CMSG Western Branch Benefit Plan

Group Benefit Plan
Active and Retired Members

Effective Date: **May 1, 2023**
Publication Date: **October 30, 2023**

Keep This Booklet in a Safe Place

Your group benefits provide an important supplement to your income and valuable protection to you and your family.

This booklet outlines the specific terms of your group benefits program as well as the coverage levels of each benefit. Be sure to keep this booklet in a safe place for future reference.

The coverage for these benefits is underwritten as follows:

Benefit	Insurer/Administrator	Policy Number	Appendix
Basic Life, Dependant Life and Long-Term Disability Insurance	Manulife Financial	G0633162	Appendix A
Weekly Indemnity (WI)Insurance	CMSG Western Branch Benefit Plan/Manulife	G0633163 (WI)	Appendix B
Accidental Death and Dismemberment (AD&D)	AIG Insurance Company of Canada	GPA 9427644	Appendix C
Out-of-province/Canada medical emergency insurance	AIG Insurance Company of Canada	CMG 9429026	Appendix D
Extended Health Care and Dental Care	CMSG Western Branch Benefit Plan/ Coughlin & Associates Ltd.	9006	See Section 2 and Section 3 of this booklet
Expedited DiagnosticTesting	TAL Insurance Brokers Limited	9006	Appendix E

If you have questions about your group benefits that are not covered in this booklet, please contact Coughlin & Associates Ltd., your plan administrator, at 613-231-2266, or toll-free 1-888-613-1234, or fax 613-231-2345, or email at info@coughlin.ca or your plan consultant, Weitzel & Associates Inc., at 604-428-2655, or toll-free 1-800-663-2865, or fax 604-879-6562 or email at don@weitzelassociates.ca.

If there are any discrepancies between the group contract and the benefits booklet, your coverage will be determined by the terms and conditions of the group contract.

Important

This document contains important information about your member benefits coverage and should be kept in a safe place. It supersedes and replaces all previous communications material and is the plan document in respect to the benefits described herein.

The Canadian Merchant Service Guild Western Branch, the plan sponsor, underwrites certain benefits on a self-insured basis as indicated in the table on the previous page. All risks in respect to these benefits are borne by the Canadian Merchant Service Guild Western Branch Trust.

As sponsor of the plan, the Canadian Merchant Service Guild Western Branch or its trustees or designates may establish rules or regulations for the administration or governance of the benefits plan and any transactions associated with it.

The Canadian Merchant Service Guild Western Branch Benefits Plan, or its trustees or designates, have the right to interpret the self-funded coverage of the plan and decide any and all matters related to it. This includes the right to clarify or remedy any possible uncertainties, omissions or inconsistencies based on applicable laws and the reasonable and customary charges and treatment for the self-funded benefits described in this booklet.

Reasonable and customary means that the treatment provided is accepted by the appropriate Canadian medical profession as being proven scientifically and effective medically and of a form, intensity, frequency and duration essential to the diagnosis and management of the disease or injury.

In respect to these benefits, no payment will be made for expenses that are related to services, treatments or supplies payable by or covered by a government plan.

The interpretations or decisions of the Canadian Merchant Service Guild Western Branch Benefits Plan, its trustees or designates with respect to the self-insured coverage, will be final and binding on all parties.

Protecting Your Personal Information

The plan administrator of your group benefit plan is Coughlin & Associates Ltd. At Coughlin, we recognize and respect every individual's right to privacy. When personal information is provided to us, we establish a confidential file that is kept in the offices of Coughlin, or the offices of an organization authorized by Coughlin. We use the information to administer the group benefit plan. We limit access to information in your file to Coughlin staff or persons authorized by Coughlin who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law.

Errors or Omissions

Every effort has been made to ensure that this booklet is accurate and complete. Should error, omission or dispute occur, the terms of the policies issued to the Canadian Merchant Service Guild Western Branch Trust will prevail. Clerical errors made by the trustees and the plan administrator will not invalidate benefits otherwise in force or continue benefits otherwise terminated.

Any fraud or willfully false statement in making a claim may invalidate your claim. You are not entitled to the claimed benefit. Sometimes, an overpayment situation may occur through no fault of yours. This means you received a greater benefit payment than you were entitled to receive. If you receive a benefit to which you are not entitled, you must immediately repay that amount to the plan sponsor, to Coughlin & Associates Ltd., which administers your group benefit plan on behalf of the plan sponsor, or to the insurer. If you receive benefits to which you are not entitled and do not repay them, any one or more of the following may occur:

a) any benefit payments to which you are entitled may be withheld to recover the amount you owe; and
b) criminal or other legal action may be brought against you.

Mission Statement

Background

The Canadian Merchant Service Guild (CMSG) Western Branch established a group health and benefit program for active and retired members of the CMSG Western Branch, their eligible dependants and survivors.

Objectives

The purpose of this program is to reimburse eligible participants for all or part of costs incurred for health care and dental care services and supplies not covered by the provincial health care plan. The CMSG Western Branch Benefit Plan is also designed to provide financial protection in the event of death or disability by providing group and optional life insurance coverage as well as accidental death and dismemberment and long-term disability insurance coverage.

The Benefit Plan will:

- provide effective group health care, dental care, life insurance and long-term disability coverage for all eligible plan members and beneficiaries;
- provide high quality, cost-effective and efficient service to members and beneficiaries; and
- operate in a way that promotes the objectives of CSMG Western Branch participants and plan members while supporting the principles of good governance and fiduciary responsibility.

The Benefit Plan document describes the coverage and provisions in detail. The benefit program may be amended at any time thereafter. Claims will be administered in accordance with any amendments and their effective dates. Members can consult the Benefit Plan document at any time through the CMSG Western Branch office.

Coughlin & Associates Ltd., the plan administrator, has been contracted to adjudicate and pay claims in accordance with the plan document.

Weitzel & Associates Underwriting Analysts Inc. is the consultant and has been contracted to provide consulting services and advice to the Trustees and members.

Table of Contents

Benefit Summary

The following is a summary of your benefit plan. For further details on each benefit, please refer to the appropriate section of this booklet.

Basic Member Life Insurance

COVERAGE PROVIDED BY MANULIFE FINANCIAL

Members Qualifying Criteria	Amount
• actively at work.	$200,000
• retired member under age 65.	$50,000
• retired member at age 65 or over.	$25,000

Life insurance coverage will continue into retirement, provided the required premiums are paid.

Termination - active member:	Retirement
Termination - retired member:	Age 70

Dependant Life Insurance

COVERAGE PROVIDED BY MANULIFE FINANCIAL

Benefit amount:	$50,000 spouse. $10,000 child.
Termination:	Member's retirement.

Active Member Accidental Death & Dismemberment (AD&D) Insurance

COVERAGE PROVIDED BY AIG INSURANCE COMPANY OF CANADA

Members Qualifying Criteria	Amount
• member under age 65:	$200,000
• retired member age 65 to 70:	$100,000

Weekly Indemnity Insurance

COVERAGE PROVIDED BY MANULIFE FINANCIAL

Benefit amount:	65% of weekly earnings.
Maximum amount	$2,000 weekly
Elimination period:	14 days accidental injury or illness, 0 days hospitalization
Maximum benefit period:	52 weeks.
Termination of coverage:	At retirement

Long-Term Disability Insurance

COVERAGE PROVIDED BY MANULIFE FINANCIAL

Benefit amount:	65% of monthly earnings.
Maximum amount:	$5,000 monthly.
Elimination period:	52 weeks.

Maximum benefit period for disabilities commencing:	
• Before January 25, 1993	To age 65
• Between January 25, 1993 and May 31, 2001	To age 62
• Between June 1, 2001 and October 31, 2009	To age 65
• Between November 1, 2009 and August 31, 2015	To age 62
• On or after September 1, 2015	To age 65

Termination of coverage:	Maximum benefit period less the elimination period; or at retirement, whichever occurs first.

The maximum amount may be reduced by benefits and payments provided from other sources as described in the *Long-Term Disability (LTD) Benefit* section of this booklet.

Out-of-Province/Canada Medical Emergency Insurance

COVERAGE PROVIDED BY AIG INSURANCE COMPANY OF CANADA

Deductible:	Nil.
Eligibility:	Class I: Active employees under age 75 Class II: Retired employees under age 75 Class III: Active employees age 75 to 80
Reimbursement level:	100% of eligible expenses.
Maximum amount:	Under age 70: Lifetime maximum of $5,000,000 per insured person. Age 70 and over: Lifetime maximum of $2,000,000 per insured person.
Coverage period:	60 consecutive days per trip.
Termination:	When you reach age 80 or earlier retirement.

Extended Health Care

REFER TO SECTION 2

Deductible:	Nil.
Reimbursement level:	100% of all eligible expenses (unless otherwise specified).
Maximum benefit:	$150,000 lifetime per insured person. The overall lifetime limit is subject to a reinstatement of $2,500 annually. Individuals whose claims do not exceed $2,500 annually will have their lifetime maximum restored each year.
Termination:	No termination date if actively working. To age 75 for retired members.

Note: Some individual benefits are subject to monthly, yearly or lifetime maximums.

Prescription drugs:

The following parameters are based on enrolment in the Fair PharmaCare Program. Refer to Section 2 – Extended Health Care for details on registration and program coverage.

• Deductible:	Nil.
• Reimbursement level:	100%, except as noted elsewhere in this booklet.
• Maximum benefit:	$15,000 per insured person per calendar year, however failure to submit proof of registration in the Fair PharmaCare program will result in a maximum $1,500 per insured person per calendar year. The $15,000 annual maximum may be waived for an insured person who is prescribed a life sustaining drug which exceeds this maximum, however the overall lifetime maximum of $150,000 remains in effect. Prior authorization is required from the plan administrator.
• Eligible drugs:	Drugs, serums, vaccines and injectables, only available by prescription with a valid drug identification number (DIN), when prescribed by a licensed health care practitioner or dentist dispensed by a pharmacist, dentist or a physician.
• Generic substitutions:	Mandatory.
• Drug card:	Yes.
• **Maximums and exclusions:**	
• Drugs:	Limited to a 34-day supply for prescription drugs or medicines and a 100-day supply for maintenance drugs.
• Viscosupplementation:	Excluded.
• Smoking cessation aids (products only):	$250 per lifetime per insured person
• Sexual dysfunction drugs:	$500 per insured person per calendar year.
• Fertility treatment:	12 treatment cycles lifetime.

Prior authorization may be required by the plan administrator for certain medications.

Hospital care:

• Reimbursement level:	100% of eligible expenses to a combined maximum of $10,000 per insured per lifetime, unless specified otherwise.
• Coverage:	Cost of a private or semi-private room for each day of hospitalization.
• Palliative care:	Covered under the hospital care coverage as indicated above.
• Convalescent care:	Covered under the hospital care coverage as indicated above.
• Chronic care:	Covered under the hospital care coverage as indicated above.
• Detoxification:	60% per member to a lifetime maximum of $15,000 per maximum 42 day confinement. 100% per dependant to a lifetime maximum of $10,000 per maximum 42-day confinement.
• Room referral care outside province of residence but in Canada:	80% of eligible expenses to a combined maximum of $10,000 per insured per lifetime for all hospital expenses

Vision care (eyeglasses, contact lenses and laser eye surgery):

• Reimbursement level:	100% of eligible expenses.
• Maximum:	$500 per insured person once every two calendar years.
• Laser eye surgery:	Lifetime maximum of $3,000.
• Glasses or contact lenses following cataract surgery:	$500 per insured person within every two calendar years.
• Artificial crystalline lenses, also known as intraocular lenses (IOL) for cataracts:	Reasonable and customary charges.

• Eye examinations, including eye refraction:	Up to a maximum of $50 per insured person for any period of two calendar years for members and dependents age 19 to 65.

Professional and paramedical services:

• Reimbursement level:	100% of eligible expenses
• Maximum per practitioner:	
• Acupuncturist*:	$200 per insured person each calendar year.
• Audiologist*:	$200 per insured person each calendar year.
• Chiropractor:	$35 per visit and up to $50 for x-rays to a maximum of $500 per insured person per calendar year.
• Christian Science Healer*:	$200 per insured person per calendar year, doctor's referral required.
• Inhalation Technician*:	$200 per insured person per calendar year, doctor's referral required.
• Occupational therapist*:	$200 per insured person per calendar year.
• Massage therapist or Orthotherapist*:	Combined maximum of $1000 per insured person per calendar year.
• Naturopath:	$200 per insured person per calendar year.
• Orthoptic Technician*:	$200 per insured person per calendar year, doctor's referral required.
• Osteopath:	$200 per insured person per calendar year.
• Podiatrist or Chiropodist:	Combined maximum of $200 per insured person per calendar year.
• Psychologist, social worker or counsellor	$1,000 per insured person per calendar year. Services of a social worker or counsellor can be accepted if proof is provided that registered psychologist is not available.
• Speech therapist*:	$200 per insured person per calendar year.
• Physiotherapist*:	$1,000 per insured person per calendar year.

***** Physician's referral required. Medical recommendation to be renewed every 12 months.

Medical supplies and services:

• Reimbursement level:	100% of eligible expenses.
• Maximum per service and/or supply:	
• Surgical brassieres:	Purchase of 4 surgical brassieres per insured person per calendar year.
• Private duty nurse:	$10,000 lifetime maximum per insured person.
• Artificial eye:	Purchase, including reimbursement for polishing or rebuilding of the artificial eye per insured person up to reasonable and customary charges.
• Stump socks:	Reasonable and customary charges.
• Orthopaedic shoes:	Purchase of one pair (custom made), up to maximum of $400 per insured person each calendar year.
• Custom made orthotics or arch support:	Purchase, $200 per insured person each calendar year.
• Elastic Support stockings:	Purchase, 4 pairs to a maximum of $100 per insured person each calendar year.
• Conventional wheelchair:	Reasonable and customary charges.
• Hearing aids:	Purchase, $1,000 per hearing aid per insured person to an overall maximum of $2,000 for any period of 36 consecutive months. A written prescription by a licensed otolaryngologist is required.
• Diagnostic services:	Reasonable and customary charges.
• Wigs as result of chemotherapy:	Purchase, lifetime maximum of $300 per insured person, doctor's referral required.
• Glucometer:	Reasonable and customary charges to a maximum of one device for any period of 36 consecutive months.

• TENS nerve stimulators:	Reasonable and customary charges, doctor's referral required.
• Out-of-province referral treatment:	Excluded.

Dental Care

REFER TO SECTION 4

Deductible:	Nil.
Fee guide:	Based on the current British Columbia Dental Association fee guide for general practitioners. An additional 10% of the general practitioner's fee schedule can be added for specialist's claims.
Reimbursement amount:	
• Basic services:	100% of eligible expenses.
• Maximum:	• Combined maximum with major services to a maximum of $3,500 per insured person each calendar year.
• Major Services	80% of eligible expenses.
• Maximum:	• Combined maximum with basic services to a maximum of $3,500 per insured person each calendar year.
• Orthodontic services:	50% of eligible expenses.
• Maximum:	• Lifetime maximum of $2,500 per insured person.
Treatment frequency:	
• Complete oral examination:	Once every 3 years.
• Recall oral examination:	Once every 6 consecutive months.
• Specific oral examination:	Unlimited.
• Emergency oral examination:	Unlimited.
• Complete series of periapical films or panoramic radiographs:	Complete series are eligible once per year. Panoramic radiographs are eligible once every 3 years.
• Polishing:	Once every 6 consecutive months.
• Bitewing radiographs:	Unlimited.
• Scaling:	8 units combined with root planning per calendar year.
• Root planning:	8 units combined with scaling per calendar year.
• Fluoride treatment:	Once every 6 consecutive months.
• Replacement fillings	Once every 12 consecutive months.
• Tooth coloured (composite) filling:	Eligible on all teeth.
• Special periodontal appliances, including occlusal guards and bruxism appliances:	Reasonable and customary charges.
• Adjustments to periodontal appliance to control bruxism:	One adjustment up to 2 units of time after the date of insertion.
• Pit and fissure sealants:	For children under age 18.
• Occlusal equilibration:	4 units per calendar year.
• Space maintainers:	Initial provision and installation.
• Oral hygiene instruction:	Excluded.
• Anaesthetic:	Eligible in relation to dental surgery only.
• Denture adjustments including minor adjustments:	Reasonable and customary charges.
• Denture rebase/reline:	Reasonable and customary charges.
• Preformed stainless steel and polycarbonate crowns:	Reasonable and customary charges.
• Crowns, inlays and onlays:	Once every 5 years. Excludes porcelain crowns for molar teeth.
• Veneers:	Once every 5 years.
• Implant services and supplies	Included.

• Laboratory fees:	Limited to the reasonable and customary fees specified for the dental treatment or service.
Termination:	No termination date if actively working. To age 75 for retired members

For orthodontic services only, members who remain insured for prolonged periods are allowed to reclaim benefits previously exceeding the limit applicable when the claim was first submitted.

If coverage is terminated and reinstated within a 6 month period, the applicable maximum at termination is carried forward. If coverage is reinstated after 6 months from the date of termination, the maximum will reset to the amount eligible during the first year of coverage.

General Information

This Plan Supplements Provincial Plans

This group benefit plan is designed to supplement protection, not duplicate or take the place of, the benefits available under provincial hospital and medical care plans. Therefore, this benefit plan excludes care and services that can be provided under a provincial plan. The group plan cannot provide any benefits where care or treatment by private insurance is prohibited.

Who is Eligible

Full-time members of an employer party to collective agreements or participation agreements with the Canadian Merchant Service Guild Western Branch will be eligible for coverage provided they:

- are members of the Canadian Merchant Service Guild Western Branch;
- have completed 90 days of employment with any one employer;
- are residents of Canada. Participating members who choose to live outside of Canada will receive the same coverage as that provided to members who reside in Canada. Non-Canadian residents will not be able to claim coverages that would not otherwise have been available to Canadian residents making claims in Canada.

Waiting Period

An eligible member will be covered following the completion of three months of continuous employment with any one employer.

When Coverage Begins

Active member:
- when the eligibility and waiting period requirements have been satisfied.

Inactive member:
- upon return to active work (absence due solely to a paid vacation or general holiday will not delay coverage.

Dependants:
- the date member coverage begins (if a dependant has been identified) or,
- the date a dependant becomes eligible for coverage; or
- the dependant coverage application date, provided the application is made within 31 days initial eligibility for dependant coverage otherwise; or,
- the date the plan administrator approves the evidence of insurability submitted for the dependant.

IMPORTANT: 31 days after the effective date of coverage, evidence of insurability must be submitted for each dependant.
Dependant coverage will be effective as of the date the plan administrator approves the evidence.

Complete a new Enrolment form to add or change a legally married or common-law spouse, or add or remove a child.

Definitions

Active work member or member actively at work: an employed and working member who performs all of usual customary duties of the occupation.

Collective agreement: the agreement in accordance with which contributions are made to the fund by the employer on behalf of a member.

Dependant child:
- an unmarried person who is a natural or adopted child; or
- a child of a common-law spouse, who resides with you and is dependent on you for support; and
  (i) younger than 21 years of age; or
  (ii) 21 years but younger than 25 years of age and in full-time attendance at an accredited institute of learning, and dependent on you for support; or
  (iii) 21 years or older and incapable of self-sustaining employment due to a mental or physical handicap. The child's coverage will be continued under the policy, provided the child's handicap has existed continuously from a time when he/she was otherwise insured as a dependant under this policy. Supporting documentation by a physician will be required.

To avoid delays or processing problems, contact the plan administrator when any change in dependant status occurs.

Disability:
- **Weekly Indemnity:** You are considered totally disabled if you are in a state of complete and continuous incapacity resulting from illness, or accidental injury, which wholly prevents you from performing the substantial duties of your own occupation.

- **Long Term and other benefits:**
  i) During the elimination period and the initial disability period specific in the Benefit Summary, you are in a state of complete and continuous incapacity resulting from illness, or accidental injury, which wholly prevents you from performing the substantial duties of your own occupation;
  ii) Following the initial disability period, you are in a state of complete and continuous incapacity resulting from illness, or accidental injury, which wholly prevents you from performing the substantial duties of any occupation for which you are or may become reasonably qualified by training, education or experience. Furthermore, you must not be able to earn 60% or more of your gross monthly income determined at the onset of disability by the insurer.

Employer: (can be any of the following)
- the Policy holder;
- employers party to collective agreements or participation agreements with the Canadian Merchant Service Guild Western Branch.

Full-time member/employee: Regularly scheduled work of at least 30 hours per week, or permanent part-time member/employee eligible for benefits under the terms of the collective bargaining agreement.

Insured person: (can be any of the following) member with coverage, spouse and dependant child.

Part-time member/employee: See full-time member/employee.

Policy holder: The Canadian Merchant Service Guild Western Branch Benefit Plan.

Retiree: is a member in good standing who:
- has or is retired and has not returned to work for a participating employer;
- participated in the benefit plan for the preceding five years, has attained age 55 and whose benefits were in force at the time of retirement;
- completed the application for retirement benefits within 31 days of retirement.

Spouse: can be:
- an individual to whom the member is legally married; or
- a common-law partner with whom the member has co-habited with for a period of at least 12 months and who is publicly represented as the member's spouse/partner.

Members must state the name of the person to be considered a spouse for the purposes of the policy. Only one spouse will be covered under the policy at any time.

Temporary lay-off: a member who has not reported to work for a participating employer.

