Group Benefits Plan

STAFF

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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 benefit plan as well as the coverage levels of each benefit. Be sure to keep this booklet in a safe place for future reference.

Although all information provided herein is meant to be exact and accurate, this document has no legal value. Only the terms and conditions of the group insurance policy and any applicable laws will be used to settle legal issues.

The insurers and administrators of these benefits are as follows:

Benefit	Insurer / Administrator	Policy Number	Appendix
Basic Employee Life and Long-Term Disability (LTD) Insurance	Canada Life Assurance	**134713**	Appendix A
Accidental Death & Dismemberment Insurance	Chubb Life Insurance	**ABT 10069601**	Appendix B
Out-of-province/Canada Travel Medical Emergency Insurance	AIG Insurance Company of Canada	**CMG 9429163**	Appendix C
Extended Health Care and Dental Care	Self-funded Administered by Coughlin & Associates Ltd.	**9703**	n/a

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 contact the PSAC Human Resources office.

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

Important

This document contains important information about your employee 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 Public Service Alliance of Canada (PSAC), 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 PSAC.

As sponsor of the plan, the PSAC 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. They also 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.

The interpretations or decisions of the PSAC, its trustees or designates with respect to the self-insured coverage, will be final and binding on all parties.

Protecting Your Personal Information

The administrator of your group benefits plan is Coughlin & Associates Ltd. (“Coughlin”). Coughlin recognizes and respects every individual’s right to privacy. We are committed to keeping personal information private, confidential, accurate and secure. When personal information is provided to us, we establish a confidential file that is kept in our office, or the office of an organization authorized by us. Personal information is kept in a secure environment. We limit access to personal information in your file to Coughlin staff or persons authorized by Coughlin who require access to perform their duties, to persons to whom you have granted access, and to persons authorized by law. We use the personal information to administer the group benefits plan. You may exercise certain rights of access to the personal information in your file, and where appropriate, to have inaccurate information corrected by sending a written request to Coughlin. For information on our Privacy Policy, visit our website at www.coughlin.ca, or send a written request to our Privacy Officer by mail or by email at privacy@coughlin.ca.

Errors or Omissions

Every effort has been made to ensure that this booklet is accurate and complete. Should an error, omission or dispute occur, the terms of the policies issued to the plan sponsor will prevail. Clerical errors made by 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.

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Benefits Summary

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

Eligibility: Please refer to the *Eligibility* section to determine your eligibility and when coverage begins.

Employee Basic Life Insurance

REFER TO APPENDIX A – CANADA LIFE ASSURANCE

Benefit amount:	Two times your annual salary rounded to the next higher $1,000, if not already a multiple.
Reduction:	Benefit reduces to 100% at the first day of the month you reach age 65 and to $1,000 the first day of the month you reach age 70.
Non-evidence maximum:	$395,000
Maximum:	$500,000.
Termination:	When you reach age 75 or retirement, whichever occurs first

Any amount of employee life insurance over $395,000 is subject to approval of evidence of insurability.

Early retirees (age 50 to 65)

Benefit amount:	Two times your annual pre-retirement salary rounded to the next higher $1,000, if not already a multiple.
Non-evidence maximum:	$395,000
Maximum:	$500,000.
Termination:	When you reach age 65.

Any amount of employee life insurance over $395,000 is subject to approval of evidence of insurability.

Basic Accidental Death and Dismemberment Insurance

REFER TO APPENDIX B – CHUBB LIFE ASSURANCE

Benefit amount:	Amount equal to the Basic Employee Life Insurance.
Reduction:	Benefit reduces to 100% at the first day of the month you reach age 65 and to $1,000 the first day of the month you reach age 70.
Termination:	When you reach age 75 or retirement, whichever occurs first

Long-Term Disability Insurance

REFER TO APPENDIX A – CANADA LIFE ASSURANCE

Benefit amount:	75% of your monthly earnings.
Maximum amount:	$10,000 per month.
Maximum benefit period:	When you reach age 65.
All source maximum:	80% of gross monthly earnings.
Tax status:	Taxable
Termination:	When you reach age 65.

Out-of-Province/Canada Travel Medical Emergency Insurance

REFER TO APPENDIX C – AIG INSURANCE COMPANY OF CANADA

Deductible:	Nil.
Reimbursement amount:	100%.
Maximum amount:	Under age 70: $5,000,000 lifetime maximum. Age 70 to 74: $2,000,000 lifetime maximum. Age 75 and over: $1,000,000 lifetime maximum.
Coverage period:	60 consecutive days.
Termination:	When your employment ends.

Extended Health Care

Deductible:	$10 per insured person, $20 per family each calendar year, to be taken from the drug card.
Reimbursement level:	100% of eligible expenses (unless otherwise specified).
Maximum benefit:	Unlimited
Termination:	When your employment ends.

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

Prescription drugs:

• Deductible:	As indicated above under Extended Health Care Benefits.
• Reimbursement level:	100% of eligible expenses (unless otherwise specified).
• 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.
• Drug card:	Yes.
• Dispensing fee cap:	$10.73 in all provinces and territories.
• Maximums and exclusions:	
- Drugs:	Limited to a 3-month supply for prescription drugs or medicines and a 1-year supply for oral contraceptives.
- Sclerosing injections for the treatment of varicosities:	Cost of medication only.
- Viscosupplementation:	$600 per insured person per calendar year. Referral from medical doctor or nurse practitioner required.
- Smoking cessation aids:	Reasonable and customary charges with the following exceptions: Nicotine patches/inhaler: $525 per insured person per calendar year. Nicorette gum: $600 per insured person per calendar year.
- Fertility drugs:	Unlimited.
- Sexual dysfunction drugs:	Unlimited.

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

Hospital care

• Reimbursement level:	100% of eligible expenses (unless otherwise specified).
• 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.

Vision care:

• Reimbursement level:	100% of eligible expenses (unless otherwise specified) including contact lenses (special conditions).
• Benefit coverage period:	Benefit coverage period begins the date of the first claim and restarts every 24 consecutive months thereafter.
• Maximum:	$450 or $500 depending on the collective bargaining agreement per insured person per 24 consecutive months. Includes prescription glasses, contact lenses and special contact lenses and plano sunglasses to treat ophthalmic diseases/conditions and laser eye surgery.
• Laser eye surgery:	Included in the maximum listed above on an ongoing basis to the full cost of the surgery per insured person combined with any other vision care expenses.
• Glasses or contact lenses following cataract surgery:	One pair, up to maximum of $450 or $500 depending of the collective bargaining agreement per insured person per period of 24 consecutive months.
• Eye examinations:	Members: Up to 2 exams every calendar year, combined eye exam and contact lens examination/assessment. Must be performed by an optometrist, optician or ophthalmologist. Dependants (spouse and children): One exam every 24 consecutive months, combined eye exam and contact lens examination/ assessment. Must be performed by an optometrist, optician or ophthalmologist.

Professional and paramedical services:

• Reimbursement level:	100% of eligible expenses (unless otherwise specified).
• Maximum per practitioner:	
− Acupuncturist or naturopath:	Combined maximum of 20 visits per insured person per calendar year. Combined maximum of one X-ray per insured person per calendar year.
− Chiropodist:	20 visits per insured person per calendar year. Maximum of one X-ray per insured person per calendar year. Maximum of one surgery per insured person per calendar year.
− Chiropractor:	Maximum of 20 visits per insured person per calendar year. Maximum of one X-ray per insured person per calendar year.
− Dietician	$300 per insured person per calendar year.
− Electrologist:	$1,200 per insured person per calendar year. Eligible services of an electrologist or physician when performing electrolysis for the treatment for removal of excessive hair from exposed areas of the face and neck when the patient suffers from severe emotional trauma. Coverage for this benefit is limited to the face and neck. Electrolysis for other areas of the body will not be considered.
− Lactation consultant:	$300 per insured person per calendar year. Services covered by the province or territory of residence must be exhausted first.
− Occupational therapist:	$300 per insured person per calendar year.
− Massage therapist:	$900 per insured person per calendar year.
− Osteopath:	Maximum of 20 visits per insured person per calendar year. Maximum of one X-ray per insured person per calendar year.
− Podiatrist:	20 visits per insured person per calendar year. One X-ray per insured person per calendar year.
− Physiotherapist:	Unlimited.

– Psychologist, or registered social service/worker:	$7,500 per insured person per calendar year.
– Speech therapist/pathologist:	$750 per insured person per calendar year.

