral contraceptives and dermal patch.
- Injectable allergy extracts (i.e., allergy serums).
- Alcohol swab/pads, lancets, insulin, needles, and syringes for the treatment of diabetes (charges for cotton swabs, rubbing alcohol, automatic jet injectors and similar equipment are excluded).

- Certain other drugs that do not require a prescription by law may be covered if they are listed in the current Compendium of Pharmaceuticals and Specialties prescribed by your Physician or Dentist. If you have any questions, contact your Plan Administrator before incurring the expense.

Covered Expenses

Charges up to the maximum and any limitations, as specified in the ***Summary of Benefits*** section of this booklet, for drugs and medicines bearing a valid DIN (Drug Identification Number) issued by the federal government necessary for treatment in respect of an illness or injury. Drugs and medicines must be provided in Canada, which require the prescription of a Physician, Surgeon or Dentist and are dispensed by a licensed Pharmacist, if you are not eligible to receive them under a provincial drug benefit plan. The drugs and medications must by law or convention require the prescription of a Physician, Surgeon or Dentist to the extent that they are generally recognized as being effective in the treatment of the injury or sickness by the Canadian medical profession.

Ingredient Cost Limitation

Your drug plan will pay the best available price plus 10% (or in Quebec a Reasonable and Customary price) on all eligible prescriptions that you purchase.

Lowest Generic Cost

Eligible Charges for any prescribed drug or medicine will not exceed the price of the lowest cost generic equivalent product that can legally be used to fill the prescription, as listed in the Provincial Drug Benefit Formulary.

No Substitution Prescriptions

If the covered person's prescription contains a written direction from a Physician that the prescribed drug or medicine is not to be substituted with another product and the drug or medicine is covered under this Plan, the Physician must submit a completed Health Canada Adverse Drug Reaction (ADR) form and a No Substitution Request form for approval before the cost of the prescribed product can be considered for coverage.

Return the completed forms to ClaimSecure's Clinical Service Department by mail or fax to:

ClaimSecure
City Centre Plaza
1 City Centre Drive, Suite 620
Mississauga, Ontario, L5B 1M2

Or via Fax: 905-949-3029

Managed Formulary

New drugs introduced in Canada are not automatically covered under this Plan. Every month a team of qualified and licensed staff pharmacists and physician consultant review newly introduced drugs in Canada to determine the drug's therapeutic value. Based on this evaluation a drug will either:

- Be not covered;
- Be fully covered; or
- Require a special authorization.

Drugs may be designated as requiring a "special authorization" because they either:

- Are used for disease conditions that have no existing therapy and may have the potential for widespread use outside their approved indications; or
- Have better efficacy and/or safety profiles, although their costs may be significantly higher compared to existing therapies covered under the formulary.

Special Authorization Program

If your Physician plans to prescribe a drug on the special authorization list, there is a strictly confidential process in place for you to obtain pre-approval from ClaimSecure. To obtain a special authorization for a drug follow these steps:

- Obtain a special authorization form from ClaimSecure's website at **www.claimsecure.com** under the forms library, or by calling ClaimSecure's bilingual national call centre at 1-888-513-4464.
- Take the form to your Physician for completion if you meet the clinical criteria.
- Return the completed form to ClaimSecure's Clinical Service Department by mail or fax to:

  ClaimSecure
  City Centre Plaza
  1 City Centre Drive, Suite 620
  Mississauga, Ontario, L5B 1M2

  Or via Fax: 905-949-3029

ClaimSecure will reply in writing within ten (10) working days upon receipt.

Drugs Requiring Special Authorization

A complete list of drugs that require Special Authorization can be obtained from the Plan Administrator.

General Limitations and Exclusions for the Prescription Drugs Benefit

A complete list of drugs that are excluded from this Plan can be obtained from the Plan Administrator.

In addition to the limitations and exclusions of this benefit plan, and those limitations and exclusions contained in the ***Summary of Benefits*** and ***Details of Benefits*** sections of this booklet, the Prescription Drug coverage is subject to the following exclusions:

1) Drugs used in the treatment of infertility, obesity, sexual/erectile dysfunction, or smoking cessation drugs.
2) Hair growth or hair inhibitory drugs (i.e., Propecia, Minoxidil, Vaniqa, etc.).
3) Diabetic supplies such as swabs, rubbing alcohol, control solution, etc.
4) Any drug or medication which may be purchased without a prescription. This further excludes over the counter (OTC) products whether prescribed or not.
5) Anabolic steroids are not covered even if prescribed for therapeutic use.
6) Items deemed cosmetic even if a prescription is legally required.
7) Vitamins (except injectable vitamins).
8) Patented Medicines and GP Products.
9) First aid and surgical supplies.
10) Atomizers and vaporizers.
11) Salt and sugar substitutes.
12) Infant formula, minerals, and dietary foods and aids.
13) Contact lens care products.
14) Diagnostic aids and laboratory tests.
15) Contraceptives other than oral.
16) Lozenges, mouthwash, toothpaste and cosmetics.
17) Non- medicated shampoos, skin cleansers, skin protectors, emollients and soaps.
18) Any benefit provided by a Government plan.
19) Preventative immunization vaccines or toxoids including but not limited to those provided by a Government plan (e.g., Chickenpox, Meningitis and Pneumonia vaccinations for children).

Note: *When your coverage terminates, you must return any drug cards issued to you back to the Company.*

DENTAL CARE BENEFIT

Dental Care claims will be paid provided that the charges incurred are the lesser of the Reasonable and Customary charge of the Dentist or Dentist Specialist and the charges specified in the suggested provincial Fee Schedule, as defined under the ***Definitions*** section of this booklet, for the dental services when the dental services are:

- Necessary Dental Services;
- Not covered or eligible for coverage by a Government program or plan;
- Subject to all applicable limitations, exclusions and maximum benefit limits and any deductible or co-insurance;
- Incurred while you are eligible under this benefit; and
- Provided by a dental provider licensed to practice in the province where the services are performed.

  Note: *A dental provider may be a licensed Dentist, Dentist Specialist, or a Denturist, as defined under the* ***Definitions*** *section of this booklet.*

If you are not sure about the eligibility or reasonableness of the cost of an item or service it is strongly recommended that you contact the Carrier/Adjudicator first for a written approval prior to your purchase.
******ALL ELIGIBLE EXPENSES MAY BE SUBJECT TO ALL APPLICABLE LIMITATIONS, EXCLUSIONS AND MAXIMUM BENEFIT LIMITS AND ANY DEDUCTIBLE OR CO-INSURANCE.******

Date of Service

An eligible expense will be deemed to be incurred on the date the service was rendered except that:

20) Where an appliance or prosthetic device is inserted, the date of service will be the date such appliance or prosthetic device was inserted; or
21) In respect of a crown, on the date such crown was placed; or
22) In respect of root canal treatment, on the date the canal was closed.