Change in Information

To ensure that you receive all correspondence and that the proper information is stored in your file, contact the plan administrator as soon as a change (i.e. new dependant, beneficiary or address) occurs.

Termination of Coverage

Member Coverage will terminate as follows:
- For members, on the last day of the calendar month in which your employment terminates;
- For employment termination with lay-days to your credit, coverage terminates on the last day of the calendar month in which the credit is exhausted.
- For LTD benefits, coverage terminates on the last day of the calendar month in which you attain age 64. If you are in receipt of LTD benefits, the last benefit payment will cease in the month in which you attain age 65.
- the member ceases to be a member of any eligible class;
- the date the member class is terminated;
- the date the member becomes a full-time member of the armed forces of any country;
- the date the policy terminates; or
- the date the member begins working for a non-union or non-participating employer.

Dependant coverage will terminate on the earliest of the following:
- the date the member's coverage terminates;
- the date the dependant ceases to be a qualified dependant;
- the date dependant coverage under the policy is terminated;
- the date contributions cease to be made for dependant coverage.

Reinstatement of Coverage

If you return to active full-time employment within six months of the date your coverage terminates, your coverage will be reinstated immediately upon your return. If you do not return to active full-time employment within the six months and have not continued benefits under the special lay-off package, you will be considered a new member and will be covered on the completion of 90 days continuous employment with any one participating employer. This does not apply to the provincial medical coverage provided by the MSPBC.

Continuation of Coverage

If a member is absent from work due to temporary lay-off or leave of absence, arrangements can be made through the plan administrator for the continuation of coverage for up to three months from the end of the month in which the lay-off or leave of absence commences. This provision does not apply in cases when an member is absent from work during any period of formal maternity or parental leave taken pursuant to provincial or federal law or mutual agreement between the member and the employer. The time limit shall be extended to the end of the maternity leave, subject to payment of premiums.

Members who have been covered under the plan for 12 consecutive months and who are working on a full-time basis will be covered for three months consisting of life, AD&D, dependant life, health and dental benefits only. These premiums will be paid by the CMSG Western Branch Benefit Plan.

Members on lay-off extending beyond three months may make arrangements with the plan administrator to continue benefits under a special lay-off package. This package is available for up to 18 months following lay-off and includes:

Member Life insurance: $50,000;
Dependant Life insurance: $10,000 spouse and $5,000 child;
Extended Health Care: Full coverage for member and eligible dependants.

The plan does not include dental care, disability insurance or MSPBC coverage. The monthly cost of the lay-off package must be funded by the member and payments directed to the plan administrator. Members who opt for the extended lay-off package will be eligible for immediate reinstatement of all benefits immediately upon return to active full-time employment with any participating employer within the 18-month period. For the purposes of this plan, lay-days constitute days of employment.

Active members: ***Health and dental benefits for dependents following death:*** If you die prior to retirement, the health and dental benefits for your dependents may be continued for one year following the date of your death. The cost of these benefits will be borne by the Plan.

Retired members: ***Health and dental benefits for dependents following death:*** The health and dental benefits for your dependents may be continued for one year following the date of your death or up to the retiree's 75th birthday, whichever comes first. The cost of these benefits will be borne by the retiree's dependents monthly at the retiree rate.

Workers' Compensation/Disabled Members' Benefits

A member who is in receipt of Workers' Compensation Board (WCB) benefits will continue to be insured under the CMSG Western Branch Benefit Plan. Claims involving re-training and/or partial WCB pensions will be reviewed by the plan trustees on an individual basis. The plan administrator will periodically request copies of the member's most recent WCB cheque stubs and related correspondence.

A disabled member will begin to receive waiver of premium benefits for his/her group life insurance and AD&D coverage to the maximum benefit period indicated for Long-Term Disability Insurance in the *Benefit Summary*. Coverage for AD&D, dependant life and member's extended health care, dental and out-of-country will continue to the maximums indicated in the *Benefit Summary.*

WCB claims involving retraining or partial payment will be reviewed by the plan trustees on an individual basis.

Benefits After Retirement/Disability

Arrangements can be made to maintain certain benefits after retirement. Benefits for members who retire require a monthly premium to be determined annually.

Retirement prior to age 65
Members can elect any or all of the following coverages:

Member Life insurance: $50,000
Extended Health Care
Dental Care

Members attaining age 65
Members can elect any or all of the following coverages:

Member Life insurance: $25,000
Extended Health Care
Dental Care

Members cannot add additional benefits at a later date. Application must be made within 31 days of retirement. Members who are disabled will be treated as retirees for the benefits beyond the maximum benefit period for Long-Term Disability Insurance indicated in the *Benefit Summary*.

Members who are disabled and in receipt of long-term disability benefits will continue to have extended health care and dental care coverage until the maximum benefit period for Long-Term Disability Insurance indicated in the *Benefit Summary*. In addition, members are eligible for a life insurance waiver of premium benefit.

Retiree benefits continue to a maximum age 70 in respect to life insurance, and age 75 in respect to extended health, dental care and out-of-country coverages.

Contact the plan administrator for information on premiums and benefits following retirement or disability.

Portability Feature Rules

Your coverage will continue until the end of the calendar month in which your employment terminates. If you return to full-time employment with a participating employer within six months of the date your coverage terminates, you will be reinstated immediately and will not have to complete the waiting period.

If you transfer to another participating employer, you will be eligible for insurance as of the date of the transfer or from the day immediately following the completion of the waiting period, whichever is later.

Beneficiary Rules

Beneficiary means the person designated in writing to receive the benefits. Upon enrolment in the plan, a member must designate the beneficiary to whom the death benefits will be payable. Subject to any legal restrictions, you may change your beneficiary by contacting the plan administrator.

Phased-in Work Reduction

The collective agreement provides for phased-in work reduction for members who attain age 60 with 20 years of service. Members electing to work under the phased-in work reduction terms will continue to receive benefits, subject to some reductions identified separately to affected members. The work/leave of absence arrangement shall be as mutually agreed upon between the officer and the company.

Co-ordination of Benefits

If you or your dependants are also covered under another health insurance program or contract, the payment of your benefits will be coordinated so that the total benefit you will receive will not exceed 100% of allowable expenses.

Subject to the consent of the covered person, the plan administrator may release to any person or corporation any data necessary to implement this provision.

Order of Benefit Determination

If you or your dependants are eligible to receive a payment under this contract and a similar payment under another benefits plan, the payment of benefits to you will follow this order:

- if the other plan does not have a COB provision, the benefits of the other plan will be paid first;
- if the other plan contains a COB provision, its benefits will be coordinated with those under this agreement so that priority will be given to the plan under which the person is eligible to receive benefits as follows:
    - other than as a dependant;
    - as a dependent child of the parent with the earlier month and day of birth in the calendar year;
    - as a dependent child of the parent whose first name begins with the earlier letter in the alphabet, if both parents have the same birthday.

In cases of separation or divorce:

- the plan of the parent with custody of the child;
- the plan of the spouse-partner of the parent with custody of the child;
- the plan of the parent not having custody of the child;
- the plan of the spouse-partner of the parent not having custody of the child.

If the person is covered under another plan, priority will go to:

- the plan where the member is an active, full-time member;
- the plan where the member is an active, part-time member;
- the plan where the member is a retiree.

If priority cannot be established according to the above, the benefits shall be paid under both plans in a ratio proportionate to the amounts that would have been paid under each plan had there been coverage under just that plan.

Extended Health Care

Payment of Benefits

If you or your dependants incur any eligible expenses for medically necessary services or supplies the benefit plan will pay a benefit subject to limitations and exclusions. The benefit payable will be based on the amount shown in the *Benefit Summary* following the payment of the annual deductible if applicable. All covered services and supplies must be considered reasonable and acceptable by the Canadian medical profession and proven to be effective and in a form, intensity, frequency and duration essential to the diagnosis and treatment of the illness or injury. Certain drugs may require prior authorization from the plan administrator.

Fair Pharmacare Program

With the exception of out-of-province charges for hospital care and services not available in your province of residence, charges for the services and supplies outlined in the book are covered at 100% after Fair PharmaCare's contribution.

Effective May 1, 2003, the universal drug and seniors drug care plans were merged to form the Fair PharmaCare program. Under the plan, deductibles and out-of-pocket maximums are based on annual reported income rather than a flat annual fee.

Members under age 65 will receive the following Fair PharmaCare assistance:

Net Annual Family Income	Family Deductible	Portion of Prescription Drug Costs paid by PharmaCare (once deductible is reached)	Family Maximum (after which 100% of costs are covered)
Less than $15,000	None Government paid	70%	2% of net income
Between $15,000 and $30,000	2% of net income	70%	3% of net income
Over $30,000	3% of net income	70%	4% of net income

Members age 65 and over will receive the following Seniors Fair PharmaCare assistance

Net Annual Family Income	Family Deductible	Portion of Prescription Drug Costs paid by PharmaCare (once deductible is reached)	Family Maximum (after which 100% of costs are covered)
Less than $33,000	None Government paid	75%	1.25% of net income
Between $33,000 and $50,000	1% of net income	75%	2% of net income
Over $50,000	2% of net income	75%	3% of net income

Plan members in British Columbia must register for the BC Fair PharmaCare program. If proof of registration is not submitted to Coughlin & Associates Ltd., the plan administrator, your drug claim coverage will be limited as outlined in the *Benefit Summary*. To register, or for more information, call toll-free 1-800-387-4977. Registration and submission of proof is a one-time occurrence.

Work-related Injuries/Expenses

Extended health care expenses for work-related injuries that are recoverable from the WCB will be refunded to the plan as they are recovered from the WCB.

Covered Expenses

The plan will pay for the following services and supplies, providing they are not covered by your provincial health care plan to the limits specified in the *Benefit Summary*:

Prescription Drugs and Medication

- Drugs, serums, compound mixtures, vaccines and injectables, including oral contraceptives, only available by prescription, are covered when prescribed by a medical doctor, or dentist.
- Brand name drugs are eligible up to the price of the generic drug equivalent.
- Diabetic supplies such as diabetic needles, syringes, test strips, lancets, alcohol swabs and glucometers (excluding batteries).
- Certain eligible medications may require the prior authorization of the plan administrator.
- Compound mixtures, when at least one ingredient is a prescription requiring medication, are eligible under the plan

Hospital Care

The plan will cover the costs for hospital care in the province where you live, up to the cost of accommodation listed in the *Benefit Summary.*

A hospital is a facility licensed to provide care and treatment for sick or injured patients, primarily while they are acutely ill. It must have facilities for diagnostic treatment and major surgery. Nursing care must be available 24 hours a day. It does not include a nursing home, rest home, home for the aged or chronically ill, sanatorium, convalescent hospital or a facility for treating alcohol or drug abuse or beds set aside for any of these purposes in a hospital.

The plan will also cover accommodations in a convalescent hospital if this care has been ordered by a doctor, up to the maximum listed in the *Benefit Summary.*

For the purposes of this plan, a convalescent hospital is a facility licensed to provide convalescent care and treatment for sick or injured patients on an in-patient basis. Nursing and medical care must be available 24 hours a day. It does not include a nursing home, rest home, home for the aged or chronically ill, sanatorium or a facility for treating alcohol or drug abuse.

A chronic care hospital is a licensed hospital that provides chronic care for patients who are chronically ill, whose chronic care needs cannot be provided at home. The patient requires a range of therapeutic services, medical management and/or skilled nursing care not available elsewhere. It does not include a nursing home, rest home, home for the aged, sanatorium, convalescent hospital or a facility for treating alcohol or drug abuse. If the plan member is confined in a chronic hospital or chronic care unit of a public general hospital, reimbursement will be made up to the maximum indicated in the *Benefit Summary.*

Palliative care establishment means any establishment in Canada designated as such by law that provides, under the supervision of a physician, care and treatment to patients, mainly during the terminal phase of their illness, and that provides nursing care 24 hours a day by a registered nurse and maintains daily records of each patient under the care of a physician. An active treatment hospital designated as such by law, extended care facility, rest home, convalescent or rehabilitation centre, home for the aged or the chronically ill, home for the mentally ill, sanatorium, convalescent hospital, or institution for the care and treatment of alcoholism or drug addiction is not considered a palliative care establishment.

Medical Supplies

The plan will cover the costs after provincial plan coverage (if applicable) for the medical services listed below when ordered by a doctor, up to the maximums indicated in the *Benefit Summary.* If no maximum is indicated, reimbursement will be based on the reasonable and customary costs in the locality where the services and supplies were provided. Reimbursement of eligible items is based on the date the items are paid in full.

- Hearing aids, or repairs to existing hearing aids plus initial batteries. Hearing aid evaluation tests, ear examinations and replacement batteries are not eligible.
- Custom-made orthopaedic shoes or modifications to orthopaedic shoes when prescribed by a doctor, podiatrist or chiropodist (must indicate medical diagnosis).

- Custom-made orthotic inserts for shoes, when prescribed by a doctor, podiatrist or chiropodist (must indicate medical diagnosis).
- Private duty nursing services when medically necessary. Services must be for nursing care, and not for custodial care. The private duty nurse must be a nurse or nursing assistant who is licensed, certified or registered in the province where you live and who does not normally live with you. The services of a registered nurse are eligible only when someone with lesser qualifications cannot perform the duties. A pre-care assessment must be provided and prior authorization by the plan administrator is required.
- External breast prosthesis (following mastectomies) and surgical brassieres.
- Elastic support stockings, including compression hose, showing the brand name and compression ratio.
- Wigs for patients who have undergone special treatment, such as chemotherapy. A doctor's referral indicating the condition being treated is required.
- Transcutaneous electric stimulators (TENS) machines. A doctor's referral indicating the condition being treated is required.
- Transportation in a licensed ground or air ambulance, if medically necessary, that takes you to and from the nearest hospital that is able to provide the necessary medical services.
- Rental or at the administrator's discretion, purchase of durable equipment including but not limited to standard-type wheelchair, wheelchair repairs, hospital bed (with or without mattresses), hospital bed rails, respirator/ventilator, oxygen and its administration, apnea monitors. In lieu of rental, the plan may, at its discretion, substitute charges for the purchase of such articles where applicable rental charges will be applied to the purchase price.
- Rental or at the administrator's discretion, purchase of braces, trusses, casts, canes, crutches, walkers, splints (excluding dental splints), cryocuffs, cervical collars, standard-type artificial limb or eye. Braces must be constructed with rigid or semi-rigid material, required for normal activities of daily living, and not solely for sports-related activities, with the written prescription of a physician.
- Diabetic supplies such as diabetic needles, syringes, test strips, lancets, alcohol swabs and glucometers (excluding batteries). Purchase of continuous glucose monitors (Dexcom G5) subject to medical requirements/criteria.
- Purchase of colostomy and ileostomy supplies (where surgical stoma exists), payable after incurred expenses exceed the provincial health plan.
- Laboratory tests performed by a commercial laboratory for the diagnosis of an illness.
- Medical services and supplies including bandages, surgical dressings, blood transfusions, plasma, radium and radioactive isotope treatments when authorized by the patient's attending physician.
- Certain diagnostic laboratory services and X-rays, except for those provided by a doctor in the course of treatment and not normally covered by the provincial health care plan.
- Fees charged by a medical practitioner for the completion of documentation related to WI and LTD cases.
- The costs of treatment for the repair or replacement of natural teeth, which require treatment as a result of accidental blow to the mouth. Damage must be caused by a direct blow to the mouth, not from an object wittingly or unwittingly placed in the mouth. The accident must have occurred after the effective date of the plan. Treatment must be completed within 6 months of the date of the accident. Reimbursement will be based on the current Dental Association fee guide for general practitioners, in the province of British Columbia.

Vision Care

Reimbursement of eligible eye wear is based on the date the items are paid in full. A written prescription by a licensed or registered optometrist or ophthalmologist is required. Reimbursement for eye exams is based on the date of the eye exam.

Paramedical Services

Medically necessary services, including X-rays, of licensed, certified or registered (in the province where treatment is given) paramedical practitioners up to reasonable and customary fees per visit when operating within their recognized fields of expertise to the maximums specified in the *Benefit Summary.* Reimbursement is based on the dates the services were rendered. All receipts must clearly indicate the names of those attending the sessions.

Expenses Not Covered

- Services covered by any provincial government plan or any workers' compensation board.
- Any care, services or supplies that are not medically necessary, as determined by the plan administrator.
- Services or supplies to the extent that their costs exceed the reasonable and customary rates in the locality where the services or supplies are provided.
- Care, services or supplies utilized as treatment of lifestyle choices, as determined by the plan administrator.
- Services or supplies that are primarily for cosmetic purposes.
- Drugs or medicines, services or supplies that have been self-prescribed, or prescribed by or for family members.
- Drugs, injectables, supplies or appliances that are experimental or that are not approved by Health Canada.
- Vitamins unless they are injected, vitamin preparations, food supplements, and drugs not approved for sale in Canada.
- Charges incurred as a result of conditions arising from war, whether or not war was declared, from participation in any civil commotion, insurrection or riot, or while serving in the armed forces.
- Vision care expenses for magnifying glasses or safety glasses of any kind.
- Additional, duplicate or replacement appliances or devices, except where the replacement is required because the existing appliance can no longer be made serviceable due to normal wear and tear, or as the result of a pathological change, unless prior approval in writing is obtained from the plan administrator.
- Vaporizers, breast pumps and nebulizers.
- Hearing aid evaluation tests, maintenance and recharging devices.
- Charges incurred as a result of self-inflicted injury or while committing, or attempting to commit, a criminal offence.
- Services or supplies purchased outside Canada except as provided under the out-of-country care provision.
- The plan will not pay for the following, even when prescribed:
    - the cost of giving injections, serums and vaccines
    - medicines obtained from a doctor or dentist
    - treatments for weight loss, proteins and food or dietary supplements
    - hair growth stimulants
    - contact lens care products and eye lubricant
    - dietary supplement, diet foods, vitamins, vitamin supplements, minerals other than hematinics, and anorexiants
    - food and food products including infant formula, infant foods, salt and sugar substitutes
    - skin and hair care products, including protectives, soaps, cleansers, emollients, lubricants, suntan lotions and deodorants
    - personal hygiene products, contraceptive preparations and devices
    - dental and oral hygiene products, including toothpastes, mouthwashes, and prophylaxis treatments
    - lozenges and cough suppressants or antacids, anti-flatulents and absorbents
    - medications for pets
    - laxatives, anti-diarrheals and hemorrhoidals
    - drugs listed as excluded in the *Benefit Summary*

Dental Care

If, while insured, you or your dependants incur any of the eligible expenses for dental services, the plan will pay a benefit subject to the dental care limitations. The amount payable will be determined based on the percentage shown in the *Benefit Summary*.

Benefits are based on the edition of the Dental Association Fee Guide for General Practitioners indicated in the *Benefit Summary*.

Dental treatments are considered eligible, if performed by a dentist, denturist, or independent dental hygienist who practices within the scope of their license.

Pre-determination of Benefits

Where a course of treatment is expected to cost $300 or more or will involve the use of crowns, inlays, onlays, bridges, dentures or orthodontic treatment, it is recommended that the insured person obtain a written estimate outlining the procedures and itemized charges, including X-rays, from the attending dentist. The estimate should be submitted to the plan administrator prior to commencement of the treatment. The plan administrator will review the estimate and advise the insured person on the amount of benefit payable.

Alternate Benefit Provision

Situations may arise where alternative methods of treatment may be available. It is solely for the member and his/her dentist to decide which method will be employed. As the basis for determining liability under the benefit plan, the plan administrator reserves the right to use the least expensive method of treatment that would provide a professionally adequate result.

This provision cannot be applied on excluded provisions, services or devices. Only those treatments listed are eligible.

Basic Services

The following services will be eligible for payment to the limits outlined in the *Benefit Summary*:

- Recall oral examinations;
- Bite-wing X-rays;
- Prophylaxis (light scaling and polishing of teeth) at time of tooth application of an anti-cariogenic agent;
- Oral hygiene instruction;
- Fluoride treatment;
- Complete oral examinations;
- Panoramic X-rays, full mouth series of X-rays;
- Simple alveolectomy (incision into tooth socket) at time of tooth extraction;
- Surgical extractions including extractions of impacted teeth;
- Surgical removal of tumours, cysts, neoplasms, plus the incision and drainage of an abscess;
- Amalgam, silicate, acrylic, and composite filings, including the inlay or onlay of one or two tooth surfaces;
- Pit and fissure sealants for children up to the age of 18;
- Therapeutic scaling;
- Provision of space maintainers for missing primary teeth, bruxism appliances and habit breaking appliances;
- Diagnostic X-ray and laboratory procedures required in relation to dental surgery;
- General anaesthetic required in relation to eligible dental treatment;
- Consultation required by the attending dentist;
- Re-lining, re-basing, adjustments or repairing of an existing denture;

- Endodontic treatment (i.e. those basic procedures necessary for pulp therapy and root canal therapy) and the bleaching of endodontically treated teeth. Root canal therapy will be limited as outlined in the *Benefit Summary*;
- Periodontic treatment (i.e. those basic procedures necessary for the treatment of tissues supporting the teeth). Occlusal equilibration is limited as outlined in the *Benefit Summary*;
- Injection of antibiotic drugs when prescribed by a dentist.