Medical supplies and services:

• Reimbursement level:	100% of eligible expenses (unless otherwise specified).
• Maximum per service and/or supply:	
– External breast prosthesis (following mastectomy):	Reasonable and customary charges.
– Surgical brassieres:	Reasonable and customary charges.
– Private duty nurse:	$20,000 per insured person each calendar year for services of a registered nurse, registered nurse assistant or licensed practical nurse in home only. Physician's referral required.
– Artificial eye:	Includes reimbursement for polishing or rebuilding of the artificial eye per insured person up to reasonable and customary charges.
– Artificial appendages:	Reasonable and customary charges. Replacements eligible after 60 months.
– Stump socks:	Reasonable and customary charges.
– Orthopaedic footwear:	$250 per insured person each calendar year. Prescription required.
– Custom made orthotics or arch support:	50%, $200 per insured person every 2 calendar years. Prescription required.
– Elastic support stockings:	Reasonable and customary charges. Physician's referral required indicating compression of at least 30mm.
– Therapeutic and mobility equipment:	Reasonable and customary charges. Purchase or rental, including repairs/parts. Referral required.
– Medical monitoring devices:	1 every 60 consecutive months. Eligible items include oxygen saturation meter, pulse saturometer, blood pressure monitor, coagulation monitor, heart monitor, portable oxygen unit, oxygen equipment & supplies, compressor & compressor supplies, oxygen concentrator, ventilator, percussor, drainage board, and oxygen cylinders.
– Hearing aids:	Unlimited. Includes hearing aids, repairs, and replacement parts including batteries, rechargeable batteries for cochlear implants. Excludes cochlear implants. Must be prescribed by an audiologist.
– Wigs as result of medical condition:	$1,500 per insured person every 60 consecutive months. Physician's referral required.
– Glucometer or reflectance meter, (includes Freestyle Libre flash monitoring system and associated sensors):	Reasonable and customary charges.
– Continuous glucose monitor supplies:	$3,000 per insured person per calendar year. For Type 1 diabetes only. Referral required.
– Diabetic monitors:	$700 every 60 consecutive months. Eligible with or without an insulin pump. Physician's referral required.
– Diagnostic services:	Reasonable and customary charges.
– Out-of-province/Canada referral treatment:	Expenses incurred outside the province of residence or out of Canada limited to a maximum $1 million per person per trip.

Prior authorization of any anticipated expenses for medical supplies and services should be obtained from the plan administrator, Coughlin & Associates Ltd. Supporting documents should be submitted for review to ensure eligibility based on the plan parameters.

Contact Coughlin & Associates regarding required documentation for prior authorization.

Dental Care

Deductible:	Nil.
Fee guide:	Based on current Dental Association fee guide for general practitioners, where service is rendered.
Reimbursement amount:	
• Basic services:	100% of eligible expenses.
– Maximum:	Unlimited
• Major services:	50% of eligible expenses.
– Maximum:	$5,000 per insured person per calendar year.
• Orthodontic services:	50% of eligible expenses.
– Maximum:	Lifetime maximum of $3,000 per insured person.
Treatment frequency:	
• Complete oral examination:	Once every 36 consecutive months.
• Recall oral examination:	Twice every 12 consecutive months.
• Specific oral examination:	Twice every 12 consecutive months.
• Complete series of periapical films or panoramic radiographs:	Once every 36 consecutive months.
• Polishing:	Twice every 12 consecutive months.
• Bitewing radiographs:	Twice every 12 consecutive months.
• Scaling:	Reasonable and customary charges.
• Root planing:	Reasonable and customary charges.
• Fluoride treatment:	Once every 6 consecutive months.
• Tooth coloured (composite) filling:	Eligible on all teeth.
• Pit and fissure sealants:	Unlimited.
• Space maintainers:	For missing primary teeth only.
• Oral hygiene instruction:	Twice every 12 consecutive months.
• Anaesthetic:	Eligible in relation to dental surgery only.
• Denture cleaning:	Twice every 12 consecutive months.
• Denture adjustments:	Once only, 3 months after initial installation.
• Denture rebase/reline:	Once every 36 consecutive months.
• Preformed stainless steel and polycarbonate crowns:	For children under age 16.
• Crowns, inlays & onlays:	Once every 5 years.
• Bridges & dentures:	Once every 5 years.
• Implants	Unlimited.
• Laboratory fees:	Limited to 60% of the fees specified for the dental treatment or service.
Termination:	When your employment ends.

General Information

Change in Information

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

Changes in Insurance Benefits

If your insurance benefits change because of an amendment to the plan, or because of a change in your age, class, earnings, etc., the new benefits become effective on the date the change affecting your benefits occurred.

When a change results in increased benefits you must be actively at work to be eligible for the new benefits. If you are not at work on the date the new benefits would otherwise become effective, the change will not become effective until you return to work.

Continuation of Employee Assistance Plan (EAP) Benefits

If you die, EAP benefits for your dependants will be continued for a period of one year.

- If your surviving children cease to qualify as eligible dependants (as defined earlier in this booklet), the health benefits being continued after your death will terminate on the date they no longer qualify.
- If a dependant is disabled on the date insurance under this continuation terminates, insurance payments for that dependant will be continued until the date the disability ends.

Coordination of Benefits (COB)

When payment for benefits provided under this plan is available to a person under any other pre-paid health service contract, insurance policy or plan, benefits shall be co-ordinated and the amount payable under this agreement shall be pro-rated and limited to the extent that the total amount available under all coverages does not exceed 100% of the eligible expenses.

The plan administrator may obtain from or release to any person or corporation, any information considered necessary to implement this provision and facilitate the payment of benefits under this plan, subject to consent of the covered member, if so required by law.

In co-ordination of benefits situations where Coughlin is secondary payer, the original Explanation of Benefits from the primary insurer and copies of the relevant receipts or dental claim form must be submitted.

Order of Benefits Determination

If you or your dependants are eligible to receive a benefit under this plan and the same or similar benefit under any other plan, benefit payment shall be decided in the following manner:

- if another plan does not contain a co-ordination of benefits provision, the benefits of that plan will be paid first prior to the application of benefits under this plan;
- if another plan contains a co-ordination of benefits provision, its benefits will be co-ordinated with the benefits under this plan as follows:

  Priority shall be attributed to the plan under which the person is eligible to receive the benefits in the following order:

  (i) the benefits payable under a plan which insures the individual other than as a dependant will be determined before the benefits of a plan which insures the individual as a dependant;

(ii) the benefits payable under a plan that insures the individual as a dependant of a covered person with the earlier month and day of birth in the calendar year; or
(iii) the benefits payable under a plan that insures the individual as a dependant 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:
  (i) the plan of the parent with custody of the child;
  (ii) the plan of the spouse-partner of the parent with custody of the child;
  (iii) the plan of the parent not having custody of the child; or
  (iv) 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:
  (i) the plan where the employee is an active, full-time employee;
  (ii) the plan where the employee is an active, part-time employee; or
  (iii) the plan where the employee 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.

Benefits Payable from Other Sources

If benefits for the same expense are payable under this plan and from any other source, the plan will reduce the amount payable under this plan to ensure that the total amount payable from all sources does not exceed the expense incurred.

General Limitations

Your health insurance does not cover services and supplies in the following situations:

- services or portion thereof provided under Workers' Compensation or similar program;
- services received for confinement which is primarily for chronic or custodial care;
- services received in a government hospital unless you are required to pay for such services;
- services to which the patient is entitled without charge, or for which there would be no charge if there were no coverage;
- services or portion thereof provided under any government sponsored hospital or medical care program;
- aesthetic surgery (cosmetic surgery for beautification purposes);
- services furnished without charge or paid for directly or indirectly by any government or for which a government prohibits payment of benefits;
- services received from a dental or medical department maintained by the employer, a mutual benefit association, labour union, trustee or similar type of group;
- service, including part-time or temporary service, in the armed forces of any country;
- services required due to war (declared or undeclared), insurrection, or participation in a riot;
- services required due to any intentional self-inflicted injury or disease, while sane or insane.

Eligibility

If you are a new indeterminate employee or a new term employee appointed to an assignment of one year or greater, you will become eligible to join the group insurance plan as follows:
- Extended health, out-of-province/country emergency medical, dental care, vision care and employee assistance program: Immediately.
- Life and accidental death or dismemberment insurance: After completion of three months of continuous service.
- Long-term disability: After completion of six months of continuous service.

If you are a new term employee appointed to an assignment for less than a year, you will become eligible to join the group insurance plan as follows:

- Employee assistance program: Immediately.
- Extended health, out-of-province/country emergency medical, dental care and vision care: Effective first day of the month following completion of three months of continuous service.
- Life, accidental death or dismemberment and long-term disability: First day after completion of one year of continuous service as a term employee, including service with a recognized employer (an employer having employees who are PSAC (union) members as per policy definition).

Participation in the plan is a condition of employment and you will be covered as soon as you become eligible.

You must be actively at work for insurance to take effect. You are considered to be actively at work if you are not disabled and you are either at work or absent for vacation, weekends, statutory holidays, or shift differentials.

Definitions

Spouse:

- an individual to whom the employee is legally married; or
- a common-law partner, with whom you have co-habited for a period of at least 12 months and who is publicly presented as your 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 and must be a resident of Canada.

Dependant child:

- an unmarried person who is a natural, adopted, or stepchild;
- 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 and not employed on a regular full-time basis; or
  (ii) up to 25 years of age, or 26 years of age in Quebec, 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.
- an unmarried child you or your insured spouse have been appointed guardian for all purposes by a court of competent jurisdiction.

Dependant coverage is not available to children who work more than 30 hours per week and are not full-time students or who are not residents of Canada.

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

Active employee or employee actively at work: an employee who performs all the usual customary duties of the occupation.

Fees and charges: considered under this plan means charges for services whose nature and severity are in accordance with the fee practices and tariffs of the official fee schedule for the profession, or if there is no official fee schedule, representative fee practices and tariffs of the profession in the area.

Inactive / unemployed: an employee who is temporarily absent from work due to disability, temporary lay-off, authorized leave of absence.