No benefits are payable for dental expenses incurred after the date your coverage under this benefit terminates. This would apply even if you had submitted a detailed treatment plan and the Carrier/Adjudicator had advised you of the amount of eligible reimbursement.

Alternate Procedures

The claims adjudicator will determine the benefits payable taking into account possible alternate procedures, services or courses of treatment based on accepted dental practice.

Payment will not be made for any portion of the charge over the usual, customary and reasonable charge of the least expensive alternate service or material consistent with adequate dental services when such alternate service or material is customarily provided.

COVERED EXPENSES

Level 1 - Diagnostic, Preventive and Minor Restorative, Crown/Bridge/Denture Maintenance, Minor Oral Surgical and Adjunctive Services

Clinical Oral Examination

- Complete oral examination.
- Recall oral examination.
- Emergency examination.
- Specific oral examination.

Radiographs

- Intra oral films:
  - Bitewing films.

  - Occlusal films.
  - Periapical films.

- Extra oral films:
  - Complete Series or Panoramic film.

Laboratory Tests

- Bacteriological tests/analyses.
- Histopathlogical tests/analyses.
- Microbiological tests/analyses.

Preventive Services

- Polishing.
- Scaling/Root Planing.
- Topical application of fluoride.
- Oral hygiene instruction.
- Finishing restorations.
- Interproximal disking.

Space Maintainers

- Space maintainers & maintenance of space maintainers.

Minor Restorative Services

- Amalgam restorations non-bonded. Bonded amalgam restorations are paid up to the cost of non-bonded amalgam restorations.
- Prefabricated restorations (prefabricated crowns) for primary teeth only.
- Tooth coloured restorations.
- Retentive pins.
- Caries/trauma/pain control.
- Prefabricated posts.

Repairs of Fixed Bridges and Crowns

- Repairs of crowns/bridgework.
- Recementation of crowns/bridgework.

Rebase, Reline and Removable Denture Repairs

- Denture repairs.
- Denture rebase.
- Denture reline.

Oral Surgical Services

- Antral surgery.
- Alveoloplasty - simple.
- Extractions & residual root removal.
- Fractures.

- Surgical exposure.
- Surgical excision (cysts and tumors) and surgical incision.
- Frenectomy.
- Vestibuloplasty.
- Hemorrhage control.
- Treatment of salivary glands.

Adjunctive General Services

- Deep sedation.
- General anaesthesia.
- Nitrous oxide.
- Nitrous oxide with oral sedation.
- Parenteral conscious sedation.
- Therapeutic injections.

Level 2 - Endodontic and Periodontic Services

Endodontc Services

- Root canal therapy. Routine initial root canal therapy. Complicated root canal therapy reduced to cost of routine root canal therapy. Retreatment of root canal is covered only if at least 36 consecutive months have elapsed from the date of the initial root canal therapy. No coverage for primary teeth.
- Pulpotomy.
- Pulpectomy.
- Apexification.
- Apicoectomy.
- Hemisection.
- Intentional removal and implantation.
- Bleaching of endodontically treated teeth.
- Isolation of endodontic tooth.
- Open & drain.
- Retrofilling.
- Root amputation.

Periodontic Services

- Management of oral disease.
- Periodontal surgery – flap approach – osteoplasty.
- Periodontal surgery – flap approach – osseous defect.
- Periodontal surgery – gingival curettage.
- Periodontal surgery – gingivoplasty.
- Periodontal surgery – gingivectomy.
- Periodontal surgery – grafts – soft tissue.
- Periodontal abscess or periocoronitis.
- Occlusal equilibration.
- Periodontal appliances and maintenance.

- Proximal wedge.

General Limitations and Exclusions for the Dental Care Benefit

In addition to the limitations and exclusions of this Plan, and those limitations and exclusions contained in the description of the benefits, the dental benefits do not cover the following:

1) Any services, supplies or equipment not listed as covered under the ***Summary of Benefits*** and ***Details of Benefits*** sections of this booklet.
2) Charges for missed or cancelled appointments, completion of forms, communications, or any other non-treatment services.
3) Charges for services or supplies that are not Necessary Dental Services or do not meet accepted standards of dental practice.
4) Charges which are covered under any other benefit in this benefit plan.
5) Professional fees for an anaesthetist.
6) Replacement of lost, stolen or broken prostheses or appliances.
7) Protective appliances for athletic purposes.
8) Implants and any dental service associated with implants.
9) Services for which the claimant is entitled to indemnity or compensation under any Workplace Safety and Insurance Board (WSIB) or similar legislation unless prohibited by any Government legislation Services covered by any provincial compensation board unless prohibited by any Government legislation.
10) Services and supplies not shown in the included list of benefits.
11) Any claim expense or service provided by an immediate family member is not eligible for coverage/payment.
12) Dental services or supplies required as a result of war, terrorism, rebellion or hostilities of any kind, whether or not the person is a covered person.
13) Dental services or supplies required as a result of participation in a riot or civil disturbance.
14) Dental services or supplies due to intentional self-inflicted injury.
15) Services or supplies not listed as covered dental expenses.

PROVISIONS AND CONDITIONS

LIFE AND LONG TERM DISABILITY BENEFITS

Eligibility Date

Subject to all other provisions of the group policy, each employee shall become eligible on the latest of the following dates:

1) On the effective date of the group policy, if he has completed 3 months of continuous service with the employer, or
2) On the date on which he has completed 3 months of continuous service with the employer.

Normal Retirement Age

For the purpose of the group policy, the normal retirement age shall be the first day of the month coincident with or next following the participant's 65th birthday.

Changes in Government Plans

The benefits provided under the group policy are complementary to the benefits provided by government plans. Any modifications to these plans after the effective date of the group policy will not modify the benefits provided under the group policy, unless an agreement to modify the benefits is signed by the authorized signing officers of the insurer and the policyholder.

Notwithstanding the preceding paragraph, this plan will be modified to reflect any changes to the maximum insurable earnings as determined under the Employment Insurance Act. In addition, if either federal or provincial legislation mandates that an insurer provide a certain type or level of coverage or the means of providing a certain type of coverage, the group policy will be deemed to have been amended to reflect the requirements of the legislation.