Major Services

- Inlays and onlays when three or more tooth surfaces are involved if the existing materials cannot be made serviceable and to the limits outlined in the *Benefit Summary*;
- Crowns, including gold and porcelain veneer restorations where other material is not suitable;
- The creation of an initial bridge or initial denture, once coverage is in force for at least 12 months;
- Repairs to an existing bridge, crown, inlay, onlay or veneer;
- The replacement of an existing bridge, crown, inlay, onlay, veneer or denture, only under the circumstances set out below:
    i) if the existing appliance is at least five years old and cannot be made serviceable; and
    ii) if the existing appliance is temporary and is replaced with a permanent appliance within 12 months of the date the temporary appliance was installed.

Orthodontic Services

All necessary dental treatment, which has as its objective the correction of malocclusion of the teeth. Reimbursement for the initial orthodontic fee must not exceed 35% of the total treatment plan. The balance of the orthodontic fees will be eligible for reimbursement on a monthly basis for the duration of the active treatment, outlined in the orthodontic treatment plan.

Reimbursement of the monthly fees will be based on the amount or date of payment, if different from the treatment plan.

General Exclusions

No payment will be made for expenses resulting from:

- self-inflicted injuries or illness while sane or insane;
- any injury or illness for which the covered person is entitled to indemnity or compensation under any workers' compensation board;
- charges levied by a physician or dentist for time spent travelling, broken appointments, transportation costs, room rental charges or for advice given by telephone or other means of telecommunication;
- cosmetic surgery or treatment (when so classified by the plan administrator) unless such surgery or treatment is for accidental injuries and commenced within 90 days of an accident;
- injury resulting directly or indirectly from insurrection, war, service in the armed forces of any country or participation in a riot;
- services, treatments or supplies, eligible under this plan and payable under any government plan, whether or not the claimant is covered under such a plan; the plan administrator will only consider that amount of an eligible expense which is over and above the amount that would be payable by the government plan;
- examinations required for the use of a third party;
- travel for health reasons;
- dental treatment received from a dental or medical department maintained by an employer, an association, or a labour union;
- any charges for services, treatment or supplies for which there would be no charge except for the existence of coverage;
- the replacement of an existing appliance that has been lost, mislaid or stolen;
- services and supplies rendered for full mouth reconstruction, for a vertical dimension correction, or for a correction to temporomandibular joint dysfunction;
- drugs, sera, injectables and supplies that are not approved by Health Canada (Food and Drugs) or are experimental or limited in use whether or not so approved;
- experimental medical procedures or treatment methods not approved by the Canadian Medical Association or the appropriate medical specialty society;
- any dental services or supplies relating to dental implants and TMJ;
- expenses required for recreation or sports;
- services or supplies received during a period of hospital confinement that began before your insurance became effective;
- transportation and delivery charges;
- hospital charges except detoxification facility charges as specified by the plan;
- services not listed as covered expenses;

How to Claim Benefits

To be eligible for reimbursement, Coughlin & Associates Ltd. must receive proof of claim within 12 months of the date of purchase or service. You have 90 days following the termination of your coverage to submit claims for reimbursement.

Life Insurance Claim

In the event of a death, your beneficiary should immediately contact Coughlin & Associates Ltd. who will provide the necessary information.

Life waiver of premium claims: Manulife Financial will not be liable for life insurance waiver of premium claims for which initial notice of the qualifying disability is submitted more than 6 months after the earlier of:

i) the end of the period following the date the member was last actively at work equal to the waiver of premium waiting period; and
ii) the date the policy terminates.

Accidental Death and Dismemberment (AD&D) Insurance Claim

In the event of a claim, immediately contact Coughlin & Associates Ltd. who will provide the necessary information.

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

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

Weekly Indemnity

In the event of a disability claim, immediately contact your employer who will provide the necessary information.

A claim must be made immediately and not later than 60 days after the commencement of your total disability. It is important that you promptly report to your employer any disability that may result in a weekly indemnity claim in order that the appropriate form can be completed.

The claim form must be completed in the following order:

1. the officer completes the member's portion;
2. the employer completes the employer's portion;
3. the doctor completes the attending physician's portion of the form before it is submitted for assessment.

Any fees charged by the attending physician for the completion of forms will be covered by the benefit plan.

Long-Term Disability Insurance Claim

In the event of a disability claim, immediately contact your employer who will provide the necessary information.

The initial notice of disability income claim should be submitted to Manulife Financial no later than 10 days after disability starts.

Manulife Financial will not be liable for long term disability income claims for which initial notice is submitted more than 3 months after the earlier of:

i) the end of the waiting period; and
ii) the date the policy terminates.

Out-of-Province/Canada Medical Emergency Insurance Claim

In the event of a claim, immediately contact your carrier who will provide the necessary information.

Your benefit plan provides for direct payment to providers in order to reduce your out-of-pocket expenses. Whenever possible the carrier will arrange for direct billing with providers, and you may choose to assign benefits to the provider of the service (hospital, clinic, physician). To facilitate direct billing be sure to present your medical assistance card to the provider.

Claims you pay out-of-pocket must be submitted directly with all original receipts and a completed claim form including the following information:

1. Your name and complete address;
2. Canadian provincial or territorial Government Health Insurance Plan number with its expiry date or version code (if applicable);
3. Claimant's date of birth, name and, if applicable, relationship to you;
4. Proof of the departure date(s) and return date(s);
5. All original prescription drug receipts (not cash register receipts), and/or itemized bills from the medical provider(s) stating the date(s) of the service(s) provided, the diagnosis, all dates and types of treatment, and the name of the medical facility and/or physician.

Extended Health and Dental Care Claims Reimbursement

To be eligible for reimbursement, Coughlin & Associates Ltd. must receive proof of claim within 12 months of the date of purchase or service. You have 90 days following the termination of your coverage to submit claims for reimbursement.

Interest shall not be payable on any reimbursement under this plan.

All expenses incurred and paid by the participants shall be deemed to have been incurred and paid in Canadian dollars and reimbursement shall be in Canadian dollars.

Reimbursement shall be made for expenses incurred and paid by a participant for any of the eligible services, substances and appliances set out in and in accordance with, the provisions set forth in the plan group agreement, provided such expenses:

i) are incurred and paid for services, substances and appliances prescribed by, and given under the direction of a physician, subject to the conditions of this agreement; and
ii) are in the opinion of the plan administrator reasonable and customary in the area in which they are rendered or supplied.

Reimbursement shall not be made for of any eligible expense unless the benefit premiums were paid when due for the months in which the service, substance or appliance was rendered or supplied.

Extended Health Care Claims

If you incur eligible extended health care expenses, complete the appropriate claim form and return it, along with any original receipts, to Coughlin & Associates Ltd. In coordination of benefits situations where Coughlin & Associates Ltd. is the secondary payer, the original explanation of benefits form of the primary insurer and copies of the relevant receipts or health claim forms must be submitted.

Claim forms may be obtained from the Coughlin & Associates Ltd. website at www.coughlin.ca.

Note: Original claims receipts will be retained by Coughlin & Associates Ltd. It is recommended that you photocopy receipts prior to submitting claims.

Dental Claims

Coughlin will process your dental claim using the electronic data interchange (EDI) claims processing service. With EDI, your dental claim can be sent directly from your dental office to Coughlin's claims department for adjudication.

Coughlin's EDI service uses the secure data networks of Telus, the dedicated claims processing network sponsored by the Canadian Dental Association. With Telus, you can be assured that the information contained in your dental claim will be transmitted to Coughlin quickly, safely and confidentially right from your dentist's office.

To take advantage of Coughlin's EDI service, inform your dentist that Coughlin is your plan administrator and present them with the following security codes:

- the Coughlin Telus carrier identification number (also known as the BIN number) is 610105 on the Telus network;
- your unique member identification number; and
- the policy number of your group benefit plan.

Coughlin can provide you with your member identification number.

When your dental care claim is submitted electronically, it will be processed within two to four business days.

Pay-Direct Drug Card / Drug Claims

You can pay for your prescription drugs directly through your drug plan using the pay-direct drug card from Express Scripts Canada (ESC) and Coughlin & Associates Ltd.

With the pay-direct drug card, your prescription drug claims will be processed on-the-spot. There are no forms to complete. Simply present the drug card to your pharmacist when you purchase prescription drugs. Your claim payment will be processed immediately.

The card can be used by you as well as your spouse and eligible dependants. The pay-direct drug card is designed to cover only prescription drug costs.

The drug card can be used at any pharmacy in Canada.

Pre-Authorized Deposit (PAD)

Members and employees of benefit plans administered by Coughlin & Associates Ltd. can have their claim reimbursements deposited directly to their bank accounts.

With Coughlin's Pre-Authorized Deposit (PAD) reimbursement program, members can receive your reimbursement within two to five days following the approval of their medical or dental claims. You will not have to wait for the arrival of a cheque and a trip to the bank before depositing your reimbursement.

To enrol in Coughlin's PAD program, just log on to the Coughlin website at www.coughlin.ca or contact the CMSG Western Branch office.

Coughlin Member Portal

You can log-in to the Coughlin member portal at www.coughlin.ca and view your personal benefits and claims account. You can:

- Manage your profile, including updating your mailing address, telephone number, email address, updating your language of preference and viewing your dependant information.
- View your claims history and the status of claims, print explanation of benefits statements, view your benefit accumulations/maximums and view your booklet (where applicable).
- Download and print claim submission and administrative forms.

Claims Appeals Process

In the event a claim is denied and the member is not in agreement, an appeal may be submitted in writing by the member to Coughlin & Associates Ltd., identifying the basis of the appeal and including supporting medical information justifying the expense as medically necessary.

These appeals will be reviewed in conjunction with our medical/dental consultants and the decision of the Board of Trustees will be communicated in writing to the member.

Contact Us

Questions?

Claims department:
Tel: 613-231-8540
Toll-free 1-877-768-3378
Email: ottclaims@coughlin.ca

All other inquiries:
Tel: 613-231-2266
Toll-free 1-888-613-1234
Fax: 613-231-2345
Email: info@coughlin.ca
Website: www.coughlin.ca

Mailing address:
P.O. Box 3517, Station C
Ottawa, ON K1Y 4H5

Business hours:
Monday to Friday: 8:30 a.m. to 4:30 p.m. EST

Appendix A – Basic Member Life, Dependant Member Life and Long Term Disability Insurance

Underwritten by MANULIFE FINANCIAL

Contact **Coughlin & Associates Ltd.**, your benefits administrator for any and all questions related to these benefits.

Group Benefits Policy

Policyholder: ***Canadian Merchant Service Guild - Western Branch Benefit Plan***

Policy Number: ***G0633162***

Policy Effective Date: ***September 1, 2016***

Policy Anniversary: ***September 1st***

Renewal Date: ***September 1st***

Table of Contents

THE MANUFACTURERS LIFE INSURANCE COMPANY
(hereafter called Manulife Financial) Waterloo, Ontario, Canada N2J 4C6

Manulife Financial agrees to pay benefits subject to the Policy's provisions which are set forth on the following pages.

Those provisions are a part of this Policy as fully as if stated over the signature below.

Signed at Waterloo, Ontario, Canada on March 18, 2019.

President &
Chief Executive Officer

2 Group Benefits Schedule

Policyholder: Canadian Merchant Service Guild - Western Branch Benefit Plan

Policy Number: G0633162

Policy Effective Date: September 1, 2016

Policy Anniversary: September 1st

Renewal Date: September 1st

Class Number(s)

001 CMSG (Plans A and B)

002 Saam Smit Westminster Non-Taxable LTD (Plans A1 and B)

Plan Number(s)

A Active Members

A1 Active Members Non-Taxable LTD

B Retired Members

Effective Date for Increases in Insurance

When first eligible for the increase

Associated Companies

None

Employee Life Insurance

Benefit Amount

$200,000

Non-Evidence Limit

$200,000

Benefit Reduction

not applicable

Waiver of Premiums

to age 65

Qualifying Period for Waiver of Premiums

52 weeks

Termination Age

retirement

Participation Basis

mandatory

Waiting Period

For Employees hired on or prior to the Policy Effective Date

3 months

For Employees hired after the Policy Effective Date

3 months

Dependent Life Insurance

Benefit Amount

Spouse - $50,000

Child - $10,000

Waiver of Premiums

to age 65

Qualifying Period for Waiver of Premiums

52 weeks

Termination Age

Employee's retirement

Participation Basis

mandatory

Waiting Period

For Employees hired on or prior to the Policy Effective Date

3 months

For Employees hired after the Policy Effective Date

3 months

Long Term Disability

Benefit Amount

65% of monthly Earnings, rounded to the next higher $1, if not already a multiple thereof, up to a maximum benefit of $5,000

CPP/QPP Integration

primary CPP/QPP benefits

Non-Evidence Limit

$5,000

Qualifying Period

52 weeks

Maximum Benefit Period

up to the 65th birthday

Termination Age

age 65 less the Qualifying Period, or retirement, whichever is earlier

Earnings

basic income including regular overtime pay, bonus and other shift premium.

Participation Basis

mandatory

Waiting Period

For Employees hired on or prior to the Policy Effective Date

3 months

For Employees hired after the Policy Effective Date

3 months

6 Group Benefits Schedule – Plan B

Employee Life Insurance

Benefit Amount

$50,000

Non-Evidence Limit

$50,000

Benefit Reduction

On attainment of age 65, the Employee's benefit amount is reduced to $25,000.

Waiver of Premiums

not applicable

Termination Age

age 70

Participation Basis

mandatory

Waiting Period

For Employees hired on or prior to the Policy Effective Date

not applicable

For Employees hired after the Policy Effective Date

not applicable

Actively at Work

at work for the Policyholder or any Associated Company shown in the Benefit Schedule on a Full-time basis at the Employee's usual place of work.

On weekends or holidays, or when on vacation, an Employee is deemed to be Actively at Work if he was Actively at Work on his last normal working day or on his last scheduled shift.

Birth

the complete live delivery of a child from its mother.

Dependent

an Employee's Spouse or Child who is insured under the Provincial Plan.

- Spouse

the Employee's legal Spouse, or the person who has, for at least one year, been continuously living with the Employee in a role like that of a marriage partner.

Only one Spouse will be eligible for insurance under this Policy, and will be as indicated by the Employee on his application for insurance under this Policy. Where this information is not contained on the Employee's application, the person who qualifies last under this Policy's definition of Spouse will be the eligible Spouse.

However, when the person is the biological or adoptive father or mother of at least one of the employee's children, the spouse will be recognized as of the date of birth or adoption, if it precedes the end of the 1 year of cohabitation.

Any dissolution of a marriage through divorce or annulment or, in the case of common-law marriage, actual separation for over 3 months, results in the loss of status as spouse.

- Child

an Employee's natural or adopted child, or stepchild, who:

a) is unmarried;

b) is not employed on a full-time basis;

c) is not eligible for insurance as an employee under this or any other group policy; and

d) is either under 21 years of age, or, if a full-time student at an accredited school, college or university, under 25 years of age.

A newborn child shall be insured from the moment of birth.

A child insured under this Policy, who is incapacitated due to a mental or physical disability on the date he reaches the age when he would otherwise cease to be an eligible Dependent, will continue to be an eligible Dependent under this Policy.

A child is considered incapacitated if he is incapable of engaging in any substantially gainful activity and is dependent on the Employee for support, maintenance and care, due to a mental or physical disability.

Manulife Financial may require written proof of the Dependent's condition as often as may reasonably be necessary.

A stepchild must be living with the Employee to be an eligible Dependent.

Disability or Disabled

the state of being Totally Disabled.

Drug

a medication that has been approved for use by Health Canada and has a Drug Identification Number.

Earnings

for a benefit which is earnings-related, the definition of earnings is shown in the Benefit Schedule. An Employee's earnings may also include other income as agreed to in writing by the Policyholder and Manulife Financial, and which is reported periodically by the Policyholder to Manulife Financial.

For the purposes of determining the amount of an Employee's benefit at the time of claim, an Employee's Earnings will be the lesser of:

a) the amount reported on the benefit claim form; or

b) the amount reported by the Policyholder to Manulife Financial and for which premiums have been paid.

Employee

a person who:

a) is directly employed by the Employer on a permanent and Full-time basis;

b) is compensated for services by the Employer; and

c) is residing in Canada.

For the purposes of those Benefits which continue beyond retirement, the term Employee also means Retiree.

- Retiree

a person who was an Employee immediately prior to his retirement.

Employer

the Policyholder or any Associated Company shown in the Benefit Schedule.

Full-time basis

For Full-time Employees: normal work schedule of at least 20 hour(s) per week.

Indefinite Lay-Off

a period during which the Employee is laid off work and for which there is no fixed recall date.

Leave of Absence

a period of absence from work for which the dates are fixed by legislation or by mutual agreement between the Employer and the Employee. Leave of absence includes Maternity and Parental Leave of Absence.

Maternity Leave of Absence

the period of formal maternity leave to which an Employee is entitled by legislation governing the Employer, or a longer period, if the Employer's normal practice permits.

For the purposes of this Policy, Maternity Leave of Absence will be deemed to commence on the earlier of:

a) the date fixed by mutual agreement between the Employee and the Employer; and

b) the date the child is born.

Medically Necessary

accepted and recognized by the Canadian medical profession and Manulife Financial as effective, appropriate and essential treatment of an illness or injury. Manulife Financial has the right after Due Diligence has been completed to determine whether the Drug, service or supply is covered under the Policy.

Net Earnings

the Employee's Earnings, less deductions normally made for federal and provincial income tax.

Non-Evidence Limit

satisfactory medical evidence must be submitted to Manulife Financial for Benefit Amounts greater than this amount.

Parental Leave of Absence

the period of formal child care leave to which an Employee is entitled by legislation governing the Employer, or a longer period, if the Employer's normal practice permits.

Physician

a doctor of medicine, licensed to practice medicine in the place where the services are provided.

Prior Plan

a previous Group Policy which insured all or some of the persons insured under this Policy and which terminated within 31 days prior to the Effective Date of this Policy.

Provincial Plan

any plan which provides hospital, medical, or dental benefits established by the government in the province where the insured person lives.

10 Definitions

Qualifying Period

a period of continuous Total Disability, starting with the first day of Total Disability, which must be completed by the Employee in order to qualify for benefits. The Qualifying Period is shown in the Benefit Schedule.

Temporary Lay-Off

a period during which the Employee is laid off work and for which there is a fixed recall date.

Vocational Plan (Vocational Rehabilitation)

a training or job placement program that is expected to facilitate a Disabled Employee's return to his own job or other gainful employment.

Waiting Period

a period of continuous active employment with the Employer, as shown in the Benefit Schedule, following which the Employee becomes eligible for insurance.

Eligibility for Insurance

Employee

An Employee is eligible for insurance under this Policy if he:

a) is a member of a Classification which is eligible for insurance, as set out in the Benefit Schedule;

b) is younger than the Termination Age shown in the Benefit Schedule; and

c) has continuously been an Employee, as defined, for a period as long as the Waiting Period shown in the Benefit Schedule.

Re-hired Employees

If an Employee is re-hired within 6 months of termination of insurance under this Policy due to termination of employment, he must re-apply for insurance under this Policy, but will not be required to satisfy another Waiting Period.

Dependent

An Employee's Dependent becomes eligible for insurance at the same time that the Employee does. However, the Employee must apply for the Employee coverage in order for the Dependent to be eligible. A person who becomes a Dependent after the Employee becomes insured is eligible on the date that person becomes a Dependent.

Amount of Insurance

The amount of insurance for which a person is eligible under any Benefit will be determined in accordance with the Benefit Schedule.

How to Become Insured

To become insured under this Policy, an eligible Employee must apply in writing on forms approved by Manulife Financial. Coverage for Dependents must also be applied for on approved forms.

When Evidence of Insurability is Required

Evidence of insurability is required for all amounts of insurance in excess of any Non-Evidence Limit shown in the Benefit Schedule. Manulife Financial will bear the cost of supplying this evidence.

Additional Evidence Requirements

For all benefits, evidence of insurability is also required whenever an Employee makes a Late Application for insurance on any person.

In this case, the Employee will bear the cost of supplying evidence which conforms to Manulife Financial's rules.

Late Application

For non-mandatory benefits, an application is considered late when an Employee:

a) applies for insurance on any person after having been eligible for more than 31 days; or

b) re-applies for insurance on any person whose insurance had earlier been cancelled.

12 Effective Date of Insurance

Effective Date of Insurance

Once an application for Employee or Dependent insurance has been completed, this insurance becomes effective as follows, if the Employee is then Actively at Work:

a) for all insurance which does not require evidence of insurability, on the date the Employee or Dependent becomes eligible for this insurance; and

b) for all insurance which does require evidence of insurability, on the date this evidence is approved by Manulife Financial.

If the Employee is not Actively at Work when insurance would otherwise take effect, this insurance will take effect on the next day on which he is again Actively at Work.

An Employee who is not Actively at Work on the Effective Date may still be eligible for insurance under this Policy through a Transfer of Benefits from the Prior Plan.

Dependent Insurance will not take effect prior to the Effective Date of the Employee's insurance.

Increases in Insurance

An increase in insurance on an Employee or Dependent will take effect as follows, if the Employee is then Actively at Work:

a) if evidence of insurability is not required, on the Effective Date for Increases in Insurance shown in the Benefit Schedule; and

b) if evidence of insurability is required, on the date this evidence is approved by Manulife Financial.

If the Employee is not Actively at Work when an increase in insurance would otherwise take effect, this increase in insurance will take effect on the next day on which he is again Actively at Work.

Decreases in Insurance

A decrease in the amount for which any person is insured takes effect when the person is first eligible for the decreased amount.

This Section applies only if this Policy replaces a Prior Plan.