Insured person: employee, spouse and dependant child with coverage.

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.

Revocable / Irrevocable beneficiary: *Revocable beneficiary* is the person that you name to receive the benefits of an insurance policy can be changed. *Irrevocable beneficiary* is the person that you name to receive the benefits of an insurance policy that cannot be changed without the irrevocable beneficiary's written consent.

Enrolment

To apply for coverage, contact the PSAC Human Resources department and obtain, complete and sign an enrolment form for your extended health/drug, vision care, dental and out-of-province/Canada emergency travel insurance. Return it to PSAC Human Resources. If you acquire your first dependant after becoming insured, you should apply for dependant's benefits within 31 days.

Termination of Benefits

Extended health insurance benefits normally cease the date your employment terminates except:

a) if any of your dependants are totally disabled when your employment terminates, the extended health benefits will be continued for 90 days;
   or,
b) if you are totally disabled and receiving benefit payments provided under the long-term disability plan, your extended health benefits will continue until the earliest of:
   - the date you recover
   - the date you attain age 65; or
   - the date of termination of this policy;

   or,
c) if you are receiving pension benefits from your employer your extended health benefits can continue up to age 65.

Monthly premiums must be paid as required.

Dental and vision benefits cease the date your employment terminates.

On your death, coverage for your dependants will continue for 31 days from the date of your death, provided that this benefit continues in force and as long as the monthly premium is paid on your behalf.

Termination of Insurance

Unless otherwise specified in this booklet, insurance coverage for yourself and your dependants cease the earlier of:

- the date your employment ends;
- the benefit plan terminates;
- the date you are no longer a member of an eligible class.

If your employment ends due to injury, sickness, leave of absence or retirement, you may be entitled to continue to be insured under this plan. Contact PSAC Human Resources for details on the types of insurance that may be continued and the length of the extensions available.

Contract Holder

PSAC is the contract holder or the party under contract with the provider of administrative services of your employee benefit program.

Contract holder does not refer to you, the employee.

Plan Administrator

The plan administrator is Coughlin & Associates Ltd. Please refer to the *How to Claim Benefits* section for contact information.

Extended Health Care Benefit

Plan members must be covered under their provincial health care plan to be eligible for this benefit.

If you and/or your eligible 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.

Prescription Drug Card

You can pay for your prescription drugs directly through your drug plan using the all-in-one card.
Your all-in-one card provides your pharmacist with immediate confirmation of covered drug expenses. This means your prescription drug claims will be processed immediately. There are no forms to complete. Simply present the drug card to your pharmacist when purchasing prescription drugs. Payment for your claim will be processed immediately.
The drug card can be used by you as well as your spouse and eligible dependants. It is designed to cover prescription drug costs only and can be used at any pharmacy in Canada.

Covered Expenses

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

Prescription Drugs and Medication

- Diabetic supplies such as diabetic needles, syringes, alcohol swabs, test strips, and lancets.
- Certain eligible medications may require the prior authorization of the plan administrator.
- Compound mixtures, when at least one ingredient is a prescription requiring medication.
- Drugs, sera, vaccines and injectables only available when prescribed by a licensed health care practitioner or dentist.
- Charges for nicotine replacement products or smoking cessation therapies.
- Fertility drugs.
- Oral contraceptives.
- Drugs and supplies available without a prescription and required as a result of a colostomy or ileostomy and/or the treatment of cystic fibrosis, diabetes and Parkinson's or heart disease.

Hospital Care

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

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.

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 Benefits Summary. Reimbursement is based on the dates the services were rendered. All receipts must clearly indicate the names of those attending the sessions.

Medical Services and 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 Benefits 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. 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 chemotherapy treatment or have a medical condition, to the limits outlined in the Benefit Summary.
- Transcutaneous electric stimulators (TENS) machines, to the maximums specified in the Benefit Summary.
- 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), 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.
- 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.
- 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 12 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 residence in effect at the time of the treatment.

Out-of-Canada/province Referral Treatment

Eligible expenses incurred outside the province of residence of the insured person as a result of a referral include the following provisions:

1) This service or treatment must not be available in Canada or in the normal province of residence of the insured person;
2) The insured person must provide the insurer with a letter of referral from a physician in his normal province of residence, indicating that he is being referred to another physician;
3) The insurer must give prior written approval;
4) The provincial health and/or hospital insurance plans must pay a portion of the eligible expenses.

The maximum amount payable by the insurer under this provision is limited to the percentage specified in the *Benefits Summary.*

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.
- Charges incurred as a result of self-inflicted injury or while committing, or attempting to commit, a criminal offence.
- All fees charged by medical practitioners for the completion of medical forms or other documentation, or charges incurred for failing to keep a scheduled appointment or for the transfer of medical files.
- 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
    - 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 Benefits Summary
- 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.

Dental Care Benefit

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 Benefits Summary.

Benefits are based on the Dental Association fee guide for general practitioners, denturists or specialist indicated in the Benefits Summary.

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

Pre-determination of Benefits / Treatment Plan

Where a course of treatment is expected to cost $500 or more or will involve major dental services, 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.

Basic Services

Examinations

- Complete oral examination, according to the frequency specified in the *Benefits Summary*
- Recall oral examination, according to the frequency specified in the *Benefits Summary*
- Specific oral examination, according to the frequency specified in the *Benefits Summary*
- Emergency oral examination, according to the frequency specified in the *Benefits Summary*

Diagnostic services

- Radiographic examination and complete intra-oral film series, according to the frequency specified in the *Benefits Summary*
- Periapical films, according to the frequency specified in the *Benefits Summary*
- Occlusal films
- Posterior bitewing films, according to the frequency specified in the *Benefits Summary*
- Extra-oral films
- Panoramic films, according to the frequency specified in the *Benefits Summary*
- Cephalometric films
- Tracing and interpretation of radiographs from another source

Preventive services

- Polishing, according to the frequency specified in the *Benefits Summary*
- Fluoride treatment, according to the frequency specified in the *Benefits Summary*
- Oral hygiene instruction, according to the frequency specified in the *Benefits Summary*
- Interproximal discing of teeth
- Finishing restorations
- Pit and fissure sealants, according to the frequency specified in the *Benefits Summary*
- Space maintainers, according to the frequency specified in the *Benefits Summary*
- Prophylactic odontotomy/enameloplasty

Restorative services

- Non-bonded amalgam restorations for primary teeth, permanent anterior and bicuspid teeth, permanent molar teeth

- Caries/trauma/pain control
- Pin reinforcement
- Acrylic or composite restorations, according to the frequency specified in the *Benefits Summary*
- Prefabricated post and core
- Stainless steel/plastic full coverage restorations for primary teeth
- Preformed stainless steel and polycarbonate crowns, according to the frequency specified in the *Benefits Summary*

Endodontic services

- Pulpotomy
- Root canal therapy
- Apexification
- Periapical services (apicoectomy / apical curettage, retrofilling)
- Root amputation
- Surgery: endodontic exploratory
- Perforations/restorative defect, pulp chamber repair, root repair, non-surgical and surgical
- Isolation of endodontic tooth/teeth
- Hemisection
- Chemical bleaching of endodontically treated tooth/teeth
- Intentional removal, apical filling and re-implantation
- Emergency procedures
- Replantation (excluding root canal therapy and surgery)
- Re-positioning of traumatically displaced tooth/teeth

Periodontal services

- Periodontal scaling and root planing
- Gingivectomy
- Flap approach with osteoplasty/osteotomy
- Flap approach with curettage, according to the frequency specified in the *Benefits Summary*
- Distal wedge procedure
- Osseous grafts
- Soft tissue grafts (free connective tissue grafts)
- Vestibuloplasty (oral manifestations / oral mucosal disorders)
- Post-surgical treatment

Adjunctive periodontal services

- Provisional splinting – intra-coronal, extra-coronal per unit of time
- Occlusal equilibration, according to the frequency specified in the *Benefits Summary*
- Special periodontal appliances, including occlusal guards and bruxism appliances, according to the frequency specified in the *Benefits Summary*
- Maintenance, adjustments and repairs to periodontal appliances, according to the frequency specified in the *Benefits Summary*.

Surgical services

- Removal of erupted tooth (uncomplicated)
- Removal of each additional tooth in the same surgical site
- Removal of erupted tooth (complicated)
- Removal of impacted tooth
- Removal of residual roots
- Surgical exposure of tooth
- Surgical repositioning of tooth
- Alveoloplasty
- Gingivoplasty and/or stomatoplasty

- Excision, removal of bone
- Surgical excision (cysts and neoplasms)
- Surgical incision
- Frenectomy
- Miscellaneous surgical services

Anaesthesia
- In relation to covered procedures, according to the frequency specified in the *Benefits Summary*

Professional visits
- Periodontal services post-operative visits, according to the frequency specified in the *Benefits Summary*

Adjunctive general services
- Drugs (injections)

Repairs and rebasing
- Denture adjustments including minor adjustments, according to the frequency specified in the *Benefits Summary*
- Denture repairs and additions
- Denture re-basing and/or re-lining
- Denture, tissue conditioning
- Resetting of teeth

Major Services

Major restorative treatment
Prosthodontic services for the replacement of an existing fixed or removable prosthesis will be considered if one of the following circumstances occurs:

- Replacement is necessitated by the extraction of additional natural teeth
- The existing prosthesis cannot be made serviceable and is in accordance with the frequency specified in the *Benefits Summary*
- The existing prosthesis is temporary and is replaced with a permanent one within 12 months

Dental implants
Dental implants and related services are covered up to the maximum listed in the *Benefits Summary*.