Medical Services and/or Supplies Covered by a Government Sponsored Plan or Program

There will be no coverage under the group policy for any expenses related, directly or indirectly, to any medical services and/or supplies which would have been covered by a government sponsored plan or program if the insured person had not elected to receive the services and/or supplies on a private basis from a medical practitioner, medical facility, clinic or hospital, whether private or public, unless the services and/or supplies are explicitly stated as being covered under the group policy.

Incontestability

Where evidence of insurability is required by the insurer in order to approve:

1) Insurance or a benefit for a participant or a dependent; or
2) An increase, addition or change in the insurance or benefit for a participant or dependent;

the statements provided by the participant or dependent as evidence of insurability will be accepted as true and will not be contested by the insurer after the latest of the following dates, provided the participant or dependent is alive at the time:

1) 2 years from the effective date of the insurance or benefit for which the evidence was provided; or
2) 2 years from the effective date of the increase, addition or change to the insurance or benefit; or
3) 2 years from the effective date of the last reinstatement of the insurance or benefit.

However, this restriction on the insurer's right to contest the evidence of insurability will not apply in cases of fraud or misstatements of age.

Where evidence is required to approve an increase, addition or change in the insurance or benefit, the insurer's right to void the insurance or benefit will be limited to that increase, addition or change.

Lawful Currency

All payments hereunder will be made in the lawful currency of Canada and according to the exchange rates effective at the time the event giving entitlement to a benefit took place.

Termination of Insurance

Participant

A participant's insurance automatically terminates on the earliest of the following dates:

1) The date the group policy is terminated;
2) The date on which the participant retires, unless otherwise specified in the Summary of Benefits;
3) The date the participant reaches the age limit specified in the Summary of Benefits if an age limit is indicated;
4) The date the participant is no longer a full-time resident of Canada;
5) The date of the participant's death;
6) The later of the following dates:
    a) The date indicated on a written notice received from the policy-holder;
    b) The date this notice was received by the insurer;
    c) The date the participant is incarcerated after committing a criminal offence for which he was found guilty;
7) The date the participant ceases to qualify as an employee as defined in the group policy.

    Insurance may be extended to a participant during periods the participant has ceased to be actively at work due to, but not limited to, illness, injury, temporary layoff or a leave of absence. The participant should contact the policyholder for further information.

Dependents

A dependent's insurance terminates on the earliest of the following dates:

1) The date the participant of whom he is a dependent ceases to be covered under the group policy;
2) The date the dependent ceases to be a dependent as defined in the group policy;
3) The date the dependent reaches the age limit specified in the Summary of Benefits, if an age limit is indicated;
4) The date the dependent is no longer a full-time resident of Canada;
5) The later of the following dates:
    a) The date indicated on a written notice received from the policy-holder;
    b) The date this notice was received by the insurer.

The above terms and conditions also apply in the case of the partial cancellation of insurance owing to the cancellation of one or more benefits.

Claims

Life Insurance

The insurer must receive notice of any claim for a Life Insurance benefit as soon as possible after the date of the event which gives entitlement to the benefit, but in any event within one year of the event.

Long Term Disability Income Insurance

The insurer must receive notice of any claim for a Long Term Disability Income Insurance benefit within 90 days of the end of the participant’s elimination period.

All notices of claims must be submitted to the insurer on the forms provided for that purpose by the insurer and must include all information that the insurer deems necessary for the assessment of the claim. If all information that is required by the insurer is not received, the insurer will have the right to deny the claim.
The insurer reserves the right to require additional proof or information regarding a claim whenever it deems necessary.

If notice of claim is not received by the insurer within the periods set out above or additional proof or information requested by the insurer is not provided, the insurer will have the right to deny the claim.

At the time of claim for a benefit which is based on the participant's salary, the amount of salary that will be used to determine the benefit will be the lesser of

1) the salary that the policyholder had last reported to the insurer and which has been used in the calculation of the premium payable; and
2) the participant's actual salary at the time of the event for which a claim is being made, as determined in accordance with the definition of salary included in the group policy.

The insurer retains the right to audit all claims at any stage, including after payment has been made, for fraud or misrepresentation. If the insurer determines that a participant has intentionally submitted a claim that contains false or misleading information, the insurer shall have the right, at its sole discretion, to notify the policyholder, decline the claim or require reimbursement if the claim has been paid. In addition, the insurer will have the right to terminate the participant's entire coverage under this policy including any coverage for the participant's dependents.

Beneficiary

The participant's beneficiary shall be the person or persons designated by the participant, in writing, to receive the death benefit payable under the Participant's Life Insurance benefit, and if applicable, the Participant's Accidental Death and Dismemberment Insurance benefit, Participant's Optional Life Insurance benefit and Participant's Optional Accidental Death and Dismemberment Insurance benefit. If the participant does not designate a beneficiary, any death benefit payable under such benefits will be payable to the participant's estate.
All benefits, other than the Participant's Life Insurance benefit, Participant's Accidental Death and Dismemberment Insurance benefit, Participant's Optional Life Insurance benefit and Participant's Optional Accidental Death and Dismemberment benefit, will be payable only to the participant, or if the participant is deceased at the time of the payment of the benefit, to his estate.

The participant will be able to designate a beneficiary or change a named beneficiary by a signed written declaration, subject to the provisions of the law.

The insurer will not be responsible for the sufficiency or validity of the beneficiary designation or change of beneficiary.

If the participant had named a beneficiary under the policyholder's prior group policy, such designation will be applicable to the insurance provided under this policy, unless the participant has changed the designation in writing with the insurer. The participant should review the beneficiary designation made under the policyholder's prior group policy to ensure that it reflects the participant's current intentions in regard to his insurance.

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

Insurer's Right to Examination of a Claimant

The insurer, at its own expense, shall have the right and opportunity, whenever it deems necessary, to require a medical examination, by a physician designated by it, of any person for whom a claim is submitted and to make an autopsy in case of death, where it is not forbidden by law. In addition, the insurer reserves the right to obtain the report of any medical practitioner who has examined the person for whom a claim was submitted.

The insurer, at its own expense and discretion, shall have the right and opportunity to conduct an examination under oath of any person who has submitted a claim or for whom a claim has been submitted under the group policy, whether or not a legal action has been commenced by the person under the group policy with respect to the claim.

Subrogation

(This provision is not applicable to the Life Insurance)

Where a benefit is payable under the group policy with respect to a participant or to a dependent of a participant and if such person has a right to recover damages from an individual or organization, the insurer will be subrogated to the rights to recovery of the participant or dependent against such individual or organization to the extent of all benefits paid in the past and all benefits payable in the future.