Concessions Granted

Manulife Financial grants the following concessions to persons who were insured under the Prior Plan when it terminated:

a) a Transfer of Coverage for Employees not Actively at Work; and

b) Coverage for Pre-Existing Conditions.

These concessions are as described below.

Transfer of Coverage

- Eligibility

An Employee who is not Actively at Work on the Effective Date is still eligible under this Policy if he:

a) was insured under the Prior Plan when that Plan terminated; and

b) would be eligible for insurance under this Policy if Actively at Work on its Effective Date.

- Amount Transferred

An Employee eligible to transfer benefits will be eligible under this Policy for the lesser of:

a) the amount for which he was insured under the Prior Plan when it terminated; and

b) the amount of insurance for which he would be eligible under the Policy if Actively at Work on its Effective Date.

- Effective Date of Transfer

Insurance under a transferred benefit will become effective on the later of:

a) the date insurance provided under the Prior Plan would terminate in the absence of this provision; and

b) the Effective Date of this Policy.

Coverage for Pre-Existing Conditions

If the Prior Plan did not have a limitation on Pre-existing Conditions, the limitation contained in the Long Term Disability Benefit section of this Policy will not apply to Employees insured under this Transfer of Benefits provision.

If the Prior Plan had a limitation on Pre-Existing Conditions, the length of time the Employee's Long Term Disability Benefit was in effect under the Prior Plan will be taken into account to determine if the limitation under this Policy is applicable.

14 Termination of Insurance

Termination of Employee Insurance

An Employee's insurance terminates on the earliest of:

a) the date the Employee no longer satisfies the definition of Employee;

b) the date the Employee ceases to be Actively at Work, unless he ceases to be Actively at Work due to retirement;

c) the date the Employer terminates the Employee's coverage;

d) the date the Employee enters the armed forces of any country on a full-time basis;

e) the date this Policy terminates or insurance on the classification to which the Employee belongs terminates;

f) the date the Employee reaches the Termination Age, as shown under each Benefit in the Benefit Schedule; or

g) the date the Employee dies.

When Employment Terminates Due to Retirement

This Policy provides coverage for some benefits for Retirees. Retiree coverage is as indicated in the Schedule pages. Insurance for those benefits which are not indicated in the Schedule pages terminates when the Employee retires.

Termination of Employment Exceptions

If an Employee ceases to be Actively at Work, his insurance will normally terminate as specified under the Termination of Employee Insurance provision. However, Manulife Financial will waive this rule and continue insurance under the conditions set out below. An Employee's insurance can only be continued on a basis that does not discriminate against another Employee.

Due to Illness or Injury

If an Employee ceases to be Actively at Work due to illness or injury, all insurance coverage will continue until the Policyholder terminates the coverage.

Due to Maternity, Parental or other Mandated Leave of Absence

If an Employee ceases to be Actively at Work due to Maternity, Parental or other leave of absence that is mandated by legislation, all insurance coverage may continue for the period of leave to which the Employee is entitled by legislation governing the Employer.

In jurisdictions where the continuation of insurance is mandated by legislation, a copy of the Employee's written and signed notice to discontinue any required premium contribution must also accompany the request for termination.

Due to Other Leave of Absence

If an Employee ceases to be Actively at Work due to a Leave of Absence, all insurance coverage may continue until the Policyholder terminates it, but in no event for more than 3 month(s) after the Employee was last Actively at Work.

Due to Temporary Lay-Off

If an Employee ceases to be Actively at Work due to Temporary Lay-Off, all insurance coverage may continue until the Policyholder terminates it, but in no event for more than 6 month(s) after the Employee was last Actively at Work.

Due to Indefinite Lay-Off

If an Employee ceases to be Actively at Work due to an Indefinite Lay-Off, insurance coverage will continue only if the Policyholder informs Manulife Financial that this is the case, but in no event for more than 6 month(s) after the Employee was last Actively at Work.

Due to Strike

If an Employee ceases to be Actively at Work due to a strike, insurance coverage will continue only if the Policyholder informs Manulife Financial that this is the case, provided that premiums continued to be paid and provided there be no individual selection, but in no event for more than 6 month(s) after the Employee was last Actively at Work. Even if insurance is to continue, any disability insurance provided under this Policy terminates when the Employee ceases to be Actively at Work.

Disability Insurance During Leave of Absence and Temporary Lay-Off

If while insured for disability benefits under this Policy, an Employee becomes disabled on or after the date Leave of Absence or Temporary Lay-Off commences, the Qualifying Period for disability benefits will start as of the date of disability. Benefits will become payable on the later of:

a) the date the Qualifying Period is satisfied; or

b) the date the Employee is scheduled to return to work.

Legislated Benefit Extensions

If legislation mandates that employee benefits continue for a limited period after an Employee's employment terminates, Manulife Financial will extend each insurance benefit for the minimum period required by law, provided that:

a) the Policyholder continues to pay premiums for Employee and Dependent insurance; and

b) this Policy remains in force.

Termination of Dependent Insurance

Insurance on an Employee's Dependent terminates on the earliest of:

a) the date the Dependent is no longer eligible for insurance under the provisions of this Policy;

b) the date written notification is received from the Employee to cease his Dependent coverage because his Dependents are covered under another insurance plan for benefits similar to the ones in this Policy;

c) the date a required contribution is due but not paid; or

d) the date the Employee's insurance terminates.

16 Life Insurance Benefit

The Benefit

If a person dies while insured for this Benefit, Manulife Financial will pay the amount for which that person was insured at the time of his death.

Settlement Options

The lump sum payable on the death of an Employee may be applied to purchase any type of annuity then being offered by Manulife Financial.

Who May Choose an Option

The insured Employee may elect the type of annuity to be purchased upon his death. If the Employee does not elect an annuity, the beneficiary may elect one when the benefit becomes payable.

Waiver of Premiums

If an Employee becomes Totally Disabled while insured for this Benefit and prior to age 65, Manulife Financial will waive the premiums required to continue that Employee's and his Dependents' Life Insurance, provided the Employee meets Manulife Financial's Entitlement Criteria.

Definition of Total Disability or Totally Disabled

Restriction or lack of ability due to an illness or injury which prevents an Employee from performing the essential duties of:

a) his own occupation, during the Qualifying Period and the 2 years immediately following the Qualifying Period; and

b) any occupation for which the Employee is qualified, or may reasonably become qualified by training, education or experience, after the 2 years specified in part a) of this provision. Furthermore, the Employee must not be able to earn 60% or more of his gross monthly Earnings determined at the onset of disability by Manulife Financial.

The availability of work will not be considered by Manulife Financial in assessing the Employee's Disability.

If an Employee is required to have a valid license issued by Transport Canada to perform the essential duties of his occupation and such license is withdrawn or not renewed solely due to medical reasons, the Employee will be considered totally disabled for the lesser of:

a) the qualifying period and the succeeding 24 months, or

b) until such time as Transport Canada reissues the license to the Employee.

Entitlement Criteria

Manulife Financial will apply the following criteria in determining an Employee's entitlement to Waiver of Premiums:

a) the Employee has been continuously Totally Disabled throughout the Qualifying Period. If the Employee ceases to be Totally Disabled during this period and then becomes Totally Disabled again within 14 days due to the same or related cause, the Qualifying Period will be extended by the number of days during which the Total Disability ceased;

b) Manulife Financial receives medical evidence documenting how the Employee's illness or injury causes restrictions or lack of ability, such that the Employee is prevented from performing the essential duties of:

   i) his own occupation, during the Qualifying Period and the 2 years immediately following the Qualifying Period; and

   ii) any occupation for which the Employee is qualified, or may reasonably become qualified by training, education or experience, after the 2 year(s) specified in part i) of this provision. Furthermore, the Employee must not be able to earn 60% or more of his gross monthly Earnings determined at the onset of disability by Manulife Financial;

c) the Employee is receiving from a Physician, regular, ongoing care and treatment appropriate for the disabling condition, as determined by Manulife Financial.

At any time, Manulife Financial may require the Employee to submit to a medical, psychiatric, psychological, functional, educational and/or vocational examination or evaluation by an examiner selected by Manulife Financial.

Termination of Waiver of Premiums

Waiver of Premiums will cease on the earliest of:

a) the date the Employee ceases to meet this Benefit's definition of Totally Disabled;

b) the date the Employee does not supply Manulife Financial with appropriate medical evidence documenting how the Employee's illness or injury causes restrictions or lack of ability, such that the Employee is prevented from performing the essential duties of:

   i) his own occupation, during the Qualifying Period and the 2 years immediately following the Qualifying Period; and

   ii) any occupation for which the Employee is qualified, or may reasonably become qualified by training, education or experience, after the 2 year(s) specified in part i. of this provision; Furthermore, the Employee must not be able to earn 60% or more of his gross monthly Earnings determined at the onset of disability by Manulife;

c) the date the Employee is no longer receiving from a Physician, regular, ongoing care and treatment appropriate for the disabling condition, as determined by Manulife Financial;

d) the date the Employee does not attend a medical, psychiatric, psychological, functional, educational and/or vocational examination or evaluation by an examiner selected by Manulife Financial;

e) the date the Employee attains the age shown under Waiver of Premiums in the Benefit Schedule; or

f) the date the Employee dies.

Recurrent Disability

Where an Employee becomes Totally Disabled again from the same or related causes as those for which premiums were waived under this Benefit and such Disability recurs within 6 months of cessation of the Waiver of Premiums, Manulife Financial will waive the Qualifying Period.

All such recurrences will be considered a continuation of the same Disability. The Employee's amount of insurance on which premiums were previously waived will be reinstated.

If the same Disability recurs more than 6 months after cessation of the Waiver of Premiums, such Disability will be considered a separate Disability.

Two Disabilities which are due to unrelated causes are considered separate Disabilities if they are separated by a return to work of at least one day.

First Premium Waived

If the Waiver of Premiums is approved, premiums will be waived from the premium due date coincident with or next following the end of the Qualifying Period.

Life Insurance Coverage Continued

While premiums are being waived, Life Insurance in force under this Policy on the Employee and on his Dependents will continue to be in force. The amount of such Life Insurance will be the amount of insurance that was in effect on the date of commencement of the Disability, subject to any age reduction or termination shown in the Policy at that time. This continuation of coverage is not affected by a subsequent termination of this Policy or of employment.

Conversion When Waiver Ceases

If an Employee is not eligible for Life Insurance under this Policy when the Waiver of Premiums ceases, that Employee and his Spouse may exercise the Conversion Privilege under this Benefit.

Conversion Privilege

If an Employee's or a Spouse's Life Insurance under this Policy terminates or reduces and the conditions outlined below are satisfied, that person will be eligible to continue all or part of the insurance by converting to an Individual Policy.

Conditions for Conversion

The insured person must satisfy the following conditions to be eligible for an Individual Policy:

a) application for the Individual Policy must be received by Manulife Financial, within 31 days after insurance under the Group Policy terminates or reduces; and

b) the first premium must be enclosed with the application.

Maximum Amount

The maximum amount that may be converted is the lesser of:

a) $200,000, or

b) the amount of insurance that terminated less the amount of insurance under any replacing Group Policy within 31 days of the termination.

The Maximum Amount refers to all amounts of group life insurance for which the Employee is insured with Manulife Financial.

Plan of Insurance

The Individual Policy may be:

a) non-convertible term insurance to age 65;

b) a permanent plan that Manulife Financial offers to the public at the time of conversion; or

c) 1-year non-renewable term insurance which may be converted while it is in force to any plan described above.

Issue of Individual Policy

Manulife Financial will apply the following rules in issuing an Individual Policy:

a) no evidence of insurability will be required;

b) the premium will be based on Manulife Financial's then current standard premium rates and will take into account the plan of insurance, the amount of insurance, the person's sex and attained age;

c) no Waiver of Premium or Accidental Death & Dismemberment Benefits will be included;

d) the effective date of the Individual Policy will be the 32nd day after the date of termination of the Group Insurance under this Benefit; and

e) if the person elects to convert a lesser amount than that which he is entitled to convert, the Individual Policy cannot be less than the current minimum for which Manulife Financial will issue the Policy.

Death during Conversion Period

If a person dies within 31 days of the date his Group Insurance terminates, on receipt of due proof, Manulife Financial will pay the maximum amount the person was eligible to convert. This will be done even if the person did not apply for an Individual Policy. If the person had applied for the Individual Policy, any premium paid will be refunded.

Subsequent Eligibility Under this Policy

If a person obtains an Individual Policy through this Privilege and later becomes eligible for insurance under this Group Policy, the amount for which he is eligible will be reduced by the amount of insurance remaining in force under the Individual Policy.

Conversion for Residents of Quebec

Please see the *Policy Addendum* ***-*** *Life Insurance conversion privilege for Insured persons who reside in Quebec* in this policy for details about administration of conversion privileges for residents of Quebec.

20 Long Term Disability Benefit

The Benefit

If an Employee becomes Totally Disabled while insured for this Benefit, Manulife Financial will pay a Disability Benefit as outlined below, provided the Employee meets Manulife Financial's Entitlement Criteria.

Benefits are payable from the end of the Qualifying Period. Benefits are not payable for or during the Qualifying Period.

Definition of Total Disability or Totally Disabled

Restriction or lack of ability due to an illness or injury which prevents an Employee from performing the essential duties of:

a) his own occupation, during the Qualifying Period and the 2 years immediately following the Qualifying Period; and

b) any occupation for which the Employee is qualified, or may reasonably become qualified by training, education or experience, after the 2 years specified in part a) of this provision. Furthermore, the participant must not be able to earn 60% or more of his gross monthly income determined at the onset of disability as deemed by the insurer.

The availability of work will not be considered by Manulife Financial in assessing the Employee's Disability.

If an Employee is required to have a valid license issued by Transport Canada to perform the essential duties of his occupation and such license is withdrawn or not renewed solely due to medical reasons, the Employee will be considered totally disabled for the lesser of:

c) the qualifying period and the succeeding 24 months, or

d) until such time as Transport Canada reissues the license to the Employee.

Entitlement Criteria

Manulife Financial will apply the following criteria in determining an Employee's entitlement to Disability Benefits:

a) the Employee has been continuously Totally Disabled throughout the Qualifying Period. If the Employee ceases to be Totally Disabled during this period and then becomes Totally Disabled again within 14 days due to the same or related cause, the Qualifying Period will be extended by the number of days during which the Total Disability ceased;

b) Manulife Financial receives medical evidence documenting how the Employee's illness or injury causes restrictions or lack of ability, such that the Employee is prevented from performing the essential duties of:

   i) his own occupation, during the Qualifying Period and the 2 years immediately following the Qualifying Period; and

   ii) any occupation for which the Employee is qualified, or may reasonably become qualified, by training, education or experience, after the 2 years specified in part i) of this provision. Furthermore, the Employee must not be able to earn 60% or more of his gross monthly Earnings determined at the onset of disability by Manulife Financial;

c) the Employee is receiving from a Physician, regular, ongoing care and treatment appropriate for the disabling condition, as determined by Manulife Financial.

At any time, Manulife Financial may require the Employee to submit to a medical, psychiatric, psychological, functional, educational and/or vocational examination or evaluation by an examiner selected by Manulife Financial.

Periods for Which the Employee is Not Entitled to Benefits

The Employee is not entitled to benefit payments for any period that he is:

a) not receiving from a Physician, regular, ongoing care and treatment appropriate for the disabling condition, as determined by Manulife Financial;

b) receiving Employment Insurance maternity or parental benefits;

c) on lay-off during which the Employee becomes Totally Disabled;

d) on leave of absence during which the Employee becomes Totally Disabled, unless the Employer is required to pay benefits during this period as a result of legislation, regulation or case law (in some provinces, Employers with a benefit plan are required to provide benefits to an Employee during the health-related portion of a Maternity Leave of Absence);

e) receiving benefits under an employer-sponsored salary continuance or short term wage loss replacement plan;

f) working in any occupation, except as provided for under the Rehabilitation Assistance provision; or

g) incarcerated in a prison, correctional facility, or mental institution by order of authority of a criminal court.

Amount of Disability Benefit

The Amount of Disability Benefit payable is the Benefit Amount shown in the Benefit Schedule, less any amount of benefits the Employee receives, or is entitled to receive, from the following sources for the same or related Disability:

a) Workers' Compensation or similar coverage;

b) Canada or Quebec Pension Plans, excluding dependent benefits;

c) any government plan, excluding Employment Insurance Benefits; and

d) Criminal Injury Compensation Act or other similiar legislation.

The benefit amount payable will be further reduced so that the Employee's total income from All Sources does not exceed 85% of the Employee's pre-disability Earnings if this Benefit is taxable, or 85% of the Employee's pre-disability Net Earnings if this Benefit is non-taxable.

All Sources include those stated above and any benefit the Employee is entitled to receive from:

a) any group, association or franchise plan;

b) any retirement or pension plan;

c) earnings or payments from any employer, including severance payments and vacation pay;

d) self-employment;

e) any government plan, excluding Employment Insurance Benefits; and

f) Canada or Quebec Pension Plans' dependent benefits.

Benefit Calculation Rules

Manulife Financial will apply the following rules in determining the Employee's Disability Benefit:

a) benefits from other sources which began before the commencement of the Employee's current Disability will not be taken into account;

b) benefits payable from other sources will not be adjusted to take into account any difference between the tax status of those benefits and the benefit payable by Manulife Financial;

c) subsequent changes in benefits from other sources, other than cost of living increases, will be taken into consideration and a new benefit amount may be established;

d) benefits payable under individual disability income insurance will not be taken into account;

e) for benefits payable other than on a monthly basis, a monthly equivalent of such benefit will be estimated by Manulife Financial; and

f) if an Employee does not apply for a benefit for which he is eligible, the amount of such benefit will be estimated by Manulife Financial and assumed to be paid.

Subrogation

Conditional monthly payments shall be made to an Employee with a potential loss of income claim against a third party who caused or contributed to the Disability. Any such payments are subject to Manulife Financial's subrogation right to reimbursement when the Employee is indemnified through a judgement or settlement.

Payment of Disability Benefits

Disability benefit payments will be made monthly in arrears. Any payment for a period of less than one month will be made at a daily rate of one-thirtieth of the Employee's monthly benefit amount.

Rehabilitation Assistance

Once Manulife Financial determines that an Employee is Totally Disabled, where appropriate and at Manulife Financial's discretion, the Employee may be offered rehabilitation to assist him in returning to gainful employment, either to his pre-disability occupation or to another occupation.

In partnership with the Employer and the Employee, Manulife Financial will provide the Employee with a structured Vocational Plan that will prepare the Employee for a return to work:

a) with the Employer;

b) with an alternate employer; or

c) in a self-employed capacity.

In considering whether Rehabilitation Assistance is appropriate for an Employee, Manulife Financial will take into account:

a) the nature, extent and expected duration of the Employee's Disability;

b) the Employee's level of education, training or experience; and

c) the nature, scope, objectives and cost of the Vocational Plan.

An Employee will continue to be entitled to Disability Benefits while participating in the Vocational Plan. The Employee's Disability Benefit will be reduced by earnings received from any employment only if the Employee's total income from all sources exceeds:

a) 100% of his pre-disability Earnings, if this Benefit is taxable; or

b) 100% of his pre-disability Net Earnings, if this Benefit is non-taxable.

If an Employee ceases to participate in a Vocational Plan because of a change in his medical status, Manulife Financial will require medical evidence documenting how the Employee's medical condition has deteriorated such that the Employee's inability to continue with the Vocational Plan is due to an increase in restrictions or lack of ability.

If the Employee is not available or does not co-operate or participate in the Vocational Plan, the Employee will no longer be entitled to Disability Benefits.

Termination of Benefit Payments

Disability benefit payments will cease on the earliest of:

a) the date the Employee ceases to meet this Benefit's definition of Totally Disabled;

b) the date the Employee does not supply Manulife Financial with appropriate medical evidence documenting how the Employee's illness or injury causes restrictions or lack of ability, such that the Employee is prevented from performing the essential duties of:

   i) his own occupation, during the Qualifying Period and the 2 years immediately following the Qualifying Period; and

   ii) any occupation for which the Employee is qualified, or may reasonably become qualified, by training, education or experience, after the 2 years specified in part i) of this provision. Furthermore, the participant must not be able to earn 60% or more of his gross monthly inflation-indexed pre-disability earnings, as deemed by the insurer;

c) the date the Employee does not attend a medical, psychiatric, psychological, educational and/or vocational examination or evaluation by an examiner selected by Manulife Financial;

d) the date on which benefits have been paid up to the Maximum Benefit Period shown in the Benefit Schedule; or

e) the date the Employee dies.

Recurrent Disability

Where an Employee becomes Totally Disabled again from the same or related causes as those for which Long Term Disability benefits have been paid under this Policy and such Disability recurs within 6 months from the end of the period for which benefits were paid under this Policy, Manulife Financial will waive the Qualifying Period.

All such recurrences will be considered a continuation of the same Disability. The benefit payable will be based on the Employee's Earnings as at the original date of Disability. Benefits for all recurrences will not be paid for a combined period longer than the Maximum Benefit Period shown in the Benefit Schedule.

If the same Disability recurs more than 6 months after the end of the period for which benefits were paid, such Disability will be considered a separate Disability.

Two Disabilities which are due to unrelated causes are considered separate Disabilities if they are separated by a return to work of at least one day.

Waiver of Premiums

Premiums required on behalf of an Employee for this Benefit will be waived during any period for which Long Term Disability Benefits are payable.