Crowns, inlays and onlays
- Acrylic, processed
- Acrylic, processed to metal
- Acrylic or plastic, transitional, direct (chairside)
- Acrylic or plastic, transitional, indirect
- Porcelain
- Porcelain fused to metal base
- Cast metal post and core as a separate procedure
- Cast metal post and core concurrent with impression for crown
- Pre-formed stainless steel (permanent anterior tooth, permanent posterior tooth)
- Pre-formed plastic (permanent tooth)
- Metal inlay restorations, including temporization
- Metal inlay, three surfaces
- Onlay, per tooth
- Retentive pins in inlays and crowns
- Porcelain inlay/onlay, including temporization

Other restorative services

- Prefabricated metal post and core
- Pin reinforced amalgam post and core
- Pin reinforced composite post and core
- Crown made to an existing partial denture clasp (additional to crown)

Prosthodontic services, fixed

- Fixed prosthetic evaluation for cases of extensive or complicated restorative dentistry

Prosthodontic services, removable

- Complete dentures
- Partial dentures
- Denture remakes
- Immediate complete or partial dentures
- Transitional complete or partial dentures

Pontics

- Metal cast pontic
- Porcelain fused to metal pontic
- Porcelain pontic, aluminous
- Acrylic processed to metal pontic
- Acrylic pontic processed, transitional during healing
- Acrylic pontic transitional, acid etched to adjacent teeth
- Retainers, inlays and onlays
- Metal inlay
- Metal onlay
- Metal onlay, acid etch bonded

Retainers, crowns

- Acrylic crown, processed, indirect, transitional during healing
- Acrylic crown, direct, transitional during healing
- Acrylic processed to metal crown
- Porcelain crown, aluminous
- Porcelain fused to metal crown
- Metal three-quarter cast crown
- Metal full cast crown
- Retentive pins in abutments

Orthodontic Services

Orthodontic services must be for a treatment that has as its primary objective the correction of malocclusion of the teeth.

An orthodontic treatment plan must be submitted prior to initial claim. Orthodontic fees will be eligible for reimbursement on a monthly basis for the duration of the active treatment, as outlined in the orthodontic treatment plan, and not on the amount or date of the payment, even if treatment is prepaid. The maximum reimbursement for the initial orthodontic payment is 35% of the total cost of the orthodontic treatment.

- Services for diagnostic purposes
- Preventive orthodontic treatment
- Comprehensive orthodontic treatment
- Appliances to control harmful oral habits

Expenses Not Covered

- Services, treatments or supplies, eligible under this plan and payable under any government plan, including any no-fault motor vehicle insurance plan.
- Expenses incurred as a result of intentionally self-inflicted injuries.
- Charges resulting from committing or attempting to commit a criminal offence.
- Dental care, services or supplies that are primarily for cosmetic purposes.
- Expenses incurred for correction of temporomandibular joint dysfunction (TMJ).
- Conditions arising from war, (whether declared or not), participation in any civil commotion, insurrection or riot, or while serving in the armed forces.
- Any dental procedure not included in the list of eligible dental services.
- Charges for procedures in excess of those stated in the fee guide as stated in the *Benefits Summary*
- Services completed after termination of coverage.
- Personal Protective Equipment (PPE).
- All fees charged by medical practitioners for the completion of medical forms or other documentation, or charges incurred for failing to keep a scheduled appointment or for the transfer of medical files.
- Services or supplies purchased outside Canada except as provided under the out-of-country care provision.

How to Claim Benefits

Life Insurance Claim

In the event of a death, your beneficiary should immediately contact your employer who will provide the necessary information.

Claims for Life benefits must be made as soon as reasonably possible. Claim forms are available from your employer.

Accidental Death and Dismemberment (AD&D) Insurance Claim

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

For any loss other than death, the claim must be received by the carrier within one year after the loss.

If the claim is the result of a death, the claim should be made as soon as possible after the death occurred. Claim forms are available from your employer.

Long-Term Disability Insurance Claim

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

To make a claim, complete the Notice of Claim for Group Long-Term Disability Benefits which is available from your employer.

The carrier must receive notice of claim on the earlier of the following dates:

- 60 days after the total disability begins.
- within 30 days of the termination of this Long-Term Disability benefit.

Part of the application process will include filling out claim forms that give as many details about the claim as possible. You, the attending doctor and your employer will be required to complete the claim forms.
In order to receive benefits, the carrier must receive these forms no later than 90 days after the end of the elimination period.

The carrier will assess the claim and send you or your employer a letter outlining the decision.

From time to time the carrier may require that you provide proof of your total disability. If you do not provide this information within 90 days of this request, you will not be entitled to benefits.

Out-of-Province/Canada Group Travel 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;

Reimbursement Details Regarding Extended Health Care and Dental Care Claims

To be eligible for reimbursement, Coughlin & Associates Ltd. must receive proof of claim within 24 months of the date of purchase or service. You have 90 days following the termination of your coverage to submit claims for reimbursement.
Interest is not payable on any reimbursement under this plan. All expenses incurred and paid by the participants will be deemed to have been incurred and paid in Canadian dollars and reimbursement shall be in Canadian dollars.

Reimbursement

Reimbursement will 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:

a. 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
b. are in the opinion of the plan administrator reasonable and customary in the area in which they are rendered or supplied.

Reimbursement will 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.

Member Portal – Electronic Claims

Coughlin & Associates Ltd. offers employees and plan members the option to submit claims for prescription drugs, health and dental online. To access this service, please register at Coughlin's plan member portal members.coughlin.ca or download the mobile app from the App Store or Google Play. Once you are on the portal or have accessed the app:

- Click *Register Account*
- Follow the on-screen instructions and provide your group and certificate numbers, both of which can be found on your all-in-one benefits card.

Once registered, Click Submit a Claim to get started with online claiming.

Pre-Authorized Deposit (PAD)

Pre-authorized deposit is the fastest way for employees and plan members to receive claim reimbursements. Claim reimbursement deposits can be made into your bank account following the approval of your claim and eliminate both the wait for cheques to arrive by mail and the trip to the bank.
To enrol in the PAD program:

- Login to Coughlin's plan member portal
- Click on your profile and select *Direct Deposit.*

Point-of-Service Claims Submission

Claims may also be submitted direct via a point-of-service claims system at approved healthcare providers. Present your all-in-one benefit card to your provider, which will provide them with the following, required information:

Pharmacy :	**Dental:**
BIN/Carrier ID #34	BIN/Carrier ID #000034
Group Number # 59277	Group Number # 59277
Certificate number – printed on your card	Certificate number – printed on your card

Please note that health and dental claims must be submitted within the time limits specified by your benefit plan.

Submitting Paper Claims

To submit claims by paper/mail, please complete the appropriate claim form and send it, along with any applicable receipts, to Coughlin & Associates Ltd. at the mailing address found below. If your claim includes a coordination of benefits and Coughlin is the secondary payer, please include the original explanation of benefits from the primary insurer, along with photocopies of the original receipts.

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

Please note that all claim receipts will be retained by Coughlin & Associates Ltd.. It is therefore recommended that you retain photocopies of receipts for your records.

Dental Care Claims

Coughlin & Associates Ltd. offers electronic submission of dental claims via Electronic Data Interchange. This fast and secure method of claiming allows your claim to be sent directly from your dental office to our claims department for adjudication.

Our 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 & Associates Ltd. quickly, safely and confidentially right from your dentist's office.

To make use of EDI for dental claim submissions, please present your all-in-one benefit card to your dental provider. You may also contact Coughlin & Associates Ltd. to receive the necessary information.

Claims Appeals Process

In the event a claim is denied and the employee is not in agreement, an appeal may be submitted in writing by the employee 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 will be communicated in writing to the employee.

Contact Us

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

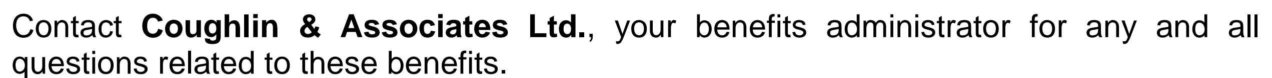
Business hours:
Monday to Friday: 8:30 a.m. to 4:30 p.m. EST

Street address:
466 Tremblay Road
Ottawa, ON K1G 3R1

APPENDIX A –
Basic Employee Life and Long Term Disability Insurance

Underwritten by **CANADA LIFE ASSURANCE COMPANY OF CANADA**

The benefit summary provides coverage highlights for these benefits.



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

My group benefit plan

canada life™

PUBLIC SERVICE ALLIANCE OF CANADA

We are pleased to offer you our services. As we adhere to principles of inclusion, all genders are incorporated in the language used in our communications with you.

BENEFIT DETAILS

Canada Life™ is a leading Canadian life and health insurer. Canada Life's financial security advisors work with our clients from coast to coast to help them secure their financial future. We provide a wide range of retirement savings and income plans; as well as life, disability and critical illness insurance for individuals and families. As a leading provider of employee benefits in Canada, we offer effective benefit solutions for large and small employee groups.