Without limiting the generality of this provision, the term "damages" will include any lump sum or periodic payments received on account of (i) past, present or future loss of income, loss of wages, or loss of earnings, and (ii) any other benefits paid or payable under the group policy. The participant or dependent shall reimburse the insurer up to the amount of any benefits paid in the past or that are payable in the future under the group policy out of the gross damages recovered whether recovered at trial, or prior to trial by way of any form of settlement, and without regard to whether the participant or dependent has obtained full recovery of his losses.

Where the participant or dependent recovers damages in a lump sum, either by way of settlement or court order, and no allocation has been made in that settlement for the benefits paid or payable by the insurer, the insurer shall be reimbursed, out of the gross damages recovered, the full amount of benefits that have been paid to the participant or dependent. The insurer shall also be entitled to be reimbursed an amount, as determined by the insurer, which reasonably reflects the value of the future benefits payable to the participant or dependent under the group policy. The insurer's recovery in this regard shall not exceed the participant or dependent's gross damages or settlement recovered. These rights of reimbursement shall be without regard to the terms of settlement or allocation that may have been agreed to by the participant or dependent and the third party or otherwise allocated.

In the event that the participant or dependent fails to reimburse the insurer in accordance with the group policy, no future benefits will be paid by the insurer until such time as the insurer recovers (a) the total amount of benefits paid to the participant or dependent; and (b) an amount that reasonably reflects, as determined by the insurer, the total amount or value of any future benefits payable to the participant or the dependent. The insurer's recovery in this regard shall not exceed the participant or dependent's gross damages or settlement recovered. The insurer shall also have the right to seek recovery directly from the participant or dependent in the event that any overpayment has resulted from the lack of reimbursement.

The participant shall notify the insurer as soon as any action is commenced by him or his dependent against any third party which involves a claim for damages. The participant or dependent shall provide the insurer information, including copies of all relevant documentation, about any judgment or settlement of any claim against a third party which involves a claim for damages. The participant or the dependent will ensure that the subrogated rights of the insurer are advanced in any third party action and shall instruct his solicitor accordingly. The insurer shall not be responsible for any legal fees or expenses in regards to the advancement of its subrogated claim unless it has clearly agreed to such fees and expenses in writing in advance. The insurer reserves the right to retain its own counsel and/or pursue its subrogated rights against the third party and, in this respect, the participant/dependent and his solicitor shall fully cooperate with the insurer in the pursuit of its claim.

The insurer's subrogated claims shall not be settled or compromised in any way without its prior written consent. Unless the prior consent of the insurer has been obtained, no such settlement of any claim against the third party shall be binding on the insurer and the insurer shall have the right to seek recovery directly from the participant or dependent in accordance with its rights under the group policy.

Limitation on Legal Actions

No action or proceeding against the insurer will be commenced within the first 60 days following the date on which written proof of claim is provided to the insurer in accordance with the terms and conditions of this policy.
Every action or proceeding against an insurer for the recovery of insurance money payable under this contract is absolutely barred unless commenced within the time set out in the Insurance Act, or other similar applicable legislation (e.g., *Limitations Act, 2002 [Ontario]*; Civil Code [Quebec]) in the participant's province.

EXTENDED HEALTH CARE AND DENTAL CARE BENEFITS

Eligibility

Subject to any other restrictions or limitations in this Plan, and unless specifically excluded by the Company, Employees and their Dependents at all locations are eligible for coverage under this Plan provided that, as of this Plan's Effective Date, the Employee and his/her Dependents have satisfied the conditions outlined under the ***Eligibility*** section of this booklet.

Submission of Claims

1) The covered person must provide original receipts or other documentary evidence of settlement of accounts rendered for services, equipment or supplies for which the claim is submitted.
2) All claims for benefits must be submitted in a form satisfactory to the Carrier/Adjudicator at its administrative office, or such other location designated by the Company or the Carrier/Adjudicator from time to time.

3) All claims must be submitted to the Carrier/Adjudicator within 12 months following the date the expense is incurred. However, upon termination of your coverage, all claims must be submitted no later than 30 days from the termination date.

   No notice may be served or legal action taken against the Carrier/Adjudicator to recover benefits until 30 days have elapsed following the date the proof requested by the Carrier/Adjudicator is received. The right to take action begins, therefore, at the end of this 30-day period.

4) All claims should be submitted using the appropriate claim form. The Carrier/Adjudicator may require certain proof and supporting documents to be submitted with a claim.

Payment of Benefits

1) The claims for benefits are payable in Canadian currency. For accounts rendered in other than Canadian currency, claims will be paid at the conversion rate in effect on the Service Date.
2) The Carrier/Adjudicator, at its option, may pay the claim for any benefit directly to the provider.

Time Limitations

No action or proceedings against the Company or the Carrier/Adjudicator for the payment of any claim for benefits under or by virtue of this Plan will be brought later than one year from the Service Date.

Clerical Errors

Clerical error, whether by the Company or the Carrier/Adjudicator, will not void the coverage of any covered person if that coverage would otherwise have been in effect nor extend the coverage of any covered person if that coverage would otherwise have ended or been reduced as provided in this Plan.

Misstatement of Age

If premiums for the Employee and his/her eligible dependent(s) are based on age and the Employee has misstated his/her age, there will be a fair adjustment of premiums based on his/her true age. If the benefits for which the Employee is covered are based on age and the Employee has misstated his/her age, there will be an adjustment of said benefit based on his/her true age. The Carrier/Adjudicator requires satisfactory proof of age before paying any claim.

Non-compliance with Policy Requirements

Any express waiver by the Carrier/Adjudicator of any requirements of this Plan will not constitute a continuing waiver of such requirements. Any failure by the Carrier/Adjudicator and/or the Plan Administrator to insist upon compliance with any plan provision will not operate as a waiver or amendment of that provision.

Workers' Compensation

This Plan does not provide coverage in lieu of and does not affect any requirements for coverage by any Workers' Compensation Act or similar law.

Subrogation

In the event of any payment by the Carrier/Adjudicator under this plan, prior to determination of any third party liability, the Carrier/Adjudicator will be subrogated to all of the covered person's right of recovery and may bring action to enforce such right in the name of the covered person against such third party without the covered person's consent. The covered person will cooperate with the Carrier/Adjudicator in respect of any such action and do whatever is necessary to secure and enforce such rights. The covered person will do nothing to prejudice the rights of the Carrier/Adjudicator. Any monies received by the covered person from such third parties in compensation for costs that have been reimbursed by the Carrier/Adjudicator will be paid over to the Carrier/Adjudicator by the covered person.