Continuation of Insurance

If an Employee's insurance terminates for reasons other than reaching the Termination Age for this Benefit, as shown in the Benefit Schedule, Manulife Financial will continue insurance under this Benefit if the Employee is Totally Disabled and:

a) entitled to receive benefits; or

b) fulfilling the Qualifying Period.

The Employee must satisfy Manulife Financial's Entitlement Criteria in order for the Disability Benefit to be payable.

The insurance continued is subject to all the provisions of this Policy.

Taxability

The Policyholder must notify Manulife Financial in writing 31 days prior to a change in the tax status of this Benefit. Manulife Financial reserves the right to adjust the amount of insurance and the premium rates if such a change occurs, whether or not notification has been given. The effective date will be the date of change.

Disabilities Not Covered

No benefits are payable for any Disability directly or indirectly related to:

a) self-inflicted injuries, unless medical evidence establishes that the injuries are related to a mental health illness;

b) war, insurrection, the hostile actions of any armed forces or participation in a riot or civil commotion;

c) medical or surgical care which is not Medically Necessary;

d) the committing of or the attempt to commit an assault or criminal offence;

e) injuries sustained while operating a motor vehicle, either while under the influence of any intoxicant or if the Employee's blood contained more than 80 milligrams of alcohol per 100 millilitres of blood at the time of injury; and

f) a Pre-Existing Condition which causes Disability within the first 12 months of insurance under this Benefit. A Pre-Existing Condition is any injury or illness (whether diagnosed or not) for which an Employee was treated or attended by a Physician, or for which Drugs were prescribed, within 90 days prior to the date the Employee's insurance under this Benefit became effective.

26 Payment of Claims

Payees

Benefits payable due to the death of an Employee are payable to the Employee's beneficiary or, if no such beneficiary is alive or has been designated, to the Employee's estate. All other benefits for an Employee and such Employee's Dependents are payable to the Employee, unless the Employee has previously authorized payment to be made to the person and/or corporation which has rendered services, treatment or supplies. If the Employee is not alive, these benefits are payable to such Employee's estate.

- Payment of Small Amounts

If any amount up to $2,000 is payable to a person who is not alive or who cannot give a valid discharge for such payment, Manulife Financial may pay the amount to:

a) any relative of that person; or

b) any person or institution incurring expenses for the care, maintenance or burial of that person.

Requirement of Proof

No claim for benefits will be paid until Manulife Financial receives satisfactory proof in writing that such benefits are payable under the terms of this Policy.

Manulife Financial reserves the right to request any additional information necessary, as determined by Manulife Financial, to validate the eligibility of a claim for benefits under this Policy. The Employee is responsible for any expenses incurred for obtaining this additional information.

Submission of Proof

Proof that benefits are payable must be submitted by or on behalf of the Employee and received by Manulife Financial at its Head Office for Canadian Operations or one of its Group Claims Offices within:

a) 90 days from the date of the loss, for claims for Life benefits;

b) 180 days from the end of the Qualifying Period, for claims for disability benefits;

Continuing Proof

If benefits are being paid or coverage continued on an insured person because of disability, Manulife Financial may require written proof that this person remains Disabled under the terms of this Policy. This proof will be required as often as may reasonably be necessary.

Examination by Manulife Financial

Manulife Financial reserves the right to have any person in respect of whom a claim is being made under this Policy submit to a medical, psychiatric, psychological, functional, educational and/or vocational examination or evaluation by an examiner selected by Manulife Financial, as often as may reasonably be required. No benefits will be payable if, without reasonable cause, the insured person fails to undergo such examination. If benefits are claimed for loss of life, Manulife Financial may require that an autopsy be performed. Manulife Financial will use the results of any such examination or autopsy to determine whether benefits are payable under this Policy.

Subrogation

If an insured person suffers personal injury or loss for which he has a right to bring action for damages against a third party, Manulife Financial shall be subrogated to the insured person's rights to recover damages to the extent that it may be obligated to pay benefits to the insured person. In such case, Manulife Financial will require the insured person to complete a subrogation reimbursement agreement.

Manulife Financial has the right to suspend payment of benefits until the completed agreement is received.

Upon judgement or settlement for damages, the insured person shall reimburse Manulife Financial for benefits paid or payable. Unless notified to the contrary, the insured person's solicitor shall also represent Manulife Financial's interests in such a recovery.

Time Limit on Legal Action

No legal action against Manulife Financial may be commenced less than 60 days after proof has been filed in accordance with the above requirements. Every action or proceeding against Manulife Financial for the recovery of benefits payable under this Policy is absolutely barred unless commenced within the time set out in the Insurance Act or other applicable legislation.

28 Administration of the Policy

Method of Administration

This Policy must be administered in accordance with Manulife Financial's instructions.

Participation Requirements

100% of eligible Employees must be insured for the mandatory benefits under this Policy. For the benefits which are non-mandatory, at least 75% must be insured. In addition, a minimum of 20 Employee(s) must be covered at all times.

For non-mandatory benefits under this Policy, eligible Employees must either:

a) apply for all the non-mandatory benefits; or

b) refuse coverage for all the non-mandatory benefits.

Notice of New Employees

The Policyholder must supply enrolment material to eligible Employees and inform Manulife Financial of the addition of new Employees as they become eligible for insurance.

Notice of Terminated Employees

The Policyholder must inform Manulife Financial of the termination of insurance on Employees on or before the date on which this insurance terminates. Payments made with respect to ineligible persons because of the late receipt of termination notice will be recovered from the Policyholder if they can not be recovered from the Employee on whose behalf they were paid.

Uniform Practices

Options available to the Policyholder must be chosen and administered by the Policyholder on a uniform basis without prejudice to any Employee.

Right of Verification

Manulife Financial shall have the right to inspect, as often as may reasonably be required, those books and records of the Policyholder or any person or organization that may have a bearing on the insurance in force under this Policy. Manulife Financial may require any insured person to provide proof of age.

Clerical Error and Misstatement

A clerical error is a mistake in writing or copying data. A clerical error made by the Policyholder or Manulife Financial will not invalidate insurance otherwise in force, or continue insurance otherwise terminated under the terms of this Policy.

If an insured person's age has been misstated, his true age will be used to determine:

a) the effective date or termination date of insurance;

b) the amount of insurance; and

c) any other rights or benefits under this Policy.

Manulife Financial will adjust the insurance in force where this is affected by a clerical error or a misstatement of age.

A premium adjustment which reflects the adjustment in insurance will be made on a subsequent premium due date.

Employee Contributions

Manulife Financial is not responsible for the collection of any employee contributions required for insurance under this Policy. However, the Policyholder may not require any contribution in respect of a person's insurance under any Benefit while the corresponding premium is being waived.

Booklets

Manulife Financial will produce a booklet for each Employee insured under this Policy, unless Manulife Financial and the Policyholder have otherwise agreed. The booklet will set out the main features of insurance coverage and state to whom benefits are payable. These booklets will be distributed by the Policyholder to each insured Employee.

Possession of a booklet alone does not entitle an Employee to insurance under this Policy. This Policy must be in effect and the Employee must satisfy all the requirements of this Policy. The booklet is not a contract of insurance, nor does it create or confer any contractual or other rights. The provisions of this Policy will govern if they are in conflict with anything stated or implied in a booklet.

If an Employee receives a booklet from the Policyholder that has not been approved by Manulife Financial, and if any claim that would otherwise be limited or denied by the provisions of this Policy, is increased or paid as a result of information included in, or missing from such booklet, the Policyholder will be responsible for reimbursing Manulife Financial for the amount of such increase or payment plus expenses and administration costs.

Naming a Beneficiary

The Employee may name a beneficiary, subject to governing law, while applying for group insurance under this Policy or by filing notice in accordance with instructions provided by Manulife Financial. An existing beneficiary may be changed by the Employee, subject to governing law, by filing notice in accordance with instructions provided by Manulife Financial. Once notice has been filed, it takes effect as of the date it was signed with respect to any payment made after the time it was filed.

Manulife Financial does not accept beneficiary designations for any benefits other than Employee Life Insurance.

30 Payment of Premiums

Time of Payment

The initial premium is due on the Effective Date and subsequent premiums are due on the first day of every month thereafter. Premiums are payable by the Policyholder to Manulife Financial at Manulife Financial's Head Office for Canadian Operations or any of its Field Offices.

Amount of Premium

The amount of premium payable by the Policyholder on each premium due date will be the aggregate of the amounts, including any retroactive premium adjustments, payable in respect of each person insured on that date.

Grace Period

After the first premium is paid, 60 days of grace are allowed for the payment of any premium. If a premium is paid during the grace period, the insurance under this Policy continues in force. However, if the premium is not paid during this time, Manulife Financial reserves the right to:

a) apply a service charge to all overdue premiums;

b) withhold payments for all claims incurred after the grace period until all monies due Manulife Financial are paid; and

c) automatically cancel this Policy at the end of the grace period.

Premium for Each Insured Person

The amount payable in respect of any insured person shall be determined according to the benefits for which that person is insured and the premium rates then applicable to those benefits.

Premium Rates

Manulife Financial may set new rates:

a) on any premium due date after the first Renewal Date, but not more than once in any policy year;

b) upon amendment of this Policy at the Policyholder's request;

c) upon amendment or termination of any other plan which provides benefits which are offset against benefits under this Policy;

d) at any time after the passage of Provincial or Federal law or regulation which results in a change to:

   i) the liability for provision of benefits under this Policy; or

   ii) the taxability of premiums or benefits.

Premium Payment Deemed Acceptance

Payment towards the first premium due on or after the date on which an amendment or a premium rate change takes effect is deemed to constitute acceptance of the amendment or premium rate change and all written terms and conditions attached to such a change. All such terms and conditions are deemed to become a part of this Policy.

Premium Adjustments

A premium adjustment will be made for each of the following changes to the amount of insurance in force under this Policy:

a) changes due to an amendment of the Policy;

b) retroactive changes made to correct the effect of a clerical error or age misstatement;

c) retroactive changes required due to the late reporting of the addition or termination of Employees; and

d) any other changes that take effect more than one month prior to the next premium due date.

Retroactive adjustments which result in a credit to the Policyholder will be limited to the lesser of:

a) 6 months; or

b) the number of complete months since the last Renewal Date.

However, this will in no way affect the actual effective date of the termination or reduction in an Employee's coverage.

Premium Due on Termination of Policy

The Policyholder shall remain liable for all premiums due and unpaid on the date this Policy terminates. If this date is not a premium due date, the last premium will be reduced to reflect the period between the date it was due and the date of termination.

32 The Policy

The Entire Contract

This Policy, the Policyholder's application, the individual Employee's applications, and any document which supports or alters the information or effect of any such applications constitute the entire contract. A copy of the Policyholder's application is included with this Policy.

In the event of a discrepancy between versions of the Policy, the most recent version issued by Manulife Financial will govern.

No alteration of the Policy is permitted by any person, except by an authorized representative of Manulife Financial.

Amendments

No provision of this Policy may be waived, changed or modified unless this is done in writing and signed by an authorized representative of Manulife Financial.

Termination of the Policy

The Policyholder may terminate this Policy by giving written notice to Manulife Financial. The Policy will terminate on the latest of:

a) the date such notice is received at Manulife Financial's Head Office;

b) the end of the period for which premiums have been paid; or

c) the date specified by the Policyholder.

Manulife Financial may terminate this Policy or a benefit under this Policy if:

a) the number of insured Employees; or

b) the percentage of insured Employees;

is less than the minimum Participation Requirements specified in this Policy.

Manulife Financial may also terminate this Policy or any benefit under this Policy on any Policy Anniversary or Renewal Date by giving at least 31 days written notice to the Policyholder.

Manulife Financial has the right to terminate this Policy at the end of the Grace Period, if premium is not paid.

The Policyholder is responsible for informing Employees when this Policy terminates.

Contesting the Policy

In the absence of fraud, the validity of this Policy will not be contested if it has been in force for two years from its issue date and all the premiums due in that time have been paid.

Contesting a Person's Insurance

In the absence of fraud, no statement made in respect of the insurability of a person may be used in contesting the validity of that person's insurance after such insurance has been in force for two years during the person's lifetime.

Assignment of Insurance

The rights or interests of an Employee under this Policy are not assignable.

Non-Participation

This Policy will not share in any surplus distributed by Manulife Financial.

Gender

In this Policy, unless the context requires otherwise, reference to the masculine gender will also include the feminine gender.

Currency of Payment

All amounts payable under this Policy, to or by Manulife Financial, are payable in Canadian currency.

Conformity with the Law

If a provision of this Policy is contrary to any law to which it is subject, this provision will be deemed to conform to the minimum requirements of such law.

Administration

Manulife Financial may from time to time adopt such administrative practices as are reasonably necessary in providing benefits under this Policy, as determined in its sole discretion.

34 POLICY ADDENDUM

Life Insurance Conversion Privilege for Insured persons who reside in Quebec

In accordance with the Quebec Regulation under the Act respecting Insurance (S. 62,63,66), the Dependent, Minimum, Maximum and Death during Conversion Period provisions of the Life Insurance conversion privilege for Insured persons who reside in Quebec will be administered as outlined in this Addendum.

If a provision of the Policy or Addendum is, in full or in part, contrary to the Regulation or any other law or regulation replacing it, that provision, or the part that is deemed to be contrary will be presumed to be amended to comply with the minimum requirements of the applicable laws and regulations.

Conversion of Dependent coverage

If the Employee's life Insurance under this Policy terminates and the Employee had coverage for a Dependent, the Employee will be eligible to continue all or part of the life insurance by converting to an Individual Policy subject to the same terms and conditions as the Employee.

Minimum/Maximum Amount

For a Group Policy of a person residing in Quebec, the minimum amount of the life insurance that may be converted is:

a) for the Employee, $10,000, and

b) for the Employee's Dependents, $5,000.

For a Group Policy of a person residing in Quebec, the maximum amount that may be converted is the lesser of:

a) $400,000; or

b) the amount of insurance that terminated less the amount of insurance under any replacing Group Policy within 31 days of the termination if any.

Death during Conversion Period

If a person dies within 31 days of the date his Group Insurance terminates, on receipt of due proof, Manulife Financial will pay the amount of coverage under their terminated insurance. This will be done even if the person did not apply for an Individual Policy. If the person had applied for the Individual Policy, any premium paid will be refunded.

Appendix B –
Weekly Indemnity Insurance

Underwritten by MANULIFE FINANCIAL

Contact **Coughlin & Associates Ltd.**, your benefits administrator for any and all questions related to this benefit.

Plan Document - Appendix A

Employer: ***Canadian Merchant Service Guild - Western Branch Benefit Plan***

Plan Number: ***G0633163***

Plan Effective Date: ***September 1, 2016***

Table of Contents

The Weekly Income Benefit is being provided directly by Canadian Merchant Service Guild - Western Branch Benefit Plan which has contracted with the Employer or the Administrator to adjudicate and administer the claims for these benefits following the standard insurance rules and practices. Payment of any eligible claim will be based on the provisions and conditions outlined in this Plan Document and the Employer's Benefit Plan.

This Plan Document produced March 2, 2020.

2 Group Benefits Schedule

Employer: Canadian Merchant Service Guild - Western Branch Benefit Plan

Plan Number: G0633163

Plan Effective Date: September 1, 2016

Class Number(s)

001 CMSG (Plan A)

Plan Number(s)

A Active Members

Effective Date for Increases in Plan Benefits

When first eligible for the increase

Associated Companies

None

Weekly Income/Short Term Disability

Benefit Amount

65% of weekly Earnings, rounded to the next higher $1, if not already a multiple thereof, with a maximum benefit of $2,000. If an Employee is receiving Employment Insurance Disability benefits (E.I.), the Employer will supplement the Employment Insurance Disability benefits in an amount equal to the difference between the Benefit Amount the Employee is eligible to receive under this Plan and the amount paid under Employment Insurance Disability Benefits.

If an Employee is not entitled to Employment Insurance Disability Benefits, the amount payable under this Plan during the 15 weeks normally payable by E.I. is the full Benefit Amount.

Qualifying Period

Accident - 14 calendar days

Sickness - 14 calendar days

If Hospitalization occurs prior to the end of the Qualifying Period, benefits are payable as of that date.

Order of Benefit Payment Periods

a) Benefits commence following the Qualifying Period and will continue up to the date E.I. benefits would normally commence.

b) Employment Insurance pays benefits during the next 15 weeks of disability. The Employer supplements any E.I. benefit payments.

c) The Employer pays benefits during the next 36 weeks of disability.

Maximum Benefit Period

52 weeks

Termination Age

retirement

Earnings

basic income including regular overtime pay, bonus and other shift premium

Participation Basis

mandatory

Waiting Period

For Employees hired on or prior to the Plan Effective Date

3 months

For Employees hired after the Plan Effective Date

3 months

4 Definitions

Accident

an unexpected or unforeseen happening or event involving an external force, causing loss or injury, independently of all other causes.

Actively at Work

at work for the Employer or any Associated Company shown in the Benefit Schedule on a Full-time basis at the Employee's usual place of work.

On weekends or holidays, or when on vacation, an Employee is deemed to be Actively at Work if he was Actively at Work on his last normal working day or on his last scheduled shift.

Administrator

the organization which the Employer may from time to time appoint for purposes of performing services for the Plan.

Disability or Disabled

the state of being Totally Disabled.

Drug

a medication that has been approved for use by Health Canada and has a Drug Identification Number.

Earnings

for a benefit which is earnings-related, the definition of earnings is shown in the Benefit Schedule.

For the purposes of determining the amount of an Employee's benefit at the time of claim, an Employee's Earnings will be the amount reported on the benefit claim form.

Employee

a person who:

a) is directly employed by the Employer on a permanent and Full-time basis;

b) is compensated for services by the Employer; and

c) is residing in Canada.

Employer

Canadian Merchant Service Guild - Western Branch Benefit Plan or any Associated Company shown in the Benefit Schedule.

Full-time basis

For Full-time Employees: normal work schedule of at least 20 hours per week

Hospitalization

admittance to a Hospital as an in-patient.

With respect to the Weekly Income Benefit under this Plan Document, Hospitalization also includes being admitted to a Hospital as an out-patient for Medically Necessary surgical procedures, chemotherapy, or laser treatment.

Indefinite Lay-Off

a period during which the Employee is laid off work and for which there is no fixed recall date.

Leave of Absence

a period of absence from work for which the dates are fixed by legislation or by mutual agreement between the Employer and the Employee. Leave of absence includes Maternity and Parental Leave of Absence.

Maternity Leave of Absence

the period of formal maternity leave to which an Employee is entitled by legislation governing the Employer, or a longer period, if the Employer's normal practice permits.

For the purposes of this Plan, Maternity Leave of Absence will be deemed to commence on the earlier of:

a) the date fixed by mutual agreement between the Employee and the Employer; and

b) the date the child is born.

Medically Necessary

accepted and recognized by the Canadian medical profession and Manulife Financial as effective, appropriate and essential treatment of an illness or injury. Manulife Financial has the right after Due Diligence has been completed to determine whether the Drug, service or supply is covered under the Plan.

Parental Leave of Absence

the period of formal child care leave to which an Employee is entitled by legislation governing the Employer, or a longer period, if the Employer's normal practice permits.

Physician

a doctor of medicine, licensed to practice medicine in the place where the services are provided.

Prior Plan

a previous Group Plan which covered all or some of the persons covered under this Plan, and which terminated within 31 days prior to the Effective Date of this Plan.

Provincial Plan

any plan which provides hospital, medical, or dental benefits established by the government in the province where the covered person lives.

6 Definitions

Qualifying Period

a period of continuous Total Disability, starting with the first day of Total Disability, which must be completed by the Employee in order to qualify for benefits. The Qualifying Period is shown in the Benefit Schedule.

Temporary Lay-Off

a period during which the Employee is laid off work and for which there is a fixed recall date.

Vehicle

means any vehicle that is capable of being driven or drawn on roads by any means other than muscular power exclusively but does not include any vehicle designed to run exclusively on rails.

Vocational Plan (Vocational Rehabilitation)

a training or job placement program that is expected to facilitate a Disabled Employee's return to his own job or other gainful employment.

Waiting Period

a period of continuous active employment with the Employer, as shown in the Benefit Schedule, following which the Employee becomes eligible for plan benefits.

Eligibility for Plan Benefits

Employee

An Employee is eligible for plan benefits under this Plan if he:

a) is a member of a Classification which is eligible for plan benefits, as set out in the Benefit Schedule;

b) is younger than the Termination Age shown in the Benefit Schedule; and

c) has continuously been an Employee, as defined, for a period as long as the Waiting Period shown in the Benefit Schedule.

Re-hired Employees

If an Employee is re-hired within 6 months of termination of coverage under this Plan due to termination of employment, he must re-apply for coverage under this Plan, but will not be required to satisfy another Waiting Period.

Amount of Plan Benefit Coverage

The amount of plan benefit coverage for which a person is eligible under any Benefit will be determined in accordance with the Benefit Schedule.

How to Become Covered

To become covered under this Plan, an eligible Employee must apply in writing on approved forms.

When Evidence of Good Health is Required

For all benefits, evidence of good health is required whenever an Employee makes a Late Application for coverage on any person.

In this case, the Employee will bear the cost of supplying evidence which conforms to the Administrator's rules.

Late Application

For non-mandatory benefits, an application is considered late when an Employee:

a) applies for coverage on any person after having been eligible for more than 31 days; or

b) re-applies for coverage on any person whose coverage had earlier been cancelled.