Canada Life Online

Visit our website at www.canadalife.com for:

- information and details on Canada Life's corporate profile and our products and services
- investor information
- news releases
- contact information
- online claims submission

Customer complaints

We are committed to addressing your concerns promptly, fairly and professionally. Here is how you may submit your complaint.

- Toll-free:
  - Phone: 1-866-292-7825
  - Fax: 1-855-317-9241
- Email: ombudsman@canadalife.com
- In writing:

The Canada Life Assurance Company
Ombudsman's Office T262
255 Dufferin Avenue
London, ON N6A 4K1

For additional information on how you may submit a complaint, please visit www.canadalife.com/complaints.

The information provided in the booklet is intended to summarize the provisions of Group Policy No. 134713. If there are variations between the information in the booklet and the provisions of the policy, the policy will prevail to the extent permitted by law.

This booklet contains important information and should be kept in a safe place known to you and your family.

The Plan is underwritten by

This booklet was prepared on: January 26, 2023

Access to Documents

You have the right, upon request, to obtain a copy of the policy, your application and any written statement or other records you have provided to Canada Life as evidence of insurability, subject to certain limitations.

Legal Actions

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), 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.

Appeals

You have the right to appeal a denial of all or part of the insurance or benefits described in the contract as long as you do so within one year of the initial denial of the insurance or a benefit. An appeal must be in writing and must include your reasons for believing the denial to be incorrect.

Benefit Limitation for Overpayment

If benefits are paid that were not payable under the policy, you are responsible for repayment within 30 days after Canada Life sends you a notice of the overpayment, or within a longer period if agreed to in writing by Canada Life. If you fail to fulfil this responsibility, no further benefits are payable under the policy until the overpayment is recovered. This does not limit Canada Life's right to use other legal means to recover the overpayment.

Quebec Time Limit for the Payment of Benefits

Where Quebec law applies, benefits will be paid in accordance with the terms of the plan within the following time period:

- for disability income benefits for which there is no waiting period, 30 days following receipt of the required proof of claim.
- for disability income benefits for which there is a waiting period, 30 days from the expiry of the waiting period provided the required proof of claim has been received.

Protecting Your Personal Information

At Canada Life, we recognize and respect the importance of privacy. Personal information about you is kept in a confidential file at the offices of Canada Life or the offices of an organization authorized by Canada Life. Canada Life may use service providers located within or outside Canada. We limit access to personal information in your file to Canada Life staff or persons authorized by Canada Life who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law. Your personal information may be subject to disclosure to those authorized under applicable law within or outside Canada.

We use the personal information to administer the group benefits plan under which you are covered. This includes many tasks, such as:

- determining your eligibility for coverage under the plan
- enrolling you for coverage
- investigating and assessing your claims and providing you with payment
- managing your claims
- verifying and auditing eligibility and claims
- creating and maintaining records concerning our relationship
- underwriting activities, such as determining the cost of the plan, and analyzing the design options of the plan
- Canada Life’s and its affiliates’ internal data management and analytics
- preparing regulatory reports, such as tax slips

We may exchange personal information with your health care providers, your plan administrator, any insurance or reinsurance companies, administrators of government benefits or other benefit programs, other organizations, or service providers working with us or the above when relevant and necessary to administer the plan.

As a plan member, you are responsible for the claims submitted. We may exchange personal information with you or a person acting on your behalf when relevant and necessary to confirm coverage and to manage the claims submitted.

You may request access or correction of the personal information in your file. A request for access or correction should be made in writing and may be sent to any of Canada Life's offices or to our head office.

For a copy of our Privacy Guidelines, or if you have questions about our personal information policies and practices (including with respect to service providers), write to Canada Life's Chief Compliance Officer or refer to www.canadalife.com.

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SCHEDULE OF BENEFITS

FOR

GROUP POLICY NO. 134713

EMPLOYEES

Basic Insurance

Active Employees	200% of annual earnings to a maximum of $500,000, reducing to 100% at age 65 and reducing to $1,000 at age 70 Any amount of Employee Life Insurance over $395,000 is subject to approval of evidence of insurability
Retirees Age 50 to 65	200% of pre-retirement annual earnings to a maximum of $500,000 Any amount of Employee Life Insurance over $395,000 is subject to approval of evidence of insurability
Long Term Disability Insurance (Not Applicable to Retirees)	75% of your monthly earnings up to a maximum of $10,000

CHANGES IN INSURANCE BENEFITS

If your insurance benefits change because of an amendment to the plan, or because of a change in your age, class, earnings, etc., the new benefits become effective on the date the change affecting your benefits occurred.

When a change results in increased benefits you must be actively at work to be eligible for the new benefits. If you are not at work on the date the new benefits would otherwise become effective, the change will not become effective until you return to work.

ELIGIBILITY

If you are a new employee, you will become eligible to join the group insurance plan except for Long Term Disability Insurance benefits after you complete 3 months of continuous employment. You will be eligible for Long Term Disability Insurance benefits after you complete 6 months of continuous service. You are considered continuously employed only if you satisfy the actively at work requirement throughout the eligibility waiting period.

- Participation in the plan is a condition of employment and you will be covered as soon as you become eligible.

- You must be actively at work for insurance to take effect. You are considered to be actively at work if you are not disabled and you are either at work or absent for vacation, weekends, statutory holidays, or shift differentials.

- Temporary and seasonal employees may not join the plan.

DEFINITION OF DEPENDENT

Dependent means:

- Your spouse (legal or common-law)
- Your insurable children

Children are insurable if they are

- your or your insured spouse's unmarried natural, adopted, or step child, or
- an unmarried child you or your insured spouse have been appointed guardian for all purposes by a court of competent jurisdiction.

Children under age 21 must not be working more than 30 hours a week, unless they are full-time students.

Children age 21 or over must either be:

(1) full-time students under age 25, or

(2) incapacitated for a continuous period beginning before age 21 **or** while a full-time student and before age 25.

Unmarried children of your spouse are considered dependents only if

- they are also your children, or
- your spouse is living with you and has custody of the children.

Children for whom you or your insured spouse have been appointed guardian are not insurable unless:

(1) Canada Life has received satisfactory proof of guardianship, and

(2) if your insured spouse is the guardian, your spouse is living with you.

Children are considered full-time students if they have been in registered attendance at an elementary school, high school, university, or similar educational institution for 15 hours a week or more sometime in the last 6 months. Children are **not** considered full-time students if they are being paid to attend an educational institution.

Children are considered incapacitated if they are incapable of supporting themselves due to a physical or mental disorder.

BENEFICIARY DESIGNATION

You may make, alter, or revoke a designation of beneficiary as permitted by law. Any designation of beneficiary you made under your employer's previous policy prior to the effective date of this policy applies to this policy until you make a change to that designation. You should review your beneficiary designation from time to time to ensure that it reflects your current intentions. You may change the designation by completing a form available from your employer.

LIFE INSURANCE FOR EMPLOYEES

- If you die, your named beneficiary will be paid the amount of your group life insurance. If you have not named a beneficiary or there is no surviving beneficiary at the time of your death, payment will be made to your estate. Your employer will explain the claim requirements to your beneficiary. (See the **Schedule of Benefits** at the front of this booklet for the amount.)

- If you become disabled while insured and before reaching age 65, and your disability continues without interruption for at least six months, your life insurance will remain in force without further premium payment. After you have been totally disabled for six months, you should submit the appropriate claim forms to Canada Life. Your premiums will be waived upon satisfactory proof of your disability but only until you reach age 65. Proof of continued disability may be required each year.

  If you are not approved for waiver of premium your life insurance will be continued on a premium paying basis until the earlier of the following:

  (1) the date your insurance is terminated by your employer, or

  (2) the date your insurance would normally terminate under the Termination of Insurance section.

- If any or all of your insurance terminates **at or before age 65,** you may be able to apply for an individual conversion policy.

  Application for an individual conversion policy must be made within 31 days after termination of insurance. During this period your life insurance under this plan will remain in force free of charge.

  See your employer for complete details about the types of conversion policies available.

LONG TERM DISABILITY INSURANCE
(Not Applicable to Retirees)

Long Term Disability insurance provides you with regular income to replace salary or wages lost because of a lengthy disability due to disease or injury. Because your employer pays all or a portion of the cost of this LTD insurance, the monthly benefit is **taxable** for income tax purposes.

Benefits Entitlement

You are entitled to benefits after you have been continuously disabled for 90 days.

If disability is not continuous, the days you are disabled can be accumulated to satisfy the waiting period as long as no interruption is longer than 2 weeks and the disabilities arise from the same disease or injury.

If your employer provides short term disability or sick leave benefits that are still being paid when the waiting period ends, the waiting period will be extended to the date the short term disability or sick leave benefits end, but not longer than one year after your disability starts.

After the waiting period, successive disabilities are considered to be in the same disability period if they arise from the same disease or injury and the later disability starts:

- within 6 months after the previous disability ends; or
- within 24 months after the end of an approved comprehensive rehabilitation program. Rehabilitation plans are not considered under this 24-month provision.

LTD benefits are payable for the first 24 months following the waiting period if injury or disease prevents you from doing your own job. You are **not** considered disabled if you can perform a combination of duties that regularly take at least 60% of your time at work to complete. Only the duties you regularly performed for the employer before disability started are considered.