If the third party recovery compensates the covered person for future loss, any benefits otherwise payable by the Carrier/Adjudicator will be reduced so that the total benefits payable in the future will not exceed 100 per cent of the loss.

The covered person will cooperate with the Carrier/Adjudicator and in no way compromise their right of subrogation. The covered person will execute a subrogation reimbursement agreement and direction and any other documentation required by the Carrier/Adjudicator and provides details of the third party claim.

The covered person must obtain the consent of the Carrier/Adjudicator to any settlement of the third party claim and this consent will not be unreasonably withheld.

If the covered person fails to obtain the Carrier/Adjudicator's consent to any settlement, the covered person will be considered to have recovered 100 per cent of the loss from the third party. If judgment is obtained in the third party action, the covered person must advise the Carrier/Adjudicator of the judgment within ten (10) days and provide the Carrier/Adjudicator with the details of the total recovery. If the covered person fails to provide these details the covered person will be considered to have recovered 100 per cent of the loss from the third party.

No benefits will be payable unless the requirements of this provision are satisfied.

Incontestability

In the absence of fraud, all statements made by the covered person or the Company will be considered representations and not warranties. If any of the statements made by the covered person or the Company in a signed application are not complete and/or not true at the time they are made:

- The covered person's claims may be reduced or denied;
- The covered person's coverage may be cancelled from the original effective date.

If the Company gives information about the covered person that is incorrect, the Carrier/Adjudicator will:

- Use the facts to decide whether the covered person has coverage under this Plan and in what amounts; and
- Make an adjustment of the premium where applicable.

After the Employee has been covered under this Plan for two (2) year(s), no statement made by the Employee or his/her eligible Dependent(s), unless it refers to age or is fraudulent, will be used to contest a claim under this Plan. The Carrier/Adjudicator may only contest coverage if the misstatement is made in a written instrument signed by the covered person and a copy is given to the Policyholder, the covered person or the beneficiary.

COORDINATION OF BENEFITS (COB)

Effect on Benefits

If an individual is covered under this contract as an Employee and as a Dependent or as a Dependent of more than one Employee or is covered simultaneously under any other plan which provides similar benefits, the amount of benefits payable under this contract for allowable expenses shall be co-ordinated and/or reduced so that the total benefits payable shall not exceed 100% of the actual allowable expenses.

How the Plans Coordinate Benefits

The plan that determines the benefits first (hereinafter referred to as "primary plan") will calculate its benefits as though duplicate coverage does not exist.

The plan that determines the benefits second (hereinafter referred to as "secondary plan") will limit its benefits to the lesser of:

1) The amount that would have been payable had it determined the benefits first, and
2) 100% of all allowable expenses reduced by all other benefits payable for the same expenses by the primary plan.

Order of Benefit Determination with another Plan

1) If the other plan does not contain a provision for coordination of benefits with this Plan, such plan will be deemed to be the primary plan.
2) If the other plan contains a Coordination of Benefits provision, determination of primary plan and secondary plan will be made on the following basis:
    a) With respect to a covered person who is covered as an employee and as a dependent under more than one plan, the plan which covers the covered person, other than as a dependent, shall be deemed to be the primary plan.
    b) With respect to a covered person who is covered as an Employee under more than one plan, the determination of which plan is the primary plan will be made in the following plan order:
        i) The plan under which the covered person is covered as a full-time employee;
        ii) The plan which the covered person is covered as a part-time employee;

iii) The plan under which the covered person is covered as a retiree.

c) With respect to a covered person who is covered as a Dependent under more than one plan and the two people of whom he is a Dependent are neither separated or divorced, the determination of which plan is the primary plan will be made on the following basis:

i) The plan which covers the covered person as the Dependent of the person whose birthday comes first in the calendar year shall be considered the primary plan.

ii) The plan, which covers the covered person as the Dependent of the person whose first name begins with the earlier letter in the alphabet, shall be considered the primary plan, in the situation where the two individuals of whom he is a Dependent have the same birth date.

d) With respect to a covered person who is covered as a dependent under more than one plan and the two people of whom he is a dependent are either separated or divorced, the determination of which plan is the primary plan will be made in the following plan order:

i) The plan of the person who has custody of the covered person;

ii) The plan of the spouse of the person who has custody of the covered person;

iii) The plan of the person who does not have custody of the covered person;

iv) The plan of the spouse of the person who does not have custody of the covered person.

3) When clauses 1, and 2 do not serve to establish an order of benefit determination, the benefits will be prorated in proportion to the amounts that would have been paid had there been coverage by just that plan.

Order of Benefit Determination within the Same Plan

The rules outlined under the Order of Benefit Determination with another Plan will be applied to ensure that the total benefits payable under this Plan shall not exceed 100% of the actual allowable expenses.

Order of Benefit Determination in the Case of a Dental Accident

If a benefit is payable due to allowable expenses incurred as a result of a dental accident, a supplementary health benefit which provides for dental accident coverage shall determine the benefits payable before a dental benefit.

Right to Receive and Release Information

For the purposes of determining the applicability of and implementing the terms of this section of this policy or any provision of similar purpose of any other plan, the Carrier/Adjudicator may, with proper authorization, release to or obtain from any other insurance company or other organization or person any information, with respect to any person, which the Carrier/Adjudicator deems to be necessary for such purposes. Any person claiming benefits under this Plan shall furnish to the Carrier/Adjudicator such information as may be necessary to implement this section.

Facility of Payment

Whenever payments which should have been made under this contract in accordance with this section have been made under any other plans, the Carrier/Adjudicator shall have the right, exercisable alone and in its sole discretion, to pay over to any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this section, and amounts so paid shall be deemed to be benefits paid under this policy and, to the extent of such payments, the Carrier/Adjudicator shall be fully discharged from liability under this Plan.

Right of Recovery

Whenever payments have been made by the Carrier/Adjudicator with respect to allowable expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this section, the Carrier/Adjudicator shall have the right to recover such payments, to the extent of such excess, from among one or more of the following, as the Carrier/Adjudicator shall determine: any person to or for or with respect to whom such payments were made, any other insurance companies, any other organizations.

Extension of Benefits

If your Dependents are covered for Extended Health and Dental Care under this Plan on the date of your death their coverage will continue without premium payment until the earliest of:

1) The date a Dependent is no longer a Dependent as defined under the ***Definitions*** section of this booklet;
2) The date similar coverage is obtained elsewhere;
3) The period indicated in the ***Extension of Benefit to Survivour*** under the ***Summary of Benefits*** section of this booklet; or
4) The date this Plan terminates.