8 Effective Date of Insurance

Effective Date of Plan Benefits

Once an application for Employee plan benefits has been completed, coverage becomes effective as follows, if the Employee is then Actively at Work:

a) for all plan benefit coverage which does not require evidence of good health, on the date the Employee becomes eligible for this coverage; and

b) for all plan benefit coverage which does require evidence of good health, on the date this evidence is approved by the Employer or the Administrator.

If the Employee is not Actively at Work when plan benefit coverage would otherwise take effect, this coverage will take effect on the next day on which he is again Actively at Work.

An Employee who is not Actively at Work on the Effective Date may still be eligible for plan benefits under this Plan through a Transfer of Benefits from the Prior Plan.

Increases in Plan Benefits

An increase in plan benefits on an Employee will take effect as follows, if the Employee is then Actively at Work:

a) if evidence of good health is not required, on the Effective Date for Increases in Plan Benefits shown in the Benefit Schedule; and

b) if evidence of good health is required, on the date this evidence is approved by the Employer or the Administrator.

If the Employee is not Actively at Work when an increase in plan benefits would otherwise take effect, this increase in plan benefits will take effect on the next day on which he is again Actively at Work.

Decreases in Plan Benefits

A decrease in the amount for which any person is covered takes effect when the person is first eligible for the decreased amount.

This Section applies only if this Plan replaces a Prior Plan.

Concessions Granted

The Employer grants the following concession to persons who were covered under the Prior Plan when it terminated:

a) a Transfer of Coverage for Employees not Actively at Work.

This concession is as described below.

Transfer of Coverage

- Eligibility

An Employee who is not Actively at Work on the Effective Date is still eligible under this Plan if he:

a) was covered under the Prior Plan when that Plan terminated; and

b) would be eligible for plan benefits under this Plan if Actively at Work on its Effective Date.

- Amount Transferred

An Employee eligible to transfer benefits will be eligible under this Plan for the lesser of:

a) the amount for which he was covered under the Prior Plan when it terminated; and

b) the amount of plan benefits for which he would be eligible under the Plan if Actively at Work on its Effective Date.

- Effective Date of Transfer

Plan benefits under a transferred benefit will become effective on the later of:

a) the date plan benefits provided under the Prior Plan would terminate in the absence of this provision; and

b) the Effective Date of this Plan.

10 Termination of Plan Benefits

Termination of Employee Plan Benefits

An Employee's plan benefit coverage terminates on the earliest of:

a) the date the Employee no longer satisfies the definition of Employee;

b) the date the Employee ceases to be Actively at Work;

c) the date the Employer terminates the Employee's coverage;

d) the date the Employee enters the armed forces of any country on a full-time basis;

e) the date this Plan terminates or coverage on the classification to which the Employee belongs terminates;

f) the date the Employee reaches the Termination Age, as shown under each Benefit in the Benefit Schedule; or

g) the date the Employee dies.

Termination of Employment Exceptions

Not Applicable to Disability

If an Employee ceases to be Actively at Work, his coverage will normally terminate as specified under the Termination of Employee Plan Benefits provision. However, the Employer will waive this rule and continue plan benefit coverage under the conditions set out below. An Employee's plan benefit coverage can only be continued on a basis that does not discriminate against another Employee.

Due to Illness or Injury

If an Employee ceases to be Actively at Work due to illness or injury, all plan benefit coverage will continue until the Employer terminates the coverage.

Due to Maternity, Parental or other Mandated Leave of Absence

If an Employee ceases to be Actively at Work due to Maternity, Parental or other leave of absence that is mandated by legislation, all plan benefit coverage may continue for the period of leave to which the Employee is entitled by legislation governing the Employer.

In jurisdictions where the continuation of plan benefit coverage is mandated by legislation, a copy of the Employee's written and signed notice to discontinue any required contribution must also accompany the request for termination.

Due to Other Leave of Absence

If an Employee ceases to be Actively at Work due to a leave of absence, all plan benefit coverage may continue until the Employer terminates it, but in no event for more than 3 months after the Employee was last Actively at Work.

Due to Temporary Lay-Off

If an Employee ceases to be Actively at Work due to Temporary Lay-Off, all plan benefit coverage may continue until the Employer terminates it, but in no event for more than 3 months after the Employee was last Actively at Work.

Disability Coverage During Leave of Absence and Temporary Lay-Off

If, while covered for disability benefits under this Plan Document, an Employee becomes disabled on or after the date Leave of Absence or Temporary Lay-Off commences, the Qualifying Period for disability benefits will start as of the date of disability. Benefits will become payable on the later of:

a) the date the Qualifying Period is satisfied; or

b) the date the Employee is scheduled to return to work.

Legislated Benefit Extensions

If legislation mandates that employee benefits continue for a limited period after an Employee's employment terminates, the Employer will extend each plan benefit for the minimum period required by law.

12 Weekly Income Benefit/Short Term Disability

The Benefit

If an Employee becomes Totally Disabled while covered for this Benefit, the Employer will pay a Disability Benefit as outlined below, provided the Employee meets Manulife Financial's the Entitlement Criteria.

Benefits are payable from the end of the Qualifying Period. Benefits are not payable for or during the Qualifying Period. The Employee must be receiving regular, ongoing care and treatment from a Physician during the Qualifying Period in order for benefits to be payable at the end of the Qualifying Period. Otherwise, benefits will not be payable until the date the Employee is first treated by his Physician.

Definition of Total Disability or Totally Disabled

Restriction or lack of ability due to an illness or injury which prevents an Employee from performing the essential duties of his own occupation.

The availability of work will not be considered by the Administrator or the Employer in assessing an Employee's Disability.

If an Employee is required to have a valid license issued by Transport Canada to perform the essential duties of his occupation and such license is withdrawn or not renewed solely due to medical reasons, the Employee will be considered totally disabled for the lesser of:

a) the qualifying period and the succeeding 52 weeks, or

b) until such time as Transport Canada reissues the license to the Employee.

Entitlement Criteria

The Administrator or the Employer will apply the following criteria in determining an Employee's entitlement to Disability Benefits:

a) the Employee has been continuously Totally Disabled throughout the Qualifying Period;

b) the Administrator or the Employer receives medical evidence documenting how the Employee's illness or injury causes restrictions or lack of ability, such that the Employee is prevented from performing the essential duties of his own occupation; and

c) the Employee is receiving from a Physician, regular, ongoing care and treatment for the disabling condition.

Periods for Which the Employee is Not Entitled to Benefits

The Employee is not entitled to benefit payments for any period:

a) he is not receiving from a Physician, regular, ongoing care and treatment for the disabling condition;

b) he does not supply the Administrator or the Employer with medical evidence documenting how the Employee's illness or injury causes restrictions or lack of ability, such that the Employee is prevented from performing the essential duties of his own occupation;

c) after he fails to participate and cooperate in a medical, psychiatric, psychological and/or functional examination or evaluation by a medical examiner selected by the Administrator or the Employer;

d) he is receiving Employment Insurance maternity, parental, compassionate care or critically ill child benefits;

e) he is on lay-off during which the Employee becomes Totally Disabled;

f) he is on leave of absence during which the Employee becomes Totally Disabled, unless the Employer is required to pay benefits during this period as a result of legislation, regulation or case law (in some provinces, Employers with a benefit plan are required to provide benefits to an Employee during the health-related portion of a Maternity Leave of Absence);

g) he is engaged in employment for wage or profit; except as provided for under the Rehabilitation Assistance Provision; or

h) he is incarcerated in a prison, correctional facility, or mental institution by order of authority of a criminal court.

Amount of Disability Benefit

The Amount of Disability Benefit payable is the Benefit Amount shown in the Benefit Schedule, less any amount(s) the Employee receives:

a) for the same or related Disability:

   i) from Workers' Compensation or similar coverage;

   ii) from any provincial motor vehicle plan or motor vehicle insurance policy that is not excluded under this Plan and that does not take into account disability benefits payable under the Employment Insurance Program; and

   iii) from an employer-sponsored salary continuance or wage loss replacement plan;

b) as earnings from the Employer, including severance and vacation pay as set out in the Employment Insurance Program, and

c) from Canada or Quebec retirement or disability Pension Plan, including dependent benefits.

Benefit Calculation Rules

The Administrator or the Employer will apply the following rules in determining the Employee's Disability Benefit:

a) benefits from other sources which began before the commencement of the Employee's current Disability will not be taken into account;

b) benefits payable from other sources will not be adjusted to take into account any difference between the tax status of those benefits and the benefit payable by the Employer; and

c) for benefits payable other than on a weekly basis, a weekly equivalent of such benefit will be estimated by the Administrator or the Employer.

Subrogation

Conditional payments shall be made to an Employee with a potential loss of income claim against a third party who caused or contributed to the disability. Any such payments are subject to the Employer's subrogation right to reimbursement when the Employee is indemnified through a judgement or settlement.

14 Weekly Income Benefit/Short Term Disability

Payment of Disability Benefits

Disability benefit payments will be made weekly in arrears. Any payment for a period of less than one week will be made at a daily rate of one-seventh of the Employee's weekly benefit amount.

Rehabilitation Assistance

Once the Administrator or the Employer determines that an Employee is Totally Disabled, where appropriate and at the Administrator or the Employer discretion, the Employee may be offered rehabilitation to assist him in returning to work.

In partnership with the Employee, the Administrator or the Employer will provide the Employee with a structured Vocational Plan that will prepare the Employee for a return to work with the Employer.

In considering whether Rehabilitation Assistance is appropriate for an Employee, the Administrator or the Employer will take into account:

a) the nature, extent and expected duration of the Employee’s Disability;

b) the Employee’s level of education, training or experience; and

c) the nature, scope, objectives and cost of the Vocational Plan.

An Employee will continue to be entitled to Disability Benefits while participating in the Vocational Plan. The Employee’s Disability Benefit will be reduced by earnings received, if the Employee’s total income exceeds:

a) 100% of his pre-disability Earnings, if this Benefit is taxable; or

b) 100% of his pre-disability Net Earnings, if this Benefit is non-taxable.

If an Employee ceases to participate in a Vocational Plan because of a change in his medical status, the Administrator or the Employer will require medical evidence documenting how the Employee’s medical condition has deteriorated such that the Employee’s inability to continue with the Vocational Plan is due to an increase in restrictions or lack of ability.

If the Employee is not available or does not co-operate or participate in the Vocational Plan, the Employee will no longer be entitled to Disability Benefits.

Termination of Benefit Payments

Disability benefit payments will cease on the earliest of:

a) the date the Employee ceases to meet this Benefit's definition of Totally Disabled;

b) the date on which benefits have been paid up to the Maximum Benefit Period shown in the Benefit Schedule;

c) the date the Employee retires; or

d) the date the Employee dies.

Recurrent Disability

Where an Employee becomes Totally Disabled again from the same or related causes as those for which Weekly Income benefits have been paid under this Plan and such Disability recurs within 14 days from the end of the period for which benefits were paid under this Plan, Manulife Financial will waive the Qualifying Period.

All such recurrences will be considered a continuation of the same Disability. The benefit payable will be based on the Employee's Earnings as at the original date of Disability. Benefits for all recurrences will not be paid for a combined period longer than the Maximum Benefit Period shown in the Benefit Schedule.

If the same Disability recurs more than 14 days after the end of the period for which benefits were paid, such Disability will be considered a separate Disability.

Two Disabilities which are due to unrelated causes are considered separate Disabilities if they are separated by a return to work of at least one day.

Taxability

The Employer must notify the Administrator in writing 31 days prior to a change in the tax status of this Benefit.

Disabilities Not Covered

No benefits are payable for any Disability related to:

a) any illness or injury for which workers' compensation benefits are payable, or which arises out of or in the course of employment;

b) medical or surgical care which is performed solely for cosmetic purposes, except if due to an illness or injury;

c) war, insurrection, the hostile actions of any armed forces or participation in a riot or civil commotion;

d) abuse of drugs, including Drugs and alcohol, unless the Employee is participating in an in-patient medical treatment program for substance abuse;

e) the committing of a criminal offence;

f) injuries sustained while operating a motor vehicle under the influence of drugs or alcohol as prohibited by law;

g) self-inflicted injuries, unless medical evidence establishes that the injuries are related to a mental health illness;

h) a motor vehicle accident unless benefits are excluded under the applicable motor vehicle legislation for reasons that would not be excluded under this group benefits plan; or

i) any claims following a settlement reached under the applicable motor vehicle legislation, which constitutes a compromise, or waiver of entitlement under the applicable motor vehicle legislation.

16 Payment of Claims

Payees

All benefits for an Employee are payable to the Employee, unless the Employee has previously authorized payment to be made to the person and/or corporation which has rendered services, treatment or supplies. If the Employee is not alive, these benefits are payable to such Employee's estate.

- Payment of Small Amounts

If any amount up to $2,000 is payable to a person who is not alive or who cannot give a valid discharge for such payment, the Employer may pay the amount to:

a) any relative of that person; or

b) any person or institution incurring expenses for the care or maintenance of that person.

Requirement of Proof

No claim for benefits will be paid until the Employer receives satisfactory proof in writing that such benefits are payable under the terms of this Plan.

The Employer or Administrator reserves the right to request any additional information necessary, as determined by the Employer or Administrator, to validate the eligibility of a claim for benefits under this Plan. The Employee is responsible for any expenses incurred for obtaining this additional information.

Submission of Proof

Proof that benefits are payable must be submitted by or on behalf of the Employee and received by the Employer or the Administrator at their respective Head Offices or at one of their local offices within 180 days from the end of the Qualifying Period, for claims for disability benefits.

Continuing Proof

If benefits are being paid or coverage continued on a covered person because of disability, the Employer may require written proof that this person remains Disabled under the terms of this Plan. This proof will be required as often as may reasonably be necessary.

Examination by the Employer

The Employer reserves the right to have any person in respect of whom a claim is being made under this Plan submit to a medical, psychiatric, psychological, functional, educational and/or vocational examination or evaluation by an examiner selected by the Administrator, as often as may reasonably be required. No benefits will be payable if, without reasonable cause, the covered person fails to undergo such examination.

Subrogation

If a covered person suffers personal injury or loss for which he has a right to bring action for damages against a third party, the Employer shall be subrogated to the covered person’s rights to recover damages to the extent that it may be obligated to pay benefits to the covered person. In such case, the Employer will require the covered person to complete a subrogation reimbursement agreement. The Employer has the right to suspend payment of benefits until the completed agreement is received.

Upon judgement or settlement for damages, the covered person shall reimburse the Employer for benefits paid or payable. Unless notified to the contrary, the covered person’s solicitor shall also represent the Employer’s interests in such a recovery.

Time Limit on Legal Action

No legal action against the Employer or the Administrator may be commenced less than 60 days after proof has been filed in accordance with the above requirements. No such action may be brought more than two years after the last day on which proof of claim would be accepted under the terms of this Plan.

18 Administration of the Plan

Method of Administration

This Plan must be administered in accordance with the Employer's instructions.

Notice of New Employees

The Employer must supply enrolment material to eligible Employees and inform the Administrator of the addition of new Employees as they become eligible for plan benefit coverage.

Notice of Terminated Employees

The Employer must inform the Administrator of the termination of plan benefit coverage on Employees on or before the date on which this coverage terminates. Payments made with respect to ineligible persons because of the late receipt of termination notice will be recovered from the Employer if they can not be recovered from the Employee on whose behalf they were paid.

Uniform Practices

Options available to the Employer must be chosen and administered by the Employer on a uniform basis without prejudice to any Employee.

Clerical Error and Misstatement

A clerical error is a mistake in writing or copying data. A clerical error made by the Employer or the Administrator will not invalidate plan benefit coverage otherwise in force, or continue plan benefit coverage otherwise terminated under the terms of this Plan.

If a covered person's age has been misstated, his true age will be used to determine:

a) the effective date or termination date of plan benefit coverage;

b) the amount of plan benefits; and

c) any other rights or benefits under this Plan.

The Employer will adjust the plan benefits in force where these are affected by a clerical error or a misstatement of age.

Employee Contributions

The Administrator is not responsible for the collection of any employee contributions required for plan benefits under this Plan.

Termination of the Plan

The Employer may refer to the Discontinuance of Agreement provision of the Administrative Agreement between the Employer and the Administrator for further information on terminating the Plan.

Gender

In this Plan Document, unless the context requires otherwise, reference to the masculine gender will also include the feminine gender.

Currency of Payment

All amounts payable under this Plan, to or by the Employer, are payable in Canadian currency.

Conformity with the Law

If a provision of this Plan Document is contrary to any law to which it is subject, this provision will be deemed to conform to the minimum requirements of such law.

Administration

Manulife Financial may from time to time adopt such administrative practices as are reasonably necessary in providing benefits under this Plan.

Appendix C – Accidental Death and Dismemberment Insurance

Underwritten by AIG INSURANCE COMPANY OF CANADA

Contact **Coughlin & Associates Ltd.**, your benefits administrator for any and all questions related to this benefit.

Group Personal Accident Booklet
Policyholder: Canadian Merchant Service Guild Western Branch
Policy No.: GPA 9427644

Why You Need Accident Insurance

A serious accidental Injury or death can have tremendous consequences for your family that may prevent you or your Spouse from meeting your financial obligations. Your Employer has provided you with accident insurance coverage underwritten by AIG Insurance Company of Canada. The policy provides a lump sum benefit to your beneficiary to help ease any financial burden if you suffer a Loss of Life as a result of an accident. The policy also provides you with 'living benefits' should you suffer an accident that results in any of the Losses listed in the Table of Losses, such as Paralysis or Loss of Hearing.

Eligibility and Principal Sum

Your plan provides Accidental Death & Dismemberment benefits for Injuries as a result of covered accidents. You are automatically covered a Principal Sum amount of $200,000.

Definitions

The following is an explanation of the terms used in this benefit booklet.

Activities of Daily Living means the following six activities:

1. Maintaining continence: ability to control urination and bowel movements, including the use of ostomy supplies or other devices such as catheters if required;
2. Transferring: ability to move in and out of a bed, between a bed and a chair, or a bed and a wheelchair;
3. Dressing: putting on and taking off all necessary items of clothing including braces, artificial limbs or other surgical appliances;
4. Toileting: use of a lavatory including getting to and from and getting on and off, to manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
5. Eating: ability to consume food or drink that already has been prepared and made available, with or without the use of adaptive utensils; and
6. Bathing: washing in either a tub or shower, including the task of getting in or out of the tub or shower or washing satisfactorily by other means.

Annual Earnings means your annual salary from employment with your Employer immediately prior to the date of loss, exclusive of overtime, bonus, incentive payments, profit sharing or commission.

Carjacking means taking unlawful possession of a Private Passenger Type Automobile by means of force or threats against you then rightfully occupying such Private Passenger Type Automobile.

Company means AIG Insurance Company of Canada.

Dependent Child means a person who is either your natural child, adopted child or step-child or a child to whom you are *in loco parentis* and who is (i) under 23 years of age, unmarried and dependent upon you for maintenance and support and not employed for more than 25 hours per week; or (ii) under 26 years of age, unmarried and enrolled in post-secondary education and dependent upon you for maintenance and support and not employed for more than 25 hours per week; or (iii) by reason of mental or physical infirmity is incapable of self-sustaining employment and who is considered your Dependent Child within the terms of the Income Tax Act (Canada).

Dependent Parent means your parents, parents-in-law, grandparents, grandparents-in-law, great-grandparents or great-grandparents-in-law that are dependent upon the you for support, maintenance and care.

Employer means the Policyholder or an affiliate or subsidiary thereof, for which you are employed.

Hospital means an establishment which:

(a) holds a licence as a hospital (if licencing is required in the jurisdiction);

(b) operates primarily for the reception, care and treatment of sick, ailing or injured persons as in-patients;

(c) provides 24 hour a day nursing service by registered or graduate nurses;

(d) has a staff of one or more licenced Physicians available at all times;

(e) provides organized facilities for diagnosis, and major medical surgical facilities;

(f) is not primarily a clinic, nursing, rest or convalescent home or similar establishment; and

(g) is not, other than incidentally, a place for the treatment of alcohol or drug addiction.

Immediate Family means a person who is related to you in any of the following ways: a spouse, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister), or child (including legally adopted or stepchild).

Injury or ***Injuries*** means bodily injury which is sustained by you as a direct result of an unintended unanticipated accident, provided such accident is external to the body and occurs while your insurance under this policy is in force.

Insured Employee means an individual who belongs to an eligible class of Insured Employees specified in the Policy Schedule Declarations provided such individual's name is on file with the Policyholder as being insured under this policy.