After 24 months, LTD benefits continue to be payable only if disease or injury prevents you from being gainfully employed in any job. Gainful employment is work you are medically able to perform, for which you have at least the minimum qualifications, and which provides you with an income of at least 60% of your pre-disability monthly earnings, indexed for inflation. The employment must exist either in the province or territory where you worked when you became disabled or where you now live. Whether or not employment is actually available is not considered in assessing your disability.

You are entitled to LTD benefits as long as your disability continues but only until you reach age 65.

Amount Payable

Your monthly LTD benefit before reduction by other income is 75% of your pre-disability monthly earnings up to a maximum benefit of $10,000 per month.

Your monthly LTD benefit is reduced by other income you are entitled to during disability.

- Your LTD benefit is first reduced by:
    - disability or retirement benefits you are entitled to on your own behalf under the Canada or Quebec Pension Plan.
    - benefits under any Workers' Compensation Act or similar law.
- Your LTD benefit is then reduced if it together with the other income listed below exceeds 80% of your pre-disability monthly earnings. This percentage is called the coordination level. In this case, your LTD benefit is reduced by the amount in excess of the coordination level. Under this provision, other income includes:
    - benefits another member of your family is entitled to on the basis of your disability under the Canada or Quebec Pension Plan.

- loss of income benefits available through legislation which you and any other members of your family are entitled to on the basis of your disability. Automobile insurance benefits are included where permitted by law.

- disability benefits under a plan of insurance available as a result of your membership in an association of any kind.

- employment income, disability benefits, or retirement benefits related to any employment, except for income from an approved rehabilitation plan or program. Rehabilitative employment income is considered only under the rehabilitation incentive.

Rehabilitation Incentive

Earnings received from an approved rehabilitation plan or program are not used to reduce your monthly LTD benefit unless those earnings, together with your income from this plan and the income used to reduce your LTD benefit under the amount payable section, would exceed 100% of your pre-disability monthly earnings. If they do, your LTD benefit is reduced by the amount in excess of 100%.

Inflation Protection

The amount payable under this plan is recalculated annually for inflation protection. At that time the coordination level under the amount payable section and the income limit under the rehabilitation incentive are adjusted to reflect increases in the Consumer Price Index.

Cost-of-living increases in Canada and Quebec Pension plan benefits that take effect after you qualify for benefits are only included as "other income" under the amount payable section when your LTD benefit payment is recalculated for inflation. At that time they are included as income to which the coordination level applies.

Rehabilitation Benefits

The rehabilitation benefit is designed to help you, as a disabled individual, return to gainful employment and therefore a more productive lifestyle.

Rehabilitation involves a training strategy or work-related activity that:

- can be expected to facilitate your return to your own or another job; and
- is recommended or approved by Canada Life.

In considering whether or not a rehabilitation proposal is appropriate, Canada Life assesses such factors as the expected duration of disability, and the level of activity required to facilitate the earliest possible return to employment.

Canada Life recognizes your needs by making a distinction between a comprehensive rehabilitation program and a rehabilitation plan.

To be classified as a comprehensive rehabilitation program, the goal must be to return to work:

- in a different job that requires extensive or prolonged training; or
- in a self-employed capacity.

Training is considered extensive or prolonged if it lasts longer than 12 consecutive months.

To be classified as a rehabilitation plan, the goal must be to return to work:

- in the same job;
- in a modified job with the same employer; or
- in a different job that capitalizes on transferable skills.

If you do not participate or cooperate in a rehabilitation plan or program that has been recommended or approved by Canada Life, you will no longer be entitled to benefits.

When Canada Life recommends or approves a rehabilitation plan or program, careful consideration is given to its duration. The duration must be approved by Canada Life. Once approved, your qualification for benefits is guaranteed for that period as long as you continue to participate and cooperate in the plan or program.

If you are participating in a comprehensive rehabilitation program that involves employment, your qualification for benefits is guaranteed until at least the end of the 24-month "own job" period described under the benefits entitlement section.

If you are participating in a comprehensive rehabilitation program that involves training rather than employment, the benefit period will be extended up to 6 months after training ends. This extension is provided for purposes of job search.

Employment income earned during this extension will be considered under the rehabilitation incentive.

To further help you return to gainful employment, Canada Life will pay for expenses, other than usual employment expenses, associated with a rehabilitation plan or program. The maximum expense benefit during a disability period is 3 times your monthly LTD benefit. Expenses claimed under this benefit must be pre-authorized by Canada Life.

If your insurance terminates at the end of a rehabilitation plan or program that requires you to change employers, you may convert your group coverage to an individual disability income policy without proof of insurability. If you are interested in obtaining an individual policy, ask your employer for further details.

Benefit Limitations

No benefits will be paid for:

- disability periods that begin before your insurance starts or after it ends.
- disability arising from a disease or injury for which you received medical care before your insurance started. This limitation does not apply if your disability starts after:
    - you have been continuously insured for 1 year; or
    - you have not had medical care for the disease or injury for a continuous period of 90 days ending on or after the date your insurance took effect.
- any period of disability after you fail to participate or cooperate in a rehabilitation plan or program that has been recommended or approved by Canada Life.
- any period in which you do not participate or cooperate in a reasonable and customary treatment program for your disability.

  Depending on the severity of the condition, the plan may require you to be under the care of a specialist.

  If substance abuse contributes to your disability, your treatment program must include participation in a recognized substance abuse withdrawal program.

- the scheduled duration of any lay-off or leave of absence. A leave of absence is considered to start on the date agreed upon by you and your employer.

  This does not apply to any portion of a period of maternity leave during which you are disabled due to pregnancy. If a child is born before a period of maternity leave is scheduled to start, the leave is considered to start on the date of birth.

- any 12-month period in which you do not live in Canada for at least 6 of those months.

- a period of confinement in a prison or similar institution.

- disability arising from war, insurrection, or voluntary participation in a riot.

Conversion Privilege

If you change jobs, you may apply for an individual LTD policy (one of the standard conversion policies offered by Canada Life) without proof of your insurability. You must apply during the 31 days after you start your new job and you must start your new job during the 6 months after you leave your present one.

You may also convert to an individual LTD policy without proof of insurability if your insurance under the group plan terminates because you cease to be in an eligible class, as long as that class remains insured. In this case, you must apply during the 31 days after your insurance terminates.

In either case, the group policy must be in force at the time you apply for conversion and your application must be acceptable to Canada Life according to its underwriting rules for individual disability insurance (other than medical evidence rules). If your application is acceptable, the individual LTD policy will take effect on the date Canada Life approves your application as long as the first premium has been paid.

CONTACT – EMPLOYEE ASSISTANCE PROGRAM
(Not Applicable to Retirees)

The Contact employee assistance program provides you and your dependents with access to confidential counselling and information services. Sessions can be conducted in-person, over the telephone or via the internet, for issues that include the following:

- marital/relationship
- family (including child care/elder care concerns)
- personal and emotional
- alcohol/drug misuse and/or abuse
- violence
- single parenting
- bereavement
- work and career
- stress
- smoking cessation

Other services the Contact employee assistance program provides include the following:

- information on child care and elder care issues
- legal assessment and general information on certain legal issues
- information on certain financial issues
- nutrition information on common nutritional questions and concerns
- health coaching

The services provided under the Contact employee assistance program are available by dialling the toll-free number shown below. This toll-free number is staffed 24 hours a day, 7 days a week by intake counsellors who can provide immediate support and counselling, respond to crisis or emergency situations, or schedule appointments.

For service in English or French:	1-866-289-6749
TTY:	1-877-338-0275

For more information on the services available under the Contact employee assistance program, please see the employee assistance program brochure provided by your plan administrator or visit the employee assistance program: login.lifeworks.com.

TERMINATION OF INSURANCE

Your insurance will terminate:

- when your employment ends, or
- when the group policy terminates, or
- for LTD, you reach age 65, or
- for Life, you reach age 75 if you are an active employee, or age 65 if you are a retiree, or
- you are no longer in an eligible class.

If your employment ends because of injury, sickness, leave of absence or temporary lay-off, you may be entitled to continued insurance under this plan. Your employer will provide you with the details on the types of insurance, if any, that may be continued and the length of the extensions available.

CONTINUATION OF CONTACT BENEFITS FOR DEPENDENTS

If you die, the Contact benefits for your dependents will be continued for a period of 1 year.

- If your surviving children cease to qualify as eligible dependents (as defined earlier in this booklet), the Contact benefits being continued after your death will terminate on the date they no longer qualify.

- If a dependent is disabled on the date insurance under this continuation terminates, insurance payments for that dependent will be continued until the earlier of the following:

  - the date the disability ends,

HOW TO MAKE YOUR CLAIMS

Life Insurance

- If you die, your employer will contact your beneficiary to explain what is required before payment of the insurance money can be made.

- For disability waiver of premium benefits, contact your employer for claim forms and procedures.

Long Term Disability Insurance

- To submit claims online, go to www.canadalife.com.

- To submit paper claims, obtain an Employee Claim Submission Guide (form M4307B) and follow the guide's instructions.

  You can get this form from your employer, or online from the Canada Life corporate website. To access the form online, go to www.canadalife.com.