General Exceptions

This Plan will not pay any claims or part of any claims for benefits where the claim or part of the claim for services, supplies or equipment is:

1) Eligible for coverage pursuant to any Federal, Provincial, Municipal or other Government program or plan, or that would have been eligible had this Plan not been in effect;
2) Eligible for coverage pursuant to any Workers' Compensation Act or any similar legislative or Government insurance plan or provision;
3) With respect to any illness or injury caused directly or indirectly by rebellion or insurrection, war, whether war has been declared or not, or by full or part-time service in any armed forces;
4) With respect to expenses of any kind that would not normally be charged to the covered person if the coverage provided under this Plan were not in effect;
5) With respect to expenses resulting from intentionally self-inflicted injuries, or injuries sustained as the result of committing or attempting to commit a criminal offence;
6) With respect to expenses associated with periodic health check-ups or examinations, cosmetic services, travel for health or change of domicile, or services, supplies or equipment required for use during sporting or sporting-related activities; and
7) With respect to expenses in connection with any services, equipment or supplies not specified as a benefit.

DEFINITIONS

Certain words and phrases used in this booklet denote actual entities as listed below:

1) **Acclaim SBA:** Acclaim Ability Management Inc., the adjudicator of Short Term Disability benefit of this Plan.
2) **Company** or **Policyholder:** Northern Communications Services Inc..
3) **ClaimSecure:** ClaimSecure Inc., the adjudicator of the Extended Health Care and Dental Care benefits of this Plan.
4) **DiBrina Sure Benefits Consulting:** DiBrina Sure Benefits Consulting (2011) Inc., a member of DiBrina Sure Group of Companies, the Plan Administrator.
5) **Industrial Alliance:** Industrial Alliance Insurance and Financial Services Inc., the insurer of Life and Long term Disability benefits of this Plan.

Certain other words and phrases used in this booklet are listed below with the definition or explanation of the manner in which the term is used for the purposes of this Plan. Where verification of eligibility is required Canada Revenue Agency (CRA) documentation must be provided.

1) **Accident** or **Injury:** An unintentional, sudden, accidental and unforeseeable event, caused exclusively by an external, violent cause, resulting in bodily injury, directly and independently of any other cause, excluding injuries sustained after death. In case of disability claim, the injury must occur and disability must begin while the Employee is covered under this Plan.
2) **Actively at Work:** If it is a scheduled work day, the participant will be considered actively at work if he reports for work at his usual place of employment or at some other location where his employer's business requires him to be and when he so reports he is able to perform all of the usual and customary duties of his occupation on a regular and full-time basis.

   If the participant is not at work due to it being a non-scheduled work day, holiday or vacation day, the participant will be considered to be actively at work if on such a date he is neither (i) hospital confined nor (ii) disabled to a degree that he could not then have reported to his usual place of employment or some other location where his employer's business requires him to be and performed all of the usual and customary duties of his occupation on a regular, full-time basis
3) **Annual salary**: The participant's annual gross base remuneration received from the employer and which the employer or policyholder has reported to the insurer including any additional income earned on a regular basis (overtime, bonuses, commissions, shift differentials, gratuities) which is included in accordance with the standards of the Employment Insurance Act.
4) **Approval of Evidence of Insurability:** The date of approval of any evidence of insurability shall mean the date the insurer receives the last document which allows it to accept the risk on the person.
5) **Basic Daily Activities:** Feeding oneself, dressing oneself, moving around and providing for one's own basic hygiene needs.
6) **Benefits** or **Coverage**: All of the terms, provisions, charges for services, equipment, or supplies as specified in the ***Summary of Benefits*** and ***Details of Benefits*** sections of this booklet, as amended from time to time, attached to and forming part of this Plan, for which the Company agrees to provide coverage, subject to the terms, conditions, limitations and exclusions of the Plan.
7) **Calendar Year:** The period from any January 1st to the next December 31st, both inclusive.
8) **Card Service Plan** or **Pay-Direct Drug Card**: A plan that permits a covered person to obtain a benefit from a provider by presenting to the provider a benefit card approved and issued by the Carrier/Adjudicator, all of which is subject to all terms, conditions, limitations and exclusions of this Benefit Plan and, without limiting the generality of the foregoing, the Prescription Drug benefit. In addition the following shall apply to the Prescription Drug Pay-Direct Card Plan:
   a) **Participating Pharmacy**: A pharmacy accredited and entitled to dispense drugs under the laws of the province in which it operates and, having a signed agreement with the drug card provider, provides pharmaceutical services to a covered person and receives reimbursement for such services directly from the drug card provider.
   b) **Drug Card:** The personalized card issued at the time when coverage commences under this Plan. The validity of the card shall lapse on the earlier of:
      i) The date the Employee is no longer covered under this Plan;
      ii) The date the Dependent is no longer eligible for coverage under this Plan if the card has been issued to a Dependent; or
      iii) The date when coverage under this Plan is terminated.

9) **Close Relative**: A spouse, son, daughter, father, mother, brother or sister of the covered person.

10) **Co-insurance:** The percentage of the eligible charges for services, supplies or equipment that will be paid by the adjudicator when the co-insurance option is selected for a particular benefit, as amended from time to time.

11) **Co-payment**: An amount that is required to be paid by the covered person toward the cost of each covered benefit under this Plan, as amended from time to time.

12) **Contract**: An agreement between the Carrier/Adjudicator and the Policyholder regarding the policy whose number is identified in the present document, including all documents integral to such agreement.

13) **Convention:** Those drugs which by law do not require a prescription, but which would not ethically be dispensed by a pharmacist without one. Examples of such drugs include digitalis, insulin, etc.

14) **Covered Person, Insured,** or **Participant**: The Employee or any Dependent for which the Employee has coverage under this plan. Covered Person or Participant will further mean an Employee eligible for benefits whose application for coverage has been approved by the Carrier/Adjudicator.

15) **Day**: A calendar day, except if otherwise defined in the group policy.

16) **Deductible**: The amount you must assume before any expenses covered under a given benefit are reimbursed.

17) **Dentist**: A qualified and specialized professional, licensed by competent government authorities to practise dentistry. This person provides oral and dental care, including oral and dental surgery, as authorized under the individual's licence to practise. This definition includes a "Denturist", "Dental Hygienist", and a "Dental Surgeon".

18) **Dentist Specialist**: A Dentist who has been certified in a specialty and who is registered as a Specialist with the Royal College of Dentists of Canada or equivalent status as determined and accepted by the Carrier/Adjudicator.