Loss when used with reference to:

(a) ***Quadriplegia***, ***Paraplegia***, and ***Hemiplegia*** means the complete and irreversible paralysis of such limbs;

(b) ***Hand or Foot*** means the complete severance through or above the wrist or ankle joint, but below the elbow or knee joint;

(c) ***Arm or Leg*** means the complete severance through or above the elbow or knee joint;

(d) ***Thumb and Index Finger*** means the complete severance through or above the first phalange;

(e) ***Fingers*** means the complete severance through or above the first phalange of all four Fingers of one Hand;

(f) ***Toes*** means the complete severance of both phalanges of all the toes of one foot;

(g) ***The Entire Sight of One Eye*** means the total and irrecoverable loss of sight such that corrected visual acuity must be 20/200 or less in such eye;

(h) ***The Entire Sight of Both Eyes*** means the total and irrecoverable loss of sight in both eyes such that corrected visual acuity must be 20/200 or less and the field of vision must be less than 20 degrees in both eyes. A Physician certified in ophthalmology must clinically confirm the diagnosis in writing;

(i) ***Hearing in One Ear*** means the diagnosis of permanent loss of Hearing in One Ear, with an auditory threshold of more than 90 decibels. A Physician certified in otolaryngology must confirm the diagnosis in writing;

(j) ***Hearing*** means the diagnosis of permanent loss of Hearing in both ears, with an auditory threshold of more than 90 decibels in each ear. A Physician certified in otolaryngology must confirm the diagnosis in writing;

(k) ***Speech*** means complete and irrecoverable loss of the ability to utter intelligible sounds; and

(l) ***Loss of Use*** means the total and irrecoverable loss of use provided the loss is continuous for 12 consecutive months and such loss of use is determined to be permanent.

Loss when used herein may also include ***Loss of Life.***

Permanent and Total Disability means Injury which prevents you from performing at least two of the six Activities of Daily Living, without assistance from another person and you have been determined on evidence satisfactory to the

Company, to be and remain, as of 12 months after the date of the Injury, incapable of performing at least two of the six Activities of Daily Living without assistance from another for the remainder of your life. The disability must be determined to be total, permanent, and irreversible and certified to be such by a Physician acceptable to the Company. Your inability to actually obtain employment is not a criteria to qualify for the Permanent and Total Disability benefit.

Physician means a medical doctor, other than you or your Immediate Family, who is licenced to administer medical treatment and prescribe drugs in the place where he or she provides medical services. The following are not considered to be Physicians: naturopath, herbalist and homeopath.

Private Passenger Type Automobile means any means of transportation not operated for commercial purposes, designed to carry passengers and that is pulled, propelled or fuelled in any way, including cars, trucks, motorcycles, mopeds, snowmobiles or boats.

Spouse means a person who is under the age of 70 and who is either legally married to you, or if there is no such person, is a person who, although not legally married to you, is cohabitating with you for a period of at least one year and is publicly represented as your domestic partner in the community in which you reside.

General Policy Provisions

Effective Date
Your coverage begins on the date you satisfy the eligibility requirements to become an Insured Employee.

Termination Date
Coverage ends on the earliest of:

1. the date the policy is terminated;
2. the premium due date if premiums are not paid when due;
3. the date you no longer satisfy the definition of an Insured Employee; or
4. the first day of the month following the date you no longer belong to an eligible class of employees as set out in the policy.

Continuance of Coverage
If you are no longer employed or actively working, your coverage shall continue in the following circumstances: (1) during a statutory leave, as set out in applicable provincial, territorial or federal employment standards legislation or equivalent, but not more than the period required under such legislation, or (2) during the notice period for termination of employment as required by law, provided premiums continue to be paid.

Conversion Privilege Benefit
If you leave your job for any reason, you have 90 days to convert your coverage to an individual insurance policy that provides comparable coverage. The amount of insurance benefit provided for the new policy shall not exceed the lesser of $500,000 or your Principal Sum in force at the time you convert your policy. The premium due will be based on the rates in force for individual policies at time of application.

Aggregate Limit Per Accident
The maximum amount the Company will pay for two or more Insured Employees injured in one accident is the amount of the Aggregate Limit Per Accident set out in the policy schedule, if any. If the total of the benefits which would be paid by the Company would exceed the Aggregate Limit Per Accident, each Insured Employee shall receive their proportionate share of the amount of the Aggregate Limit Per Accident paid by the Company.

Benefits and Coverages

Accidental Death, Dismemberment, Paralysis and Loss of Use

If a covered Loss occurs within 365 days after the date of the accident causing the Loss, the Company will pay the indicated percentage of the Principal Sum as set out in the following Table of Losses. If you sustain more than one Loss as a result of the same accident, only one amount, the largest, will be paid.

Table of Losses	Percentage Principal Sum Payable
Loss	
Loss of Life	100%
Loss of Both Hands or Both Feet	100%
Loss of Entire Sight of Both Eyes	100%
Loss of One Hand and One Foot	100%
Loss of One Hand and the Entire Sight of One Eye	100%
Loss of One Foot and the Entire Sight of One Eye	100%
Brain Death	100%
Loss of One Arm or One Leg	80%
Loss of One Hand or One Foot	75%
Loss of The Entire Sight of One Eye	75%
Loss of Thumb and Index Finger of the Same Hand	33.3%
Loss of Speech and Hearing	100%
Loss of Speech or Hearing	75%
Loss of Hearing in One Ear	66.7%
Loss of Four Fingers of One Hand	33.3%
Loss of All Toes of One Foot	25%
Loss of Use	
Loss of Use of Both Arms or Both Hands	100%
Loss of Use of One Hand or One Foot	75%
Loss of Use of One Arm or One Leg	80%
Paralysis	
Quadriplegia (total paralysis of both upper and lower limbs)	Two times the Principal Sum up to a maximum of $1 million
Paraplegia (total paralysis of both lower limbs)	Two times the Principal Sum up to a maximum of $1 million
Hemiplegia (total paralysis of upper and lower limbs of one side of the body)	Two times the Principal Sum up to a maximum of $1 million

Additional Benefits

These benefits shall only apply if selected by your Employer and the appropriate premium paid. The Benefit Description is a summary only and does not include all of the provisions, sub-limits, conditions and exclusions.

Benefit	Maximum	Benefit Description
DISAPPEARANCE	Principal Sum	Pays the Loss of Life Principal Sum if your body has not been found within one year of a forced landing, stranding, sinking or wrecking of a conveyance in which you were an occupant.
REHABILITATION BENEFIT	$15,000	Pays the expenses incurred for occupational training up to the Maximum if such expenses are incurred within three years of the accident and are as a result of an Injury for which you receive a benefit under the policy.
HOME ALTERATION AND VEHICLE MODIFICATION	$15,000	Pays a one-time benefit up to the Maximum for covered home alternation and vehicle modification expenses if you suffer an Injury for which you receive a benefit under the policy and require a wheelchair to be ambulatory.
WORKPLACE MODIFICATION AND ACCOMMODATION	$5,000	Pays a one-time benefit to your Employer up to the Maximum if you suffer an Injury for which you receive a benefit under the policy and require special adaptive equipment or workplace modification in order for you to return to work full-time for the Policyholder.
PSYCHOLOGICAL THERAPY	$5,000	Pays a benefit up to the Maximum if you suffer an Injury for which you receive a benefit under the policy and require psychological therapy within two years of the Injury.
IN-HOSPTIAL BENEFIT	$2,500/month	Pays a benefit of (i) 1% of the Principal Sum up to the Maximum for hospital confinements of more than 30 nights, or (ii) 1/30th of the amount determined under (i) for hospital confinements of more than five but less than 30 nights, if you suffer an Injury for which you receive a benefit under the policy and are confined to hospital as a result of such Injury, for a maximum of twelve months.
FAMILY TRANSPORATION	$15,000	Pays a benefit up to the Maximum for the expenses incurred for the transportation of an Immediate Family member to your hospital if you suffer an Injury for which you receive a benefit under the policy and as a result are confined to a hospital more than 100 kilometres from home.
REPATRIATION BENEFIT	$15,000	Pays a benefit up to the Maximum to cover the expenses to return your body to your city of residence if you suffer a covered accidental death while at least 50 kilometres from home.
IDENTIFICATION BENEFIT	$5,000	Pays a benefit up to the Maximum for the transportation and commercial lodging of an Immediate Family member to identify your body if you suffer a covered accidental death at least 150 kilometres from home and a law enforcement agency requests such identification.
DAY CARE BENEFIT	$5,000/year	Pays an annual benefit of up to 5% of the Principal Sum up to the Maximum for the day care costs of each Dependent Child under age 13 who is enrolled, or who enrolls within 90 days, in a day care facility if you suffer a covered accidental death. The benefit is payable for up to four consecutive years.
DEPENDENT CHILD EDUCATIONAL BENEFIT	$5,000/school year	Pays an annual benefit of up to 5% of the Principal Sum up to the Maximum for the tuition costs of each Dependent Child who is enrolled as a full-time student in post-secondary education if you suffer a covered accidental death. The benefit is payable for up to four consecutive years.
SPOUSAL EDUCATIONAL BENEFIT	$15,000	Pays a benefit up to the Maximum for your Spouse's expenses in enrolling in a professional or trades training program for the purpose of obtaining an independent source of income, if you suffer a covered accidental death and such expenses are incurred within 36 months of your death.

Benefit	Maximum	Benefit Description
FUNERAL EXPENSE	$5,000	Pays a benefit up to the Maximum to reimburse funeral expenses if you suffer a covered accidental death.
BEREAVEMENT BENEFIT	$1,000	Pays up to the Maximum if you suffer loss of life in a covered accident and your eligible dependents require counselling within one year of your loss of life.
SEAT BELT AND AIR BAG BENEFIT	$50,000	Pays a benefit of 10% of the Principal Sum up to the Maximum if you suffer a covered accidental death while operating or riding as a passenger in a Private Passenger Type Automobile in which your seatbelt was properly fastened. If the seat belt benefit is payable and you were in a seat protected by a properly functioning supplemental restraint system which inflated on impact, an additional benefit of 10% of the Principal Sum will be paid. The Seat Belt and Air Bag Benefit is payable up to the Maximum combined.
DISABILITY FITNESS BENEFIT	$5,000	Pays a benefit up to the Maximum if you suffer an Injury for which you receive a benefit under the policy and require specially designed fitness training or athletic equipment for disabled persons, which would not have been required except for such Injury. Only such expenses incurred within the first two years from the date of Injury are eligible. Only one benefit shall be payable, the largest, under the policies issued by the Company and shall not duplicate benefits payable under any other insurance.
PARENTAL CARE BENEFIT	$10,000	Pays a benefit of an additional 10% of the Principal Sum up to the Maximum for any Dependent Parents, if you suffer a covered accidental death. The benefit is payable if at the time of accident, your Dependent Parent is in a licensed nursing care facility, enrolled in a home health care program, living with you or receiving financial support and care by you. Only one Parental Care Benefit will be payable regardless of the number of eligible Dependent Parents.
CARJACKING BENEFIT	$25,000	Pays an additional benefit of 10% of the Principal Sum up the Maximum if you suffer a covered accidental Injury and the Injury which caused the Loss is a result of a Carjacking while you were operating or riding in, or getting in or out of, a Private Passenger Type Automobile.
FELONIOUS ASSAULT BENEFIT	10% of Principal Sum	Pays an additional benefit of 10% of the Principal Sum if you suffer an Injury for which you receive a benefit under the policy as a result of a deliberate felonious act of another person directed at you as an employee of the Policyholder, unless such an act was committed by a fellow employee or a member of your family or household.
COSMETIC DISFIGUREMENT BENEFIT	$25,000	Pays a percentage of the Principal Sum up to the Maximum if you suffer a third degree burn by means of exposure to fire, heat, caustics, electricity or radiation. Please see the policy for details including the percentage payable.

Policy Exclusions

The policy will not cover any losses caused in whole or in part by, or resulting in whole or in part from, the following:

(a) suicide or any attempt thereat by you while sane;

(b) self inflicted Injury or any attempt thereat by you while sane or insane;

(c) declared or undeclared war or any act thereof;

(d) sickness, disease, or bodily infirmity whether the Loss or claim results directly or indirectly from any of these;

(e) mental incapacity whether the Loss or claim results directly or indirectly from any mental incapacity;

(f) Injury sustained while you are undergoing the medical or surgical treatment of sickness, disease, or bodily or mental infirmity;

(g) stroke or cerebrovascular accident or event; cardiovascular accident or event; myocardial infarction or heart attack; coronary thrombosis; aneurysm;

(h) travel or flight in or on (including getting in or out of, or on or off of) any aircraft, if you are:

  (i) riding as a passenger in any aircraft not intended or licensed for the transportation of passengers;

  (ii) performing, learning to perform or instructing others to perform as a pilot or crew member of any aircraft; or

  (iii) riding as a passenger in an aircraft owned, leased or chartered by the Policyholder;

(i) travel or flight in or on (including getting in or out of, or on or off of) any aircraft or craft designed to fly or glide above the Earth's surface:

  (i) except as a passenger on a regularly scheduled commercial airline; or

  (ii) being used for crop dusting, spraying or seeding, fire-fighting, traffic patrol, air ambulance, pipeline or power line inspection, aerial photography or exploration, racing, endurance tests, stunt or acrobatic flying; or

  (iii) operating to or from off-shore landing sites; or

  (iv) used in any operation that requires a special permit from the Civil Aviation Branch of Transport Canada, even if it is granted (this does not apply if the permit is required only because of the territory flown over or landed on).

(j) infections of any kind regardless of how contracted, except bacterial infections that are directly caused by botulism, ptomaine poisoning or an accidental cut or wound independent and in the absence of any underlying sickness, disease or condition including but not limited to diabetes;

(k) Injury or Loss sustained if you are on full-time active duty in the armed forces or organized reserve corps of any country or international authority;

(l) Injury or Loss sustained while you are under the influence of alcohol and operating any vehicle or means of transportation or conveyance while your blood alcohol is over 80 milligrams in 100 millilitres of blood;

(m) Injury or Loss sustained while you are under the influence of a drug or substance which is controlled as specified under the Controlled Drug and Substances Act (Canada) unless taken pursuant to the advice of and in strict accordance with the instructions of a duly licensed Physician;

(n) the commission or attempted commission by you or Injury incurred while you are in the course of committing or attempting to commit any act which if adjudicated by a court would be an indictable offence under the laws of the jurisdiction where the act was committed; and

(o) an act, attempted act or omission taken or made by you, or an act, attempted act or omission taken or made with your consent, for the purposes of interrupting the blood flow to your brain or to cause asphyxiation to you whether with intent to cause harm or not; and

(p) natural causes.

Claims Process

Beneficiary Designation

You have the option to designate a beneficiary, should you choose not to, in the event of accidental Loss of Life, the benefit will be paid to the beneficiary you have designated in writing under your Employer's current group life policy. If there is no written designation then the benefit will be paid to your estate.

All other benefits will be payable to you.

How to Make a Claim

In the event of claim, claim forms can be obtained from your Employer.

Written notice of claim to the Company must be given no later than 30 days from the date of accident. Within 90 days from the date of the accident, proof of claim must be submitted to the Company. Proof may include a certificate as to the cause and nature of the accident or Injury caused thereby, for which the claim is made and as to the duration of the Injury or Loss, from legally qualified medical practitioner.

Failure to give notice of claim or furnish proof of claim within the time prescribed above will not invalidate the claim if the notice or proof is given or furnished as soon as reasonably possible and in no event later than one year from the date of the accident or the Injury and if it is shown that it was not reasonably possible to give notice or furnish proof within the time as prescribed.

Important Notes

This booklet, as may be amended, provides only a summary of the provisions for the Group Personal Accident coverage and the Additional Benefits. The full coverage details are contained in the policy including eligibility, limitations, exclusions and termination provisions. In the event of a discrepancy between this booklet and policy, the terms of the policy shall govern.

The booklet is provided for information purposes only and does not create or confer any contractual rights or obligations. Possession of this booklet alone does not mean that you or your dependents are covered. The policy must be in effect and you must satisfy all the requirements.

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the Insurance Act (for actions or proceedings governed by the laws of Alberta and British Columbia), The Insurance Act (for actions or proceedings governed by the laws of Manitoba), the Limitations Act, 2002 (for actions or proceedings governed by the laws of Ontario), The Limitations Act (for actions or proceedings governed by the laws of Saskatchewan) or other applicable legislation. For those actions or proceedings governed by the laws of Quebec, the prescriptive period is set out in the Quebec Civil Code.

Insurance is underwritten by AIG Insurance Company of Canada.

Appendix D – Out-of-Province/Canada Medical Emergency Insurance

Underwritten by AIG INSURANCE COMPANY OF CANADA

Contact **Coughlin & Associates Ltd.**, your benefits administrator for any and all questions related to this benefit.

EMERGENCY OUT OF PROVINCE MEDICAL

For all in benefit Members of

Canadian Merchant Service Guild
Western Branch Benefit Plan

POLICY NUMBER
CMG 9429026

September 2022

EMERGENCY OUT-OF-PROVINCE MEDICAL COVERAGE

Each Canadian province provides a provincial medical plan with comprehensive benefits for hospital confinement, the service of medical doctors and other health practitioners, ambulance services, etc. In many cases, the benefits provided by these plans will pay all, or almost all, of the expenses you incur in your home province. (Note: In this Plan, "province" also refers to a "territory" of Canada, where applicable; "you" and "your" includes the Insured Members and their eligible dependents.)

When you are outside your province of residence and require these services, your provincial medical plan will usually make a payment towards your expenses; but that payment is usually limited to the amount that would have been paid for the same service in the province in which you reside. Unfortunately, there is often a considerable difference between the cost of these services outside your province of residence and the amount allowed by your provincial medical plan, which you would have to pay yourself were it not for this valuable benefit.

This Plan provides extensive coverage for many services rendered outside your province of residence. It is important to note that such expenses are covered provided that they were unexpected and of an emergency nature.

ELIGIBILITY

All in benefit Members and Retirees under the Canadian Merchant Service Guild Western Branch Benefit Plan and their eligible dependents whose names are on file with the Policyholder are insured under this Plan.

Class I: All eligible active Employees under age 75.
Class II: All eligible retired Employees under age 75.
Class III: All eligible active Employees ages 75 to 80.

PERIOD OF COVERAGE

You and your dependents are covered while outside your province of residence for such reasons as business or vacation. Expenses incurred by you are not covered in the event that you had left the province for the purpose of obtaining medical treatment, (except as indicated under the Referral Services benefit).

Trips are limited to a maximum of 60 consecutive days.

EMERGENCY COVERAGE FOR HOSPITAL, MEDICAL AND THERAPEUTIC SERVICES OUTSIDE PROVINCE OF RESIDENCE

When injuries or sickness result in emergency hospitalization, medical or therapeutic services, the Company will pay benefits for the period this contract is in force, not to exceed the maximum benefit amount shown below for the actual expenses incurred outside your province of residence that exceed the amount which is payable with respect to such expenses under any government hospitalization or medical care plan in your province of residence (GHIP), or if you are not covered under any such plan, to the extent that they exceed any amount which would be payable with respect to such expenses under the provincial medical plan if you were covered under any such plan.

Benefit Maximum amount reduces as follows:

Under age 70 - $5,000,000.00 lifetime maximum
Age 70 and over - $2,000,000.00 lifetime maximum

HOSPITAL CONFINEMENT

Benefits are payable for confinement as a resident in-patient in a hospital, including semi-private accommodation and charges made by the hospital for services and supplies rendered by such hospital and provided for use during such confinement.

In the event that you are confined to hospital at the end of your trip outside Canada and thus prevented from returning to Canada, insurance will continue for the period of such confinement, but in no event for more than 12 months from the date the first insured expense was incurred.

MEDICAL AND THERAPEUTIC SERVICES:

Benefits are payable for:

a) the services of a legally qualified physician or surgeon (other than an insured person);

b) laboratory tests and X-ray examination by a legally qualified doctor of medicine for the purpose of diagnosis;

c) the services of a registered graduate nurse (other than a relative by blood or marriage), up to a maximum of 50 nursing shifts at the usual and customary fee, but not more than $100 per shift;

d) rental of crutches or hospital type bed, or the cost of splints, canes, slings, trusses, braces or other approved prosthetic appliances;

e) the services of a legally qualified anaesthetist;

f) drugs or medicines that require a legally qualified physician's written prescription;

g) services of a chiropodist, chiropractor, osteopath, physiotherapist or podiatrist (other than a relative) up to a maximum of $300 per practitioner;

h) expenses for accidental injury to natural and sound teeth (capped or crowned teeth are considered whole or sound natural teeth) which requires treatment by a legally qualified dentist or dental surgeon within 30 days from the date of the accident, not to exceed in the aggregate the amount of $2,000 as the result of any one accident;

i) expenses for the relief of dental pain, other than pain caused by an accident, initiated within 48 hours of the onset and completed no later than 90 days after initial treatment, not to exceed $500; and

j) out-patient services provided by a hospital.

AUTOMOBILE RETURN

If you become totally disabled and you are unable to continue your trip or vacation, the Company will pay the actual charges of a commercial agency for the return of your private or rental vehicle used for the trip, to your place of residence or nearest rental agency, up to a maximum of $4,000.

"Totally Disabled" means your complete inability, on medical evidence, to continue your duties or activities and to continue your trip or vacation.

REPATRIATION BENEFIT

When injuries or sickness covered by this Plan result in your loss of life in a province or country other than your place of residence and within 365 days after the date of the incident, the Company will pay the actual expense incurred for preparing your body for burial or cremation and shipment of your body to your place of residence in Canada, the amount not to exceed $15,000.

IDENTIFICATION BENEFIT

If your body requires identification following your loss of life for which a benefit is paid or payable hereunder, the Company will pay to one of your Immediate Family members, the reasonable and necessary expenses actually incurred by such Immediate Family member for:

a) commercial lodging and board while en route and/or during the stay in the city or town where the body is located (not to exceed a maximum duration of 3 consecutive nights); and

b) transportation by the most direct route to such location.

This benefit is payable by the Company only if the body is located outside the Immediate Family member's normal province of residence and the identification of the body is requested by the police or a similar law enforcement agency having authority over such matters.