Please ensure that your claim is submitted to Canada Life as soon as possible, but no later than 6 months after the end of the waiting period.

From time to time other forms will be sent to you for completion. Fill them in and return them promptly to your employer or the benefit payments office.

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APPENDIX B – Accidental Death & Dismemberment Insurance

Underwritten by **CHUBB LIFE INSURANCE**

The benefit summary provides coverage highlights for these benefits.

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

CHUBB

Basic Accidental Death & Dismemberment Insurance

For the full-time employees of:
Public Service Alliance of Canada

Policy Number:
AB10069601

Underwritten by:
Chubb Life Insurance Company of Canada

Effective Date:
10/01/16

This brochure has been prepared in connection with a group plan underwritten by Chubb Life Insurance Company of Canada (“Chubb Life”). For ease of reference it contains a brief description only and does not mention every provision of the contract issued. Please remember that rights and obligations are determined in accordance with the contract and not this brochure. For the exact provisions applicable, please consult your Employer.

COVERAGE

The plan offers you full 24-hour protection against accidents, on or off the job, on business, on vacation, at home.

ELIGIBILITY

All active, full-time employees of the policyholder, working a minimum of 17 ½ hours per week, under age 75.

BENEFIT AMOUNT

You are covered for a Principal Sum that is equal to two times your annual earnings* rounded to the next $1,000 (if not already a multiple thereof) to a maximum of $500,000.

*The term “annual earnings” as used herein shall mean an Insured Person’s basic annual salary excluding overtime, bonus, or commission.

Benefit terminates at age 75 or earlier retirement.

In the event of your death, the benefit amount is payable to the beneficiary you have named under your Group Life Insurance Plan or in the absence of such designation, to your Estate.

SCHEDULE OF LOSS

Accidental Death & Dismemberment

If such injuries shall result in any one of the following specific losses within one year from the date of the accident, Chubb Life will pay the percentage of the benefit amount, based on the amount stated under the Benefit Amount section, however, that not more than one (the largest) of such benefits shall be paid with respect to injuries resulting from one accident.

	Percentage of Benefit Amount
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 Entire Sight of One Eye	100%
Loss of One Foot and Entire Sight of One Eye	100%
Loss of Speech and Hearing in Both Ears	100%
Brain Death	100%
Loss of Use of Both Arms, Both Hands, Both Legs or Both Feet	200%
Quadriplegia	200%
Paraplegia	200%
Hemiplegia	200%
Loss of One Arm or One Leg	75%

Loss of Use of One Arm or One Leg	75%
Loss of One Hand or One Foot	66 2/3%
Loss of Entire Sight of One Eye	66 2/3%
Loss of Use of One Hand or One Foot	66 2/3%
Loss of Speech or Hearing in Both Ears	66 2/3%
Loss of Thumb and Index Finger of Same Hand	33 1/3%
Loss of Four Fingers of Same Hand	33 1/3%
Loss of Hearing in One Ear	25%
Loss of All Toes of Same Foot	12 1/2%

"Loss" shall mean with respect to hand or foot, the actual severance through or above the wrist or ankle joint; with respect to arm or leg, the actual severance through or above the elbow or knee joint; with respect to eye, the total and irrecoverable loss of sight; with respect to speech, the total and irrecoverable loss of speech which does not allow audible communication in any degree; with respect to hearing, the total and irrecoverable loss of hearing which cannot be corrected by any hearing aid or device; with respect to thumb and index finger, the actual severance through or above the first phalange; with respect to fingers, the actual severance through or above the first phalange of all four fingers of the same hand; with regard to toes, the actual severance of both phalanges of all toes of the same foot. If an Insured Person suffers complete severance of a hand, foot, arm or leg as described above, then Chubb Life will pay the amount specified in the Schedule of Losses even if the severed limb is surgically reattached, whether successful or not.

"Loss" as used with reference to quadriplegia (paralysis of both upper and lower limbs), paraplegia (paralysis of both lower limbs), and hemiplegia (total paralysis of upper and lower limbs of one side of the body), means the complete and irrecoverable paralysis of such limbs.

"Loss of Use" shall mean the total and irrecoverable loss of function of an arm, hand, foot or leg such loss of function is continuous for 12 consecutive months and such loss of function is thereafter determined on evidence satisfactory to Chubb Life to be permanent.

"Brain Death" means irreversible unconsciousness with total loss of brain function; and complete absence of electrical activity of the brain, even though the heart is still beating.

Repatriation Benefit

When injuries covered by this plan result in a loss of life outside 150 km from your city of permanent residence or outside Canada and the loss of life occurs within 365 days from the date of the accident, Chubb Life will pay the actual expense incurred for preparing the deceased for burial and shipment of the body to the city of residence of the deceased, but not to exceed $15,000.

Rehabilitation Benefit

When injuries result in a payment being made by Chubb Life under any benefit excluding the Loss of Life Benefit, Chubb Life will also pay the reasonable and necessary expenses actually incurred up to a limit of $15,000 for special training provided:

a. such training is required because of such injuries and in order for you to become qualified to engage in an occupation in which you would not have been engaged except for such injuries;
b. expenses are to be incurred within two years from the date of the accident;
c. no payment will be made for ordinary living, travelling, or clothing expenses.

Family Transportation Benefit

When injuries result in your confinement as an in-patient in a hospital outside 150 km from your city of permanent residence or outside Canada and requires personal attendance of a member of your immediate family as recommended by the attending physician, in writing, Chubb Life will pay for the expense incurred by your family member, for the transportation by the most direct route by a licensed common carrier to you, while confined, but not to exceed an amount of $15,000.

"Member of your immediate family" means your spouse, (legal or common-law), parents, grandparents, children over age 18, brother, or sister.

Spousal Occupational Training Benefit

When injuries to you result in a payment being made by Chubb Life under the Loss of Life Benefit, Chubb Life will pay in addition, the expenses actually incurred, within 365 days from the date of the accident, by your spouse for a formal occupation training program for the purpose of specifically qualifying your spouse to gain active employment in an occupation for which your spouse would otherwise not have sufficient qualifications. The maximum payable hereunder is $15,000.

Home Alteration and Vehicle Modification Benefit

In the event you sustain an injury which results in a payment being made under the Schedule of Losses, excluding the Loss of Life Benefit, and such injury subsequently requires the use of a wheelchair to be ambulatory, Chubb Life will pay the reasonable and necessary expenses actually incurred within 365 days from the date of the accident for:

1. the one-time cost of alterations to your principal residence to make it wheelchair accessible and habitable; and
2. the one-time cost of modifications necessary to a motor vehicle utilized by you to make the vehicle accessible or operable for you.

Benefit payments herein will not be paid unless:

i. home alterations are made by a person or persons experienced in such alterations and recommended by a recognized organization, providing support and assistance to wheelchair users; and
ii. vehicle modifications are carried out by a person or persons with experience in such matters and modifications are approved by the Provincial vehicle licensing authorities.

The maximum amount payable under both items 1 and 2 shall be the greater of $10,000 or 10% of your benefit amount to a maximum of $50,000.

Day Care Benefit

If you suffer a loss of life in a covered accident while the policy is in force, Chubb Life will pay, in addition to all other benefits payable under the policy a “Day Care Benefit” equal to the reasonable and necessary expenses actually incurred, subject to the lesser of 5% of your benefit amount or a maximum of $5,000 per year, on behalf of your dependent child who is enrolled in a legally licensed day care centre on the date of the accident or who enrolls in a legally licensed day care centre within 365 days following the date of the accident. The “Day Care Benefit” will be paid each year for four consecutive years, but only upon receipt of satisfactory proof that your child is enrolled in a legally licensed day care centre.

“Dependent Child” means either a legitimate or illegitimate child, adopted child, step-child or any child who is in a parent-child relationship with you and who is 12 years of age and under and dependent upon you for maintenance and support.

Special Education Benefit

If you suffer a loss of life in a covered accident while the policy is in force, Chubb Life will pay, in addition to all other benefits payable under this policy, a "Special Education Benefit" up to 5% of your benefit amount, subject to a maximum of $5,000 per year, on behalf of any dependent child who, on the date of the accident, is enrolled as a full-time student in any post-secondary institution beyond the 12th grade level, or was at the 12th grade level and subsequently enrolls as a full-time student in an institution of higher learning within 365 days following the date of the accident.

The "Special Education Benefit" is payable annually for a maximum of four consecutive annual payments but only if the dependent child continues his/her education as a full-time student in an institution of higher learning.

Bereavement Benefit

When injuries covered by this policy result in loss of life within 365 days from the date of the accident, Chubb Life will pay the reasonable and necessary expenses actually incurred by the spouse and dependent children of the Insured Person for up to six sessions of grief counseling, by a Professional Counsellor, subject to a maximum of $1,000.

"Professional Counsellor" means a therapist or counsellor who is licensed, registered or certified to provide such treatment.

In-Hospital Confinement Monthly Income

In the event you sustain an injury which results in a payment being made under the Schedule of Losses excluding the Loss of Life Benefit and you are hospital confined as an in-patient and are under the care of a legally qualified and registered physician or surgeon other than himself, Chubb Life will pay for each full month, one percent (1%) of your Benefit amount, subject to a maximum benefit of $2,500, or one-thirtieth of such monthly benefit for each day of partial month, retroactive to the 1st full day of such confinement but not to exceed 365 days in the aggregate for each period of hospital confinement.