19) **Dependent:** For the purpose of all, except Life and Long term Disability Benefits, means only the following:

    a) **Spouse:**

        i) The Employee's partner of the opposite sex or of the same sex who is married to the Employee by virtue of a valid religious or civil marriage ceremony and cohabitating (i.e., not legally separated) from the Employee;

        ii) Is living common-law with you, and has a child with you, and whom you have designated in writing to the Carrier/Adjudicator as your spouse;

        iii) Has been living common-law with you for at least 12 months, and whom you have designated in writing to the Carrier/Adjudicator as your spouse; or

        iv) If, according to the above definitions, the Employee has had more than one Spouse, Spouse will mean the individual most recently qualified and designated in writing to the Carrier/Adjudicator.

        The status of spouse ends when:

        i) In the case of a marriage or civil union, you and this person have been separated for more than 3 months or have obtained a divorce or annulment of your marriage or civil union; or

        ii) In the case of a common-law union, you and this person have been separated for more than 3 months.

    b) **Child**: A stepchild, legally adopted child, common-law child, or natural child (but does not include a foster child) of the Employee or the Employee's Spouse who is unmarried and dependent on the Employee for financial support and:

        i) has not attained age 18 and is not employed for more than 20 hours a week;

        ii) is at least 18 years of age but under 25 years of age (age 26 for Employees who reside in Quebec) and is attending an accredited educational institute, college or university on a full-time basis and is wholly dependent on the Employee for support; or

        iii) is 18 years of age or older who by reason of mental or physical disability is incapable of self-sustaining employment and is totally dependent upon the Employee for support and provided such child was covered under this plan prior to attainment of age 18. However, for the purposes of this policy, anyone who is:

            (1) In the armed forces of any country or state or international organization, or a civilian force auxiliary to any military force; or

    c) **Common-law Spouse**: An individual who is publicly represented as the Employee's Spouse, who has resided with the Employee for at least twelve (12) months and the Employee has filed that Spouse as such with CRA.

    d) **Common-law Child**: A child of the Employee's common-law Spouse from another relationship who resides with and is in the care and custody of the Employee and his/her common-law Spouse.

20) **Dependent:** For the purpose of Life and Long term Disability Benefits, the participant's spouse or a child of the participant or of the spouse. If dependents are insured under the group policy, "spouse" and "child" shall have the following meanings:

    a) **Spouse:** The person who is married to or is in a civil union with the participant, or the person designated by the participant, whom he declares publicly to be his spouse and with whom he has been living on a permanent basis for at least one year.

    A de facto separation of more than 3 months will result in the person no longer qualifying as the participant's spouse for the purposes of the group policy.

    If according to this definition, the participant has had more than one spouse, spouse shall mean the person most recently qualified.

    b) **Child:** An unmarried child of the participant or of his spouse who wholly depends on the participant for support and maintenance and who meets at least one of the following conditions:

        i) He is under 18 years of age; or

        ii) He is under 25 years of age and is attending a recognized educational institution on a full-time basis; or

        iii) He is mentally or physically handicapped and is incapable of earning his own living due to such handicap provided such handicap commenced while he was a child as defined in (i) or (ii).

21) **Disability Period**: A continuous absence from work due to disability.

22) **Disability Resulting From an Accident**: A disability resulting exclusively from an accident that begins within 90 days of the date of the accident, provided that you were covered under the relevant Disability benefit at the date of onset of disability. Any other disability is considered to be the result of an illness.

23) **Elimination Period**: The period that begins at the onset of a disability and must elapse before you are entitled to Disability benefits.

24) **Emergency**: An acute unexpected condition, illness, disease or injury that requires immediate assistance.

25) **Employee**: A person who is employed by his employer on a permanent, full-time basis and who is working a minimum of 25 hours per week for such employer.

26) **Employer**: The Company, the group Policyholder, or any employer whose employees, or a class of employees, are represented by the group Policyholder.

27) **Family Member**: A spouse, son, daughter, father, mother, stepfather, stepmother, father in law, mother in law, brother, sister, half brother, half sister, brother in law, sister in law, son in law, daughter in law, grandparent or grandchild.

28) **Fee Schedule**: The schedule of fees approved and published by a Provincial Dental Association and stipulated for use under this Plan, which includes dental procedure codes, definitions, headings, preambles and other material contained therein, or, when treatment outside Canada is necessary, the approved fee schedule for the province in which the Employee normally resides, unless otherwise specified by the Company.

29) **Full-time Employee**: A person who customarily works a regularly scheduled workweek with the Company and satisfies the condition specified in the ***Member Eligibility*** section of this booklet.

30) **Full-time Resident of Canada:** Has a permanent residence in Canada and resides in Canada for at least 182 days a year.

31) **General Products (GP)**: As it relates to Prescription Drugs coverage, means products that are either available over the counter (OTC), are not assessed by Health Canada, or do not have a DIN number assigned by Health Canada.

32) **Health Care Provider**: A licensed, certified, registered or chartered practitioner licensed to practice in the jurisdiction where the services are provided.

33) **Hospital**: An institution licensed as a hospital (if licensing is required) and operated pursuant to law for the care and treatment of sick and injured persons, which institution provides 24 hours nursing care and has facilities both for diagnosis, and, except in the case of a hospital primarily concerned with the treatment of chronic diseases, for major surgery. The term "hospital" will not be construed to include a hostel, hotel, rest home, nursing home, convalescent home, place for custodial care, home for the aged, or a place used primarily for the confinement or treatment of drug addicts or alcoholics, or a privately owned/operated hospital or care facility.

34) **Hospitalization** or **Hospital Confinement**: A case in which a person is confined in a hospital, for the purposes of this Plan, only if his/her confinement continues for a minimum of 18 consecutive hours (if applicable, minimum of 24 consecutive hours for the purpose of a disability benefit) or longer or if a board and room charge is made in connection with this confinement or if the confinement results from a non-occupational injury requiring emergency care and commences prior to midnight of the day following the date of the injury, or if the confinement is required because of a day surgery or surgical procedure.

35) **Illness**: Any deterioration in health requiring regular, continuous and curative care actively provided by a physician. Organ donation and any related complications are considered an illness for the purposes of the Short Term Disability Benefit.

36) **IME**: An Independent Medical Evaluation performed by a third party of the Company's choice.

37) **Insured Person**: A participant or a dependent of a participant who is insured under the group policy.

38) **Medical Specialist**: Any Physician holding a specialist licence duly authorized to practise in any of the specialist fields related to the benefits provided for in this Plan.

39) **Medically Necessary:** Services, equipment, or supplies consistent with the diagnosis and treatment of the condition and in accordance with standards of good medical practice, but does not include services, equipment or supplies obtained for the convenience of the covered person, the covered person's family or the provider of the services, equipment or supplies. The order, recommendation, or approval of a Physician does not make the service Medically Necessary. The determination of Medically Necessary will be made by the Carrier/Adjudicator at its sole discretion.