Payment will not be made for ordinary living, travelling or clothing expenses, other than as specifically stated above. If transportation occurs in a vehicle or device other than one operated under the license for the conveyance of passengers for hire, the reimbursement of transportation expenses will be limited to a maximum of $0.40 per kilometre travelled.

The maximum amount payable for this benefit is $5,000 per Insured Person.

TRIP INTERRUPTION BENEFIT

If your scheduled departure is delayed for at least 12 hours due to sickness or hospitalization as provided by the Plan, or due to sickness or hospitalization of your covered travelling companion, the Company will reimburse you up to a maximum of $500 for the extra cost of your one-way economy/charter air fare via the most cost-effective itinerary to your next scheduled travel destination or original departure point of the same trip.

The Company will also reimburse the additional and unplanned hotel and meal expenses, telephone calls and taxi fares up to a combined maximum of $300 per day to a maximum of 5 days.

In order to claim any of the above outlined expenses, original itemized invoices must be provided at time of claim. The combined maximum amount payable for this benefit is $2.000 per Insured Person per incident.

FAMILY TRANSPORTATION BENEFIT

If you suffer injury or sickness, resulting in being confined to a hospital located outside your province of residence, the Company shall pay the reasonable and necessary expenses actually incurred for the transportation of an Immediate Family member to the hospital.

This benefit is only payable if:

a) confinement to hospital occurs within 365 days of the sickness or the accident causing the injury; and

b) reimbursement of expenses are limited to the cost of one economy class return air fare via the most direct route, or the equivalent amount toward another type of common carrier transportation for such immediate family member.

The maximum amount payable for this benefit for any one sickness, or for all injuries resulting from any one accident, is $15,000 and incidental travel expenses up to a maximum of $200 per day to a maximum of $800 per Insured Person.

RETURN TRANSPORTATION FOR TRAVELLING COMPANION

If you are repatriated to Canada in accordance with the Repatriation Benefit, or return to Canada in accordance with the Ground or Air Transportation benefit, the Company will pay a benefit to you (or your estate) for the extra cost of a one-way economy air fare transportation on a commercial flight or charter via the most cost effective itinerary to transport your Travel Companion to Canada.

The maximum amount payable for this benefit for any one trip is $5,000 per Insured Person for the transport of one Travel Companion.

RETURN AND ESCORT OF DEPENDENT CHILDREN UNDER AGE

If you are repatriated to Canada in accordance with the Repatriation Benefit, or return to Canada in accordance with the Ground or Air Transportation benefit, the Company will pay a benefit to you (or your estate) for the cost of a one-way economy air fare transportation on a commercial flight or charter via the most cost effective itinerary to transport your Dependent Children travelling with you on a trip to their home, plus reasonable overnight hotel accommodation and meal expenses and for the services of an attendant to escort your Dependent Children under age 16, if required.

The maximum amount payable for this benefit for any one trip is $5,000 per repatriated or returned Insured Person.

REFERRAL SERVICES

In the event you are referred to a hospital outside your province of residence as a resident in-patient, the Company will pay benefits for reasonable and customary charges for standard ward accommodation and for charges made by the hospital for services and supplies to the extent that such are medically necessary. Coverage shall also include the reasonable and customary services of a physician or legally qualified surgeon.

Prior to the commencement of any referral treatment, written pre-authorization from your provincial medical plan and the Company must be obtained. The government hospitalization or medical care plan in your province of residence (GHIP) may cover most, or all, of these costs. Any referral requires written recommendation from the physician or legally qualified surgeon stating the reason for the referral, and a letter from GHIP outlining their liability. Failure to comply in obtaining pre-authorization will result in non-payment.

The maximum amount payable for this benefit in any consecutive 12 month period is $50,000 per Insured Person.

It is understood and agreed that expenses incurred under the Referral Services provision are not due to an emergency. It is further understood and agreed that exclusion h) is not in effect for expenses incurred under the Referral Services provision.

EMERGENCY TRAVEL ASSISTANCE OFFERS THE FOLLOWING FEATURES:

Travel assistance is provided by Global Excel Management Inc. With centres worldwide they will:

- help locate the most appropriate medical facility for you;
- confirm coverage with AIG Insurance Company of Canada and assure the hospital that you are covered;
- guarantee payment for hospitalization, if necessary;
- arrange for admission to a hospital;
- provide translation services;
- contact your own doctor for recommendations, when required;
- contact your family and employer, when required;
- arrange for/co-ordinate emergency medical evacuation; and
- co-ordinate your return home.

HOW TO CLAIM

If you require emergency medical care or hospitalization, you or someone acting on your behalf should contact Global Excel Management Inc. immediately. If circumstances prevent you from calling Global Excel Management Inc. right away, you should contact them as soon as you can. Global Excel Management Inc. will help ensure that you receive the medical care you need and, if possible, will make claims payment arrangements directly with the hospital or service provider.

If you contact GLOBAL EXCEL MANAGEMENT INC. right away, your claim may be pre-approved so you can avoid having to pay upfront and claim for reimbursement later.

If you are not able to contact Global Excel Management Inc. before being billed for the charges, or if your medical needs are minor in nature (i.e., costing less than $500), it is your responsibility to pay the bill promptly yourself and then submit a claim as soon as you return from your trip. In any case, your claim should be submitted no later than 90 days after the expense was incurred. Global Excel Management Inc. and the insurance company are not responsible for dealing with any payment reminders or collection notices that you receive from medical providers.

To make a claim for out-of-pocket expenses, contact a Global Excel Management Inc. operator at:

From Canada & U.S., call toll free 1-877-207-5018
Outside Canada & U.S., call collect 1-819-566-3940

Give the operator your name and your Policy Number: CMG 9429026.

The operator will send you a claim form. When you complete the form, provide the patient's name and provincial health plan number and your certificate number. Be sure to attach detailed statements and original receipts showing the services rendered and the charges for each service.

Mail your completed claim form and attachments to:

Global Excel Management Inc.
73 Queen Street
Lennoxville, QC, J1M 1J3

Please make sure you obtain your medical records, statements or detailed receipts at the time of treatment and/or discharge, to submit with your claim. All claims must be submitted to Global Excel Management Inc. as soon as possible, and no later than 90 days after the expense was incurred.

COORDINATION OF BENEFITS

Global Excel Management Inc. will co-ordinate coverages with other policies according to the CLHIA's Coordinating Coverage Guidelines for Out-of- Country/Province Health Care Expenses. The total amount payable from all sources may not exceed the expenses you incurred.

IN AN EMERGENCY, HERE'S WHAT TO DO

Call Global Excel Management Inc. immediately in the event of a serious medical emergency.

Their operators are backed by a team of emergency care professionals - physicians and nurses who work closely with the doctor looking after you, and if necessary, your family or company doctor, to help ensure that you receive the medical care you need.

An operator will ask you the following:

Your name, location and the details or your emergency.
Your Policy Number: CMG 9429026
Service Support Telephone Numbers:

Telephone:
From Canada & U.S., call toll free 1-877-207-5018
Outside Canada & U.S., call collect 1-819-566-3940

GROUND TRANSPORTATION

The use of a licensed ground ambulance to a maximum of $5,000 any one accident or sickness.

AIR TRANSPORTATION

a) If an injury or sickness commencing during the course of your trip results in a medically necessary Air Transportation, the Company will pay benefits for covered expenses up to a maximum of $500,000. An Air Transportation must first be approved by the Company and it must be ordered by a legally licensed physician or surgeon who certifies that the severity of your injury or sickness warrants your Air Transportation and that such is medically necessary.

b) If, due to the geographical area at the onset of your medical emergency an air ambulance is deemed necessary, the Company will pay the cost of a licensed air ambulance for your transport to the nearest hospital or medical facility where appropriate medical treatment can be obtained.

Air Transportation means:

a) your medical condition warrants immediate transportation from the place where you suffered the injury or sickness to the nearest hospital where appropriate medical treatment can be obtained; or

b) after being treated at a local hospital, your medical condition warrants transportation to the place where you reside (provided such residence is located in Canada) to obtain further medical treatment or to recover; or

c) both **a)** and **b)** above.

Covered expenses are only those reasonable and customary expenses, up to the maximum, for transportation, medical services and medical supplies which are medically necessary and incurred in connection with your Air Transportation. All transportation arrangements made for transporting you must be by the most direct and economical route. Expenses for special transportation must be recommended by the attending physician or surgeon or required by the standard regulations of the conveyance transporting you.

Expenses for medical supplies and services must be recommended by the attending physician or surgeon. Air Transportation means any land, water or air conveyance required in connection to transport you during an Air Transportation. Special Transportation includes, but is not limited to, air ambulance, land ambulances, commercial airlines and private motor vehicles.

Charges for use of a local ambulance and/or the use of a scheduled air carrier on physician's advice, up to the cost of a one-way economy air fare for you and $250 for incidental travel expenses; if return by stretcher is required, the cost of such additional economy class seating as is necessary; if a medical attendant is required to accompany you, the Company will pay the fee of such attendant plus one return economy air fare and reasonable incidental travel expenses.

EXCLUSIONS AND LIMITATIONS

Benefits are not payable for:

a) injuries received while you are participating in any maneuvers or training exercises of the armed forces;

b) pregnancy, miscarriage, voluntary termination of pregnancy, childbirth or their complications except that in the case of a pregnancy, complications which occur before the end of the seventh month will be covered if they occur while insured hereunder;

c) sickness or injury where the trip is undertaken for the purpose of securing medical treatment or advice for such sickness or injury;

d) dental surgery or cosmetic surgery unless such surgery is a result of a covered injury;

e) emotional or mental disorders unless you are hospitalized;

f) sickness or injury due to participation in professional sports;

g) treatment or services that contravene any government hospital or medical plan in Canada;

h) expenses incurred on an elective (non-emergency) basis;

i) loss or injury as a result of suicide or any attempt thereat or self-inflicted injuries while sane or insane;

j) an act of declared or undeclared war, civil war, rebellion, revolution; insurrection, military or usurped power or confiscation or nationalization or requisition by or under the order of any government or public or local authority;

k) any services or supplies provided by an Insured Person;

l) any treatment or surgery not required for the immediate relief of acute pain or suffering;

m) any treatment or surgery which reasonably could be delayed until you return to your province of residence; and

n) anticipated medical treatments required on an ongoing basis or for continued stabilization of a medical condition known to you prior to departure.

o) a medical condition that had deteriorated, or had to be treated or investigated in the three (3) months immediately preceding the Insured Person's departure from Canada. Applicable to Class III only.

All expenses must be incurred on a non-elective emergency basis and are in excess of any individual, group or provincial medical plan.

EXTENDED COVERAGE AFTER TERMINATION

In the event of the delayed arrival of your common carrier hospitalization this Plan will automatically be extended at no charge:

1) 24 hours in the event of a delayed common carrier;
2) the period of hospitalization plus 24 hours after you are released from hospital.

TERMINATION OF COVERAGE

Coverage will terminate on the earliest of:

1) the date you cease to meet the eligibility requirements of the Plan;
2) the date any required premium is unpaid; or
3) the date the Master Policy terminates or in accordance with any other terms and conditions stated in the Master Policy.

WHAT TO DO IN A MEDICAL EMERGENCY

You or someone acting on your behalf should call Global Excel Management Inc. immediately, before you get medical assistance. If you can't call right away, contact Global Excel Management Inc. as soon as you are able to do so.

Call:

U.S. & Canada 1-877-207-5018
Outside U.S. & Canada 1-819-566-3940 collect

The operator will ask you for:

Your name, location and the details of your emergency
Your Policy Number: CMG 9429026

The operators are backed by a team of emergency care professionals - physicians and nurses who work closely with the doctor looking after you, and if necessary, your family or company doctor, to help ensure that you receive the medical care you need.

This brochure has been prepared to help you understand your coverage and, as such, does not create or confer any contractual or other rights. The terms and conditions governing the insurance are set out in the group Master Policy issued by AIG Insurance Company of Canada. In the event of any variation between information in this brochure and the provisions of the policy, the latter will prevail.

AIG

Appendix E –
Additional Benefit Services

QuikCare Platinum

Contact **Coughlin & Associates Ltd.**, your benefits administrator for any and all questions related to this benefit.

COUGHLIN
employee benefits specialists

1-844-900-8357
24/7 Dedicated Helpline

QuikCare
PLATINUM

Expedited Access to Healthcare

- MRI
- CT Scan
- Neurology
- Cardiology
- Urology
- General Surgery
- Ophthalmology
- Rheumatology
- Gastroenterology
- Ear, Nose & Throat
- Ultrasound
- Neurosurgeon
- Orthopedics

When your health is at risk you shouldn't have to wait!

Canadian medical specialists are limited to how many new patients they are able to diagnose each month due to the budgetary constraints within the Canadian Healthcare system. This creates average wait times of over 8 months to see a specialist and over 3 months for a diagnostic scan. Call **1-844-900-8357** to setup your consultation with one of our intake specialists.

All this time your condition could be worsening, you may be stressed, worried, unable to work and participate in your usual day-to-day activities. This adversely affects your health and well-being which can have a substantial impact to the you and your family.

You don't have to wait...

QuikCare Platinum is designed to assist you so you can focus on taking care of your well being.

QuikCare Platinum provides a unique healthcare benefit to you by allowing those who are placed on a medical wait list, immediate access to diagnostic scans (MRI/CT Scans) and specialist consultations with the cost fully covered.

QuikCare Platinum will give you peace of mind knowing diagnostic scans will be booked and performed within 72 hours and you will see specialists within weeks not months.

QuikCare Platinum assists in the alleviating the pain and worrying and returning you to a healthier life.

How does QuikCare Platinum work?

When your physician recommends a diagnostic procedure or refers you to a specialist you call the QuikCare Platinum Helpline **(1-844-900-8357)** for rapid intervention. QuikCare Platinum will liaise with you to obtain the required documentation and then utilize a network of specialists and diagnostic imaging services to coordinate and pay for the required services.

Covered Specialists

· Cardiology · Gastroenterology · General Surgery · Neurosurgery · Ear, Nose & Throat
· Orthopedics · Ophthalmology · Rheumatology · Urology · Neurology

What is required?

All that is required for you to rapidly access expedited health care treatment is a diagnostic requisition form or a specialist referral from your physician.

You must first contact our helpline (1-844-900-8357) in advance of receiving a diagnostic procedure or specialist consultation and obtain approval from our Case Management team in order to have your expedited health care arranged and paid for. Fees for diagnostic testing and specialist consultations are paid by QuikCare directly to health care providers. You do not have to pay for your health care treatment and then seek reimbursement.

The 4 Easy Steps of QuikCare Platinum Expedited Health Care

1 Call QuikCare Platinum Helpline

When you receive a physician's diagnostic requisition or a physician's referral letter for a specialist, simply call the QuikCare Platinum helpline at 1-844-900-8357.

2 Case Management

Our Case Management team will coordinate with you to obtain the required documentation and assist you in every step.

3 Expedited Health Care

QuikCare will arrange the required expedited health care and will advise you of the appointment time and location.

4 Follow Up

Following the scan or specialist appointment our Case Management team will follow up and ensure the results are sent to your physician and to arrange any further treatment.

What are the different types of diagnostic scans and specialists covered?

Magnetic Resonance Imaging (MRI):

Magnetic Resonance Imaging (MRI) is a medical diagnostic technique that uses strong magnetic fields, radio waves, and field gradients to generate images of the internal organs of the body. Unlike CT Scans, it does not utilize x-rays. MRIs allow healthcare professionals to assess internal issues that would otherwise be undetectable, providing more accurate and detailed diagnoses, which in turn yields shorter recovery times.

Computed Tomography Scan (CT Scan):

Computed Tomography Scan (CT Scan) is essentially a three-dimensional x-ray; a computer combines a series of many x-rays taken at different angles to create a single cross-sectional image of the area scanned. Various structures in the body absorb the x-rays to varying degrees, and will appear on the CT Scan with varying intensity, allowing a doctor to easily identify abnormalities. Being able to look into the body of a patient to find otherwise difficult to diagnose problems is an invaluable tool in providing quick and effective healthcare.

Ultrasound:

An Ultrasound is an imaging technique that uses high frequency sound waves to penetrate the human body and create an image based off of the return of said sound waves. They echo off of the tissues to varying degrees, which is then recorded by a computer and displayed as an image. The main advantage of an ultrasound is that it provides images in real-time, so doctor and patient can determine the cause of injury or illness, and begin treatment, immediately.

Orthopedic:

Orthopedics is the branch of medicine concerning conditions involving the musculoskeletal system. An orthopedic specialist will help patients who suffer from bone fractures, the gradual degeneration of joints, sprains and strains of tendons and ligaments, and other such musculoskeletal issues.

Cardiologist:

A Cardiologist is a specialist of the heart, as well as other parts of the circulatory system. A healthy heart is vital to a long and active life, so it is absolutely essential that problems involving the heart are treated with accuracy and haste.

Neurologist:

A neurologist is a medical specialist focused on disorders of the nervous system, including the brain, the spinal cord, and peripheral nervous system. Observation and analysis by a trained neurologist is imperative when it comes to a disorder of the nervous system; the entire human body relies on its proper function and health.

Gastroenterologist:

Disease affecting any part of the organ system used to digest food – the “gastrointestinal tract” - are the concern of a gastrointestinologist. An illness of the gastrointestinal tract can be substantially life altering; Crohn's disease and Irritable Bowel Syndrome, for example, can be lifelong ailments that require the diagnosis and treatment of a gastroenterologist to establish a manageable routine.

General Surgeon:

A General Surgeon specializes in the abdominal contents of the body, in particular the stomach, liver, pancreas, gallbladder, and other internal organs. Typically, the treatment of traumatic and emergency injury or illness falls to the general surgeon, however they also are responsible for the execution of a variety of other surgeries, such as transplants, mastectomies, laparoscopic procedures, pediatric surgeries.

Ear, Nose & Throat (ENT):

An Ear, Nose & Throat (ENT) specialist deals with conditions of the ears, nose and throat, but also other structures at the base of the skull. Allergies, snoring, voice disorders, cleft lip/palates, and thyroid issues are all problems an ENT can help resolve.

Ophthalmologist:

Somewhat like an optometrist, who provides primary eye care, an Ophthalmologist specializes further in the health and physiology of the eyeball and the orbit. They can provide treatment for many eye diseases, as well as surgeries to improve vision.

Urologist:

A urologist specializes on the male and female urinary tract, as well as the male reproductive organs. A urologist may use medical management to treat conditions not requiring surgery, such as UTIs, as well as surgical management to treat more serious conditions, such as cancer or kidney stones.

Rheumatologist:

As the name might suggest, one of the most well-known rheumatological conditions is Rheumatoid Arthritis; it is one of a collection of disorders that causes chronic, often intermittent pain in the joints and/or connective tissue. A Rheumatologist can help treat such conditions that appear in various places on the body, including the back, shoulder, neck, knees and hands.

Neurosurgeon:

A neurosurgeon can prevent, diagnose and treat disorders of the nervous system, including the brain, spinal cord, and peripheral nerves. A healthy nervous system is critical to nearly every function within the body. When a neurological condition is treatable via surgery, such as brain cancer or a hemorrhage, a neurosurgeon will operate, and can literally save a life.

The QuikCare Platinum Helpline (1-844-900-8357) is a dedicated 24/7 toll free helpline.

Case Study 1

A member was injured when he was involved in a dirt biking accident, preventing him from working in any capacity. QuikCare Platinum expedited an MRI scan in one day for this member whereas he would have normally waited up to 6 months. The MRI led to a definitive diagnosis of a complete tear of the anterior cruciate ligament (ACL) and the member was referred to an orthopaedic surgeon. The consultation with the surgeon confirmed that an ACL reconstruction surgery would be necessary in order for him to recover and return to work. QuikCare Platinum booked the appointment and the surgery was completed in 7 days.

As QuikCare Platinum was able to have an MRI scan together with a referral to a surgeon and the actual surgery carried out within 7 days, the member was off work for a total of 6 weeks. Had QuikCare Platinum not been involved, months after the accident the member would still have been waiting for a specialist referral and surgery.

Case Study 2

A member had been diagnosed with a fracture and was directed to be off work for 8 weeks. The member expressed to QuikCare Platinum that he did not feel like he was getting any better and in fact, he is not even sure what caused the fracture. He did not have a family doctor so he was only assessed by a physician at the hospital. The worker advised us that a bone scan was recommended to rule out osteoporosis, but nothing was done to book the appointment.

QuikCare Platinum arranged an independent assessment in order to assess the member's inability to work and to help facilitate his referral for a bone scan. Following his appointment, not only was he given the referral for the bone scan, he was also cleared to return to work on modified duties immediately to assist with his recovery and rehabilitation.

With QuikCare Platinum's quick intervention, not only did the member get the expedited health care he needed, but he was also able to return to work quicker and earn his full wages. Given the proactive approach taken there was only a total of 2 weeks of being off work as opposed to 8 to 12 weeks.

Confidentiality Statement:

QuikCare Platinum exercises utmost diligence to safeguard the confidential information of members and protects it against disclosure, misuse, loss and/or theft. We acknowledge that exchange and access to confidential information is a requirement to provide services. This information is secured in our paperless filing system and password protected at all times. QuikCare Platinum can confirm that without the prior written consent of the member, confidential information, except to the extent that such use or disclosure is required in connection with the performance of services or as required under the agreement, will not be disclosed or made available to any unauthorized parties.

24/7 Dedicated Phone Line
1-844-900-8357