"Hospital" as used herein means a legally constituted establishment which meets all of the following requirements: (1) operates primarily for the reception, care and treatment of sick, ailing or injured persons as in-patients; (2) provides 24 hour a day nursing service by registered or graduate nurses; (3) has a staff of one or more licensed physicians available at all times; (4) provides organized facilities for diagnosis and surgical facilities; and (5) is not primarily a clinic, nursing home or convalescent home or similar establishment nor, other than incidentally, a place for alcoholics or drug addicts.
"In-Patient" means a person admitted to a hospital as a resident or bed-patient and who is provided at least one day's room and board by the hospital.

Cosmetic Disfigurement Benefit

If, you suffer a third degree burn in a non-occupational accident, Chubb Life will pay a percentage of the Benefit amount depending on the area of the body which was burned according to the following table:

Body Part	(A) Area Classification	(B) Maximum allowable % for Area Burned	(C) Maximum % of Benefit Amount Payable
Face, Neck, Head	11	9%	99%
Hand & Forearm	5	4.5%	22.5%
Either Upper Arm	3	4.5%	13.5%
Torso (Front or Back)	2	18%	36%
Either Thigh	1	9%	9%
Either Lower Leg (below knee)	3	9%	27%

The maximum percent of Benefit amount Payable (C) is determined by multiplying the Area Classification (A) by the Maximum Allowable percent for Area Burned (B). In the event of a 50% surface burn, the Maximum Allowable percent for Area Burned (B) is reduced by 50%. This table only represents the maximum percent of the Benefit amount payable for any one accident. If the Insured suffers burns in more than one area as a result of any one accident, benefits will not exceed a maximum of $25,000.

Continuance of Coverage

In the case of a Primary Insured who is (1) laid-off on a temporary basis, (2) temporarily absent from work due to short-term disability, or (3) on leave of absence, coverage shall be extended for a period of 12 months following the beginning of any such event subject to payment of premiums.

In the case of a Primary Insured who is on maternity or parental leave coverage shall be extended for a period of up to 18 months following the beginning of any such event subject to payment of premiums.

If an Insured assumes other occupational duties during the leave or lay-off period, no benefits shall be payable for a loss occurring during the performance of such other occupation.

Seat Belt Benefit

In the event you sustain an injury which results in a payment being made under the Schedule of Losses, your Benefit amount will be increased by 10% to a maximum of $25,000 if, at the time of the accident, you were driving or riding in a vehicle and wearing a properly fastened seat belt. Due proof of seat belt use must be provided as part of the written proof of loss.

"Vehicle" means a private passenger car, station wagon, van, or jeep-type automobile. **"Seat Belt"** means those belts that form a restraint system.

Identification Benefit

In the event accidental Loss of Life is sustained by you not less than 150 km from your normal place of residence and identification of the body by a member of the immediate family has been requested by the police or a similar governmental authority, Chubb Life will reimburse the reasonable expenses actually incurred by such member for:

a. transportation by the most direct route to the city or town where the body is located; and
b. hotel accommodation in such city or town, subject to a maximum duration of three days.

The reimbursement of such expenses incurred is subject to the accidental loss of life indemnity being subsequently payable in accordance with the terms of this policy following the identification of the body as the Insured Person. The maximum amount payable will not exceed $15,000 for all such expenses.

Payment will not be made for board or other ordinary living, travelling or clothing expenses, and transportation must occur in a vehicle or device operated under a license for the conveyance of passengers for hire.

Exposure and Disappearance

Loss resulting from unavoidable exposure to the elements shall be covered to the extent of the benefits afforded you. If your body has not been found within one year of disappearance, stranding, sinking or wrecking of the conveyance in which you were riding at the time of the accident, it shall be presumed, subject to all other conditions of this policy, that you suffered a loss of life resulting from bodily injuries sustained in an accident covered under this policy.

CONVERSION PRIVILEGE

On the date of termination of employment or during the 31-day period following termination of employment, you may convert your insurance to an individual ACCIDENTAL DEATH AND DISMEMBERMENT only insurance policy of Chubb Life. The individual policy will be effective either as of the date that the

application is received by Chubb Life or on the date that coverage under the group policy ceases, whichever occurs later. The premium will be the same, as a person would ordinarily pay when applying for an individual policy at that time the amount of insurance benefit converted will not exceed that amount of issued during employment, up to a combined policy maximum of $200,000. The individual policy will cover ACCIDENTAL DEATH and DISMEMBERMENT only.

WAIVER OF PREMIUM

If you are under age 65 and become totally disabled* while you are insured under this plan and satisfactory evidence of your total disability is provided to Chubb Life on an annual basis, payment of premium will be waived until the earlier of the following occurs:

a. you return to active employment with your employer;
b. you attain age 65;
c. the master policy underwritten by Chubb Life is terminated.

Once you return to active employment with your employer, your coverage will continue only upon the commencement of premium payments.

*You will be considered totally disabled if you are unable to engage in any business or occupation and perform in any work for compensation or profit and your disability has existed continuously for a period of at least 12 months or is in accordance with the waiver of premium requirements under the Policyholder's Group Life Insurance Policy.

EXCLUSIONS

The plan does not cover any loss, which is the result of:

a. Intentionally self-inflicted injury, suicide or any attempt thereat;
b. Declared or undeclared war, or any act of war, terrorism, riot or insurrection, or service in the armed forces of any country, government or international organization;
c. Travel or flying in an aircraft owned or leased by the Policyholder, an Insured or a member of an Insured's household, or aircraft being used for any test or experimental purpose, firefighting, power line inspection, pipeline inspection, aerial photography or exploration;
d. Losses occurring while the Insured is serving on full-time active duty in the Armed Forces of any country or international authority (any premium paid to be returned by the Company pro-rata for any such period of full-time active duty.
e. Travel or flight in any vehicle or device for aerial navigation;
f. This insurance does not apply to the extent that trade or economic sanctions or other laws or regulations prohibit us from providing insurance, including, but not limited to, the payment of claims. All other terms and conditions of the policy remain unchanged.

GENERAL PROVISIONS

Beneficiary

An employee or any spouse has the right to name a beneficiary when he applies for insurance.

It is understood that the beneficiary designation made under the Policyholder's Group Life Insurance Policy shall be recognized as the beneficiary under the policy, unless a further designation has been made that specifically identifies the policy. Failing such designation, all benefits will be paid to the estate of the insured person.

All other indemnities of the policy will be payable to the insured person.

An insured person can change his beneficiary at any time, where permitted by law. The Company assumes no responsibility for the validity of such designation or change of beneficiary.

The beneficiary designation made by the insured person (if any) under the replaced policy has been retained. The insured person should review the existing designation to ensure it reflects his/her current intention.
The policy contains a provision removing or restricting the right of the insured person to designate persons to whom or for whose benefit insurance money is to be payable.

Legal Actions

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, Limitations Act, 2002 or other applicable legislation in the Insured's province of residence.

Change of Insurer

An insured person under a former policy may not be excluded from the new policy or be denied benefits solely because of a pre-existing condition limitation that was not applicable or that did not exist in the former policy, or because the person is not at work on the date of coming into force of the new policy.

The insured person and any claimant under the policy has the right, as determined by law applicable in the insured person's province of residence, to obtain a copy of his/her application, any written evidence of insurability (as applicable) and the Policy, on request, subject to certain access limitations.

HOW TO CLAIM

In the event of a claim, claim forms can be obtained from the Plan Administrator.

Notice of claim must be given to Chubb Life 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 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 reasonably 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 accept notice of claim beyond one year.

02/22

CHUBB

Chubb Life is part of the Chubb group of insurance companies, with operations in 54 countries, Chubb provides commercial and personal property and casualty insurance, personal accident and supplemental health insurance, reinsurance and life insurance to a diverse group of clients.

Chubb Limited, the parent company of Chubb Life, is listed on the New York Stock Exchange (NYSE: CB) and is a component of the S&P 500 index.

APPENDIX C –
Out-of-Province/Canada Travel Medical Emergency Insurance

Underwritten by **AIG INSURANCE COMPANY OF CANADA**

The benefit summary provides coverage highlights for these benefits.

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

Provided by
Global Excel Management Inc.

PUBLIC SERVICE ALLIANCE OF CANADA (PSAC) AND CANADIAN UNION OF LABOUR EMPLOYEES (CULE)

INSURANCE IDENTIFICATION **CMG 9429163**

In the event of a medical emergency, you must contact Global Excel immediately:

From Canada and the U.S. call:	**1-877-207-5018**
or collect from anywhere else call:	**1-819-566-3940**

WORLDWIDE COVERAGE

For all in benefit Members of

Public Service Alliance of Canada (PSAC)
and Canadian Union of Labour Employees (CULE)

POLICY NUMBER
CMG 9429163

November 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 Insured Members and Retirees under the Public Service Alliance of Canada (PSAC) and Canadian Union of Labour Employees (CULE) 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 active Employees over age 70 and under age 85.
Class III: All eligible retired Employees under age 75.

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 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 to 74 - $2,000,000.00 lifetime maximum
Age 75 and over - $1,000,000.00 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 9429163.

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 9429163
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.

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 9429163

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.