40) **Monthly Salary**: The participant's annual salary divided by 12.

41) **Necessary Dental Services:** Dental services that are consistent with the diagnosis and treatment of the condition and in accordance with standards of good dental practice, including preventive services that are provided within the standards of good dental practice, but does not include services, equipment or supplies obtained for the convenience of the covered person, the covered person's family or the provider of the services, equipment or supplies. The order, recommendation, or approval of a Dentist or Dentist Specialist does not make the services Necessary Dental Services. The determination of Necessary Dental Services will be made by the Carrier/Adjudicator at its sole discretion.

42) **Net Salary:** your salary at the onset of disability, after deduction of federal and provincial income taxes.

43) **Normal Retirement Age**: The age indicated in the Summary of Benefits.

44) **Occupational Claim**: Any claim, which is the result of an injury or disease, which arises from or is sustained in the course of any employment for wage or profit.

45) **Participant**: An employee who is insured under the group policy.

46) **Physician**: A doctor of medicine who is legally qualified to practice medicine or surgery and is licensed by the appropriate board in the jurisdiction where his/her services are rendered to the covered person.

47) **Plan**: Any arrangement providing benefits or coverage for services, equipment, or supplies under this or any other insurance, plan, or program of any kind whatsoever, including but not limited to other Group Benefits plan, Government programs, or any coverage.

48) **Plan Administrator**: An individual or organization, appointed by the Policyholder, responsible for the administration of this Plan.

49) **Pregnancy:** includes childbirth or miscarriage and any disease or infirmity resulting from or aggravated by the pregnancy.

50) **Premium Period**: The interval for the payment of premiums as agreed to by the Company and the Carrier/Adjudicator.

51) **Prescription Drugs:** Drugs which are Medically Necessary and that have been approved by the Carrier/Adjudicator for coverage under this Plan and appear on the current formulary and which by federal or provincial law may only be dispensed pursuant to a prescription of a Physician, Dentist or Dentist Specialist.

52) **Policy:** Where applicable and unless otherwise specified, means a written contract or certificate of insurance.

53) **Policy Month**: The period of one month beginning with the day in each calendar month which corresponds to the day of the month on which premiums are payable, whether payable monthly or otherwise.

54) **Policy Year**: The period, which begins, as to the first policy year, with the policy effective date, and as to each subsequent policy year, with a contract anniversary, and ends with the date immediately prior to the next policy anniversary.

55) **Pregnancy Leave of Absence**:

a) Any period of Pregnancy leave taken by the Employee pursuant to Provincial or Federal statue or pursuant to a mutual agreement between the Employee and the Company;

OR

b) Any Pregnancy leave, which the Company requires the Employee to take pursuant to a Provincial or Federal statute.

However, if the Employee has not taken or has not been required to take a Pregnancy Leave of Absence, as defined in above clauses a) or b), she will be deemed to have commenced a Pregnancy Leave of Absence on the date of the Child's birth. The Pregnancy Leave of Absence will be deemed to continue until she is again actively at work or if unable to return to work because of a disability, the end of the period specified by a Provincial or Federal statute for a Pregnancy Leave of Absence.

56) **Proof:** Evidence or proof deemed satisfactory by the Carrier/Adjudicator.

57) **Provider** or **Practitioner**: Any Person that provides goods and services to an Employee pursuant to a benefit covered in this Plan and includes, without limitation, a Pharmacist, Optician, Dentist, Physician or other Health Care Provider. In addition the following will apply for each respective Practitioner if specified throughout this booklet:

a) **"Optometrist"** means a member of the Canadian Association of Optometrists or any other applicable associated provincial association.

b) **"Pharmacist"** means a person who is licensed to practise pharmacy and whose name is listed on the pharmacists' registry of the licensing body for the jurisdiction in which the pharmacist is practising.

c) **"Ophthalmologist"** means a person who is a medical doctor who is legally licensed to practise ophthalmology.

58) **Province**: All references to the term "province" in the present contract and should be interpreted to include the Yukon, Northwest Territories and Nunavut.

59) **Reasonable and Customary**: A charge that it does not exceed the general level of charges being made by others of similar standing in the locality where the charge is incurred, when furnishing like or comparable treatment, services or supplies to individuals of the same sex and of comparable age and income, for a similar disease or injury. The term "locality" means a county or such greater area as is necessary to establish a representative cross section of persons or other entities regularly furnishing the type of treatment, services or supplies for which the charge was made. Reasonable and Customary also means expenses or fees usually charged to an individual who does not have benefits coverage, i.e., the amount of which must not exceed that normally charged for a particular service in the region where the service was rendered. This amount is based on the various provincial or national professional association fee guides.

60) **Registered Nurse:** A graduate nurse who has been legally registered to practice after examination by a provincial board of nurse examiners or similar regulatory authority and who is legally entitled to use the designations "Registered Nurse" or "R.N."

61) **Reimbursement Plan:** A plan that requires the covered person to purchase Medically Necessary services and supplies, submit receipts to the Carrier/Adjudicator and receive reimbursement from the Carrier/Adjudicator in accordance with all terms, conditions, limitations and exclusions of this Plan.

62) **Salary:** Your regular salary, excluding bonuses, commissions, payments for overtime, shift premiums, fees, accommodation and meal allowances, as well as amounts paid by the employer as fringe benefits, isolation allowances and any lump sum payments. Premiums and benefit payments are calculated based on either your salary, as defined above, or your insurable earnings, as specified under the "Employment Insurance Act", whichever is higher.

63) **Service Date**: The date upon which a covered person receives the services, equipment or supplies for which a claim is submitted.

64) **Specialist**: A physician licensed by the appropriate provincial licensing authority to practice medicine with a specialization.

65) **Subrogation**: The substitution of one person or thing in the place of another with respect to a lawful claim.

66) **Summary of Benefits**: The listing and description of benefits contained in this booklet.

67) **Surgical Procedure**: The following:

a) A cutting operation or Suturing of a wound;

b) Treatment of a fracture;

c) Reduction of a dislocation;

d) Radiotherapy (excluding radioactive isotope therapy) if used in lieu of a cutting operation for removal of a tumour;

e) Electro cauterization;

f) Diagnostic and therapeutic endoscopic procedures; or

g) Injection treatment of hemorrhoids and varicose veins.

68) **Weekly salary**: The participant's annual salary divided by 52.

69) **You**, **Your**, and **Yours:** Means the covered person directly.